eBook

How to Improve Star Ratings for Enhanced Health Plan Performance

A Guide for Health Plans

Get Started

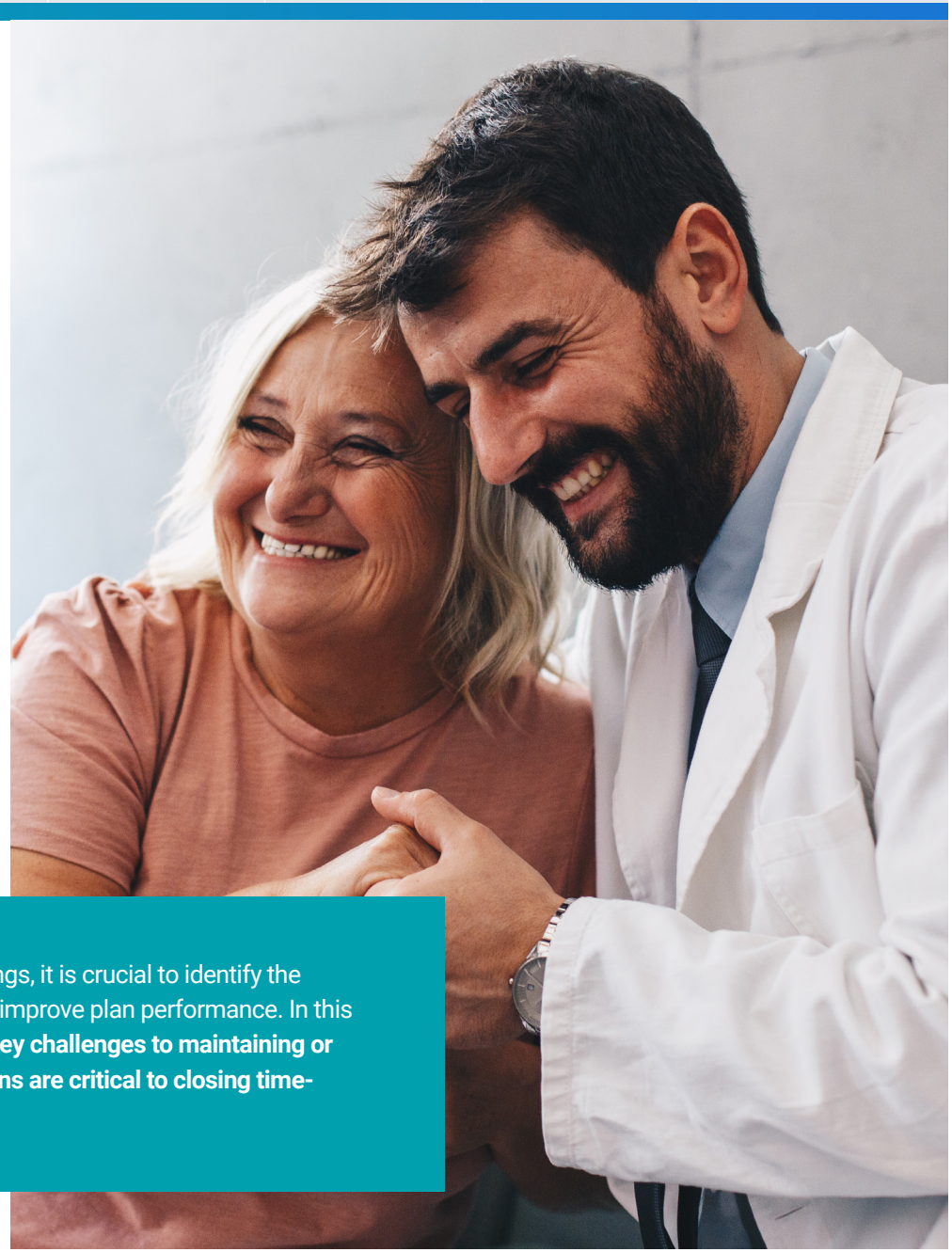
PointClickCare®

Table of Contents

Introduction

For health plans in the U.S., performance and financial reimbursement are tied to quality measures such as the **Centers for Medicare and Medicaid (CMS) Star Ratings and the Healthcare Effectiveness Data and Information Set (HEDIS)**. Effectively coordinating and delivering high-quality care that meets these performance benchmarks is crucial. With the CMS goal to have 100% of Medicare patients enrolled in value-based care plans by 2030, health plans need to have a strategy in place to ensure their success in the coming years.

