



AAVBC

AMERICAN ACADEMY OF VALUE BASED CARE

Controlling Blood Pressure Quick Reference Guide

2026

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MEASURE SNAPSHOT

CMS Part C Star Measure: C14 - Controlling Blood Pressure

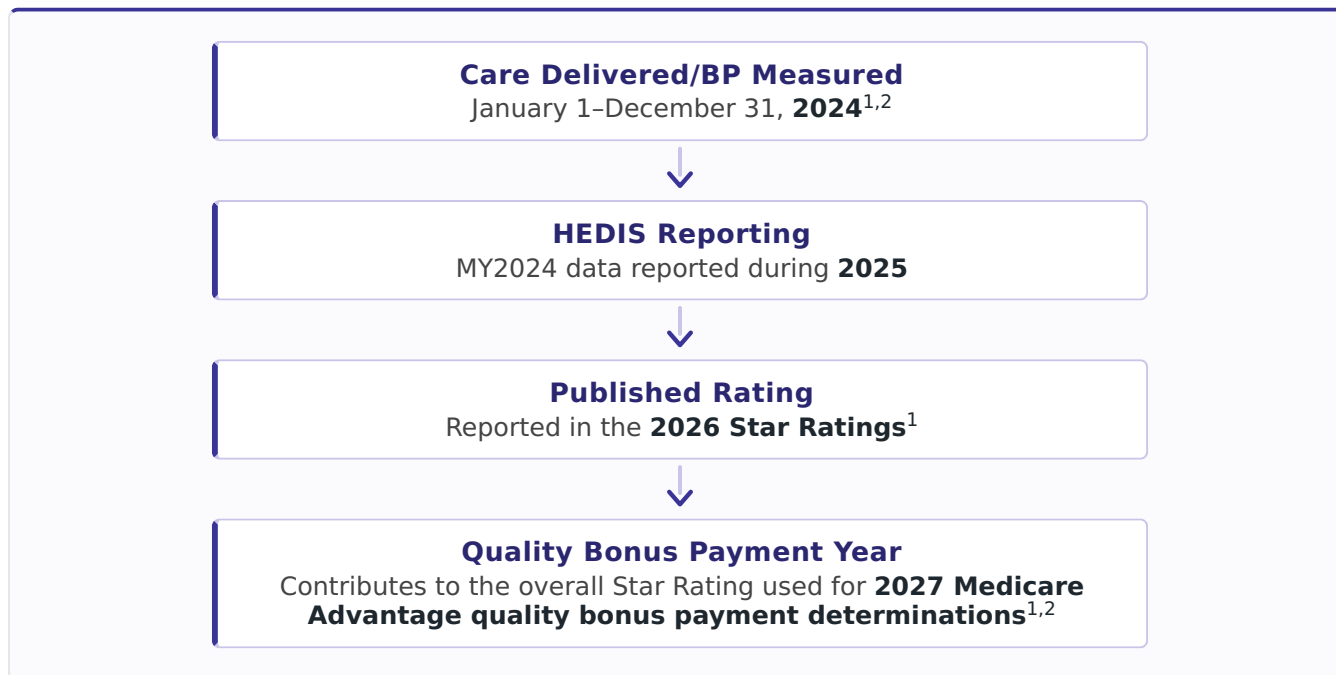
CMS Definition: Percentage of Medicare Advantage patients aged **18-85 years with hypertension** whose blood pressure was **adequately controlled at <140/90 mm Hg** during the measurement year.¹

For PCP teams, the priority is to obtain an **accurate qualifying BP**, address persistent uncontrolled hypertension, and ensure the most recent eligible reading is captured correctly.¹

FIELD	ENTRY
CMS measure name	Controlling Blood Pressure
HEDIS measure name	Controlling High Blood Pressure (CBP)
CMS measure ID	C14
Domain	Managing Chronic (Long Term) Conditions
CMS weighting category	Intermediate Outcome Measure
Weight	3 — triple-weighted
Primary data source	HEDIS
HEDIS reporting method	Administrative or Hybrid
Eligible population	MA patients 18-85 years with hypertension
Numerator threshold	<140/90 mm Hg
Unit of measurement	CMS contract-level measure; individual practices do not receive a C14 Star Rating ¹
Trend direction	Higher is better¹
Case-mix adjusted	No^{1,2}
Improvement Measure	Included¹
CAI usage	Included²
Statistical method	Clustering ¹
Measurement period	January 1 - December 31, 2024¹

ABBREVIATIONS: BP = blood pressure; CBP = Controlling High Blood Pressure (HEDIS label); CMS = Centers for Medicare & Medicaid Services; MA = Medicare Advantage

How the Years Line Up



In One Sentence

For Medicare Advantage patients aged **18-85 with hypertension**, C14 measures the percentage whose **most recent qualifying blood pressure during the measurement year is <140/90 mm Hg**.

