Medicare Advantage Stars Rating Guide

Strategies to Improve Your MA Stars Ratings

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1. Understanding the Stars Rating System

The Medicare Advantage (MA) Star Ratings system is CMS's primary tool for measuring health plan quality and performance. Stars ratings range from 1 to 5 stars, with 5 representing excellent performance. These ratings have significant financial and competitive implications for MA organizations.

Purpose of Stars Ratings

- Provide consumers with quality information to make plan choices
- Drive quality improvement across the MA program
- Determine Quality Bonus Payments (QBP) for high-performing plans
- Support CMS oversight and accountability objectives
- Enable employer groups and brokers to evaluate plan quality

Rating Scale

- 5 Stars: Excellent performance
- 4 Stars: Above average performance
- 3 Stars: Average performance
- 2 Stars: Below average performance
- 1 Star: Poor performance (triggers CMS enforcement)

> *Financial Impact: Plans rated 4+ stars receive Quality Bonus Payments worth 5-10% of their benchmark payment. A large MA plan can gain tens of millions in additional revenue by achieving 4+ stars.*

2. Star Measures and Domains

CMS evaluates approximately 40+ measures across multiple domains for MA-PD contracts. Measures are drawn from HEDIS, CAHPS, HOS, and CMS administrative data.

Part C (Medical) Domains

- Staying Healthy: Preventive screenings and vaccinations
- Managing Chronic Conditions: Diabetes, cardiovascular, kidney disease care
- Member Experience: CAHPS survey results
- Complaints and Access: CTM complaints, access to services
- Health Plan Responsiveness: Appeals timeliness and accuracy

Part D (Pharmacy) Domains

- Drug Plan Customer Service: CAHPS pharmacy measures
- Member Complaints: Part D CTM data
- Member Experience: Getting prescriptions and drug plan information
- Drug Safety: Medication adherence and safety measures
- Drug Plan Responsiveness: Coverage determination timeliness

High-Weight Measures

The following measures carry triple weight in Stars calculations:

- Improving or Maintaining Physical Health (HOS)
- Improving or Maintaining Mental Health (HOS)
- Overall Rating of Health Plan (CAHPS)
- Overall Rating of Drug Plan (CAHPS)
- Medication Adherence measures (statins, RAS antagonists, diabetes)

3. How Stars Ratings Are Calculated

Measurement and Cut Points

Each measure is assigned a star level (1-5) based on performance relative to CMS-established cut points. Cut points are updated annually based on the distribution of plan performance.

- Measures scored against absolute thresholds or peer performance
- Cut points use clustering methodology for most measures
- Guardrails prevent excessive cut point movement year-to-year
- New measures may use different methodology initially

Weighting and Aggregation

- Measures are weighted (1x, 1.5x, or 3x) based on importance
- Domain scores are the weighted average of measure stars within the domain
- Summary rating is the weighted average across all Part C and D domains
- Improvement measures provide bonus credit for year-over-year gains

Key Timing

- Measurement Year: Calendar year data collection
- Star Rating Release: October of the following year
- Rating Applied: Affects payments and enrollment 2 years after measurement
- Example: CY2024 data - October 2025 rating - CY2026 payment impact

4. Impact of Stars on Revenue and Enrollment

Quality Bonus Payments

- 4+ star plans receive 5% benchmark bonus (10% in qualifying counties)
- 3+ star plans receive quality bonus payment rebate percentage increase
- Revenue impact can be $50M+ annually for large MA plans
- Bonus funds can be used for supplemental benefits or reduced premiums

Enrollment Impact

- 5-star plans eligible for year-round Special Enrollment Period
- Higher-rated plans attract more voluntary enrollment
- Employer groups and brokers prefer 4+ star plans
- CMS publishes ratings on Medicare.gov Plan Finder

Low-Performing Plan Consequences

- Plans rated below 3 stars for 3+ years face CMS sanctions
- Potential enrollment freeze for persistently low performers
- Contract termination for plans rated below 3 stars for 5+ years
- Required Quality Improvement Plans and CMS oversight

5. Clinical Quality Measures

Preventive Care Measures

- Breast cancer screening rates
- Colorectal cancer screening
- Annual flu vaccination
- Monitoring for nephropathy in diabetes
- Osteoporosis management after fracture

