eBook

What 4-Star Plans Do Differently: An Executive Guide to Building Better Star Rating Performance.

The operating model behind time-critical Star measures

Get Started

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Table of Contents

Page

3 The Multiplier Effect

4 The Rating Is Set. The Next Measurement Year Is Already Underway

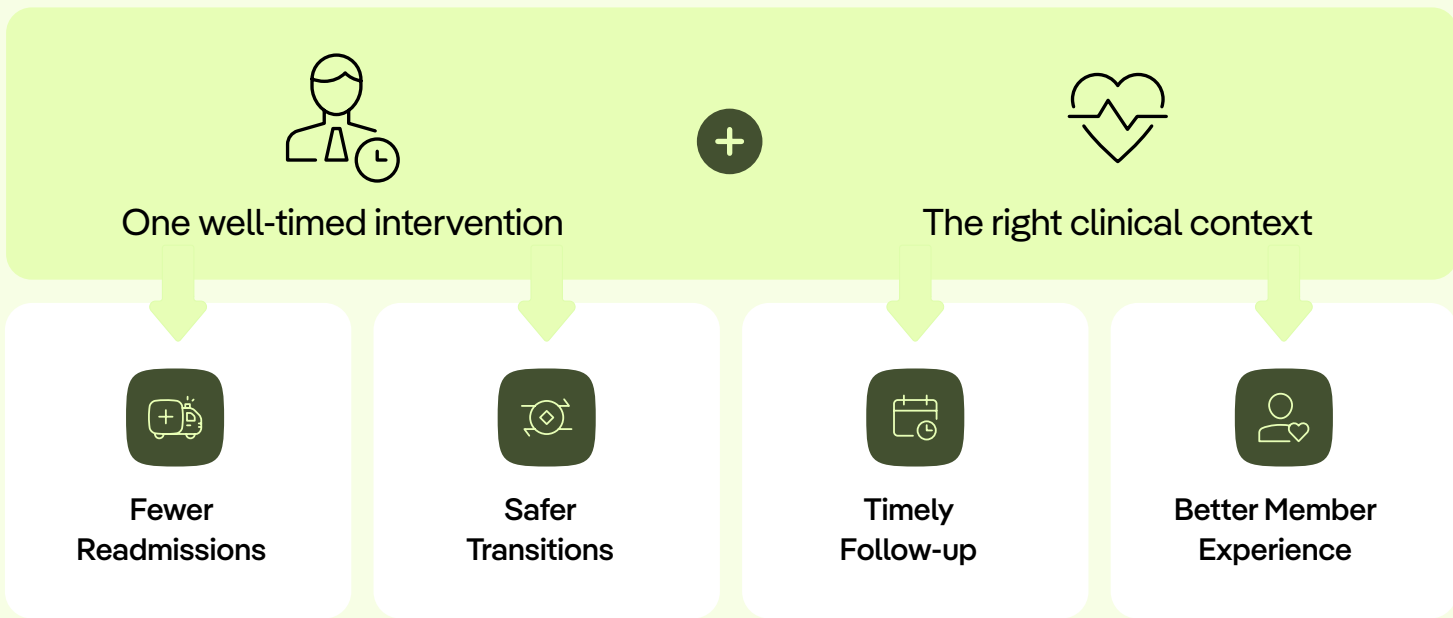
6 Where Star Performance Is Won or Lost

7 What 4-Star Plans Do Differently

11 What to Build for Your Teams Now

12 Every Discharge Is a Measure in Motion

The Multiplier Effect



One well-timed intervention, supported by the right clinical context, can advance readmissions, transitions, follow-up, and the member's experience of care coordination at the same time.

The Rating Is Set. The Next Measurement Year Is Already Underway.

When Star Ratings are released, the number quickly becomes a business conversation. Some plans are looking at a rating they did not expect. Others are holding 4 Stars and wondering how long they can. Either way, the stakes are significant. Contracts rated 4 Stars or higher qualify for quality bonus payments.[1] Star performance also affects rebates that help fund the benefits members compare at enrollment. CMS reports that Medicare Advantage rebates have remained above $2,400 per member annually on average.[2]

To put those stakes in perspective, for a 50,000-member contract, quality bonus payments could represent roughly $20 million a year in additional Medicare payments, based on published industry averages.[3] This illustrative estimate uses an average payment increase of approximately $400 per enrollee in bonus-eligible plans. The more useful question is operational: What capabilities help plans reach 4 Stars, hold that performance, and build from wherever they stand today?

