Beyond Star Ratings:
The Quality-Revenue Link

HOW PAYERS ARE **RETHINKING QUALITY**
IN A SHIFTING PAYMENT LANDSCAPE

Time for Quality and Revenue to Link Up

Payers find themselves in limbo. In what is now a $4.5T healthcare industry, the push to meet quality performance standards has in many ways converged with the push to be profitable. At least it ought to: quality and revenue need each other for growth.

65% of healthcare executives say the development of growth strategies for increasing revenue is a top priority. Fifty-three percent say it's improving consumer experience, engagement, and trust (Deloitte).

At the same time, 70% of healthcare consumers say they can't afford healthcare now or couldn't if costs increase (PwC). And healthcare insurance costs are certainly increasing (Government Accountability Office). All of which leaves organizations looking for innovative ways to meet both consumer demands and organizational growth imperatives.

Can better quality go hand in hand with better revenue?

Yes. But payers will have to adapt. In this ebook, we'll look at what payment leaders can do in response to growing financial pressures, without sacrificing their north star:

Member-centered outcomes.

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A Changing World for Health Plans

Regulatory Shifts and Financial Pressures Mount

Health plans face unprecedented challenges. Recent shifts in regulatory expectations have created significant concerns, especially with respect to revenue and cost management.

Plans are struggling to keep up with all the updates, memos, and new requirements. These include significant changes to Star ratings, data sharing, and interoperability stipulations. Additionally, the new focus on the most vulnerable members adds another layer of complexity.

Medicare Advantage Snapshot:

In 2024, 32.8 million people (54% of the eligible Medicare population) were enrolled in a Medicare Advantage plan (Kaiser Family Foundation)

Enrollment in Special Needs Plans increased 14% between 2023 and 2024 (Better Medicare Alliance)

3.92

Average Star Rating for an MA-PD Plan in 2024 (CMS, Star Year 2025)

The increased membership and change in risk pools puts pressure on health plans to streamline operations, cut costs, and improve quality performance, all while trying to stay profitable. As plans grapple with how to address these challenges, the need for innovative solutions and strategic planning has never been more critical.

Elimination of 5% coinsurance for catastrophic phase

Addition of opt-in for maximum monthly cap for Prescription Payment Plan

Proposed health equity index (HEI) reward, beginning with the 2027 Star Ratings

Part D $2,000 cap on prescription costs

So Many Regulatory Changes, It's Hard to Keep Up

Clarifications and revisions to the regulations governing Utilization Management Requirements

4.33% increase in MA payments (on average) from 2025 to 2026 (CY 2026 Advanced Notice)

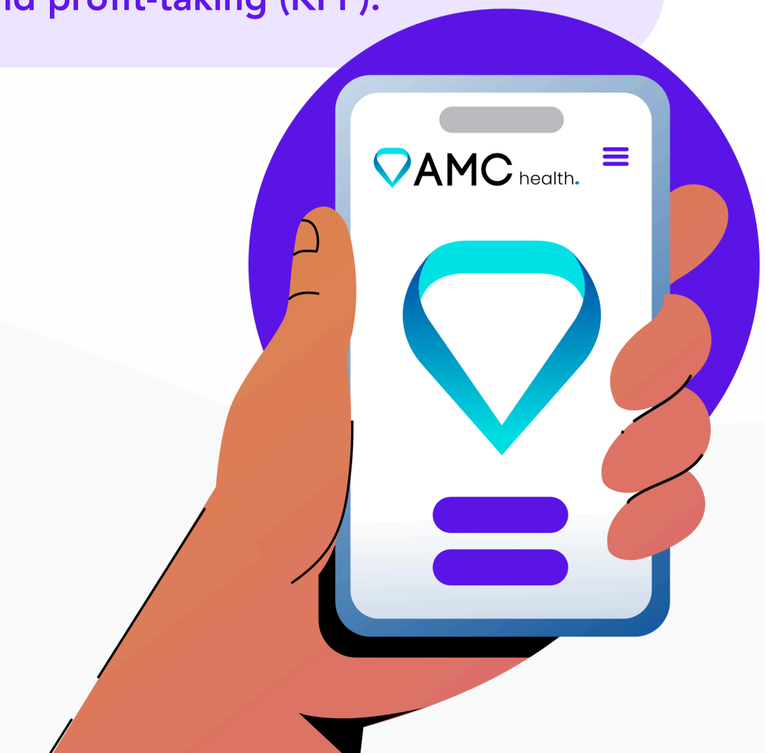
Expansion of Low-Income Subsidy (LIS) or Extra Help program

Source: Contract Year 2026 Policy and Technical Changes (CMS)

Strategies for When Star Ratings Aren't Enough

For years, efficacy has been the name of the game for Quality. Now, as the discipline faces more questions about cost—"what's the ROI on this"?—it's time to get creative. To achieve a greater balance between efficacy and cost—to improve, individualize, and tailor different programs—Quality must ask the tough questions.

