2023 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**	Breast cancer screening **(BCS)****	Breast cancer screening by mammography **Date range:** Oct. 1, 2021–Dec. 31, 2023 (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
Display	**0.0**	Colorectal Cancer Screening **(COL-P)****	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	**3.0**	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	Palliative care, patients in hospice or using hospice services; patients who have had total colectomy or colorectal cancer; patients 66–75 years of age living long term in an institutional setting and/or with frailty and advanced illness.	50 to 75	Yes[1]	Yes
3.0	**3.0**	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 or using hospice services; patients who died; patients with evidence of ESRD, dialysis, nephrectomy, kidney transplant and non-acute inpatient admissions; 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	**3.0**	Osteoporosis management in women who had a fracture **(OMW)***	Women who suffered a fracture between July 1, 2021, and June 30, 2022, 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, 2021–Dec. 31, 2023, for a DEXA scan and/or prescription filled for medication to treat/prevent osteoporosis July 1, 2022 – Dec. 31, 2023	Palliative care; patients who died; 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 or using hospice services; 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 or using hospice services; patients who died; 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]
Care Coordination measures							
1.0	**1.0**	Follow-Up After Emergency Department Visit for People with High-Risk Multiple Chronic Conditions **(FMC)****	Follow-up visit or service within seven days of an emergency department visit for patients with multiple high-risk chronic conditions **Date range:** Jan. 1 – Dec. 24	Patients in hospice or using hospice services; patients who died; any ED visit that results in an inpatient admission on the day of or within seven days following the ED visit or ED visits occuring within the same eight day period.	≥ 18	Yes	No
3.0	**3.0**	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)	Patients in hospice or using hospice services; pregnancy related admission; patients who died during stay; planned admissions for chemotherapy, rehabilitation, transplant etc; stays with discharge dates of Dec. 2-31.	≥ 18	No	No
1.0	**1.0**	Transitions of Care – Medication Reconciliation Post-Discharge **(TRC–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 or using hospice services; patients who died.	≥ 18	Yes	No
	1.0	Transitions of Care – Patient Engagement After Inpatient Discharge **(TRC–PED)***	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				
	0.0	Transitions of Care – Notification of Inpatient Admission **(TRC–NIA)**	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			No	No
	0.0	Transitions of Care – Receipt of Discharge Information **(TRC–RDI)**	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				
Diabetes Care – 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**	Diabetes Care – Hemoglobin A1c Control for Patients with Diabetes **(HBD)*****	Eligible diabetic patients who have evidence of an HbA1c test with a level <8%; reports will include patients with HbA1C poor control (> 9%) **Date range:** January through December (one year)	Palliative care; patients in hospice or using hospice sercvices; patients who died 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	**3.0**	Diabetes Care – Eye Exam for Patients with Diabetes **(EED)***	Annual diabetic retinal exam (DRE) performed during the current measurement year or evidence of a negative DRE performed in the prior year; patients with bilateral eye enucleation are considered compliant **Date range:** January through December (one year) for DRE performed in 2023; or Jan. 1, 2022 – Dec. 31 2023 for evidence of negative retinopathy			Yes[1]	No
Display*	**1.0**	Kidney Health Evaluation for Patients with Diabetes **(KED)***	Patients who received at least two diabetic medication fills and also received a statin medication **Date range:** January through December (one year)	Palliative care; patients in hospice or using hospice services; patients who died; patients 66–75 years of age with frailty and advanced illness and/or living long term in an institutional setting; patients 81 years old and older with frailty only; patients with no diagnosis of diabetes and who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid- induced diabetes in any setting during the measurement year or the year prior.	18 to 85	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 or using hospice services; patient who died.	SNP ≥ 66	Yes	No
1.0	**1.0**	Care for Older Adults – Pain Screening **(COA–PNS)**	At least one pain assessment or pain screening during the current measurement year **Date range:** January through December (one year)			Yes	No
Display*	**1.0**	Care for Older Adults – Functional Status Assessment **(COA–FSA)***	At least one functional status assessment during the current measurement year **Date range:** January through December (one year)			Yes	No
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 less than 8%. [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' measure classification, 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.
†MRP stand-alone measure was anticipated to retire in MY22 given its inclusion in the calculation of the TRC – Average measure. Based on the latest data, however, the stand-alone Star measure is still active, but CMS has confirmed it is calculated the same way as the TRC – Average measure version.

LEGEND not calendar year | triple weighted | display measure