★★★★

4 Stars or higher qualifies contracts for quality bonus payments.[1]

$2,400+

Average annual Medicare Advantage rebate per member, as reported by CMS.[2]

$20M

Illustrative annual quality bonus payments for a 50,000-member contract.[3]

[1] Centers for Medicare & Medicaid Services, Medicare 2027 Part C & D Star Ratings Technical Notes, quality bonus payment eligibility requirements.
[2] Centers for Medicare & Medicaid Services, "2026 Medicare Advantage and Part D Advance Notice Fact Sheet," January 2025.
[3] KFF, "Medicare Will Spend More Than $13 Billion on the Medicare Advantage Quality Bonus Program in 2026," August 2026.

Quotes from Brendan Generelli and Kari Clements throughout this guide are drawn from the Fierce Healthcare webinar, **One Transition, Multiple Measures: Protecting Quality Revenue in an Outcomes-First Era.**

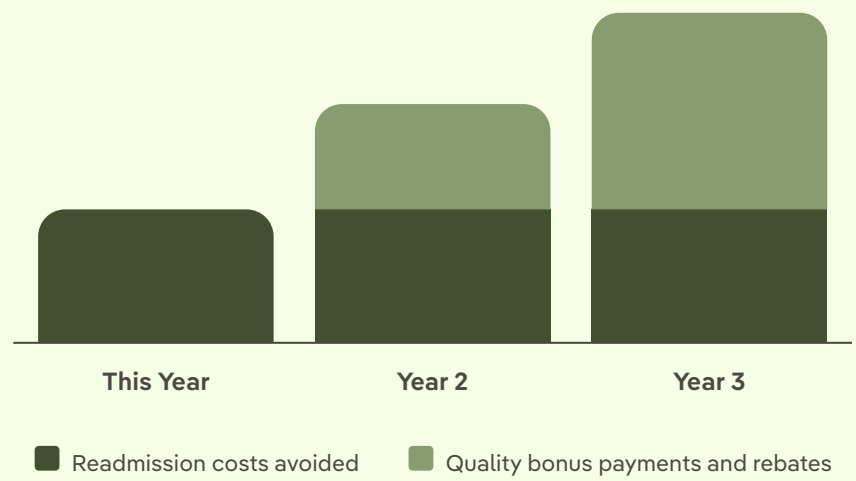
> Take that $18,000 average readmission cost times all of your members who got readmitted — you have a couple million dollars you can bring to your CFO and say, with a more effective transition of care program, we can reduce this.

Brendan Generelli
Director of Medicare Stars and Quality,
Johns Hopkins Health Plans

Annual Readmission Costs	
Readmission cost savings	Remaining Cost

For finance leaders, the most immediate return is not a future ratings cycle. It is the cost avoided this year when better transitions prevent even a portion of costly readmissions.

Stronger Star performance can then compound that value over the next two to three years through quality bonus payments and more favorable rebates, giving plans a near-term savings case and a longer-term revenue case for investing now.



Where Star Performance Is Won or Lost

The CY 2027 Final Rule removed 11 administrative measures from the Star Ratings program.[4]

CMS is rebalancing Star Ratings toward clinical outcomes. In the 2027 measure set, Plan All-Cause Readmissions carries triple weight, while patient-experience measures have been rebalanced to double weight.[5]

> CMS has moved this measure set to a place where it is no longer checking boxes. It really is about managing the member...This is not an era in HEDIS where we can any longer just focus on gap closure.
>
> **Kari Clements**
> Staff Vice President,
> HEDIS Improvement, Elevance Health

The same capabilities that help teams act inside today's time-critical measure windows also create the foundation for improving outcomes as CMS continues to evolve the program. Outcomes cannot be improved retrospectively; plans need timely signals, clinical context, and coordinated action while there is still an opportunity to change what happens next.

