eBook

How Medicare Advantage Plans Protect Stars Revenue Through Better Care

A Practical Guide for Protecting Stars Revenue, Preventing Avoidable Readmissions, and Improving Experience

Get Started

PointClickCare®

Table of Contents

Introduction: The CMS Shift

As CMS shifts Stars weight toward clinical and outcome measures, care transitions are where a growing share of bonus revenue is decided. The plans capturing it at scale aren't working harder on care transitions. They're operating on three capabilities most plans haven't built.

Capabiliity	How it unlocks Stars revenue
Real-time visibility into the moments that move the measures	The plan sees the member enter the denominator in time to act, turning every triggered measure into a closable measure.
A workflow that converts visibility into action inside the measurement window	One coordinated outreach closes multiple measures at once, multiplying yield per care manager hour and protecting revenue across the care transitions cluster.
Coordination across the plan, the provider network, and the post-acute network	The measures that depend on action outside the plan's four walls become closable, expanding the surface area of Stars revenue the plan can actually capture.

In this eBook, you'll see how to act faster on care transitions—starting with earlier, connected discharge visibility. We break down the member journey stage by stage and translate PCR, TRC, MRP, FMC, and CAHPS Care Coordination requirements into a practical operating model. You'll take away an approach for building connected workflows so your team can act within hours of discharge, reduce avoidable readmissions, improve experience, and protect Stars-driven revenue at scale.

Understanding the Financial Stakes

Before we walk through the member journey, it helps to frame what you stand to gain or lose based on your care transitions performance.

Star ratings also determine the rebate percentage retained when bidding below benchmark (65% at 3.5–4.0 stars vs. 70% at 4.5+ stars).

Metric	At 3.5 Stars	At 4.0 Stars	At 4.5+ Stars
Quality Bonus	0%	5%	5%
Rebate Retention Rate	65%	65%	70%
Bonus Value PMPM (gross)	$0	$50	$50
Plan-retained value PMPM	$0	$32.50	$35
Retained value/member/year	$0	$390	$420
Gross benchmark headroom (100K)	$0	$60M	$60M
Plan-retained reinvestment (100K)	$0	~$39M	~$42M

Why 4.0 Stars is a financial inflection point

For a 100,000-member plan with a benchmark near $1,000 PMPM, reaching 4.0 stars activates a 5% quality bonus across the entire membership: roughly $60 million in additional benchmark value each year. Plans retain 65% of that through the rebate, which translates to approximately $39 million in reinvestment capacity for richer benefits, lower cost sharing, and reduced premiums. A plan one half-star below captures none of it. At 4.5 stars, higher rebate retention (70% vs. 65%) expands that capacity further and compounds the advantage over time.

The bonus is awarded at a threshold, not earned on a curve. Nothing accrues between 3.5 and 4.0 stars, so the entire swing depends on which side of the line the contract finishes. The measures with the greatest influence on that outcome are concentrated in the care transitions cluster: Plan All-Cause Readmissions (weighted 3x), CAHPS Care Coordination (2x), and Transitions of Care, Medication Reconciliation Post-Discharge, and Follow-Up After ED Visit (1x each). Together they represent eight weighted points in the 2026 Star Ratings, all moveable through a single operational workflow.

The Member Journey: Stage by Stage

Stage 1: The Discharge Event: Identifying Who Needs You and Why

The critical moment: A member is discharged from the hospital or emergency department. Multiple time-sensitive HEDIS care gaps just opened. TRC requires action within 2 calendar days. Follow-up visits need to happen within 7 days. Medication reconciliation windows are counting down. The clock is running.