CMS Cut Points

These are the CMS 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.

PLAN TYPE	1 STAR	2 STAR	3 STAR	4 STAR	5 STAR
MA/MA-PD	<67%	≥67% to <75%	≥75% to <80%	≥80% to <86%	≥86%

ABBREVIATIONS: MA = Medicare Advantage; MA-PD = Medicare Advantage Prescription Drug

2026 Industry Performance

National Numeric Average: C14 performance increased from **76% in the 2025 Star Ratings to 79% in 2026**.¹

Average Measure Rating: The average C14 rating increased from **3.0 to 3.4 Stars**.³

2026 Cut-Point Context: The 4-Star threshold decreased from **≥84% to ≥80%**, and the 5-Star threshold decreased from **≥90% to ≥86%**. Cut points are rating-year specific and should be used as directional benchmarks, not prospective guarantees.⁴

WHAT THE MEASURE IS ASKING



AAVBC PERSPECTIVE — WHAT THIS MEASURE REWARDS

C14 is a **HEDIS intermediate-outcome measure based on blood-pressure control**, not simply whether treatment was prescribed. An order, medication change, or follow-up plan does not by itself create numerator credit; the patient must have a **qualifying BP <140/90 mm Hg**.

In Plain Language

C14 asks whether an eligible patient with hypertension has a **most recent qualifying BP below 140/90 mm Hg** during the measurement year. For PCP teams, the priority is to obtain a reliable reading, appropriately reassess an elevated BP, address medication adherence and treatment barriers, and ensure follow-up produces a documented qualifying measurement.⁵

Why it Exists

Hypertension is a major modifiable risk factor for **cardiovascular disease and stroke**. Control may be limited by inaccurate measurement, medication intolerance or cost, nonadherence, therapeutic inertia, and incomplete follow-up. Effective primary care therefore requires both **accurate BP assessment and timely management of persistent uncontrolled hypertension**.^{1,6,7}

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 measurement quality, clinical management, access, data capture, and follow-through that contribute to C14 performance. What follows is the part of this measure a care team can influence directly.

DIRECTLY WITHIN THE PRACTICE	INFLUENCED, SHARED WITH OTHERS	OUTSIDE THE PRACTICE
• Use standardized BP technique — appropriate rest, positioning, arm support, cuff size, and no talking • Reassess an elevated intake BP when appropriate rather than treating a potentially inaccurate value as final • Act on persistent uncontrolled BP through adherence assessment, medication review, treatment adjustment, and timely follow-up • Identify treatment barriers including side effects, cost, refill gaps, regimen complexity, and health literacy • Document exact numerical BP values in the appropriate structured field • Assess orthostatic symptoms and fall risk when clinically indicated, particularly in older or frail patients	• Clinical pharmacy support for medication synchronization, adherence, tolerability, and regimen optimization • Home BP monitoring/RPM including device access, correct cuff size, technique, and return of readings • Specialty/comorbidity management for CKD, cardiovascular disease, diabetes, or other relevant conditions • Access and SDoH support for medication affordability, transportation, health literacy, and digital barriers • Care coordination for unresolved BP, missed visits, or incomplete follow-up	• NCQA HEDIS specifications and value sets • CMS cut points, clustering, and CAI methodology • Contract-level Star calculations and adjustments

MEASURE SPECIFICATION

HEDIS Controlling High Blood Pressure (CBP)

Official C14 performance is governed by the applicable **NCQA HEDIS MY2024 specification**. For PCP teams, the key technical distinction is between an eligible qualifying BP and a reading that cannot be used for measure reporting.

ELEMENT	SPECIFICATION
Denominator	MA patients 18-85 years with hypertension who meet applicable HEDIS eligibility requirements and do not meet a measure-defined exclusion ²
Numerator	Most recent qualifying BP during the measurement year is <140/90 mm Hg²

ELEMENT	SPECIFICATION
Most recent BP	Use the most recent eligible BP date during the measurement year ²
Multiple readings on the same date	Use the lowest systolic and lowest diastolic values from that date ; they do not have to come from the same individual reading ²
No qualifying BP	Missing BP, incomplete BP, or BP ≥140/90 mm Hg is not numerator compliant
Home BP	Patient-measured BP may qualify when obtained with an eligible digital device and documented as exact numerical values in the medical record
Nonqualifying readings	Do not use readings from an acute inpatient stay or ED visit , certain procedure-related readings requiring diet/medication changes, or patient self-measurement using a non-digital manual device
Data collection	Administrative or Hybrid HEDIS methodology ^{1,2}
Measurement year	January 1 - December 31, 2024
ABBREVIATIONS: ED = emergency department; ESRD = end-stage renal disease; HEDIS = Healthcare Effectiveness Data and Information Set; I-SNP = Institutional Special Needs Plan; MA = Medicare Advantage; NCQA = National Committee for Quality Assurance	

