



AAVBC

AMERICAN ACADEMY OF VALUE BASED CARE

Annual Flu Vaccine Quick Reference Guide

2026

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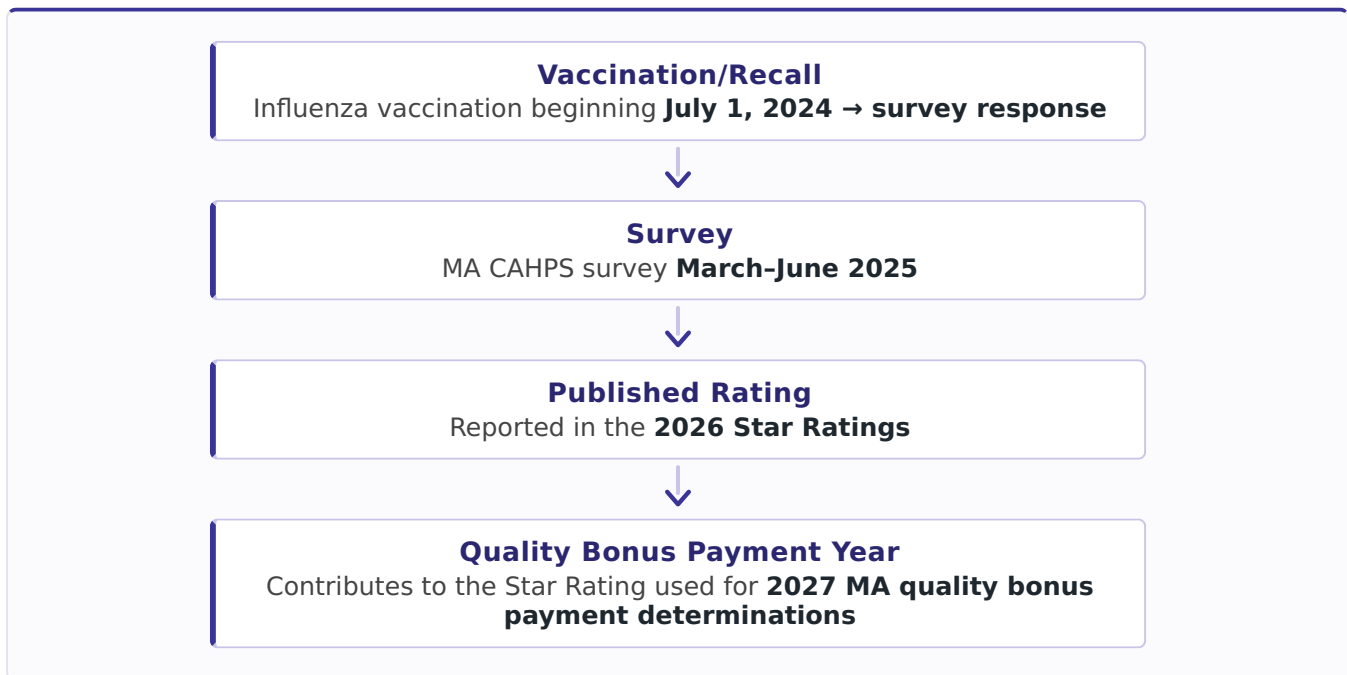
1 MEASURE SNAPSHOT

CMS Definition: Percentage of sampled Medicare Advantage enrollees who report receiving an influenza vaccination since July 1 of the prior year. For the 2026 Star Ratings, the MA CAHPS survey asked, **“Have you had a flu shot since July 1, 2024?”** Measure performance is based on survey responses, not claims or medical-record documentation.^{1,2}

FIELD	
CMS measure name	Annual Flu Vaccine, FLU
Medicare plan finder name	"Yearly Flu Vaccine"
Domain	Staying Healthy: Screenings, Tests and Vaccines
CMS weighting category	Process Measure
Weight	1 — standard-weighted
Primary data source	MA CAHPS survey — patient-reported
Unit of measurement	CMS contract-level measure — Individual clinicians and practices do not receive a C03 Star Rating
Trend direction	↑ Higher is better
Case-mix adjusted	No
Measurement period	March–June 2025, MA CAHPS administration
Recall window	July 1 of the year before the survey — not the calendar year and not the last six months ¹
Star measure credit	Patient answers “Yes” on the MA CAHPS survey. Claims, EHR documentation, pharmacy data, and immunization registries do not independently create numerator credit
Statistical method	Relative Distribution and Significance Testing. Cut points alone do not assign the star — CMS also applies significance testing ¹
Not reported for	Prescription Drug Plans
Documentation codes (internal tracking, does not contribute to measure)	Vaccine Product Code + Vaccine administration (Medicare Part B beneficiaries HPCPS G0008 or CPT 90471/90460 for commercial/Medicaid plans for), ICD-10-CM Z23 where applicable ³

ABBREVIATIONS: CAHPS = Consumer Assessment of Healthcare Providers and Systems; CAI = Categorical Adjustment Index; CMS = Centers for Medicare & Medicaid Services; I-SNP = Institutional Special Needs Plan; PDP = Prescription Drug Plan

How The Years Line Up



The 2026 Star Rating reflects care and patient recall from an earlier period; current-season vaccination affects future ratings, not the already-published 2026 result.

In One Sentence

Of the Medicare Advantage patients CMS surveys, this measure counts the share who say they had a flu shot since the previous 1 July.

