GOLD COAST HEALTH PLAN
TOTAL Care ADVANTAGE℠

MEDICARE STAR RATING SYSTEM FREQUENTLY ASKED QUESTIONS

1. What is the Medicare Star Ratings System?

The Centers for Medicare & Medicaid Services (CMS) uses the Medicare Star Ratings System to evaluate the quality and performance of Medicare Advantage (MA) plans and Part D prescription drug plans. Plans are rated from 1 to 5 stars, with 5 being the highest score a plan can achieve.

The Medicare Star Ratings for health plans are updated and published annually and enables individuals, payers, and others to compare plans across multiple dimensions. It helps individuals find and select the best plan to meet their health care needs. It also helps plans earn quality bonus payments from CMS to improve their member services.

2. Who participates in the Medicare Star Ratings System?

- Medicare Advantage (MA) Plans (Part C)
  - Health plans that provide Medicare benefits under contract with CMS
  - Includes Special Needs Plans (SNPs), like Dual Eligible SNPs (D-SNPs)
- Medicare Prescription Drug Plans (PDPs, Part D)
  - Stand-alone Part D plans that cover prescription drugs
  - Rated separately from MA plans
- Medicare Advantage – Prescription Drug Plans (MA-PDs)
  - Most MA plans also include drug coverage
  - These plans are rated on both health care quality (Part C) and drug plan performance (Part D)
- Note: Gold Coast Health Plan Total Care Advantage (HMO D-SNP) is a Medicare Advantage – Prescription Drug plan (MAPD).

3. What is the purpose of the Medicare Star Ratings System?

The Medicare Star Ratings System was designed to empower beneficiaries and drive quality improvement among Medicare Advantage plans in the following ways:

- Help beneficiaries make informed choices
  - Give Medicare members an easy way to compare health and drug plans on quality, service, and performance.
  - The 1 to 5 Star scale is designed to be simple and consumer-friendly.
- Measure and improve quality of care
  - Evaluate how well MA and Part D plans deliver preventive services, manage chronic conditions, and support medication adherence.
  - Encourage health plans (and their provider networks) to focus on quality and outcomes.

- Evaluate accessibility of care.
- Develop performance improvement initiatives based on identified opportunities.
- Compare performance with other health plans.

- Incentivize high performance
  - Plans that earn 4 Stars or higher qualify for CMS quality bonus payments, which they can reinvest in extra benefits, lower premiums, or provider incentive programs.
  - This creates competition that drives improvements in care.

4. What is the difference between the Medicare Star Ratings System and HEDIS®?

HEDIS® is a comprehensive set of more than 90 standardized performance measures developed by the National Committee for Quality Assurance (NCQA) to evaluate health plan quality across commercial, Medicare and Medicaid populations. It evaluates preventive care, chronic disease management, behavioral health, utilization, and access to care.

The Medicare Star Ratings System, in contrast, was developed by CMS and is applied only to Medicare Advantage (Part C) and Drug Prescription Drug plans (Part D).

The system consists of 42 to 45 measures that use a subset of HEDIS® measures and additional data sets such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) member experience survey, a Health Outcomes Survey (HOS), prescription drug event data (PDE), and operations data to assess areas like customer service.

5. How is the Medicare Star Rating System reported?

- Health plans submit star measure data to CMS annually.
  - Total Care Advantage will submit HEDIS® data in June and PDE data continuously.
    - Medicare Star Ratings measure data is submitted through Health Plan Management System (HPMS), a secure online system for Medicare Advantage and Part D sponsors to upload, manage, and preview their performance data, including that for the Star Ratings program.
  - CAHPS surveys are conducted by a CMS-approved vendor once a year, typically March through May.
  - HOS surveys are conducted by a CMS-approved vendor once a year, typically April through July.
- CMS also collects administrative data for health plans, including complaints, appeals, and call center performance, throughout the year.
- CMS then combines all this data and calculates the plan's Star Ratings, which it releases each October.
  - The ratings are posted on the public CMS consumer website, www.medicare.gov.
  - ▶ Note: After CMS calculates preliminary Star Ratings, but before public release, there is a preview period giving health plans a chance to review their measure data in HPMS, verify accuracy, and submit corrections or disputes so the final ratings accurately reflect their performance.
  - Providers can support the Medicare Star Ratings preview period by:
    - Ensuring timely, complete, accurate documentation

