2021 Centers for Medicare & Medicaid Services (CMS) Clinical Star Ratings Measures*

CMS Weight	CarePlus Weight+	Measure	Measure description	Exclusions	Age	Can be SATISFIED by telehealth (includes audio only)	Can be SATISFIED with an in-home test kit
1.0	1.0	Transitions of Care – Medication reconciliation post-discharge **(MRP)**	Medications reconciled from the date of discharge through 30 days after discharge (31 total days) **Date range:** Jan. 1 through Dec. 1	Patients in hospice	≥ 18	Yes	No
Display*	0	Transitions of Care – Patient Engagement After Inpatient Discharge	Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge **Date range:** Jan. 1 through Dec. 1	Patients in hospice	≥ 18		
Display*	0	Transitions of Care – Notification of Inpatient Admission	Documentation of receipt of notification of inpatient admission on the day of admission through two days after the admission (three total days) **Note:** Administrative reporting is not available for this indicator **Date range:** Jan. 1 through Dec. 1				
Display*	0	Transitions of Care – Receipt of Discharge Information	Documentation of receipt of discharge information on the day of discharge through two days after the discharge (three total days) **Note:** Administrative reporting is not available for this indicator **Date range:** Jan. 1 through Dec. 1				
1.0	1.0	Controlling blood pressure **(CBP)*** **	Patients with a hypertension diagnosis with adequately controlled blood pressure (< 140/90 mm Hg) **Date range:** January through December (one year)	Palliative care, patients in hospice; patients 66–80 years of age with frailty and advanced illness; or patients 81 years of age or older with frailty	18 to 85	Yes[4]	No
1.0	1.0	Breast cancer screening **(BCS)****	Breast cancer screening by mammography **Date range:** Oct. 1, 2019 – Dec. 31, 2021 (27-month lookback)	Palliative care, patients who have had a bilateral mastectomy or who have had both a unilateral left and unilateral right mastectomy; in hospice; or patients 66–74 years of age with frailty and advanced illness and/or living long term in an institutional setting	50 to 74	Yes[1]	No
1.0	1.0	Colorectal cancer screening **(COL)****	iFOBT/gFOBT *or* **Date range:** January through December (one year) Sigmoidoscopy *or* **Date range:** current measurement year or previous four years CT colonography *or* **Date range:** current measurement year or previous four years Colonoscopy *or* **Date range:** current measurement year or previous nine years Cologuard test **Date range:** current measurement year or previous two years	Patients in hospice; patients who have had total colectomy or colorectal cancer; patients 66 to 75 years of age living long term in an institutional setting and/or with frailty and advanced illness	50 to 75	Yes[1]	Yes
1.0	1.0	Osteoporosis management in women who had a fracture **(OMW)****	Women who suffered a fracture between July 1, 2020, and June 30, 2021, and completed a bone mineral density test (DEXA) and/or have a prescription filled for medication to treat/prevent osteoporosis within six months of the fracture date; or, who had a bone mineral density test within two years and/or a prescription filled for medication to treat/prevent osteoporosis within one year prior to the fracture date **Date range:** July 1, 2019 – Dec. 31, 2021, for a DEXA scan and/or prescription filled for medication to treat/prevent osteoporosis July 1, 2020 – Dec. 31, 2021	Palliative care, patients who had a bone mineral density test within two years and/or a prescription filled for medication to treat/prevent osteoporosis within one year prior to the fracture date; patients in hospice; patients 66–85 years of age living long term in an institutional setting; patients 67–80 years of age with frailty and advanced illness; or patients 81–85 years of age with frailty	67 to 85	No	No
1.0	1.0	Statin therapy for patients with cardiovascular disease **(SPC)**	Patients who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and were dispensed at least one high- or moderate-intensity statin medication during the measurement year and remained on a high- or moderate-intensity statin medication for at least 80% of the treatment period **Date range:** January through December (one year)	Palliative care, patients in hospice; patients 66–75 years of age with frailty and advanced illness and/or living long term in an institutional setting; with services or diagnoses in prior or current year for pregnancy, in-vitro fertilization (IVF), dispensed clomiphene medication, end- stage renal disease (ESRD) or cirrhosis; or with diagnoses in current year for myalgia, myositis, myopathy or rhabdomyolysis	Men 21 to 75; women 40 to 75	No[5]	No[5]
Display*	1.0	Plan all-cause readmissions **(PCR)**	Patients readmitted for any diagnosis within 30 days of an acute inpatient stay **Date range:** January through December (one year)	Pregnant women and patients in hospice	≥ 18	No	No
Comprehensive diabetes care (CDC) — patients are identified with type 1 or type 2 diabetes based on diagnoses submitted on claims in the year prior to the current measurement year							
