AAVBC
AMERICAN ACADEMY OF VALUE BASED CARE

Transitions of Care

Quick Reference Guide

2026

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MEASURE SNAPSHOT

CMS Part C Star Measure: C20 – Transitions of Care

CMS Definition: The percentage of patients who received follow-up care **after a hospital stay**. Follow-up care includes receiving information about the health problem and next steps, having a visit or call with a doctor, and having a doctor or pharmacist confirm that the patient's medication records are current.[1]

The measure is calculated as the average of four component rates: **Notification of Inpatient Admission**, **Receipt of Discharge Information**, **Patient Engagement After Inpatient Discharge**, and **Medication Reconciliation Post-Discharge**.[1]

FIELD	ENTRY
CMS measure name	Transitions of Care, TRC
Domain	Managing Chronic (Long Term) Conditions
CMS weighting category	Process Measure
Weight	**1 — standard-weighted**
Primary data source	HEDIS — claims and medical-record documentation
Unit of measurement	CMS contract-level measure; individual clinicians and practices do not receive a C20 Star Rating
Trend direction	Higher is better
Case-mix adjusted	No[1]
Measurement period	01/01/2024 – 12/31/2024, two years before reporting year[1]
Star measure credit	Each eligible discharge is assessed on all **four components separately**. Credit comes from qualifying claims and encounter data or from dated documentation in the outpatient record that meets the NCQA specification. The two notification components depend on the record; there is no survey and no patient-reported pathway[1,2]
Composite structure	The health plan score is the mean of the four component rates. Each component is assessed against its own measurement window: • **Notification of Inpatient Admission**; within 3 days of admission • **Receipt of Discharge Information**; within 3 days of discharge • **Patient Engagement After Inpatient Discharge**; within 30 days of discharge • **Medication Reconciliation Post-Discharge**; within 31 days of discharge