CMS Cut Points

These are the CMS base-group cut-point ranges used for the 2026 Star Ratings. Final measure-level Star assignment also incorporates CMS statistical significance testing; the cut points should not be interpreted as guaranteed prospective thresholds.¹

PLAN TYPE	1 STAR	2 STAR	3 STAR	4 STAR	5 STAR
MA/MA-PD	<57%	≥57% to <61%	≥61% to <68%	≥68% to <73%	≥73%
PDP	N/A	N/A	N/A	N/A	N/A

2026 Industry Performance (2025 → 2026 Trend)

- **National Numeric Average:** Annual Flu Vaccine performance declined from **69% in the 2025 Star Ratings to 66% in the 2026 Star Ratings**¹
- **Average Measure Rating:** Despite the three-percentage-point decline, the average Annual Flu Vaccine rating remained **3.2 stars** in both 2025 and 2026¹
- **Lower 2026 Base-Group Cut Points:** For the 2025 Star Ratings, C03 four Star was $\geq 71\%$ to $< 76\%$ and five Star was $\geq 76\%$. For the **2026 Star Ratings**, the corresponding **thresholds declined** to $\geq 68\%$ to $< 73\%$ and $\geq 73\%$, respectively¹
- **Broader MA Market Context:** Approximately **64%** of MA-PD enrollees are in contracts with four or more overall stars for 2026. Eighteen MA-PD contracts earned an overall 5-Star rating¹
- **Survey-Based Performance Risk:** Because C03 is scored through CAHPS, a completed vaccine documented in claims, the EHR, or an immunization registry does not independently determine the Star measure result. Operational success requires both vaccination delivery and accurate member recall when the survey is administered¹

2 WHAT THE MEASURE IS ASKING



AAVBC PERSPECTIVE

C03 is measured through patient-reported MA CAHPS responses, not through claims or medical-record abstraction. Documentation remains essential for safe care, continuity, outreach, and record accuracy, but it does not independently determine Star measure credit.

In Plain Language

CMS surveys a sample of Medicare Advantage enrollees and asks whether they received an influenza vaccination since July 1 of the prior year.¹ **The patient's survey response determines measure credit;** CMS does not use claims, EHR documentation, or immunization-registry records to establish the numerator. For care teams, the clinical priority remains straightforward: identify vaccination status, recommend vaccination when appropriate, improve access, administer or facilitate vaccination, reassess status at future encounters, and clearly communicate the care received.

Why it Exists

Influenza vaccination can reduce the risk of influenza illness and its complications, although effectiveness varies by season, circulating strains, vaccine match, age, and patient characteristics.

Its greatest clinical importance in Medicare populations is reducing the burden of severe illness, hospitalization, and complications among patients at increased risk. Interim estimates for the 2025–26 season found vaccine effectiveness of **30%** against influenza-associated hospitalization in adults, and 22% to 34% against outpatient visits.⁴ Older adults and patients with chronic cardiopulmonary disease are among those at increased risk for severe influenza outcomes.⁵



QUALITY OUTCOME — WHY VACCINATION MATTERS

Influenza can cause serious complications in older adults and patients with chronic disease. Seasonal vaccination can reduce influenza-associated illness and severe outcomes, including hospitalization. Interim U.S. estimates for the 2025–26 season found approximately **30% vaccine effectiveness against influenza-associated hospitalization among adults**, although effectiveness varies by season and patient population.^{4,5}

What A Care Team Actually Controls

Star Ratings are calculated at the CMS contract level, not for individual clinicians or practices. Care teams nevertheless influence the clinical experiences and workflows that contribute to measure performance.

CARE TEAM CAN DIRECTLY INFLUENCE	SHARED ACROSS THE CARE SYSTEM	OUTSIDE THE CARE TEAM'S CONTROL
• Assess and follow-up on vaccination status during appropriate encounters • Provide a clear, individualized recommendation • Offer same-visit vaccination when clinically appropriate • Use standing orders where permitted • Clearly explain what vaccine was administered • Provide/update the patient's vaccination record	• Vaccination delivered by pharmacies, hospitals, specialists, or community sites • Timely exchange and reconciliation of external immunization records • Outreach reaching the patient through current contact information • Preventive opportunities across specialty, acute-care, and community settings	• Which enrollees CMS samples • Survey administration and response patterns • CMS cut points and statistical methodology • Contract-level adjustments and CAI methodology

ABBREVIATIONS: CMS = Centers for Medicare & Medicaid Services; COPD = chronic obstructive pulmonary disease

- **Complete documentation does not create Star measure credit for a survey-based measure.** There is no chart-abstraction path and no supplemental data submission
- **Performance reflects care and patient experience across the recall period**, not the documentation quality of a single encounter



AAVBC PERSPECTIVE

Because C03 is survey-based, documentation alone cannot determine the measure result. Improvement comes from the fundamentals of preventive care: identifying patients who may benefit, reducing access barriers, offering timely vaccination, coordinating records across settings, and communicating clearly about care delivered.