- During each visit, documenting / updating all chronic conditions thoroughly, using correct coding, and including severity and treatment plan
- Verifying coding and claims submissions accurately reflect services provided

6. What is a provider's role in Medicare Star Ratings performance?

Providers play a significant role in promoting the health of Total Care Advantage members. The following practices outline specific ways providers can contribute to improved Medicare Star Ratings performance:

- Prioritize preventive care:
  - Proactively remind patients to get recommended cancer screenings (like mammograms and colonoscopies), annual wellness visits, and flu shots.
  - Screen all patients aged 65 and older for fall risk, especially those who report a fall, have issues with balance, or use walking aids.
  - Use the Inovalon® Provider Enablement Quality Gaps Insights to identify members with gaps in care.
  - Make outreach calls and/or send letters to advise members of the need for a visit or screening.
  - Include educational information with outreach.
  - Track and document completion and when the member declines.
- Assess timeliness of care / appointments and work with office staff to optimize scheduling.
- Manage chronic conditions:
  - Closely track and manage patients with chronic diseases like diabetes and cardiovascular disease.
  - Ensure they receive all required labs and screenings (e.g., eye exams for diabetics) and that their conditions are well-controlled.
- Improve medication adherence:
  - Review and discuss medications with patients and caregivers, as appropriate, at every visit.
  - Instruct patients to contact your office if they are experiencing side effects and not to stop the medication before doing so.
  - Provide written instructions to reinforce teaching and include caregivers as appropriate.
  - Encourage members to utilize pillboxes or organizers.
  - Address barriers to medication adherence.
- Coordinate care effectively:
  - When members need to see a specialist or get follow-up care after a hospital stay, seamless coordination between providers is critical.
  - Ensure members discharged form the hospital or ER are seen timely.
    - Document follow-up plans, visits, medication reconciliation, and member / caregiver education
  - Refer to GCHP Care Management to assist: GCHP Care Management referrals can be made by submitting the referral form available on the GCHP website or by contacting the Care Management team by phone or email.
    - Care Management Contact: 1-805-437-5656
    - Care Management Email: CareManagement@goldchp.org
- Document all care in the patient's medical record.
  - Clearly document and code ALL chronic conditions - diagnosis, severity, and status.

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  - » Use the most specific ICD-10 codes available.
- Code for all services completed and submit claims timely.
- Respond timely to requests for medical records.
- Stay up-to-date with Medicare Star Measure requirements, coding, and documentation by reviewing GCHP Provider Star Measure Tip Sheets and clinical updates.

7. Do I need member consent to release personal health information (PHI) for Medicare Star Measure reporting?

- No. Under the Health Information Portability and Accountability Act (HIPAA), data collection for Medicare Star Ratings is permitted.
  - » Health plan requests for medical records do not require additional patient consent or authorization.
- Total Care Advantage members' PHI is maintained in accordance with all state and federal laws.

8. What data sources are used in Medicare Star Ratings Reporting?

- Medical records
- Administrative data: claims, encounter, pharmacy, member and provider data
- Supplemental data: lab, vision, immunization registry, electronic health records
- Survey sources: CAHPS and HOS. Member-reported data collected by CMS-approved vendors

9. What Medicare Star Ratings performance measures are reported?

There are 42 to 45 Medicare Star performance measures for Measurement Year (MY) 2026 / Reporting Year (RY) 2027.

CMS organizes Star Measures into domains - groups of related measures that reflect different aspects of care and plan performance.

