What Are CMS Star Ratings?

The Centers for Medicare & Medicaid Services (CMS) uses a five-star quality rating system to measure Medicare beneficiaries' experience with their health plans and the health care system. This rating system applies to all Medicare Advantage (MA) lines of business: Health Maintenance Organizations (HMO), Preferred Provider Organization (PPO), Private Fee-For-Service (PFFS) and prescription drug plans PDP).

This program is a key component in financing health care benefits for MA plan enrollees. Ratings are posted on the CMS website, www.medicare.gov, to give beneficiaries help in choosing among the MA plans offered in their area.

Health plans receive an overall summary Star Rating for the health plan as well as for individual measures within each domain. The domains focus on 5 major areas. Star ratings are a crucial part of maintaining our contract with Medicare.

CMS goals for the Five-star Rating System

- Implement provisions of the Affordable Care Act
- Clarify program requirements
- Strengthen beneficiary protections
- Strengthen CMS' ability to distinguish stronger health plans for participation in Medicare Parts C and D and to remove consistently poor performers.

Star Ratings are based on measures of health plan's rating across five categories known as Domains.

- Staying Healthy: Screenings, tests and vaccines (such as annual PCP visits, and colorectal cancer screening).
- Managing Chronic Conditions (such as diabetes, COPD, etc).
- Plan responsiveness, care and quality (such as getting needed care as well as getting appointments and care quickly).
- Member complaints, problems getting services and choosing to leave the plan (such as complaints about the health plan).
- Customer Service (such as timely appeal decisions).

Each domain represents a series of individual measures. The Medicare Star Ratings are currently comprised of a total of 53 measures. Part C (above) is comprised of 36 separate measures across the five different domains listed

above. Medicare Part D (prescription drug plan) is comprised of 17 separate measures. The measures selected are reported using a combination of different data sources. These data sources include:

- **HEDIS (Healthcare Effectiveness Data and Information Set) data:** Some of the current quality measures in the national Star Ratings report card are calculated based on the collection of HEDIS data from claims and encounters submitted and medical record review as needed. For example, the glaucoma screening measure is collected through a review of claims and encounters, whereas the controlling blood pressure measure is reported using only medical record review.
- **CAHPS (Consumer Assessment of Healthcare Providers and Systems) survey data:** The CAHPS survey is conducted annually in the spring. Survey responses are collected from a sample of Medicare health plan members who receive the survey. Some star rating measures are based on survey results, such as flu and pneumonia shot rates and rates of satisfaction.
- **HOS (Health Outcomes Survey) Data:** The Health Outcomes Survey (HOS) is conducted annually of Medicare members. Some star ratings are based on survey results, such as questions related to falls risk, physical activity and urine leakage.
- **Health Plan Operational Data:** Some of the star ratings are also based on data reported to the Centers for Medicare & Medicaid Services by health plans. Some examples include complaints and appeals rates.

Benefits to Providers

- Improving the patient doctor relationship
- Improve your relationship with the health plan
- Greater focus on preventive medicine and early disease protection
- Strong benefits to manage chronic conditions

Benefits to Patients/Members

- Improving the patient doctor relationship
- Greater focus on access to care
- Increased level of customer service
- Greater focus on preventive health services

How providers can help

- Continually encourage patients to obtain annual preventive screenings
- Create office best practices to identify noncompliant patients at the time of their appointments.
- Submit accurate claims/encounters
- Use proper coding procedures
- Understand all of the measures and how you impact them.
- Increase patient interactions: ask “do you have any questions?”

- Carefully review and use the provider profiles (list of members that are in need of key tests and exams) that Health Plan of Nevada/Sierra Health and Life sends quarterly.