3.0	3.0	Comprehensive diabetes care – blood sugar controlled **(CDC2_HBAPOOR)*** **	Eligible diabetic patients who have evidence of an HbA1c test with a level ≤ 9%; reports will include patients with HbA1C poor control (> 9%) **Date range:** January through December (one year)	Palliative care, patients in hospice or patients 66–75 years of age with frailty and advanced illness and/or living long term in an institutional setting	18 to 75	Yes[1]	Yes[2]
1.0	1.0	Comprehensive diabetes care – eye exam **(CDC2_EYE)****	Annual diabetic retinal exam (DRE) performed or evidence of negative DRE performed during the measurement year or the prior year (patients with bilateral eye enucleation are compliant) **Date range:** January through December (one year) for DRE performed in 2021; or Jan. 1, 2020 – Dec. 31 2021, for evidence of negative retinopathy			Yes[1]	No
1.0	1.0	Comprehensive diabetes care – kidney disease monitoring **(CDC2_NPH)**	Diabetic patients receiving attention for nephropathy (albumin/protein test or documented evidence of nephropathy) **Date range:** January through December (one year)			Yes[3]	Yes
Care for older adults (COA) — Special Needs Plan (SNP) members 66 and older and Medicare-Medicaid (dual-eligible) members							
1.0	1.0	Care for older adults – medication review **(COA_MDR)**	Medication review (conducted by a practitioner with prescribing authority or clinical pharmacist) with the presence of a medication list in the medical record (need both to count) **Date range:** January through December (one year)	Patients in hospice	SNP ≥ 66	Yes	No
1.0	1.0	Care for older adults – pain screening **(COA_PNS)**	Comprehensive pain assessment – pain screening during the measurement year **Date range:** January through December (one year)			Yes	No
Display*	1.0	Care for older adults – functional status assessment **(COA_FSA)**	Functional status assessment – functional status assessment during measurement year **Date range:** January through December (one year)				
Part D measures							
1.0	1.0	Comprehensive medication review **(CMR)**	Patients who had a pharmacist (or other healthcare professional) help them understand and manage their medications through a comprehensive medication review (CMR) within 60 days of medication therapy management (MTM) program enrollment **Date range:** January through December (one year)	Not applicable	≥ 18	Yes	No
1.0	1.0	Statin use in persons with diabetes **(SUPD)**	Patients who received at least two diabetic medication fills and also received a statin medication **Date range:** January through December (one year)	Patients in hospice or with ESRD	40 to 75	No[5]	No[5]
Medication adherence – patients who fill/refill their prescriptions often enough to cover 80% or more (portion of days covered [PDC] more than 80%) of the time they are supposed to be taking the medications							
3.0	3.0	Medication adherence – diabetes	Patients taking diabetes medication as directed (In this measure, diabetes medication means a biguanide drug, a sulfonylurea drug, a thiazolidinedione drug, a DPP-IV inhibitor, an incretin mimetic, a meglitinide or an SGLT2 inhibitor; patients who take insulin are not included) **Date range:** January through December (one year)	Patients who filled a prescription for insulin; patients in hospice or with ESRD	≥ 18	No	No
3.0	3.0	Medication adherence – hypertension	Patients taking blood pressure medication as directed (In this measure, blood pressure medication means an angiotensin-converting enzyme [ACE] inhibitor, an angiotensin receptor blocker [ARB] drug or direct renin inhibitor [DRI] drug) **Date range:** January through December (one year)	Patients who filled a prescription for sacubitril/valsartan; patients in hospice or with ESRD		No	No
3.0	3.0	Medication adherence – cholesterol	Patients taking cholesterol medication as directed (In this measure, cholesterol medication means a statin drug) **Date range:** January through December (one year)	Patients in hospice or with ESRD		No	No

[1]Can be satisfied during a telehealth visit when a patient-reported service is documented in a submitted medical record. [2]Can be satisfied with a returned hemoglobin A1c (HbA1c) test kit results of 9% or less. [3]Can be satisfied with a telehealth visit only if the telehealth visit is with a nephrologist. [4]Can be satisfied with a telehealth visit when the patient is using a remote monitoring device that digitally stores and directly transmits results to the provider for interpretation. Patients can also visually share the results by displaying the device, a screenshot of it or a printout. Patient-reported readings are also now acceptable for this measure. [5]Prescription written at the time of care may satisfy associated measure.

+ CarePlus weights are aligned with CarePlus' Star reports and the Star Rewards Program. Measure weights may differ from CMS weights and are subject to change.

(*) CarePlus' measure classificaiton, weights and thresholds may differ from CMS'. Please reference reports provided by the health plan.

(**) CarePlus accepts supplemental data for this measure.

(***) Last value captured either administratively or documented in the patient's medical record during the measurement year.

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LEGEND					
	not calendar year		triple weighted		display measure