3 MEASURE SPECIFICATION

CAHPS Survey-Based Measure

ELEMENT	SPECIFICATION ^{1,2}
Numerator	Eligible respondents who answer “Yes” to the Annual Flu Vaccine survey item. Claims, EHR entries, pharmacy records, and immunization registries do not alter the survey-based measure result
Denominator	Eligible MA CAHPS respondents with a usable response to the Annual Flu Vaccine item, after applicable CMS survey processing
Sampling population	CMS draws the survey sample at the contract level from eligible enrollees; individual practices do not determine who is sampled
The question	<i>“Have you had a flu shot since July 1, 2024 or [prior year]?”</i> <i>–The year advances with each survey cycle</i> Response options are Yes, No, and Don’t know
Recall period	Begins July 1 of the year before survey administration and continues through the patient's survey response. For the 2026 Star Ratings, the question referenced vaccination since July 1, 2024¹
Who is eligible to be sampled	CMS survey-sampling eligibility • Age ≥18 years • 6 months of continuous enrollment in the contract before the January sample draw • Enrolled in the contract at sample selection • Resident in the United States • Not known to be deceased • Not known to reside in an institutional setting • No more than one sampled enrollee per household These are survey-sampling rules, not clinical exclusions from influenza vaccination

ELEMENT	SPECIFICATION ^{1,2}
Case-mix adjustment	Not applied. Annual Flu Vaccine is not case-mix adjusted for Star measure scoring
Measure-specific clinical exclusions	None identified in the 2026 Star Ratings specification. Clinical circumstances such as a vaccine contraindication, hospice care, frailty, advanced illness, or patient declination do not themselves create a C03 measure exclusion if the individual is otherwise eligible for the CAHPS sample. Clinical judgment still governs whether vaccination is appropriate for an individual patient. Measure eligibility should never supersede a contraindication or patient preference

ABBREVIATIONS: CAHPS = Consumer Assessment of Healthcare Providers and Systems; CMS = Centers for Medicare & Medicaid Services; EHR = electronic health record; FEMA = Federal Emergency Management Agency; MA = Medicare Advantage; MA-PD = Medicare Advantage Prescription Drug; PDP = Prescription Drug Plan



RED FLAG — DECLINATION IS NOT A MEASURE EXCLUSION

A documented declination does not remove an otherwise eligible patient from C03. A patient may reconsider later or receive vaccination elsewhere, so document the specific concern, respect the patient's decision, and revisit vaccination when clinically appropriate.

Commonly Misunderstood

- **External vaccination is assumed to create measure credit → it does not.** Pharmacy and registry records improve continuity and outreach accuracy, but C03 measure performance is determined through the patient's MA CAHPS response
- **Documented vaccination is assumed to close C03 → it does not.** Documentation supports safe care, continuity, billing, and accurate outreach; it is not the Star-scoring pathway
- **The recall period is assumed to be the calendar year → it is not.** The Annual Flu Vaccine item asks about vaccination beginning July 1 of the prior year

4 HOW PERFORMANCE IS MEASURED

Patient Survey

For C03, the survey item is central to measurement, but the full measure also depends on CMS sampling, survey-processing, and Star-scoring methodology. ²

ITEM TEXT

"Have you had a flu shot since July 1, [prior year]?"

Response options

Yes • No • Don't know²



CLINICAL PEARL — SURVEY, NOT CLAIM

"Don't know" is an available survey response, so uncertainty about prior vaccination can affect the reported result even when vaccination may have occurred. Clear communication and an accessible vaccination record support patient understanding and continuity of care. Because the recall period begins July 1 of the prior year, vaccination timing should be interpreted against the actual survey window rather than the calendar year.²

Official Star-Scoring Pathway

C03 measure performance is derived from eligible MA CAHPS responses after applicable CMS survey processing. Claims, coding, EHR entries, pharmacy records, and immunization registries support care and record accuracy but are **not** supplemental data sources for C03 Star scoring.^{1,2}

CMS assigns the final measure-level Star Rating using the applicable cut points together with its statistical methodology, including significance testing. **Prior-year cut points provide historical context and should not be treated as guaranteed future thresholds.**

Internal Performance Is Not the Official Star Result

Internal dashboards can support care improvement, but they should be distinguished from the official CMS result because the populations, denominators, and data pathways differ.^{1,2}

CALL IT THIS	WHICH MEANS
Official result	The contract-level result calculated and published by CMS using MA CAHPS data and CMS methodology
Internal proxy	An organization's internal estimate based on its own patient population and available records. Useful for improvement work, but not equivalent to the official C03 result
Documentation completeness	How consistently vaccination status and related care are captured in structured records
Patient understanding	Whether patients leave encounters with a clear understanding of what vaccination they received and when, supported by an accessible record

ABBREVIATIONS: CMS = Centers for Medicare & Medicaid Services

Internal estimates should be labeled clearly and interpreted separately from the official CMS contract-level result because the populations, denominators, and measurement pathways differ.

Adjustment and Comparability

C03 is not case-mix adjusted. As a result, measured differences across contracts may reflect not only care delivery but also differences in access, social conditions, prior vaccination patterns, language, transportation, trust, and other factors that influence vaccination uptake and survey response. Stratifying internal data can help care teams identify inequities and design outreach or access supports that are responsive to patient needs.

5 HIGH-YIELD INTERVENTIONS

Missed vaccination opportunities often arise from access barriers, uncertainty about prior vaccination, fragmented records, vaccine concerns, and competing priorities during clinical encounters. Care teams can improve preventive care by assessing vaccination status consistently, offering vaccination when appropriate, reducing access barriers, reconciling external records, and communicating clearly about care received. Immediate opportunities occur during existing patient encounters; longer-term improvement depends on reliable outreach and record reconciliation.