Star Ratings play a substantial role in performance outcomes for health plans, and increasing Star Ratings requires a deep understanding of how they are calculated. Payers must also equip themselves to address the challenges that frequently prevent health plans from maintaining quality Star Ratings. Care collaboration between health plans, hospitals, and providers will be a key factor in any strategy to enhance Star Ratings. HEDIS measures are increasingly time-bound, which means health plans need real-time access to insights about changes in patient status to support a timely response. Health information technology (health IT) **plays an essential role** in the collaborative care model required for improved performance and quality Star Ratings.



As major health plans continue to experience a decrease in Star Ratings, it is crucial to identify the factors that drive these decreases and implement solutions that can improve plan performance. In this ebook, we examine the **basics of Star Rating performance, identify key challenges to maintaining or improving Star Ratings, and consider how effective health IT solutions are critical to closing time-sensitive care gaps.**

The Basics:
Determining Star Ratings

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At its core, the Medicare Star Ratings system was designed to help beneficiaries in the Medicare Part C (Medicare Advantage, or MA) and Medicare Part D plans determine the quality of the health and drug plans in which they choose to enroll.

The results of Star Ratings measures by health plan are published annually by CMS in its Medicare Plan Finder. Ratings for 2025 were published in October of 2024, and those results impact 2026 MA quality bonus payments to insurers.

Scores range from 1-star to 5-star, with contract ratings broken down by type of contract:

Medicare Advantage Prescription Drug (MA-PD): rated on up to 40 quality and performance measures

MA-only contracts (minus Part D coverage): rated on up to 30 quality and performance measures

PDP contracts: rated on up to 12 measures

For each measure, "cut points," or CMS-established thresholds, determine how performance for each measure is rated on the 1–5-star rating scale. Quality measures like Plan All-Cause Readmissions, Transitions of Care (also a **HEDIS measure**), and Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions can receive poor performance ratings when plans do not address these measures within a specified amount of time.

Health plans with an overall Star Rating below 3 stars risk being dismissed from the Medicare Advantage program altogether, but even minor shifts in ratings above 3 stars have significant implications for healthcare providers.

By the Numbers:
Impacts of Star Rating Declines

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Impacts of Star Rating Declines

The recent release of the 2025 Star Ratings illustrates the importance of effectively addressing quality measures. In this report, **top health plans saw a 0.23% decline** in their total Star Ratings, with 62% of plans at 4 stars or above. This is in contrast to 79% of plans with the same rating just one year ago.

Star Ratings affect health plan outcomes in several ways. First, they allow consumers to shop for the best-rated health plans, affecting new enrollment and current member retention rates. Additionally, plans with a 5-star rating are allowed to open up a special enrollment period outside of standard enrollment windows, further enhancing member growth.

While this impacts market competitiveness and overall revenue, there is a secondary impact as well: **quality bonus program** payouts. Plans with a 4-star quality rating and above receive an additional 5% quality bonus adjustment for the following year. Data suggests that an increase from a 3- to a 4-star rating represents an 8-12% bump in enrollment and a **13.4-17.6% increase** in revenue.

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Star Ratings impact health plan outcomes by directly affecting enrollment, retention, and quality bonus payments, all of which are substantial drivers of plan enrollment and revenue. Even a 1-star shift from 4 to 3 stars can have significant impacts.

Calculating Star Ratings: Key Components

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As touched on above, multiple elements impact overall plan performance on Star Ratings. Across all measured elements, the key components encompass **patient satisfaction**, care outcomes, and **quality metrics**.

Not all measures hold equal weight, but health plans should expect the measures to touch on these three categories:

- **Plan** administration
- **Member satisfaction** (including customer service response, number of complaints, and number of people who leave the plan each year)
- **Management** of chronic health conditions, including access to preventive care

Proactive case management and timely response to changes in patient status are included in this as part of recent updates.