- Part C Domain and Measure Details
  Domain: 1 - Staying healthy: screenings, tests and vaccines
  Domain: 2 - Managing chronic (long-term) conditions
  Domain: 3 - Member experience with health plan
  Domain: 4 - Member complaints and changes in health plan's performance
  Domain: 5 - Health plan customer service
- Part D domain & measure details
  Domain: 1 - Drug plan customer service
  Domain: 2 - Member complaints and changes in drug plan's performance
  Domain: 3 - Member experience with the drug plan
  Domain: 4 - Drug safety and accuracy of drug pricing

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Part C (Medicare Advantage) — Five Domains

Domain	Focus	Examples of Measures
1. Staying Healthy: Screenings, tests, and vaccines	Preventive care and early detection.	• Breast cancer screening (BCS) • Colorectal cancer screening (COL) • Osteoporosis management in Women who had a fracture (OMW) • Kidney health evaluation for diabetes (KED) • Flu vaccine
2. Managing chronic conditions	Managing and monitoring members with chronic diseases.	• Controlling blood pressure (CBP) • Diabetes care - blood sugar controlled • Eye exam for patients with diabetes (EED) • Statin therapy for patients with cardiovascular disease (SPC) • Reducing the risk of falling • Improving bladder control • Care for older adults (COA) – medication review • Care for older adults (COA) – Pain screening • Plan all-cause readmissions (PCR) • Medication reconciliation post-discharge (MRP) • Transitions of care (TRC) • Follow-up after emergency department visit for people w/multiple high-risk chronic conditions (FMC)
3. Member experience with health plan	How members rate their care and service.	• Getting needed care • Getting appointments & care quickly • Customer service • Rating health care quality • Rating health plan • Care coordination
4. Member complaints and changes in the health plan's performance	Frequency of complaints, plan improvement trends, and member retention.	• Complaints about the health plan • Members choosing to leave the plan • Health plan quality improvement
5. Health plan customer service	Responsiveness and quality of plan operations.	• Call center accessibility-interpreter/TTY services • Appeals processing timeliness • Reviewing appeals decision

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Part D (Prescription Drug Plan) — 4 Domains

Domain	Focus	Examples of Measures
1. Drug plan customer service	Quality and timeliness of service to members.	• Call center accessibility-interpreter/TTY services • Appeals timeliness • Reviewing appeals decisions
2. Member Complaints and Changes in the Drug Plan's Performance	Member satisfaction, complaints, and plan stability.	• Complaints about the drug plan • Members choosing to leave the plan • Drug plan quality improvement
3. Member Experience with the Drug Plan	Member perceptions of access and service.	• Getting needed prescriptions • Rating of the drug plan
4. Drug Safety and Accuracy of Drug Pricing	Safety, adherence, and pricing accuracy.	• Medication adherence for diabetes medications (MAD) • Medication adherence for hypertension (RAS antagonists) (MAH) • Medication adherence for cholesterol (statins) (MAC) • MTM program completion rate for CMR • Statin use in persons with diabetes (SUPD) • MPF price accuracy (Part D)

10. Where can I find more information on Medicare Star Ratings measures?

To educate and assist providers with increasing their Star Measure performance, GCHP has created Provider Tips Sheets for measures where actions have the greatest impact.

- These tips sheets outline the key aspects of the Star Measures, the medical codes associated with each, and documentation guidance.
- They are located on the GCHP website at: www.goldcoasthealthplan.org > providers > resources > Medicare Star Ratings Measures.
- You can click here to view the Medicare Star Measure Tips Sheets.
- You can learn more about Star Measures, including detailed explanations and technical guidance, as well as how CMS calculates and reports Medicare Star Ratings, by clicking here.
- You can learn about HEDIS® measures on NCQA's website by clicking here.
- You can also submit questions about the Medicare Star Ratings system to qualityimprovement@goldchp.org.