Without Connected Visibility	With Connected Visibility
Discharge events surface through claims or periodic reports days/weeks/months later. By the time members appear on a worklist, 2-day windows may already be closed.	The moment a discharge triggers a time-sensitive HEDIS measure, the member appears in a real-time prioritized worklist—same day, no claims lag.
Care managers work flat lists with no urgency stratification. A member with 2 days remaining gets the same treatment as one with 28 days.	The worklist consolidates all open gaps per member, stratified by time remaining. Members closest to deadline surface first. Care managers see how many gaps are closable in a single outreach.
There's no consolidated view of gaps per member. Assignment and tracking are manual—spreadsheets, shared inboxes, no team-wide visibility into who's working whom.	Status tracking (not started, in progress, completed) is visible across the team. No duplicate outreach, no members falling through cracks. Outreach rates by measure serve as a leading performance indicator.

What the member notices:
Instead of not hearing from the plan for days or weeks, the member is identified and queued for outreach within hours. That's when confusion, medication errors, and missed follow-ups are most likely.

Provider network activation:
At the same time the plan's care team is mobilizing, the member's PCP receives what they need. Admission notifications and discharge information are delivered directly into the provider's workflow via direct secure message, with documentation designed for audit purposes. No faxes, no manual coordination.

Stage 2: The Outreach: Arriving with the Clinical Story

The critical moment: The care manager is ready to reach the member. The quality of that outreach depends entirely on what they know before they pick up the phone.

Without Connected Visibility	With Connected Visibility
No clinical context from the encounter. The call begins with "Tell me about your hospital stay." The member educates the plan. Information gathering consumes the intervention window.	Within 24 hours, AI-powered summarization extracts key clinical details and surfaces them in the member profile: diagnosis, medication changes (with Beers Criteria flagging), discharge instructions, and follow-up requirements.
Medication reconciliation requires separate processes—faxes, portal lookups, facility calls. High-risk medications go undetected unless the member or pharmacy flags them.	The call begins with clinical context: "I see you were discharged with a CHF exacerbation, you're on three new medications, and you need a cardiology follow-up within 7 days." The care manager is guiding, not investigating.
Each call starts from zero. Time spent gathering information is time not spent addressing barriers to recovery.	Member and PCP contact info (including historical phone numbers from ADT data) are in the same workflow. The same care manager, in the same time, completes more calls that are each more effective.

What the member notices:
They speak with someone who already understands their situation, with no retelling. The conversation stays focused on what's next: medication clarity, follow-up scheduling, transportation, and support at home. This directly influences CAHPS Care Coordination.

Provider network activation:
Leading plans use member-roster-based CM assignment for a simple reason. Members answer the phone for someone they know, and they ignore calls from unknown numbers. Pickup rate is the gating factor for every downstream measure. When the assigned CM arrives with full clinical context already in hand, the relationship that drives pickup and the preparation that drives effectiveness reinforce each other in a single call.

The multiplier begins here:
A single clinically informed outreach can simultaneously advance TRC, complete medication reconciliation (MRP), and reduce readmission risk for PCR. When provider notification runs in parallel, one discharge event triggers a coordinated response across your care team and provider network. Multiple measures move through one connected workflow.

Stage 3: The Post-Acute Stay: Managing What You Could Never See

The critical moment: For members who transition to a skilled nursing facility, the episode is far from over. This is where readmissions are determined, length of stay drives cost, and discharge planning succeeds or fails. Yet most plans have historically had zero visibility. And the stakes are concentrated here: nearly 1 in 4 SNF

Without Connected Visibility	With Connected Visibility
Once the member enters a SNF, visibility drops to zero. The care management team relies on phone-based census calls, faxed records, and claims arriving weeks later. Readmission risk is invisible during the stay.	Real-time SNF clinical data is visible directly from the facility EHR—vitals, medications, progress notes, therapy notes, and functional assessments. AI-driven predictive Return to Hospital (pRTH) scoring flags high or rising rehospitalization risk while the member is still in the facility.
Discharge readiness is guessed at based on arbitrary timelines. No real-time signal of functional progress. Discharge planning is reactive—often happening with limited lead time, after the member is already preparing to leave.	Discharge readiness is grounded in clinical data (functional status, therapy progress, MDS). Discharge planning intelligence surfaces what the member will need (DME, home health, transportation, LTSS) so coordination starts before the stay ends.
Caseload management is flat—all SNF members get the same attention regardless of risk. Care managers spend significant time calling facilities and chasing records.	Risk-based caseload prioritization focuses the team on members who need intervention most urgently. SNF admission and readmission notifications enable immediate coordination.