Closing Care Gaps:
A Limited Window of Time

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As Medicare Advantage plans grapple with the best ways to address performance metrics across HEDIS measures and Star Ratings, closing time-sensitive care gaps is a clear priority.

This is due to NCQA HEDIS and CMS Star Ratings metrics increasingly emphasizing time-sensitive interventions around transitions of care. For example, the **FMC HEDIS measure** requires follow-up within seven days of an emergency department (ED) visit for patients with multiple chronic conditions.

Four HEDIS Transitions of Care (TRC) measures impact Star Ratings:

Notification of inpatient admission

Documentation in the medical record of receipt of notification of inpatient admission on the day of admission or within the following two calendar days

Receipt of discharge information

Documentation in the medical record of receipt of discharge information on the day of discharge or within the following two calendar days

Patient engagement after inpatient discharge

Evidence of contact with the patient within 30 days of discharge (this can include an office visit, telehealth visit, or home visit)

Medication reconciliation post-discharge

Medication reconciliation conducted on the date of discharge through 30 days after discharge (31 total days)

The average of these four measures becomes the basis for calculating the TRC portion of a health plan's Star Ratings.

Without **timely insights**, it becomes impossible to report on or react to these measures effectively. In some cases, these key metrics hold special weight in determining Star Rating outcomes for health plans, with **CMS giving triple weight to measures** after the first year they are counted in Star Rating calculations.

Closing Care Gaps Challenges:

Closing Care Gaps:

Challenge #1

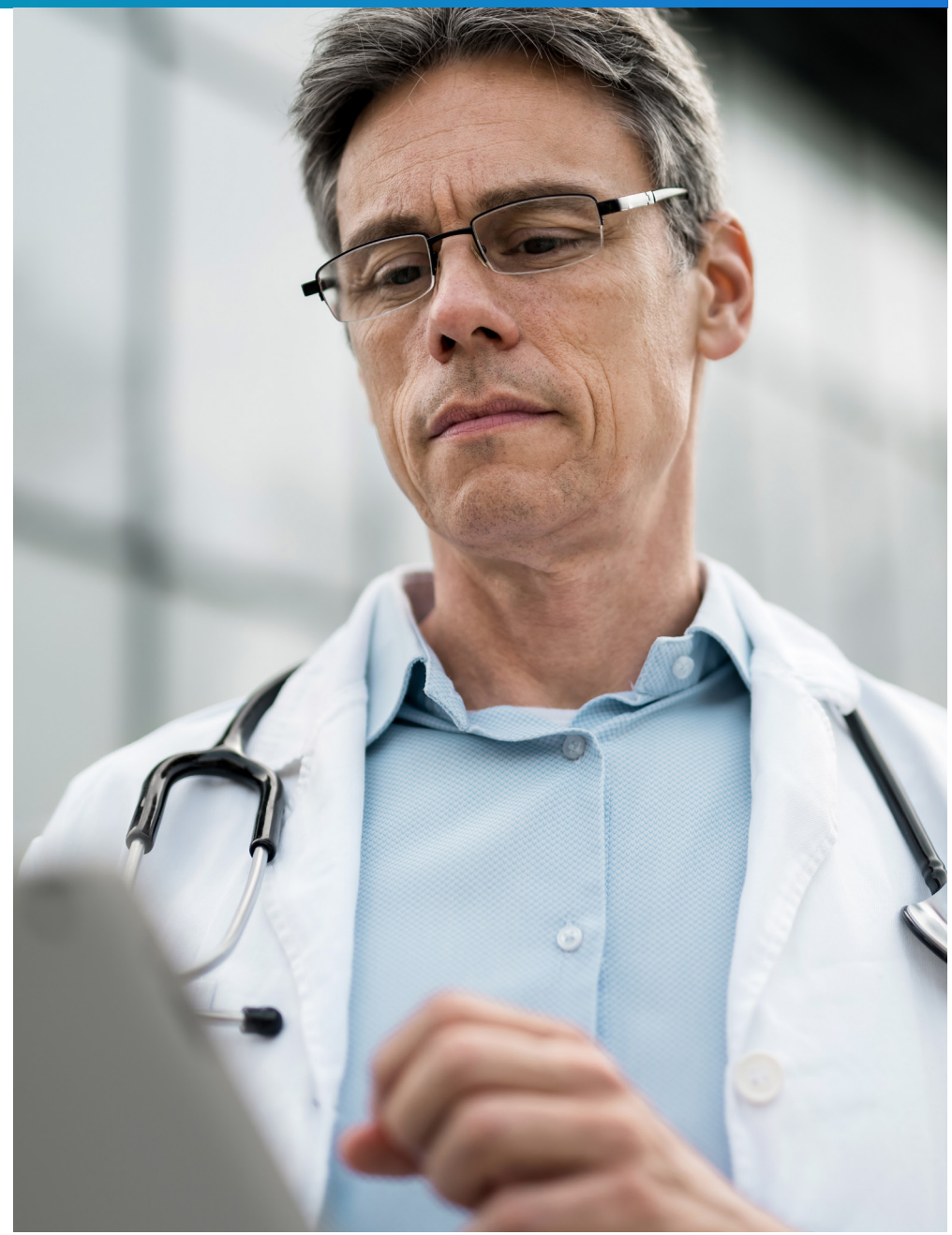
Lack of Real-Time Awareness

Historically, many health plans have relied on delayed census and claims data to gain visibility into patient status. When looking at time-sensitive measures, the data lag created by this approach prevents successfully closing gaps in transitions of care.

Open claims data from sources like pharmacies, practice management systems, and other healthcare providers, for example, typically have a **one to three week lag time**. For the time-sensitive measure "notification of inpatient admission," documentation must be sent to the member's primary care physician (PCP) on the day of admission through two days after the admission (three days total). It is easy to see how this is a critical shortfall.

CMS performance data shows how this gap in real-time data is affecting Star Ratings for payers. In 2024, the national average for meeting the display measure Receipt of Discharge Information was just 23%.

Average lag time for claims data is 1-3 weeks, far too long to successfully meet time sensitive measures that require action within 3 days of admission.



Closing Care Gaps:

Challenge #2

Data Access and Exchange Capabilities

Access to data across the care continuum is a bi-directional challenge for payers. Efficient plan-provider collaboration is hampered by manual workflows and segmented data where both plans and providers have to share critical patient alerts and status changes that may rely on outdated reports, phone calls, and searching disparate electronic health records (EHRs) for valuable and actionable patient insights.

Remember, documentation of “receipt of discharge information” noted above is just one part of the TRC HEDIS metrics — and this requires seamless communication and data visibility between health plans and the providers they notify.

Health Information Technology to Close Care Gaps: Quality and Coding Management

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Clearly, the critical need for real-time access to time-sensitive data calls for effective health IT solutions. The days of time-consuming and costly manual workflows are long past, with health IT offering health plans the opportunity to enhance transitions of care with insights that support true value-based care. By improving access to the data necessary to drive this care, health plans can successfully illustrate positive outcomes with improved Star Ratings and HEDIS measures.

Effective health IT solutions promote collaboration with seamless data exchange between payers and providers, eliminate data lags, and are designed around TRC and other HEDIS requirements to facilitate improved quality metrics. Additionally, they create conditions where intuitive data access — with alerts focused on highlighting important details about a patient's status — help health plans execute quality care.

PointClickCare's **Quality & Coding Management** (QCM) solution provides case managers with visibility into member care needs and coding gaps to help improve collaboration and timely intervention, optimizing quality, and performance metrics.

Health Information Technology to Close Care Gaps:
Quality & Coding Management

By enabling real-time collaboration, QCM allows payers to drive quality improvement across their provider networks, with the following features:

- Real-time notifications to enable proactive intervention and care coordination
- Pre-configured HEDIS specifications to streamline provider follow up and performance monitoring for members that require attention
- Actionable alerts shared with providers to address quality and coding gaps and support continuity of care
- Enhanced tracking and performance on key HEDIS and Star Ratings measures

Your Solution to Improve Star Ratings for Enhanced Health Plan Performance

If you're ready to learn more about leveraging technology for real-time visibility into to critical information needed to meet time-sensitive quality measures, request a demo today.

Learn More