Measure-Defined Exclusions

EXCLUSION	WHAT QUALIFIES
Hospice	In hospice or using hospice services during the measurement period ²
Death	Died during the measurement period ²
Palliative care	Receiving palliative care or qualifying palliative-care encounter ²
ESRD	Qualifying diagnosis indicating end-stage renal disease ²
Pregnancy	Pregnancy diagnosis during the measurement year
Age ≥66 — institutional status	Enrolled in an I-SNP or living long-term in an institution
Age 66-80 — frailty and advanced illness	Must meet BOTH required frailty and advanced-illness criteria
Age ≥81 — frailty	At least two indications of frailty on different dates of service during the measurement year ^{1,2}

**RED FLAG — DO NOT INFER AN EXCLUSION**

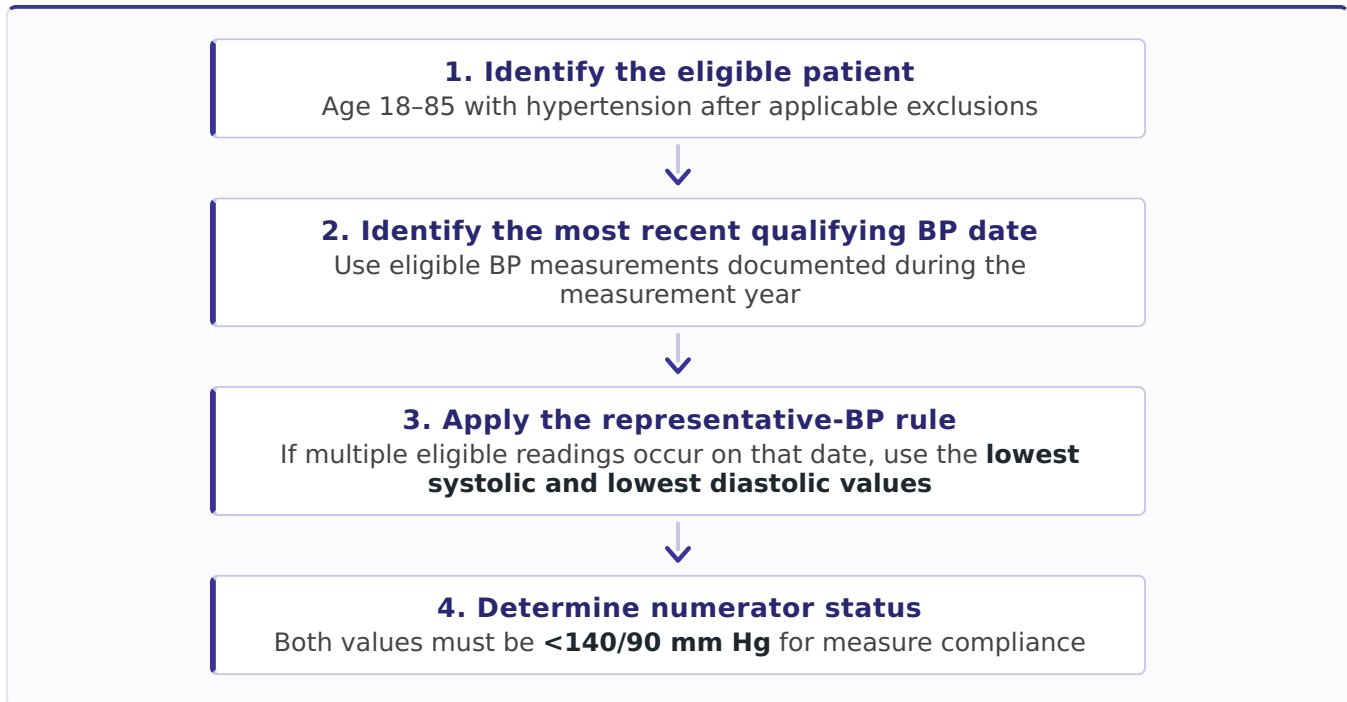
Frailty alone does not exclude a patient aged 66-80. That age group must meet both the specified **frailty and advanced-illness criteria**. A dementia diagnosis alone is not automatically an exclusion; a **dispensed dementia medication may satisfy the advanced-illness component**, but the frailty requirement still applies. For patients aged **≥81**, the frailty rule differs.

