What Is the Star Ratings System, and How Are Audits Related?

What Is the Star Ratings System? The Star Ratings System evaluates the quality of care beneficiaries receive from Medicare Advantage and Part D plans on a 1 to 5 scale based on performance on more than 40 individual measures. The system was originally developed to help beneficiaries choose between available plans.

Medicare Advantage plans with higher Star Ratings of at least 4 stars receive increased funding as an incentive to achieve high performance. Plans use these funds to provide additional benefits and reduce beneficiary cost-sharing.

How Do Audits and Compliance Actions Impact Star Ratings? The measures in the Star Ratings System are a combination of administrative measures developed by the Centers for Medicare & Medicaid Services (CMS), process and outcomes-based quality measures developed by the National Committee on Quality Assurance (NCQA) and Pharmacy Quality Alliance (PQA), beneficiary experience of care measures from surveys, and other measures.

The results of audits and compliance actions affect Star Ratings in two ways. First, CMS uses audit and compliance findings to calculate a Beneficiary Access and Performance Problems (BAPP) measure. Second, CMS, through its rigid data integrity policy, automatically downgrades scores to 1 star on four appeal measures whenever it identifies issues with appeal data through an audit. In the past, CMS maintained a policy of automatically downgrading the overall Star Rating of contracts under sanction. However, CMS suspended this policy in 2017.

How Is the Star Ratings System Different from Program Audits?

The purpose and intent of Medicare Advantage program audits is not consistent with the design and goals of the Star Ratings System. Program audits are an important tool used by CMS to monitor plan compliance with a series of regulatory requirements. However, these audits are qualitative assessments of Medicare Advantage plan and Part D sponsor processes and protocols, and may identify negative findings based on a sample of select individual cases in which CMS determines plan operations are not entirely in compliance with specific program requirements. In some cases, a single incident

Star Ratings and Audits: By the Numbers

<table>
<thead>
<tr>
<th>Measure</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of measures in the Star Ratings System that reflect audit findings and enforcement actions, either directly or through the CMS data integrity policy.</td>
<td>5</td>
</tr>
<tr>
<td>The percent of Medicare Advantage enrollees in plans with Star Ratings that were negatively impacted by audit findings or enforcement actions, representing 12.5 million beneficiaries.</td>
<td>68%</td>
</tr>
<tr>
<td>The number of beneficiaries in 3.5 Star plans in 2017 that had 4+ Stars in 2016 but were penalized for audit findings or enforcement actions.</td>
<td>2.2m</td>
</tr>
</tbody>
</table>
can result in an audit finding. Conversely, the Star Ratings System uses representative statistical samples from a variety of data sources to measure and compare clinical quality and beneficiary outcomes in one contract’s beneficiary population with the beneficiary populations of other contracts.

CMS acknowledged the lack of correlation between Star Ratings and audit findings in the 2015 Part C and Part D Program Audit and Enforcement Report: “the lack of a stronger inverse relationship [with Star Ratings] suggests that program audits reveal unique information about sponsor performance and compliance that other data do not show.”

**How Do Audit Findings Distort the Star Ratings System?**

CMS has the flexibility to enforce compliance violations through a broad range of significant financial and regulatory penalties, including civil money penalties, sanctions, and enrollment suspensions. By incorporating audit findings into the Star Ratings System, CMS levies penalties that duplicate compliance actions for the same violation. Furthermore, audit and compliance actions can impact Star Ratings and payment long after a plan has resolved an issue, due to the lag in how Star Ratings affect payment. Lower Star Ratings due to audit findings can impact beneficiaries by reducing additional benefits offered by plans or increasing cost-sharing requirements.

Plans are committed to the collection and submission of complete and accurate data, including the administrative and clinical quality data that underlie the Star Ratings System. Star Ratings should be based on actual plan performance, as reported in a robust and validated data set. However, the current data integrity policy that CMS imposes – also based on audit findings – leads to additional penalties that are methodologically inconsistent with the Star Ratings System, and potentially reduces funding for plans that achieve high clinical and customer service scores.

CMS’s use of audit and compliance actions to deduct from a contract’s Star Rating therefore leads to a double penalty on plans for the same compliance issues.

**What Is CMS Proposing to Do?**

Although CMS has proposed to continue its suspension of the automatic downgrading policy in 2018, the Agency has not changed its policy to continue to link audit results and compliance actions to Star Ratings – despite the concerns plans have expressed regarding how program audits distort the Star Ratings System.

CMS is proposing several modifications to the BAPP measure that will change how audit findings and enforcement actions are reflected. The Agency is also asking for comments on the addition of potential new compliance-related Star Ratings measures, expanding its monitoring of appeals timeliness for data integrity to more plans, and will be applying data integrity reviews to medication therapy management.

**What Should CMS Do?**

CMS should eliminate the link between audit and compliance actions and Star Ratings.

Beginning with contract year 2018, CMS should ensure that quality bonus payments based on Star Ratings are not reduced as a result of arbitrarily downgraded appeal measures due to audit findings. Program audit findings are properly addressed through regulatory enforcement activities specifically authorized under CMS regulations in such cases.