Forecasting ROI is difficult, but critical: Insurance companies must spend at least 80% premium dollars on claims and quality improvement, leaving only 20% for admin, marketing, and profit-taking (KFF).



Are we harnessing data and analytics to drive meaningful quality improvements?

How can we integrate digital health tools to elevate our service quality and care?

Do we need to address any organizational siloes?

Is our approach to quality improvement a continuous or periodic effort?

How do we empower our team members to champion quality initiatives?

1. Unlock Data and Analytics

“Who are our at-risk members and how can we tailor interventions more effectively?”

Information may well be a payer’s most critical asset. Moving forward, successful plans will:

- **Gather data across member touchpoints**
- **Understand what member data to gather**
- **Structure data for cross-organizational access**
- **Use advanced analytics to uncover critical insights**

Data-Driven Decisions and Member Engagement

Health plans have a wealth of data; in order to effectively tailor their programs, plans must make that data actionable. This requires effective data collection, management, and analytics, which can in turn inform more efficient program strategies, outreach, and support.

Every member touchpoint, each communication and digital interaction, creates valuable data. Advanced plans will strategize around democratizing access to this data:creating cross-functional teams or member communications governance structures supports efficient resource allocation as well as a holistic understanding of member experiences and health outcomes.

Spotlight: Predictive Analytics

Predictive models can simultaneously help member experience and the bottom line. Predictive AI, in particular, has proved effective in deepening the scale and business value of these models. Forward-thinking payers use predictive analytics to not only understand specific patient needs, but evaluate their plan's ability to provide the required care. This is especially true of predicting and planning for future high-risk populations.

Studies show that AI predictive analytics can be effective in detecting conditions, predicting post-op surgical recovery and complications, and forecasting conditional prognosis and therapeutic effectiveness (National Institute of Health).

Real-Time Data Transfer

Advancements in Internet of Things (IoT) and 5G capabilities open new doors for real-time data transfer in healthcare. In the field of remote patient monitoring, for example, IoT-enabled devices allow providers to collect patient data for analysis and intervention, with great potential to improve patient outcomes (Healthcare IT News).

Yet gathering and leveraging patient data is one thing; keeping it secure, in accordance with the latest regulatory guidelines, is wholly another. In December 2024 alone, there were 66 large healthcare data breaches reported to the Department of Health and Human Services Office for Civil Rights (The HIPAA Journal).

2. Integrate Digital Health Tools

“When was your last colonoscopy?”

It’s time to find better ways to interact with members. Start by meeting members where they are—tap into people’s lives the way they’re already interacting with digital, be it particular devices, mobile apps, or social media.

Benefits of Integrated Digital Health Tools:

- Run pulse surveys
- Recommend interventions
- Inform and educate
- Gather patient data
- Personalize the member journey

The goal is to create an ecosystem of tools that enhance the member experience. While this requires considerable backend work, on the behalf of vendors and health plans, the frontend result can be a seamless digital experience that allows for richer data capture.

Getting the Fundamentals Right

You’d be surprised how many plans still don’t offer basic digital health tools, such as blood pressure monitoring, or accessible telehealth. Accessibility is paramount when meeting the needs of the people who need the most support. When selecting digital health vendors, consider whether they:

- ✓ Allow for low-broadband access
- ✓ Cater to limited language proficiency
- ✓ Account for less sophisticated tech (Bluetooth, for example)
- ✓ Include underrepresented and at-risk communities

Today, up to 24% of Americans don’t have a broadband connection to the internet, rendering mobile health technology useless (npj Digital Medicine). **For more on expanding digital access in healthcare, see the Digital Healthcare Equity Framework from Johns Hopkins Bloomberg School of Public Health.**

3. Burst the Quality Bubble

"We might have different goals, but don't we both need the same information to achieve them?"