ACTION	WHEN/WHO	WHY IT MATTERS FOR THIS MEASURE
Standing orders —Implement standing orders, where permitted, so appropriately trained clinical staff can assess eligibility and administer influenza vaccination under an approved protocol	Week 1/Practice leadership, then MA or nurse	Standing-order programs can increase vaccination uptake by reducing avoidable delays and allowing vaccination to occur during routine workflow. The Community Preventive Services Task Force found standing orders alone raised vaccination rates by a median of 16 percentage points , and by 27 points when combined with other interventions ⁶
Assess vaccination status during encounters —Identify patients with unknown or incomplete vaccination status during pre-visit planning and verify status during rooming, including vaccination received at pharmacies, workplaces, hospitals, or community sites	Every encounter/ Practice team	Routine assessment helps identify both patients who may benefit from vaccination and patients whose externally administered vaccine has not yet reached the clinical record ⁷

ACTION	WHEN/WHO	WHY IT MATTERS FOR THIS MEASURE
Clinician recommendation + same-visit vaccination —Provide a clear, individualized recommendation and offer same-visit vaccination when clinically appropriate; if vaccination will occur elsewhere, facilitate a specific plan before the patient leaves	Every encounter/ Clinician	A clear clinician recommendation can support informed vaccine acceptance, while same-visit administration reduces the need for an additional visit and may improve access
Explain what was administered —Tell the patient what vaccine was administered, when and where it was given, and provide or update an accessible vaccination record	Vaccine Administration/ Vaccine administrator	Clear communication supports patient understanding, reduces uncertainty about future vaccination status, and strengthens continuity across care settings
Pharmacy/IIS reconciliation — Reconcile pharmacy, immunization information system (IIS), and other available external records before generating outreach lists	Bimonthly/ Quality or care-coordination team	Record reconciliation can reduce duplicate vaccination, improve outreach accuracy, and avoid contacting patients about care they have already received
Reminder and recall —Use multimodal reminder and recall strategies, with live outreach when automated methods do not reach the patient or when additional support is needed	30 days, sustained/ Care coordinator, then nurse	Reminder and recall raised adult influenza vaccination with a pooled relative risk of 1.29 — roughly 9 percentage points . ⁸ Digital-only outreach may not reach patients facing technology, language, access, or contact barriers; person-to-person outreach can extend reach when additional support is needed
Continue vaccination beyond autumn —Continue offering influenza vaccination throughout the season when clinically appropriate, including after October	Whole practice	Influenza activity frequently extends beyond autumn, and later vaccination can still provide clinical benefit to an unvaccinated patient during the ongoing season ⁵

ABBREVIATIONS: CDC = Centers for Disease Control and Prevention; MA = medical assistant

Risk Stratification — Who to Reach First

Prioritize outreach according to clinical vulnerability and access need.

TIER	CRITERIA	WHAT TO DO
Higher clinical priority	No verified current-season vaccination plus one or more factors associated with greater risk of severe influenza or barriers to timely vaccination: age ≥ 65 years, chronic cardiopulmonary disease, chronic kidney disease, diabetes, immunocompromising conditions, or recent acute-care use ⁵	Consider live outreach and convenient same-day, walk-in, or scheduled vaccination
Already coming in	Status unknown or unvaccinated, with an appointment in the next 30 to 60 days	Use pre-visit planning and rooming workflows to verify vaccination status and offer vaccination during the scheduled encounter when appropriate
No visit scheduled	Not seen in more than six months, or no response to a first digital reminder	Use multimodal outreach with direct scheduling or a specific community vaccination option; consider live outreach when automated approaches are unsuccessful or additional support is needed
Vaccination status needs reconciliation	Uncertain or externally documented vaccination status: patient reports vaccination, external vaccination identified, or record awaiting reconciliation	Complete the structured entry, reconcile registry and claims, give the patient a record and the verbal anchor, and re-contact temporary deferrals

ABBREVIATIONS: aIIV3 = adjuvanted trivalent inactivated influenza vaccine; CKD = chronic kidney disease; COPD = chronic obstructive pulmonary disease; ED = emergency department; EHR = electronic health record; HD-IIV3 = high-dose trivalent inactivated influenza vaccine; RIV3 = trivalent recombinant influenza vaccine

6 COMMON PITFALLS AND PRACTICAL FIXES

FAILURE MODE	WHY IT HAPPENS	WHAT PREVENTS IT
Treating documentation as the pathway^{1,2}	Because many quality measures rely on claims, structured EHR data, or medical-record abstraction, teams may reasonably assume that complete influenza-vaccination documentation directly determines C03 performance	Clarify that C03 is survey-based: documentation supports safe care, continuity, outreach accuracy, and billing, but it is not the Star-scoring pathway for this measure
Confusing an internal rate with the Star result¹	Internal dashboards may track documented vaccination across a practice population, but these figures differ from the official CMS result in population, denominator, sampling, and data source	Label internal estimates clearly and interpret the CMS contract-level result separately from the performance of any individual clinician or practice
The one-and-done October campaign⁵	Vaccination efforts may be concentrated early in the season, leaving later opportunities underused for patients who remain unvaccinated	Maintain vaccination workflows throughout the influenza season and continue offering vaccination when clinically appropriate, including after October ⁴
Calling patients who are already vaccinated⁷	Vaccinations delivered at pharmacies, hospitals, workplaces, or community sites may not appear promptly in the practice's structured EHR, creating uncertainty in outreach lists ⁷	Reconcile available pharmacy and IIS data before outreach when feasible. This reduces unnecessary contacts, duplicate vaccination risk, and confusion for patients who have already been vaccinated
Silence at the moment of vaccination⁷	Vaccination may be documented correctly while the patient leaves without a clear understanding of what was administered or how to verify it later	Use clear, plain-language communication about the vaccine administered and provide or update an accessible vaccination record. This supports patient understanding and continuity across care settings