Commonly Misunderstood

- **The “best BP of the year” is assumed to count → it does not.** The measure uses the **most recent eligible BP date**²
- **Two readings on the same date are assumed to require one intact BP pair → not necessarily** HEDIS uses the **lowest systolic and lowest diastolic values from that date**²
- **“Home BP is in the 120s/70s” is assumed to be enough → it is not.** Document **specific numerical systolic and diastolic values**; ranges do not satisfy the measure specification²
- **The <140/90 measure threshold is assumed to be every patient's clinical treatment goal → it is not.** It is the HEDIS performance threshold; individualized clinical judgment still applies^{1,2}

HOW PERFORMANCE IS MEASURED

From Reading to Result



CLINICAL PEARL — RECHECK AN ELEVATED READING WITH STANDARDIZED TECHNIQUE

If the intake BP is elevated, allow appropriate quiet rest and repeat the measurement when clinically indicated. A same-day repeat may affect the representative HEDIS BP, but the purpose is **measurement accuracy—not repeatedly checking until a passing value appears**.^{2,8}

Coding Reference

CPT CATEGORY II — BP RESULT EXAMPLES

SYSTOLIC

3074F — <130 mm Hg
3075F — 130–139 mm Hg
3077F — ≥140 mm Hg

DIASTOLIC

3078F — <80 mm Hg
3079F — 80–89 mm Hg
3080F — ≥90 mm Hg

CPT CATEGORY II — BP RESULT EXAMPLES

ABBREVIATIONS: CPT = Current Procedural Terminology

****CPT Category II codes can support administrative capture of BP results; they do not replace the applicable HEDIS specification or clinical documentation**

Internal Performance is not the Official Star Result

CALL IT THIS	WHICH MEANS
Official result	CMS contract-level C14 result calculated from HEDIS data
BP-control proxy	Practice tracking of patients whose latest documented eligible BP is <140/90
Measurement-quality proxy	Whether elevated intake readings receive appropriate standardized reassessment
Follow-up proxy	Whether uncontrolled BP results in a defined clinical action and subsequent reassessment

ABBREVIATIONS: CMS = Centers for Medicare & Medicaid Services

Adjustment and Comparability

C14 is **not case-mix adjusted**, although CMS includes the measure in its **Categorical Adjustment Index methodology**. Internal stratification by race/ethnicity, dual status, age/frailty, CKD, medication access, and other clinical or social factors can help identify inequities and target support; those internal strata should not be confused with official risk adjustment.

HIGH-YIELD INTERVENTIONS

Performance is commonly lost at four points: **measurement is inaccurate, an elevated reading is not confirmed, persistent uncontrolled hypertension does not lead to action, or follow-up/home-BP data never return.**

ACTION	WHEN/WHO	WHY IT MATTERS FOR THIS MEASURE
Use standardized rooming technique and repeat an elevated intake BP when appropriate	Rooming — MA/clinical staff	Recent activity, talking, poor positioning, inadequate rest, or wrong cuff size can distort the measurement ^{2,8}

ACTION	WHEN/WHO	WHY IT MATTERS FOR THIS MEASURE
Identify the medication barrier and use rapid pharmacy handoff when needed	Encounter or early follow-up — PCP/ pharmacist	Cost, adverse effects, refill timing, regimen complexity, health literacy, and therapeutic inertia can prevent sustained control. Address the actual barrier rather than repeating generic adherence counseling ^{7,8,9}
Use structured home BP monitoring when appropriate	Between visits — care team	Provide a validated digital upper-arm device/cuff when possible, teach technique, and specify what readings should be returned ²
Close the loop on home readings	Follow-up — care coordinator/clinical staff	Document exact values and dates ; vague ranges or unread home logs do not establish reliable longitudinal control
Consider orthostatic and fall risk when intensifying treatment in vulnerable patients	Clinical reassessment — PCP	Numeric control should not come at the expense of symptomatic hypotension, syncope, or fall safety
ABBREVIATIONS: BP = blood pressure; MA = medical assistant; PCP = primary care provider		

AAVBC Clinical Prioritization - Who to Reach First

Prioritize outreach by degree of BP elevation, clinical vulnerability, unresolved treatment needs, and follow-up gaps. These tiers are **AAVBC operational guidance and are not CMS/HEDIS numerator categories or official Star-rating strata**.