Historically, departments within health plans have remained siloed from each other. Quality often operates as a small team, where the focus may be on Star ratings, HEDIS®[1], and accreditation efforts. Risk, finance, and case management (among others) operate in their own siloes, too, with little interplay between different rooms in the house.

In this new paradigm, the silos must come down.

Encourage Cross-Functional Collaboration

Foster collaboration between different departments, such as quality, risk, member services, and claims.

Enable Data Sharing and Transparency

Share data and information across departments to align goals and improve overall performance.

Enlist Leadership in the Cultural Shift

Lean on leaders to foster a "culture of quality" and make silo-busting a top priority within the organization.

Push for Transparency
Transparency across all levels of leadership is key. When department leaders understand organizational goals and their impact on finance and growth, they can align their projects effectively. The more stakeholders see how their efforts influence key metrics, the more engaged and invested they become.

1 HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)

4. Make Quality a Year-Round Sport

"Should we be doing more?"

Gone are the days of relying on the "Q4 Push." Quality improvement has become a year-round effort, centering on the members' journey within the plan. It's not just about the fourth quarter push, or seasonal spikes. It's about building a holistic understanding of all that goes into each member's healthcare, then meeting members where they are.

YEAR-ROUND QUALITY FOCUS

- Quarterly quality audits
- Employee training
- Key performance indicators (KPIs)
- Culture of continuous improvement
- Quality management software
- Provider- and partner-level collaboration

OPTIMIZE MEMBER TOUCHPOINTS

- Customer journey mapping
- Omnichannel communication strategy
- Data-backed personalizations
- UI/UX optimizations
- AI-powered process automations
- Regular member feedback

BALANCING INVESTMENT AND ROI

- Cost-benefit analyses
- High-impact initiatives
- Performance monitoring
- Vendor and partner relationships
- Regulatory compliance
- Culture of financial stewardship

AVOID MISSED OPPORTUNITIES

- Member data insights
- Maximized touchpoint engagements
- Proactive care recommendations
- Member advisory board
- Competitive intelligence
- Cross-functional enablement

5. Champion Quality

“How much will this actually cost?“

When the entire organization understands their role in Quality improvement and incentives are aligned, championing quality becomes a team activity. With transparent and structured data, Quality teams are better equipped to make the business case for home-health blood pressure monitoring, or a data and analytics platform.

Moving forward, aligning quality and performance means answering the tough questions:

- **Why are we going to spend this money?**
- **How does it align with strategic goals (member outcomes, network enhancement, efficiency)?**
- **Do you have evidence that it will be worth the investment?**
- **How many years has the partner collected virtual patient care data?**
- **How are you going to evaluate the program post-implementation?**

Show, Don’t Tell

Stewarding quality means helping the other parts of the organization see how their efforts impact Quality. From member services, to claims and case management, everyone has a part to play. The onus is on Quality leaders to help other parts of the organization understand their piece.

Partner with Risk Adjustment

Quality and Risk Adjustment go hand-in-hand. These departments can join together to better understand the population being served, identify interventions, and report outcomes across quality and revenue. A collaborative business case may include:

- Population assessments
- Cost and revenue forecasting
- Quantified operational and financial risk
- Integrated long-term planning

Undervalued Skill: Project Management

Professional project managers handle less than half of projects. And only 36% of organizations realize the benefits that their projects were meant to deliver (Wellingtone). Now more than ever, Quality leaders have to pull people together to monitor, track, evaluate, and report on their projects. Look for PM skills to become indispensable in this space—especially on the execution side, where only 60% of planned value is realised (Harvard Business Review).

Next Steps

In periods of great flux, successful organizations find ways to adapt. For payers, this means navigating a shifting regulatory, technological, and consumer landscape. It means taking pragmatic steps toward aligning projects and programs across the organization, in service of both quality and overall business growth.

Thankfully, you don’t have to go it alone. From data and analytics to member engagement and cross-functional collaboration, the right partner can help reduce time to value for your most pressing initiatives.

To learn more about how AMC Health can support and optimize your Plan's ability to positively impact member care and outcomes—to drive greater ROI—visit www.amchealth.com or talk to one of our experts today.

About AMC Health

For more than 20 years, AMC Health has been a leader in end-to-end digital health solutions that provide care-connected insights that empower the right clinical decisions. Get in touch with a member of our team today to learn what AMC Health can do for you and your members.

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