FAILURE MODE	WHY IT HAPPENS	WHAT PREVENTS IT
The flu conversation deprioritized under load	Visits often contain multiple competing clinical priorities, and preventive care may be deferred when time is limited ⁷	This is a workload problem, not a motivation problem. Design the workflow so vaccination assessment can occur during pre-visit planning or rooming under an approved protocol, reducing dependence on clinician memory during a time-limited encounter

ABBREVIATIONS: A1c = hemoglobin A1c; EHR = electronic health record

CAHPS Survey Integrity — What CMS Prohibits

Contracts, their personnel and their agents are not permitted to:

- Attempt to influence or encourage enrollees to answer survey questions in a particular way;
- Imply that the organization or its staff will be rewarded or benefit from positive feedback;
- Offer incentives of any kind to prompt, influence or increase participation;
- Show or provide the survey or its cover letters to enrollees before administration;
- Indicate that the goal is for enrollees to answer “10,” “Definitely yes,” or “Always.”

These prohibitions are CMS’s own, set out in the MA & PDP CAHPS Quality Assurance Protocols & Technical Specifications. CMS also strongly discourages fielding other enrollee surveys in the four weeks before, during and four weeks after administration, and discourages asking CAHPS items in focus groups.²



AAVBC PERSPECTIVE

Routine vaccine education, accurate records, and clear communication are part of good clinical care. They should not be used to rehearse CAHPS questions, suggest preferred answers, or influence how a patient responds to the survey. The goal is informed, accessible care; CMS independently measures that experience through CAHPS.

7 BARRIERS AND EVIDENCE-BASED SOLUTIONS

Patient-side

BARRIER	HOW IT SHOWS UP	WHAT HELPS
"The flu shot gave me the flu"	A respiratory or gastrointestinal illness that occurs soon after vaccination may be attributed to the vaccine, shaping future vaccine decisions	Address the mechanism, not the belief: <i>"The flu shot cannot cause influenza. It helps lower your risk of influenza and can reduce the chance of serious illness or hospitalization if you do become infected."</i> One clear response, then move on.
"It doesn't work anyway"	A patient may interpret influenza after vaccination as evidence that the vaccine provided no benefit. Protection is incomplete and varies by season, but vaccination can reduce influenza illness and the risk of severe outcomes	Be transparent that vaccine effectiveness varies by season, circulating strains, age, and patient characteristics. Interim 2025–26 estimates found 30% effectiveness against influenza-associated hospitalization in adults. ³ Frame the benefit as staying out of hospital rather than never being unwell
"I never get the flu"	Low perceived vulnerability — common in patients well for years, and in adults under 65 who qualify for Medicare through disability ⁷	Connecting vaccination to the patient's age, chronic conditions, and individual risk can make the recommendation more clinically meaningful
Access, not attitude	Transport, limited clinic hours, limited access to nearby vaccination sites, unstable housing, no regular medical home, or a work schedule with no daytime slot ⁷	Offer convenient options such as walk-in or vaccination-only visits, extended hours, a specific nearby vaccination site, transportation support where available, or home-based vaccination when covered and clinically appropriate

BARRIER	HOW IT SHOWS UP	WHAT HELPS
"I think I already had it"	Genuine uncertainty. The patient was vaccinated somewhere at some point and cannot place it — and "Don't know" is an available survey answer ²	Search available immunization records before assuming either status, document the source and date when identified, and explain clearly what the updated record shows

ABBREVIATIONS: COPD = chronic obstructive pulmonary disease



CLINICAL PEARL — ADDRESS THE TIMING, NOT THE PATIENT'S EXPERIENCE

Influenza vaccination does not create a period of increased immune vulnerability. Protective antibodies generally develop over about 2 weeks, so influenza infection acquired shortly before or soon after vaccination can occur before full vaccine-induced protection develops. Other respiratory illnesses may also occur coincidentally after vaccination. Acknowledging the patient's experience while explaining this timing can support an informed conversation.

System and Workflow

BARRIER	HOW IT SHOWS UP	WHAT HELPS
Pharmacy-to-practice data silos	A patient is vaccinated at a retail pharmacy. The record stays there, or arrives as a scanned document nobody can query, and the practice still shows the vaccine as outstanding ⁷	Use available IIS, electronic health information exchange, pharmacy data feeds, or other established interfaces to reconcile externally administered vaccines, with a defined workflow for entering verified information into structured immunization fields
External records landing in free text⁷	Pharmacy faxes and patient reports get typed into a note instead of the structured immunization module, so no report can find them	Structured entry with date, product where known, location and verification source. Vaccination documented only in narrative text may be difficult to retrieve through structured reports, clinical decision support, or outreach workflows
Order depends on locating the clinician	The vaccine waits for a signature, the visit ends, and the opportunity closes	Standing orders or other approved vaccination protocols can reduce avoidable delays and support consistent vaccination during appropriate encounters ⁶

BARRIER	HOW IT SHOWS UP	WHAT HELPS
Alerts that fire at the wrong moment	Prompts that occur late in the encounter may leave insufficient time to assess eligibility, address questions, and administer vaccination	Place decision support earlier in the workflow—such as pre-visit planning or rooming—when there is still time to act

ABBREVIATIONS: IZ = immunization

Equitable Access and Differences in Vaccination Coverage

Overall vaccination rates can obscure meaningful differences in access and vaccination coverage across patient populations. Because C03 is not case-mix adjusted, understanding these differences locally can help care teams identify barriers and design more equitable access and outreach strategies.

