MY2026 Star hospital measures – Quick reference guide

Measure	Criteria	Required exclusions	Tips to increase measure compliance
Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)	The percentage of emergency department (ED) visits between **Jan. 1 – Dec. 24, 2026**, for Medicare patients 18 years of age and older with multiple high-risk chronic conditions diagnosed before the ED visit who had a follow-up service on or within 7 days of the ED visit (8 days total).	• Patients receiving hospice any time during 2026 • Patients who died any time during 2026	Having strategies and a source of admission and discharge alerts/notifications in place will help providers meet the tight timeframe of this measure. • Have some flexibility in schedules to accommodate follow-up visits • Utilize telehealth visits when appropriate. There is no provider or specific visit type other than outpatient required for follow-up.
Transitions of Care (TRC)	The percentage of acute or nonacute inpatient discharges between **Jan. 1 – Dec. 1, 2026**, for Medicare patients 18 years of age and older who had the four following components completed within the specified timeframes. • Notification of inpatient admission. Documentation of receipt of notification of inpatient admission and evidence that it was filed and available in the outpatient record on the day of admission through 2 days after the admission (3 total days). • Receipt of discharge information. Documentation of receipt of discharge information (6 required elements) and evidence that it was filed and available in the outpatient record on the day of discharge through 2 days after the discharge (3 total days). • Patient engagement after inpatient discharge. Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge. Not on the day of discharge. • Medication reconciliation post-discharge. Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).	• Patients receiving hospice any time during 2026 • Patients who died any time during 2026	Having strategies and a source of admission and discharge alerts/notifications in place will help providers meet the tight timeframes of this measure. • Review documentation requirements and ensure required documentation is complete • Have some flexibility in schedules to accommodate follow up visits • Contact patients within 3-4 days of discharge to schedule follow-up visits asap, allowing for rescheduling if needed • Consider having strategic plans in place that include nurse contacts with the patient within the 30-day discharge time frame; ensuring patient needs are met and avoiding setbacks that could lead to readmission • Utilize telehealth visits when appropriate
Plan All-Cause Readmissions (PCR)	For Medicare patients 18 years of age and older from **Jan. 1 – Dec. 1, 2026**, 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).	• Patients receiving hospice any time during 2026	The goal of this measure is to prevent patients from having a readmission. • Having excellent transitional care management strategies will be essential for this measure • Continual comorbid coding will also assist in risk scoring for this measure, as patients with a higher expected readmit rate will have a lesser impact on PCR scores

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