PRIORITY GROUP	CRITERIA	RECOMMENDED RESPONSE
Near-threshold uncontrolled BP — rapid reassessment	Recent isolated BP around 140/90–145/95 mm Hg , especially without an upcoming visit	Arrange standardized office/ nurse recheck or structured home BP monitoring. Confirm the reading before assuming persistent uncontrolled hypertension
Higher clinical vulnerability	Uncontrolled BP with diabetes, CKD, prior stroke/MI, advanced age/ frailty, or other high-risk multimorbidity	Prioritize clinician/pharmacist review, adherence assessment, treatment optimization, and timely reassessment ⁶

PRIORITY GROUP	CRITERIA	RECOMMENDED RESPONSE
Repeated BP >160/100 mm Hg, repeated missed visits, or persistent uncontrolled BP despite prior intervention	Repeated BP around >160/100 mm Hg , repeated missed visits, or persistent uncontrolled BP despite prior intervention	Use intensive care management : medication/adherence review, SDoH assessment, close follow-up, and additional support as needed
ABBREVIATIONS: CKD = chronic kidney disease; MI = myocardial infarction		

COMMON PITFALLS AND PRACTICAL FIXES

FAILURE MODE	WHY IT HAPPENS	WHAT PREVENTS IT
The intake BP becomes the final value despite poor technique	Patient was rushed, talking, not rested, poorly positioned, or measured with wrong cuff	Standardize technique and appropriately repeat an elevated reading ^{2,8}
The high BP is acknowledged, but no clinical action follows	Therapeutic inertia or competing visit priorities	Assign a specific action, owner, and follow-up interval before the encounter closes ⁷
Control is documented in words instead of numbers	"BP improved," "130s/80s," or similar shorthand enters the note	Record the exact systolic/diastolic value in a structured field ²
Home BP data are vague or cannot be used	Patient reports a range, device/source is unclear, or values remain in a message	Capture exact values, dates, and source/device context in the clinical record ⁹
Medication is changed without a defined reassessment	The prescription changes, but no one owns follow-up	Pair medication changes with a defined BP reassessment and responsible owner ²
ABBREVIATIONS: BP = blood pressure		



RED FLAG — THE MEASURE THRESHOLD IS NOT A UNIVERSAL TREATMENT TARGET

C14 uses **<140/90 mm Hg for measure classification**, but an individual patient's safest clinical target may differ. Do not intensify therapy solely to achieve the measure threshold when symptoms, orthostasis, frailty, or fall risk warrant individualized management.

BARRIERS AND EVIDENCE-BASED SOLUTIONS

BARRIER	HOW IT SHOWS UP	WHAT HELPS
Medication side effects or intolerance	Fatigue, dizziness, cough, cramps, urinary frequency, or other effects lead to skipped doses or discontinuation	Ask specifically about tolerability. Adjust timing/ regimen when clinically appropriate rather than assuming unwillingness ⁹
Medication cost and access	Patient stretches doses, delays refills, or stops treatment	Ask about affordability and refill access. Use lower-cost options, pharmacy/plan support, or synchronization when appropriate ⁷
White-coat/anxiety or inconsistent technique	Office readings remain higher than home values or vary substantially between encounters	Use standardized quiet rest, repeat office measurement, and structured home BP monitoring when clinically appropriate ⁸
Home-monitoring/device barriers	No digital monitor, wrong cuff size, difficulty using the device, or readings never reach the care team	Provide validated-device guidance, correct cuff sizing, simple instructions, and a clear pathway for submitting readings



CLINICAL PEARL — GIVE HOME BP A CLOSED LOOP

Home BP monitoring works only when the patient knows **when to measure, what values to record, how to submit them, and who will review them**. A home-BP plan should end in a documented clinical decision—not an unread log.^{2,8}

System and Workflow

BARRIER	HOW IT SHOWS UP	WHAT HELPS
Inconsistent rooming technique	Rest time, cuff size, positioning, or repeat measurement varies by staff member	Build a standardized rooming BP protocol with a repeat-elevated-BP workflow

BARRIER	HOW IT SHOWS UP	WHAT HELPS
Short visits absorb the recheck	Visit proceeds before adequate rest/reassessment occurs	Use pre-visit/rooming workflows so remeasurement happens before the PCP must make the clinical decision
Home readings have nowhere to go	BP values remain in portal messages, paper logs, or device apps without clinical review	Assign a defined inbox/owner and structured documentation workflow for home readings ²
Registry or gap lists lag behind current care	Patients continue to appear uncontrolled after a qualifying repeat reading or updated clinical assessment	Reconcile new eligible BP values and follow-up outcomes into the quality workflow promptly

Equitable Access and Differences in Blood Pressure Control

C14 is not case-mix adjusted. Internal stratification can help practices identify differences in BP control, medication access, follow-up, and home-monitoring support; those practice-level analyses should remain separate from official CMS contract-level methodology. C14 is among the measures used in CMS's CAI methodology, but CAI operates at the contract level rather than as a PCP patient-risk tier.^{6,10}