POPULATION SEGMENT	PATIENT IMPACT	INTERVENTIONS
Black and Hispanic adults	National data show lower adult influenza-vaccination coverage among Black and Hispanic adults than among White adults. Structural barriers, prior experiences of discrimination, and medical mistrust may amplify missed opportunities and weaken generic outreach ⁹	Use culturally and linguistically appropriate communication, trusted clinicians and community partners, convenient vaccination access, and locally stratified data to identify where barriers persist
Medicare-Medicaid dual-eligible and low-income beneficiaries	Transportation limitations, unstable contact information, food or housing insecurity, low health literacy, and competing priorities can make portal-only or single-message outreach ineffective ⁹	Use multimodal outreach, live telephone contact, transportation support, walk-in vaccination, home-based administration when covered and appropriate, simplified instructions, and direct scheduling rather than asking the member to arrange vaccination independently
Adults younger than 65 years, including Medicare members eligible because of disability	Younger adults have substantially lower influenza-vaccination coverage than adults aged 65 years or older and may have fewer routine primary-care visits or less perceived vulnerability ⁹	Use pharmacy routing, urgent-care and specialty-clinic prompts, text reminders, workplace-compatible hours, and vaccination during every available encounter. Avoid limiting campaigns to traditional senior-focused flu clinics

POPULATION SEGMENT	PATIENT IMPACT	INTERVENTIONS
Rural and medically underserved populations	Members without reliable transportation, internet access, or nearby vaccination sites may not respond to standard portal-based or clinic-only outreach	Use telephone outreach, mobile or community clinics, pharmacy and public-health partnerships, and IIS exchange to improve access and consolidate vaccines administered outside the primary-care network ¹²



DOCUMENTATION REMINDER — ABSENCE IS NOT EVIDENCE

A blank immunization record does not establish that vaccination was not received. Patients may receive influenza vaccines at pharmacies, workplaces, urgent-care centers, hospitals, or community sites. When feasible, reconcile available external records before outreach to reduce unnecessary contacts, duplicate vaccination, and patient confusion.⁷

8 CLINICAL CONTEXTS AND APPLICATIONS

Clinical Contexts

CONDITION OR SITUATION	CLINICAL IMPLICATION ⁵	WHAT TO WATCH FOR ⁵
Chronic obstructive pulmonary disease (COPD)	Influenza can precipitate an exacerbation, an emergency visit or an admission in patients with limited respiratory reserve.	Prioritize for live outreach and same-visit vaccination. Do not delay an available age-appropriate vaccine while searching for a preferred product
Heart failure and cardiovascular disease	Acute influenza adds physiologic stress to patients with little cardiopulmonary reserve and can precipitate decompensation	Use cardiology and transitional-care visits as opportunities to assess and offer influenza vaccination when appropriate
Diabetes	Greater vulnerability to severe infection, and frequently coexisting cardiovascular and renal disease	Include influenza vaccination status in diabetes pre-visit planning alongside glycemic review, kidney health evaluation, eye care, and medication review

CONDITION OR SITUATION	CLINICAL IMPLICATION ⁵	WHAT TO WATCH FOR ⁵
Chronic kidney disease	Comorbidity burden raises the consequences of respiratory infection and hospitalization	Coordinate vaccination assessment and record reconciliation across nephrology, dialysis, primary care, and pharmacy encounters
Adults 65 and older, including frailty	This group carries a disproportionate share of severe influenza outcomes	For adults aged ≥65 years, preferentially offer HD-IIV3, RIV3, or aIIV ³ when available. If none is available at the vaccination opportunity, use another age-appropriate influenza vaccine rather than delaying solely to obtain a preferred product
After a hospital or emergency department visit	Recent acute-care use may indicate greater clinical vulnerability and creates an opportunity to reassess preventive-care needs	Include vaccination status in post-discharge review and medication reconciliation. Do not assume the hospital or skilled nursing facility gave it

ABBREVIATIONS: A1c = hemoglobin A1c; aIIV3 = adjuvanted trivalent inactivated influenza vaccine; HD-IIV3 = high-dose trivalent inactivated influenza vaccine; RIV3 = trivalent recombinant influenza vaccine

Patient Journey

BEAT	CONTENT
Presents as	A patient in their early seventies with COPD and diabetes, and one admission in the past year, arrives for routine follow-up. The EHR shows no influenza vaccine on record. The patient thinks they may have had one at a pharmacy but is not sure
What happens	The medical assistant searches the state immunization registry during rooming and finds a pharmacy-administered vaccine from October. The record is imported into the structured immunization module rather than pasted into the note. The MA then says: <i>"I found the influenza vaccine you received at the pharmacy in October and added it to your immunization record. I'll also give you a copy for your records."</i> The patient is given a printed vaccination record before leaving
Outcome	The reconciled record reduces the risk of duplicate vaccination and improves the accuracy of future outreach. The patient leaves with a clear understanding of when and where the vaccine was received and has an updated vaccination record available for future care

BEAT	CONTENT
Follow-up	At the next appropriate encounter, the care team confirms that the reconciled influenza vaccination remains documented in the structured immunization record and reassesses any other preventive-care needs. If vaccination status is still uncertain or a temporary deferral was documented, the team rechecks available records and revisits vaccination when clinically appropriate

ABBREVIATIONS: COPD = chronic obstructive pulmonary disease; EHR = electronic health record; MA = medical assistant

