Health Plan of San Joaquin | Mountain Valley Health Plan

CMS Star Ratings: A Provider's Guide

Part 1 of 3 — Program Overview

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D-SNP Provider Network Training Series

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SERIES ROADMAP

A Three-Part Training Series

Today is Part 1. Here's how the full series fits together.

TODAY

Part 1

Program Overview

What CMS Star Ratings are, why they exist, how the score is built at a high level, and why they matter for D-SNP patients.

NEXT SESSION

Part 2

Staying Healthy & Managing Chronic Conditions

A closer look at the preventive-care and chronic-condition-management measures — what they require and how they're documented.

FINAL SESSION

Part 3

HOS, CAHPS & Drug Safety / Pricing Accuracy

Member experience surveys (HOS, CAHPS) and the Part D measures covering medication safety and drug pricing accuracy.

What We'll Cover Today

What Star Ratings Are

The 1-5 star system CMS uses to grade Medicare health plans.

Why the Program Exists

The purpose behind CMS's quality and transparency effort.

How Timing Works

The measurement year, data lag, and when ratings are published.

Why Stars Matter

The funding, benefits, and reputation riding on the plan's score.

How the Score Is Built

The broad categories behind the ratings - no measure-level detail yet.

Your D-SNP Patients & Your Role

Why this population needs extra attention, and how your work fits in.

What Is the CMS Star Ratings Program?

Each year, the Centers for Medicare & Medicaid Services (CMS) rates every Medicare Advantage and Part D plan on a scale of 1 to 5 stars — a public scorecard of quality and member experience.

- Published annually by CMS, typically each fall
- Rates the health plan as a whole — not an individual clinic or provider
- Built from clinical quality data, member surveys, and operational performance
- Ratings are public — Medicare beneficiaries can see and compare them

THE SCALE

5	Excellent
4	Above Average
3	Average
2	Below Average
1	Poor

Why CMS Built This Program

Star Ratings weren't created just to grade plans — they were built to drive better care.

Consumer Transparency

Give Medicare beneficiaries a clear, simple way to compare plans and make informed choices.

Quality Accountability

Hold plans accountable for the quality of care their networks deliver, not just cost or access.

Drive Better Outcomes

Tie funding to performance so plans are financially motivated to invest in preventive and coordinated care.

Continuous Improvement

Measures and benchmarks are revisited yearly, pushing the whole industry toward higher standards over time.

The Measurement Timeline

There's a real lag between when care happens and when it shows up in a rating — understanding it helps explain why early, consistent care matters.

Measurement Year

Care is delivered and documented throughout the calendar year

→

Data Collection

Claims, chart data, and survey results are gathered the following year

→

Rating Published

CMS releases the new Star Rating that fall - roughly a year after care was delivered

→

Payment Year

Bonus payments tied to that rating take effect the year after publication

Why this matters: a screening completed — or missed — in January of this year won't show up in a published rating until roughly the following fall. Consistency early and all year round protects the score, not just a last-minute push in December.

Why the Star Rating Matters

A higher rating isn't just a badge — it changes what the plan can offer members.

Quality Bonus Payments

Plans rated 4 stars or higher receive bonus payments from CMS - additional funding the plan can reinvest in member benefits and services.

Richer Member Benefits

Bonus dollars fund extras like transportation, dental, vision, and over-the-counter allowances - things that matter most to dual-eligible members.

Enrollment & Trust

Star Ratings are public. Beneficiaries and caregivers use them to choose - and stay with - a plan.

Plan Reputation & Standing

Consistently low ratings can trigger CMS oversight, and in severe cases affect a plan's ability to operate.

What Goes Into the Rating

The overall Star Rating rolls up several broad categories of measures. Parts 2 and 3 go deep on individual measures — today, just the shape of it.

Staying Healthy

Preventive care — screenings, vaccinations, wellness visits (the focus of Part 2)

Managing Chronic Conditions

Ongoing management of conditions like diabetes, blood pressure, and behavioral health (also Part 2)

Member Experience & Satisfaction

How members rate their care and the plan, via HOS and CAHPS surveys (the focus of Part 3)

Drug Safety & Pricing Accuracy

Part D measures covering medication safety and accurate drug pricing (also Part 3)

Complaints & Customer Service

Complaint volume, appeals, and call center performance

Where Star Ratings Data Comes From

This is the part that touches your day-to-day work most directly.

Claims & Encounter Data

What gets billed and coded — the record of care that was delivered

HEDIS Clinical Data

Chart-review and supplemental data confirming care was completed

Member Surveys

CAHPS and Health Outcomes Survey — members describing their own experience

Pharmacy & Part D Data

Prescription fills, medication adherence, and drug pricing accuracy

The common thread: nearly all of this data originates in your office or pharmacy — the visit, the documentation, and the coding. Accurate, complete records are what allow good care to actually count.

QUICK PAUSE

Let's Take a Moment

Where in your day-to-day workflow do you think Star Ratings data is already being generated — even if no one calls it that?

Take a minute to think or jot a note — we'll take a few responses before continuing.

Your D-SNP Patients Are the Center of This Story

- Dually eligible for Medicare and Medi-Cal — often navigating two systems at once
- Higher rates of multiple chronic conditions and behavioral health needs
- More likely to face transportation, housing, or social barriers to care
- Frequently harder to reach for both appointments and surveys

What This Means for Star Ratings

- These same complexities make it easier for a gap in care to open — and harder for a member to close it alone
- Every missed screening or hard-to-schedule follow-up shows up in the same measures used to rate the plan
- That makes your outreach and care coordination especially high-leverage for this group

Small Actions, Measurable Impact

Complete Recommended Screenings

Deliver and document preventive and chronic-condition care at the point of service

Code Accurately & Completely

Make sure the care you provided is fully reflected in claims and charts

Coordinate Across Settings

Close loops on referrals, specialists, and post-discharge follow-up

Support the Member Experience

Access, communication, and respect shape how members answer survey questions

How It All Connects

Quality Care Delivered

Screenings, chronic care management, coordinated referrals

→

Captured in the Data

Accurate coding and documentation reflect the care given

→

Reflected in the Rating

Measure performance rolls up into the plan's Star score

→

Reinvested in Members

Bonus funding expands benefits — especially for D-SNP members

And it loops back: richer benefits and stronger plan performance make it easier to reach and support members — which drives even better care next year.

What's Next in This Series

This was Part 1. Here's what the next two sessions will cover in detail.

PART 2

Staying Healthy & Managing Chronic Conditions

- Preventive screening measure specifications
- Chronic condition management (diabetes, hypertension, and more)
- Timing windows and documentation requirements

PART 3

HOS, CAHPS, & Drug Safety and Pricing Accuracy

- What the Health Outcomes Survey and CAHPS actually ask members
- How office practices shape survey responses
- Part D medication safety and drug pricing accuracy measures

Key Takeaways

- Star Ratings are CMS's annual, public 1–5 scorecard for the whole health plan
- There's roughly a year of lag between care delivered and the rating it affects — consistency all year matters
- A higher rating means more bonus funding — and richer benefits for members
- The data behind the score comes almost entirely from care delivered and documented in your office
- D-SNP members face extra barriers, which makes your outreach especially high-leverage
- Part 2 covers Staying Healthy & Chronic Conditions; Part 3 covers HOS, CAHPS, and Drug Safety & Pricing Accuracy

THANK YOU!

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Next up: Part 2 — Staying Healthy & Managing Chronic Conditions

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