POPULATION SEGMENT	PATIENT IMPACT	INTERVENTIONS
Black adults	Hypertension burden and disparities in treatment, access, and control can increase cardiovascular risk ^{6,10}	Verify accurate measurement, assess medication/access barriers, and use closed-loop follow-up for uncontrolled BP rather than relying on repeated reminders alone ¹⁰
Low-income and dual-eligible patients	Medication cost, transportation, food insecurity, work schedules, and limited device access can interfere with treatment and follow-up	Ask about affordability and access before finalizing the plan. Use lower-cost regimens when appropriate, refill synchronization, plan/community resources, nurse visits, and home-BP support
Patients with CKD or complex multimorbidity	Complex regimens and competing care needs can increase medication burden and make longitudinal BP management harder ⁶	Simplify the plan when possible, coordinate pharmacy/specialty care, and establish a clear owner for BP follow-up

POPULATION SEGMENT	PATIENT IMPACT	INTERVENTIONS
Rural patients	Distance to care may delay repeat measurement, medication follow-up, or device support	Use structured home BP monitoring, telehealth when clinically appropriate, local pharmacy/community resources, and explicit follow-up ownership
ABBREVIATIONS: CKD = chronic kidney disease		

CLINICAL CONTEXTS AND APPLICATIONS

Clinical Contexts

CONDITION OR SITUATION	WHY THIS MEASURE MATTERS HERE	WHAT TO WATCH FOR
Diabetes with hypertension	Diabetes and hypertension commonly coexist, and the same patient may have concurrent C12 blood-sugar and C14 blood-pressure care needs . Both are intermediate-outcome Star measures ⁶	Coordinate the visit rather than treating each gap separately. Confirm accurate BP, review medication adherence/tolerability, and align follow-up across both conditions without conflating their separate measure requirements
Chronic kidney disease	CKD increases cardiovascular risk and may complicate antihypertensive selection, dosing, and laboratory monitoring. CKD alone is not a C14 exclusion; ESRD/dialysis is measure-defined exclusion evidence⁶	Coordinate BP management with renal care and monitor renal function/electrolytes as clinically indicated. Do not incorrectly remove a patient from C14 because of CKD alone^{1,2}
Prior stroke or myocardial infarction	These patients have high cardiovascular risk, making sustained BP management clinically important beyond the Star measure ⁶	Prioritize timely reassessment and treatment of persistent uncontrolled BP, while keeping the HEDIS <140/90 performance threshold separate from individualized secondary-prevention treatment goals

CONDITION OR SITUATION	WHY THIS MEASURE MATTERS HERE	WHAT TO WATCH FOR
Older adult with frailty or advanced illness	Measure-defined exclusion logic is age specific . For ages 66–80 , the applicable exclusion requires both frailty and advanced illness; the frailty rule differs for patients ≥ 81 ¹	Before intensifying therapy or closing a gap, verify the actual exclusion criteria and assess orthostasis, symptoms, fall risk, medication burden, and patient goals
Suspected white-coat effect/discordant office and home BP	An elevated office BP may differ from longitudinal home readings, but vague home ranges do not establish measure compliance	Repeat the office BP using standardized technique and, when appropriate, use eligible home readings documented as exact values with date and source/device . Avoid unnecessary treatment changes based on a single poorly obtained reading ^{2,8}

ABBREVIATIONS: CKD = chronic kidney disease; ESRD = end-stage renal disease

Patient Journey

BEAT	CONTENT
Presents as	A 72-year-old patient with hypertension and CKD returns after a prior BP of 158/94 mm Hg . The patient reports taking medications “most days” but sometimes skips the diuretic because of urinary frequency when away from home
What happens	The care team repeats BP using standardized technique; BP remains elevated. Medication reconciliation identifies the adherence/tolerability barrier. The PCP reviews the regimen and coordinates a clinical-pharmacy handoff , adjusts timing or therapy when clinically appropriate, and establishes structured home BP monitoring with a clear pathway for returning exact readings
Outcome	The patient begins the revised plan and submits dated, exact home BP values through the defined workflow. Follow-up confirms improved BP control without dizziness or other treatment-limiting symptoms
Follow-up	The care-team owner reassesses BP, medication adherence/tolerability, and home readings at the planned interval; renal function/electrolytes are monitored when clinically indicated. Persistent uncontrolled BP triggers further clinical reassessment rather than another reminder alone

ABBREVIATIONS: PCP = primary care provider Note: Case is illustrative and is not a reported individual case