The effect is that more of a plan's rating depends on what happens while members are in motion: leaving the hospital, the emergency department, or a skilled nursing facility. Yet many plans still manage these transitions in claims time, learning what happened weeks or months after the opportunity to act. The measures that shape the rating do not wait that long.

The deadlines are unforgiving. Readmissions are measured during the 30 days after discharge. Key Transitions of Care activities begin on the day of admission or discharge and extend only two calendar days. Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC) closes in seven days for eligible members.[6] These are not reporting problems that can be solved after the fact. They are execution windows. Delayed or fragmented information can leave teams without the context to act before those windows close.

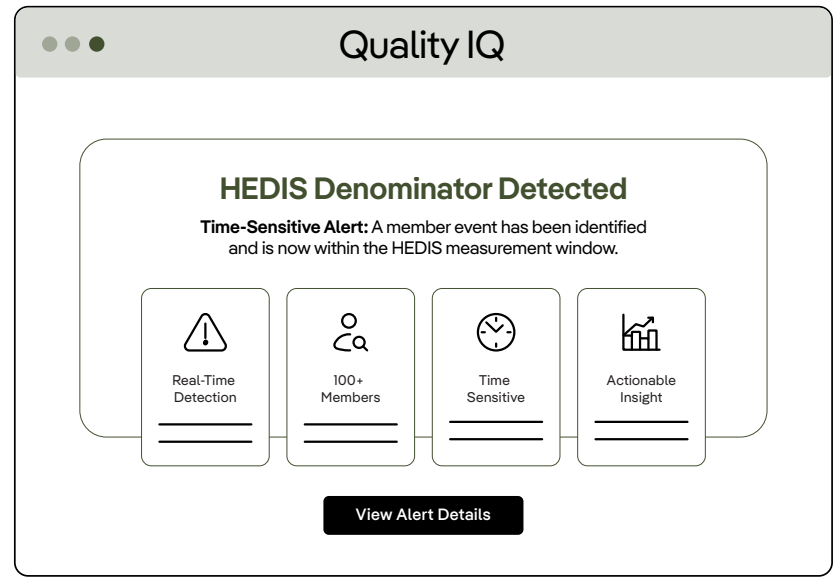
[4] Centers for Medicare & Medicaid Services, "Contract Year 2027 Medicare Advantage and Part D Final Rule," April 2, 2026.
[5] Centers for Medicare & Medicaid Services, "2026 Medicare Advantage and Part D Advance Notice Fact Sheet," January 2025.
[6] Centers for Medicare & Medicaid Services, "Medicare 2027 Part C & D Star Ratings Technical Notes.

What 4-Star Plans Do Differently

1 They See the Transition in Real Time

High-performing operations do not wait for a claim to confirm that a member was admitted, discharged, or moved to a skilled nursing facility. They capture the transition as it happens and turn it into prioritized work. A member with two days left in a measure window should not sit beside one with 28 days remaining on a flat list.

In practice, this means one reliable view of members in motion across hospital, emergency department, and post-acute settings. Work is ranked by urgency, risk, and days remaining in the relevant measure window, not divided across disconnected spreadsheets and queues.



What this asks of your team:

Work one prioritized list, with clear ownership and escalation rules.

2 They Act Inside the Window With the Clinical Story in Hand

The first outreach should begin with context, not investigation. The care manager should already know why the member received care, what changed, what follow-up is required, which medications need review, and what barriers could derail the plan.

That changes the conversation. Instead of spending the opening minutes reconstructing the episode, the care manager can guide the member through the next step. At the same time, the plan can ensure the appropriate provider receives admission and discharge information within the required window and document that the handoff occurred.

Reducing readmissions, strengthening discharge planning and safe transitions, and helping care managers focus on the members who need attention first are not separate priorities. They depend on the same operational foundation: timely information, clear prioritization, and clinical context that supports action.

The Care Manager Should Already Know

- ✓ Why the member received care
- ✓ What changed
- ✓ What follow-up is required
- ✓ Which medications need review
- ✓ Barriers that could derail the plan

What this asks of your team:

Begin each outreach with clinical context in hand, coordinate provider handoffs within the required windows, and spend time resolving barriers rather than reconstructing the episode.