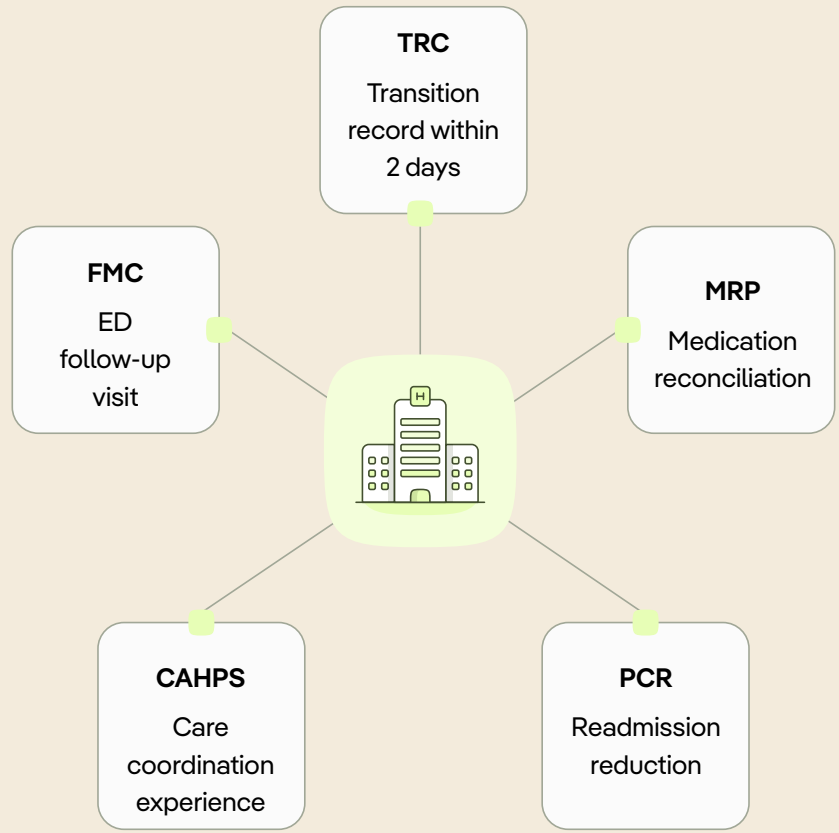
What the member notices:
When they're ready to go home, the transition is coordinated. Home health is scheduled, DME is in place, follow-up is confirmed, and transportation is arranged. For members with multiple chronic conditions or limited support, that coordination can be the difference between a safe transition and a preventable readmission.

The Multiplier Effect: How One Coordinated Transition Moves Multiple Measures

The HEDIS measures that carry the most revenue weight are not independent. They are triggered by the same event (discharge), addressed through the same workflow (transitional care outreach), and closed through overlapping clinical actions.

When your team acts on the right member within hours—with full clinical context and a complete view of all open gaps—**a single transition workflow can advance TRC, MRP, FMC, and PCR outcomes at once, while improving CAHPS Care Coordination**.

For members who transition to a SNF, this logic extends across the full episode. The initial outreach sets the foundation. Real-time post-acute visibility maintains the thread. Coordinated discharge planning ensures the transition home doesn't undo the work.



One call. One workflow.

Five measures closeable in a single outreach.

This is how plans protect quality-linked revenue through operational execution rather than measure-by-measure remediation.