Companion Guides - Making Connections

GUIDE	WHEN TO REACH FOR IT
Diabetes Care - Blood Sugar Controlled QRG (C12)	Use when hypertension coexists with diabetes and the same encounter can coordinate separate blood-pressure and glycemic-control priorities
Medication Adherence for Hypertension QRG (D09)	Use when uncontrolled BP may reflect RAS-antagonist refill gaps or medication adherence , particularly when pharmacy claims and the clinical history tell different stories
Kidney Health Evaluation for Patients with Diabetes QRG (C13)	Use when diabetes, hypertension, and kidney-risk evaluation overlap and eGFR/uACR follow-up can be coordinated with BP care
Plan All-Cause Readmissions QRG (C18)	Use when hypertension management intersects with recent hospitalization, post-discharge medication changes, or readmission risk

ABBREVIATIONS: QRG = Quick Reference Guide; RAS = renin-angiotensin system

DOCUMENTATION THAT SUPPORTS CARE

Documentation that Reflects the Care

- Document the **exact BP value**, relevant measurement context, clinical interpretation, action taken, and follow-up plan
- When home readings inform care, capture the **exact value, date, source/device, and patient-reported status** when applicable
- When treatment is individualized or a measure-defined exclusion applies, document the **specific clinical rationale or supporting evidence** rather than relying on a vague label²

What Belongs in the Record

ELEMENT	WHAT TO RECORD
The BP reading	Exact systolic/diastolic values , date/time, and appropriate structured field. If an elevated intake BP is repeated, retain both values rather than replacing the original ²
Measurement context, when relevant	Cuff size, position, rest/repeat measurement, or other context needed to interpret an unexpectedly elevated or discordant reading

ELEMENT	WHAT TO RECORD
Home BP values	Exact values, dates, source/device, and patient-reported status when applicable . Enter usable values into the appropriate structured workflow rather than leaving them only in a scanned log or portal message ²
Clinical interpretation	Whether BP is controlled/uncontrolled; relevant adherence, tolerability, orthostatic symptoms, or reason for not intensifying therapy
Plan, owner, timeframe, outcome	Medication adjustment or deliberate hold, home-monitoring plan, follow-up/recheck interval, and who owns the next step
Exclusion evidence	Specific support for hospice, palliative care, ESRD/dialysis, pregnancy, institutional status, or applicable age-specific frailty/advanced-illness criteria ¹

ABBREVIATIONS: ESRD = end-stage renal disease

Clinical Documentation Optimization - SOAP Example

S — Subjective

Patient with hypertension and type 2 diabetes presents for routine follow-up. Taking lisinopril and amlodipine as prescribed. Reports home BP monitoring with a validated digital upper-arm device and provides exact recent readings. Denies dizziness, syncope, medication adverse effects, or recent missed doses.

O — Objective

Intake BP **146/92 mmHg** after rooming. After **5 minutes of seated rest with appropriate positioning**, repeat BP **134/82 mm Hg**. Home readings reviewed and entered as patient-reported values: **132/78 on [date]** and **135/79 on [date]**, with digital upper-arm device documented

A — Assessment

Hypertension **controlled on repeat office measurement and concordant home readings**. Initial elevation is consistent with measurement context/possible office effect rather than persistent uncontrolled hypertension. No symptoms suggesting hypotension or immediate treatment intolerance

P — Plan

Continue the current regimen. Reinforce standardized home-BP technique and the pathway for submitting **exact dated readings**. Recheck BP at the planned follow-up interval; if subsequent qualifying readings remain $\geq 140/90$ mm Hg, reassess adherence, tolerability, and need for treatment adjustment rather than relying on repeat measurement alone^{2,8}

Documentation caution: keep the intake value and the repeat value. Document why the repeat was obtained, identify exact home readings with date/source when used, and make the **clinical decision, follow-up owner, and timeframe** visible to the next clinician

Documentation Examples

Complete — Persistent Uncontrolled BP / Medication Barrier

“Repeat BP **154/92 mm Hg** after standardized seated reassessment. Patient reports intermittent missed doses related to refill access. Barrier reviewed and medication-access plan initiated; pharmacist follow-up assigned and BP reassessment scheduled. Patient understands the revised plan and when to return home readings.”

Complete — Home BP Incorporated Into the Record

“Patient-reported BP from validated digital upper-arm device: **128/78 on [date]** and **132/80 on [date]**. Values entered into a structured record with source documented. Continue regimen and planned follow-up.”

Not enough — Incomplete

- “BP looks better, around 130s/80s.” → **Range, not an exact value**
- “Home BPs fine.” → **No values, dates, or source**
- “Average home BP <140/90.” → **Threshold statement, not an exact numerical BP²**



DOCUMENTATION REMINDER — WRITE NUMBERS THE NEXT READER CAN ACT ON

Document exact values, dates, and sources. If a repeat measurement changes the clinical interpretation, retain it beside the intake value. If home BP informs care, enter usable exact readings into the clinical record rather than relying on ranges, scanned logs, or narrative summaries.