Note: Case is illustrative and is not a reported individual case

Companion Guides - Making Connections

GUIDE	WHEN TO REACH FOR IT
Heart Failure QRG	A heart failure visit in autumn is a vaccination opportunity; decompensation after influenza is the outcome both guides are trying to prevent
Diabetes QRG	Pre-visit planning already gathers A1c, kidney and eye measures — vaccination status belongs on the same list
Chronic Kidney Disease QRG	Care is split across nephrology and primary care, which is exactly where vaccination records go missing
After-hospital and transitional care guidance	Post-discharge review is the highest-yield moment to catch an unvaccinated, clinically vulnerable patient

ABBREVIATIONS: A1c = hemoglobin A1c; QRG = Quick Reference Guide

9 DOCUMENTATION THAT SUPPORTS CARE

Documentation that Reflects the Care

- Clear, structured documentation supports safe care, continuity across settings, avoidance of duplicate vaccination, accurate outreach, and appropriate billing
- Vaccination documented only in narrative text may be difficult to retrieve through structured reports, clinical decision support, and outreach workflows. Enter verified vaccination information into the structured immunization record when possible
- **Document the specific reason for declining or deferring vaccination rather than relying on a nonspecific label such as “refused.”** Prior adverse experiences, concerns

about effectiveness, access barriers, uncertainty about prior vaccination, and temporary precautions may require different follow-up

- **Coding:** For Medicare claims, use the appropriate influenza vaccine product code with **HCPCS G0008** for administration and **ICD-10-CM Z23** when applicable. Accurate coding and structured immunization data support **billing, continuity, outreach lists, and population-level review to identify patients whose vaccination status is missing, uncertain, or needs updating**. These data support care improvement but do **not** determine C03 measure credit⁷

What Belongs in the Record

For vaccinations administered or reconciled by the practice, capture the applicable clinical and administration details in structured fields whenever possible.⁷

ELEMENT	WHAT TO RECORD
Administration detail	Date vaccine product/formulation dose route/site manufacturer lot number expiration date, as applicable administering clinician or qualified staff member
Where it happened	Practice location or external vaccination site. For an outside vaccine, document the source of the information and how the administration was verified
Status, stated once	One clear status rather than an implied one — see the taxonomy below
The barrier and what was done	Patient concern or access barrier clinical recommendation education provided vaccination offered or administered external-record search, if applicable agreed follow-up plan
Follow-up	Document the planned reassessment or next step when vaccination is declined, deferred, scheduled elsewhere, or remains uncertain

ABBREVIATIONS: HCPCS = Healthcare Common Procedure Coding System; ICD-10-CM = International Classification of Diseases, Tenth Revision, Clinical Modification

One Status, Clearly Stated

Vaccination status is more clinically useful when it distinguishes uncertainty, current eligibility, completed vaccination, declination, and temporary deferral rather than reducing every situation to “done” or “not done.”

STATUS	WHAT IT MEANS, AND WHAT FOLLOWS FROM IT
Unknown	Not yet assessed, or the patient is unsure. Check available immunization records before classifying the patient as unvaccinated

STATUS	WHAT IT MEANS, AND WHAT FOLLOWS FROM IT
Due	No current-season vaccination identified, and vaccination is clinically appropriate now
Scheduled	A specific plan exists—for example, a scheduled date or identified vaccination site
Given here	Vaccination administered by the practice and documented in the structured immunization record
Given elsewhere, verified	External administration confirmed through an IIS, pharmacy record, claim, or other reliable source. Document the verification source
Patient reports it, not yet verified	Document the patient as the source of the vaccination history and reconcile available external records when feasible. Do not automatically classify patient-reported vaccination as “unvaccinated”
Declined	Document the patient’s specific concern or reason for declining, the discussion that occurred, and whether reassessment is planned
Deferred — acute illness or precaution	Document the clinical reason for deferral and when vaccination should be reconsidered

Clinical Documentation Optimization - SOAP Example

S — Subjective

Patient is unsure whether influenza vaccination is necessary because they “rarely get the flu.” Denies prior severe allergic reaction to an influenza vaccine. Reports no current moderate or severe acute illness.

O — Objective

Current-season influenza vaccination not found in the structured EHR, pharmacy claims, or available IIS query. Patient aged 72 years with COPD and diabetes.

A — Assessment

Current-season influenza vaccination due. Patient is at elevated risk for influenza-related complications because of age and chronic cardiopulmonary disease. No contraindication identified.

P — Plan

Influenza vaccination recommended after review of expected benefits, common reactions, limitations, and relevant precautions. **Current-season, age-appropriate influenza vaccine administered under an approved protocol.** Product, dose, route, site, manufacturer, lot number, and expiration documented as applicable. Appropriate billing and diagnosis codes entered. Vaccination recorded in the structured immunization record and transmitted to the applicable IIS when available. **Patient provided an updated vaccination record.**

Documentation Examples

Vaccinated in the clinic

*"Current-season influenza vaccine administered today. Contraindications and precautions reviewed; no contraindication identified. **Product, dose, route, site, manufacturer, lot, and expiration documented as applicable.** Expected reactions and vaccine limitations reviewed. Vaccination entered into the structured immunization record and applicable IIS. Patient provided an updated vaccination record."*

Vaccine Received Externally

"Patient reports receiving the current-season influenza vaccine at [location] on [date]. External administration verified through [IIS/pharmacy record/other source]. Vaccination date, product when available, administering location, and verification source entered into the structured immunization record. No additional influenza vaccination indicated at this time based on available information."