Member Journey Summary: Disconnected vs. Connected Care

	Hospital Discharge	First 24 Hours	SNF Stay	Transition Home	30 Days Post-Discharge
Without Connected Visibility	Discharge invisible for days/weeks; no prioritization; flat worklists	No clinical context; information gathering consumes intervention window	Zero visibility; readmission risk unknown; discharge planning invisible	Incomplete discharge info; missed med rec; no DME/home health setup, no PCP follow up scheduled	Readmission; gaps missed; PCR penalty; member churn
With Connected Visibility	Real-time alerts; risk-stratified worklists; gap consolidation per member	AI-powered clinical summaries within 24 hours; informed, targeted outreach	Real-time clinicals; pRTH risk trending; discharge planning intelligence	Full discharge plan; medication lists delivered; service needs coordinated pre-discharge	Preventable readmission reduction, member stable; multiple gaps closed in single outreach; PCR protected; member retained
Star Measures Impacted	TRC, FMC, MRP, PCR	TRC, MRP, FMC, CAHPS Care Coordination	PCR, TRC	PCR, TRC, MRP, CAHPS	PCR, TRC, MRP, FMC, CAHPS

How Leading Medicare Advantage Plans Are Operating Today

This isn't aspirational. It's how leading plans are already executing on care transitions at scale.

Quality and care management leaders aren't looking for "one more tool." They're looking for a way to execute the same high-stakes workflow (identify, prioritize, engage, coordinate, and document) faster and more consistently across every discharge.

> "If we had continued to practice the way we were, we wouldn't have captured any of the withhold revenue."

Chief Medical Officer, National Virginia Medicaid Plan

In practice, leading plans optimize for a few things:

Speed to intervention for TRC and FMC windows

Clinical context before outreach so calls solve problems instead of gathering facts

Provider activation in parallel (PCP notified and equipped, not chasing faxes)

Post-acute visibility to reduce avoidable readmissions and manage length of stay

One connected workflow with audit-ready tracking, plus less swivel-chair work between vendors