One Status, Clearly Stated

STATUS	WHAT IT MEANS, AND WHAT FOLLOWS
No qualifying BP this year	No usable measurement-year BP identified; arrange an appropriate office or eligible home measurement
Controlled — current qualifying BP	Most recent eligible BP is <140/90 mm Hg ; continue clinically appropriate care and routine follow-up
Elevated — needs confirmation	Elevated intake reading requires appropriate reassessment/confirmation before the care plan is finalized
Elevated — confirmed/plan active	Persistent uncontrolled BP has led to a defined clinical action and scheduled reassessment
Home monitoring underway	Exact dated digital-device readings are being collected; ensure they return through a defined review/documentation pathway
Clinical target differs from measure threshold	Individualized care may appropriately use a different target; document the rationale while recognizing that C14 scoring still uses the HEDIS threshold
Valid exclusion documented	Specific measure-defined exclusion evidence is present and supported in the record/data pathway

KEY TAKEAWAYS

1 C14 is determined by the most recent eligible BP—not the best BP of the year

Both systolic and diastolic values must meet the **<140/90 mm Hg** measure threshold. Missing or incomplete BP data do not establish control.²

2 Measurement quality comes before treatment decisions

Use standardized technique and appropriately repeat an unexpectedly elevated intake BP. If multiple eligible readings occur on the same date, HEDIS uses the **lowest systolic and lowest diastolic values from that date**.^{2,8}

3 Remeasurement is not treatment

If BP remains uncontrolled after appropriate reassessment, move to **adherence/tolerability review, clinical management, and follow-up** rather than repeatedly checking for a lower number.

4 Home BP is useful only when exact values return to the clinical record

Eligible patient-measured BP may contribute when obtained with an appropriate digital device and documented as **specific numerical values**. Ranges such as “130s/80s” do not meet the measure requirement.

5 Medication barriers should be identified before adherence is labeled a patient failure

Ask about **side effects, cost, refill access, regimen complexity, urinary effects, and health literacy**, then match the intervention to the actual barrier.

6 Measure-defined exclusions require specific evidence

CKD alone is not an exclusion. Apply the actual **ESRD/dialysis, pregnancy, hospice/palliative-care, institutional, and age-specific frailty/advanced-illness rules** rather than broad clinical labels.

7 The HEDIS <140/90 threshold is not a universal treatment target

Individualized clinical goals may differ when **orthostasis, frailty, fall risk, limited life expectancy, or treatment intolerance** changes the risk-benefit balance.

8 Blood-pressure control is a closed-loop team process

Accurate measurement, PCP decision-making, pharmacy support, home monitoring, structured documentation, and timely reassessment should connect into **one workflow with a clear owner**.^{7,9}

Changes to Monitor

KIND OF CHANGE	GOOD PRACTICE
Measure status and specifications	Reconfirm C14's official name, Intermediate Outcome category, weight, eligible population, numerator threshold, exclusions, data source, and measurement year. Controlling Blood Pressure remains an Intermediate Outcome Measure with weight 3 for the 2027 Star Ratings ^{1,11}
Rating-year methodology	Revalidate current cut points, clustering methodology, CAI treatment, Improvement Measure inclusion, and applicable disaster adjustments each Star-rating cycle. Prior-year thresholds should not be carried forward automatically ¹
HEDIS technical specification/data collection	Recheck the governing HEDIS specification for the most-recent-BP rule, same-day multiple readings, home-BP eligibility, exclusions, and Administrative/Hybrid collection requirements before each annual revision ¹¹
Clinical guidance	Recheck current hypertension guidance for treatment thresholds, medication selection, older-adult/frailty considerations, CKD, orthostasis, and self-measured BP . Keep individualized treatment recommendations separate from the C14 performance threshold ⁵

KIND OF CHANGE	GOOD PRACTICE
Coding and data exchange	Verify current CPT Category II/value-set codes, SMBP/RPM documentation conventions, structured EHR fields, and home/external BP data workflows . Codes and documentation should support—rather than substitute for—the applicable HEDIS specification ^{2,8}
Internal tools and patient materials	Review the rooming protocol, repeat-elevated-BP trigger, home-BP instructions/submission pathway, pharmacy handoff, outreach logic, and reassessment ownership at least annually. Retire outdated cut points, dates, and workflow instructions
ABBREVIATIONS: CPT = Current Procedural Terminology; EHR = electronic health record; RPM = remote patient monitoring; SMBP = self-measured blood pressure	

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