3 They Can See Inside the Post-Acute Stay

Post-acute is where risk concentrates and visibility often disappear.

Most plans are missing these windows. In the 2027 Star Ratings, 268 out of 510 Medicare Advantage contracts scored below 4 Stars on Transitions of Care, and the average rating on the measure was 3.4.

This is not a knowledge gap. Plans know the windows. It is an information gap: the signal arrives after the window closes.

2027 Star Ratings Transitions of Care

268 out of **510**

Medicare Advantage contracts scored below 4 Stars on Transitions of Care.

3.4

Average Star Rating on the measure

PointClickCare analysis of CMS 2027 Star Ratings measure data.

> The skilled nursing facility angle, from a health plan perspective, is pretty blank space. I don't think health plans have done a lot of engagement with their skilled nursing facilities to improve the transition from the SNF to home... it's one that healthcare may have overlooked or taken for granted. We really need to focus in on that as an industry.
>
> **Kari Clements, Elevance Health**

Most plans have accepted this stretch of the journey as unmanageable. They assume the information inside the facility is out of reach. Care managers are left calling the SNF to ask whether the member is still there, how the stay is progressing, and what comes next, or waiting for the claim to arrive. Leading plans have stopped accepting that delay.

> I think there are oodles of opportunities with utilizing SNF data. It's one that's globally untouched by a lot of health plans...from a large payer perspective, it's a big opportunity.
>
> **Kari Clements, Elevance Health**

They treat the SNF stay as a period worth managing and equip their teams with timely clinical information while there is still an opportunity to act.

Leading operations manage risk while the member is still in the facility. They can see the course of the stay, including changes in condition, medications, therapy progress, and signs that readmission risk is rising. They can also see the discharge plan taking shape before the member leaves, while there is still time to confirm follow-up, equipment, home health, transportation, and member instructions.

What this asks of your team:

Treat the SNF stay as an active quality-management period, with clear ownership for monitoring risk, coordinating next steps, and intervening before the member leaves the facility or returns to the hospital.

For a closer look at the post-acute capabilities that support this work, see The Post-Acute Levers Inside Your Star Rating.

What to Build for Your Teams Now

Make Transition Risk Visible Early Enough

Give teams one real-time view of hospital, ED, and post-acute transitions, with work prioritized by urgency and risk.

Enable teams to act before the window closes

Put timely clinical information in front of care managers, route outreach clearly, and capture documentation as work happens.

Maintain Visibility After Discharge

Surface post-acute updates, readmission risk, discharge plans, and support needs while there is still time to intervene.

Fully Align Your Network

Deliver timely admission and discharge updates, coordinate plan and provider outreach, and replace one-off handoffs with consistent collaboration.

Build workflows that scale across transitions

Keep data, accountability, and early performance indicators connected as members move across hospitals, post-acute providers, and community-based care.

Use these capabilities to assess where your operating model is ready to support time-critical measures and where teams may still be working in claims time.

Operational control, not another dashboard:
Tie each capability to a measure window, a day-to-day workflow, and a leading indicator leadership can monitor before the next annual rating.

Every Discharge Is a Measure in Motion

The next rating will reflect work happening now.

> CMS wants to move away from checking the box to how did you help the person at the end of the day?
>
> **Brendan Generelli, Johns Hopkins Health Plans**

Plans working to reach or hold 4 Stars do not leave transition dependent measures to delayed data and after-the-fact follow-up. They give teams **timely signals, actionable clinical context**, and **visibility through the post-acute episode.** Compare your operating model against these three capabilities. The gaps will show where the next improvement plan should begin.

Use the self-diagnostic toolkit to identify which capabilities are in place, where teams are still working in claims time, and which gaps deserve priority this measurement year.

Get Toolkit

Measures used by 4-Star Plans

- **Timely transition signals**
- **Actionable clinical context**
- **Visibility through the post-acute episode**

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.

By bringing hospital, emergency department, and post-acute signals into more connected workflows, plans can move from delayed investigation to earlier, more informed intervention.

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