Declination

"Influenza vaccination recommended today. Patient declined because of concern that a previous influenza vaccine caused illness. Clinician reviewed that injectable influenza vaccine cannot cause influenza, discussed expected short-term reactions and potential benefits, and addressed questions. Patient continued to decline. Educational information provided as appropriate. Reassessment planned at a future encounter."

Not enough - Incomplete

"Had flu shot." · "Flu shot discussed." · "Got it at the pharmacy." — none of these establishes the date, the season, the product, the location, the source, or whether the vaccine was recommended, offered, given, declined, deferred or scheduled. These entries do not establish the vaccination date, season, source, verification status, or clinical disposition and may limit continuity, record reconciliation, and future vaccination assessment.

KEY TAKEAWAYS

1 C03 is a patient-reported measure, not a documentation measure.

The official result is derived from eligible **MA CAHPS survey responses** at the CMS contract level. Claims, coding, EHR documentation, pharmacy records, and immunization registries support care and record accuracy, but they do **not independently create C03 Star measure credit**.

2 The clinical objective is timely influenza prevention—not the survey response.

Care teams should consistently assess vaccination status, provide an individualized recommendation, offer vaccination when appropriate, address barriers, and revisit vaccination when it is declined, deferred, or uncertain. **Good measure performance should follow good preventive care rather than drive it.**

3 The most important missed opportunity is often not vaccination itself, but an unreliable care pathway.

Standing orders, pre-visit planning, rooming-stage assessment, same-visit vaccination, reminder and recall, and continued vaccination later in the season can reduce avoidable delays and make preventive care easier to receive.

4 A missing EHR entry does not necessarily mean a patient is unvaccinated.

Influenza vaccines are frequently given outside primary care. **Reconciling pharmacy, IIS, hospital, community, and patient-reported vaccination information** helps prevent duplicate vaccination, improves continuity, and makes outreach more accurate.

5 Structured documentation has value far beyond billing.

Accurate immunization records allow care teams to distinguish **due, unknown, given elsewhere, declined, and temporarily deferred** patients and support population-level searches for people whose vaccination status is **missing, uncertain, or needs updating**. For C03, however, structured documentation remains a care-support tool rather than the scoring pathway.

6 Clinical vulnerability and access need should guide outreach.

Older adults, patients with chronic cardiopulmonary disease, CKD, diabetes, immunocompromising conditions, recent acute-care use, and patients facing transportation, language, technology, or access barriers may benefit from more proactive support. **Prioritization should reflect clinical need and equitable access—not ease of closing a measure.**

7 Clear patient communication is part of care, not survey preparation.

Explain what vaccine was given, address concerns accurately, and provide an accessible vaccination record. Patients should understand their care, but teams should **never rehearse CAHPS questions, suggest preferred answers, or influence survey participation or responses.**

8 Influenza vaccination is not an autumn-only activity.

For patients who remain unvaccinated, continue assessing and offering vaccination throughout the influenza season when clinically appropriate. The reason is **ongoing clinical benefit**, not simply that a later vaccination may fall within a measure recall period.



RED FLAG — THE MOST COMMON REVISION ERROR

Carrying prior-year dates, cut points, survey windows, or vaccine guidance into a new cycle without revalidation is a common revision error. Recheck year-specific details against current CMS and CDC guidance before reuse.

Changes to Monitor

KIND OF CHANGE ^{1-3,5,7,10}	GOOD PRACTICE
Measure status and specifications	Confirm that C03 Annual Flu Vaccine remains an active Part C Star measure , and recheck its official name, weighting category, weight, eligible population, exclusions, data source, and scoring methodology. CMS finalized broader changes to the Star Ratings measure set for future years, including removal of 11 measures beginning with the 2027 measurement year; therefore, measure status should not be assumed from one rating cycle to the next
Rating-year methodology	Revalidate the applicable cut points, statistical methodology, Categorical Adjustment Index treatment, and inclusion in the Part C Improvement Measure when CMS publishes each new Star Ratings cycle. CMS also publishes annual Rate Announcement updates that can include measure-specification, improvement-measure, CAI, and disaster-adjustment information
Survey wording and measurement dates	Update the July 1 date embedded in the MA CAHPS question , survey administration period, and corresponding Star Rating year. The recall window changes with each survey cycle, so prior-year dates should not be carried forward automatically
Current-season clinical guidance	Update influenza-vaccine recommendations to the current vaccination season , including vaccine composition, age indications, timing, contraindications/precautions, and any preferential recommendations for older adults. For the 2026-27 season , all three vaccine virus components were updated from 2025-26, reinforcing why prior-season product language should not simply be reused
Coding, coverage, and data exchange	Confirm current influenza vaccine product codes, administration coding, Medicare coverage guidance, and IIS/pharmacy data-exchange workflows before each season. These elements support accurate clinical records and population-level review but remain separate from the MA CAHPS scoring pathway

KIND OF CHANGE ^{1-3,5,7,10}	GOOD PRACTICE
Internal tools and patient materials	Review EHR prompts, standing-order protocols, outreach logic, documentation templates, patient education, and vaccination records for outdated season names, products, dates, or clinical recommendations . Historical Star thresholds or prior-season vaccine language should be clearly labeled when retained for context

ABBREVIATIONS: CMS = Centers for Medicare & Medicaid Services; FDA = Food and Drug Administration; IIV4 = quadrivalent inactivated influenza vaccine; IZ = immunization

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