Chronic Condition Management

- Diabetes: HbA1c control (<8%), eye exams, kidney monitoring
- Cardiovascular: Statin therapy, blood pressure control
- Medication Adherence: Diabetes, RAS antagonists, statins (triple-weighted)
- Controlling Blood Pressure
- Rheumatoid Arthritis Management

Improvement Strategies for Clinical Measures

- Identify members with care gaps through claims/encounter data
- Implement proactive member outreach (calls, mailers, texts)
- Provider incentive programs tied to quality measure performance
- Pharmacy programs for medication adherence (refill reminders, MTM)
- Supplemental data collection to capture services outside network
- In-home health assessments for hard-to-reach populations

6. Member Experience (CAHPS) Measures

CAHPS measures are among the most heavily weighted in Stars calculations. Improving member experience requires organizational commitment to service excellence.

Key CAHPS Measures

- Getting Needed Care (ease of getting appointments and referrals)
- Getting Appointments and Care Quickly (timeliness)
- Customer Service (helpfulness, respect, information quality)
- Rating of Health Care Quality
- Rating of Health Plan (triple-weighted)
- Rating of Drug Plan (triple-weighted)
- Care Coordination

CAHPS Improvement Strategies

- Member services training focused on first-call resolution
- Reduce hold times and improve IVR navigation
- Proactive outreach to new members and those with complaints
- Provider communication skills training
- Streamline prior authorization and referral processes
- CAHPS pre-survey outreach to optimize response rates
- Service recovery programs for dissatisfied members

Key Insight: CAHPS measures reflect member perceptions, which are influenced by every interaction - from enrollment to claims to provider visits. Improving CAHPS requires an organization-wide commitment to member-centric service design.

7. Operational and Access Measures

Complaints and Access

- Complaints to CMS (CTM data) - rate per 1,000 members
- Members choosing to leave the plan (voluntary disenrollment)
- Access to primary care and preventive services
- Beneficiary access and performance problems

Appeals and Grievances

- Appeals auto-forward timeliness
- Appeals upheld rate at IRE level
- Grievance resolution timeliness
- Call center abandonment rates and hold times

Part D Operational Measures

- MPF (Medication Price File) accuracy
- Coverage determination and appeals timeliness
- Transition fill compliance
- Accurate and timely Part D data reporting

8. Stars Improvement Strategies

Data-Driven Prioritization

- Analyze current performance against cut points for each measure
- Identify "threshold" measures where small improvements yield star gains
- Focus on triple-weighted measures for maximum impact
- Model the financial ROI of improvement investments
- Monitor performance monthly with early warning indicators

Quick-Win Opportunities

- Medication adherence programs (pharmacy outreach, refill sync)
- Supplemental data capture for services already rendered
- Provider directory and call center accuracy improvements
- CTM complaint reduction through root cause analysis
- Transition fill automation for new Part D enrollees

Long-Term Initiatives

- Provider network quality improvement collaboratives
- Care model redesign for chronic condition management
- Member experience transformation programs
- Health equity initiatives to reduce disparities
- Technology investments in member engagement platforms

9. Provider Engagement for Stars

Provider Incentive Programs

- Pay-for-quality programs tied to Stars-relevant measures
- HEDIS gap closure incentives for primary care
- Specialist quality metrics for condition-specific measures
- Practice-level reporting and benchmarking
- Bonus payments for top-performing providers

Provider Education and Support

- Regular data sharing on quality measure performance
- Clinical practice guideline dissemination
- Care gap alerts integrated into EHR workflows
- Quality improvement coaching and practice facilitation
- Annual Stars awareness campaigns for provider offices

Collaborative Improvement

- Quality improvement learning collaboratives
- Best practice sharing across high-performing practices
- Joint care coordination programs for complex patients
- Co-investment in population health infrastructure

10. Building a Stars-Focused Organization

Organizational Alignment

- Executive accountability for Stars performance
- Stars-linked incentive compensation at leadership level
- Cross-functional Stars steering committee
- Department-level Stars goals and action plans
- Regular Stars performance reporting to Board

Operational Integration

- Embed Stars awareness into new employee orientation
- Align operational workflows with measure requirements
- Automate quality measure identification and outreach
- Integrate Stars metrics into daily management systems
- Celebrate Stars improvements and recognize contributors

Ready to improve your Stars ratings? Contact Ginete Healthcare Consulting Group:
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