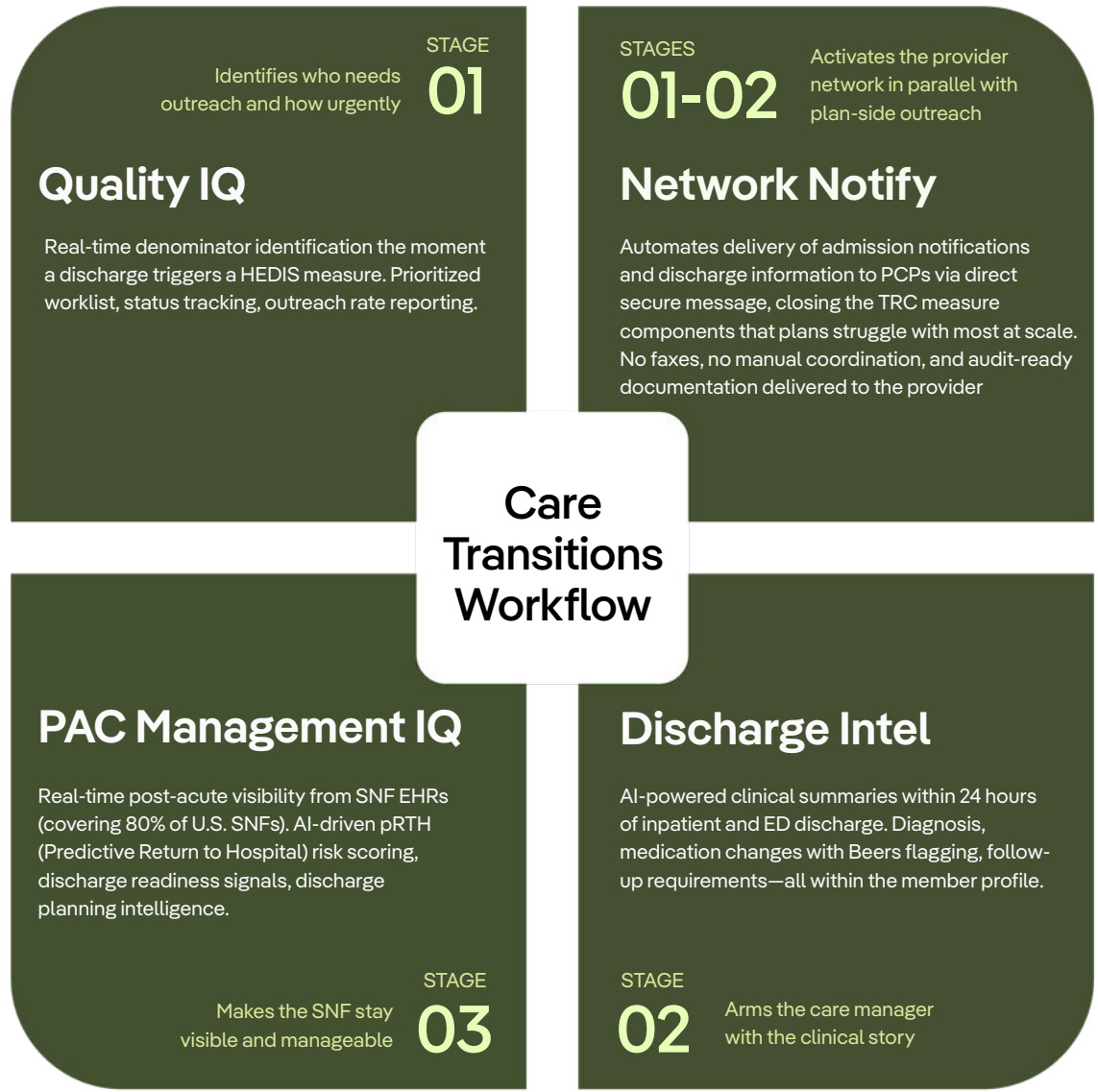
That's why portfolio synergy matters. When the discharge signal, encounter documentation, provider notifications, and post-acute clinicals all run on the same connected network, you reduce handoffs and make the transition workflow repeatable at scale.

Together, four capabilities work as one care transitions workflow. The data follows the member, and each step (plan outreach + provider coordination + post-acute management) reinforces the next.

Why it matters:

The average TRC Star Rating across all MA contracts is 3.1 in the 2026 Star Ratings. This means most plans are underperforming on a measure that is fundamentally an operational and data-exchange problem, not a clinical one.

> Post-acute care is where risk concentrates, but visibility often disappears. The measures with the most financial weight require the fastest action in the settings where you typically have the least insight.



Conclusion: From Exposure to Competitive Advantage

Care transitions have long been a major point of exposure for many Medicare Advantage plans. Visibility is limited, insight is delayed, and windows are narrow. In those windows, the right action makes a measurable difference. These moments are decided quickly, often in hours, not days.

Connected visibility turns those same transition moments into an operational advantage.

With connected visibility, you can see critical transition moments as they happen, equip your care teams with the right context, and act with confidence at scale. PointClickCare helps you turn post-discharge uncertainty into a disciplined, repeatable workflow. As a result, transitions are managed with intention and Stars-driven revenue is protected.

Ready to see how it works in your environment?

Learn more at PointClickCare.com/industry-challenges/real-time-quality-performance/, or contact us to schedule a tailored walkthrough of how our solutions support your quality and care management goals.

Learn More **Schedule a Demo**

PointClickCare is a leading health tech company with one simple mission: to help providers deliver exceptional care. With the largest long-term and post-acute care dataset, we power AI-driven healthcare to deliver intelligent transitions, insightful interventions, and improved financial performance. Enhanced by our Marketplace of 400+ integrated partners and trusted by over 30,000 provider organizations and every major U.S. health plan, we're redefining healthcare, so it doesn't just survive — it thrives.

Discover more

PointClickCare®

Scan to Discover more