AAVBC

AMERICAN ACADEMY OF VALUE BASED CARE

Transitions of Care

Quick Reference Guide

2026

Table of Contents

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

FIELD	ENTRY
Statistical method	Clustering. Cut points are **recalculated each year** from the distribution of health plan scores and are not fixed targets[1]
Not reported for	Prescription Drug Plans[1]
Reporting codes (support administrative capture)	**CPT II 1111F**: discharge medications reconciled with the current outpatient list; billable alone, no visit required **CPT 99495 / 99496:** Transitional Care Management, when the contact and visit timing requirements are met The two notification components have no reporting code, they are established through dated documentation in the outpatient record[2]

ABBREVIATIONS: CMS = Centers for Medicare & Medicaid Services; CPT = Current Procedural Terminology; NCQA = National Committee for Quality Assurance; TRC = Transitions of Care

Measurement Timeline Example (2026 Reporting Year)

Care Delivered
Eligible discharges and all **four component actions**, January 1 to December 31, 2024, with eligible discharges ending December 1 so every discharge gets its full 31-day reconciliation window[1,2]

↓

Data Reported
HEDIS reporting and medical-record review during 2025, through the health plan's certified HEDIS submission

↓

Published Rating
Reported in the 2026 Star Ratings, published October 2025[1]

↓

Payment Year
Contributes to the Star Rating used for 2027 Medicare Advantage quality bonus determinations
The 2026 Star Rating reflects discharges that have already happened and windows that have already closed. A discharge managed well this month is measurement-year 2026 care and will appear in the **2028** Star Ratings[1]

In One Sentence

For every eligible hospital discharge, this measure asks **four questions: did the practice learn of the admission within 3 days, receive the discharge information within 3 days, see or speak with the patient within 30 days, and reconcile the medications within 31 days.** The health plan Stars score is drawn from the **average of the four rates**.

CMS Cut Points

These are the CMS base-group cut-point ranges used for the 2026 Star Ratings. Final measure-level Star assignment also incorporates CMS statistical significance testing; the cut points from the 2024 measurement year can be used as a directional benchmark but should not be interpreted as guaranteed prospective thresholds.

PLAN TYPE	1 STAR	2 STAR	3 STAR	4 STAR	5 STAR
MA/MA-PD	<44%	≥44% to <56%	≥56% to <69%	≥69% to <79%	≥79%

ABBREVIATIONS: MA = Medicare Advantage; MA-PD = Medicare Advantage Prescription Drug

2026 Industry Performance

National Numeric Average: The **Transitions of Care (C20)** measure has a **national average rate of 63%**, corresponding to anaverage measure rating of **3.1 Stars** in the 2026 Star Ratings.

Component Variance: The composite does not apply evenly across the four components. The two 3-day notification components are generally the hardest to sustain, since a missed window cannot be corrected afterward. The 30- and 31- day components are typically easier to improve.

Broader MA market context: Roughly **64%** of MA-PD enrollees are in health plans rated four or more Stars for 2026, and 18 MA-PD health plans earned an overall 5-Star rating.[3]

WHAT THE MEASURE IS ASKING

AAVBC PERSPECTIVE

C20 is measured primarily through **claims data**. Where no qualifying code reaches the plan, credit for that component is instead determined by what is documented in the outpatient record. **Each of the four components have their own measurement window**. The window begins on the date of the inpatient admission or discharge, depending on the component.

In Plain Language

The days following a hospital discharge require **close attention**. Roughly **one in five patients** experience an adverse event within three weeks of discharge, most commonly an **adverse drug event**, and a substantial share of these events are preventable or ameliorable.[4] This measure checks whether the outpatient practice was connected to the hospitalization: whether it learned of the admission, received the discharge information, saw the patient, and reconciled the medications.

For care teams, the priority is **straightforward**: identify the admission or discharge as soon as possible, obtain the discharge summary, complete the follow-up visit, reconcile medications, and document each action with the date it occurred and who performed it.

CLINICAL PEARL: EARLY OUTREACH REDUCES READMISSIONS

The measure allows up to **30 days** for the engagement visit, but treating 30 days as the target increases readmission risk. **Outreach within 72 hours of discharge**, and **a visit within 7 to 14 days**, is associated with lower 30-day readmission rates and lower utilization than following up later in the 30-day window. Practices should treat **72 hours and 7 to 14 days** as the working targets, not the measure's 30-day deadline.

Why it Exists

Transitions of care from hospital to outpatient settings commonly involve gaps in communication and coordination. **Direct communication between hospitalists and primary care clinicians occurs in a small minority of discharges**, and the discharge summary is available at the first post-discharge visit as little as 12% to 34% of the time.[5] Patients are frequently discharged with new or changed prescriptions, and roughly a quarter of medication changes made at discharge are not followed up within 30 days.[6] The four components of this measure address the points where these gaps most commonly occur.

QUALITY OUTCOME — WHAT THIS MEASURE PROTECTS

A timely outpatient follow-up visit after discharge is associated with roughly a **21%** lower risk of 30-day readmission in pooled analyses across heart failure, COPD, myocardial infarction and stroke populations.[7] **Medication reconciliation** performed by **telephone** in the first week after discharge **identifies discrepancies** between the discharge and outpatient medication lists before they could cause harm. The windows in this measure align with the period when post-discharge deterioration is most common.

What a Care Team Actually Controls

Star Ratings are calculated at the CMS contract level, not for individual clinicians or practices. Care teams nevertheless influence the clinical experiences and workflows that contribute to measure performance. What follows is the part of this measure a care team can influence directly.

CARE TEAM CAN DIRECTLY INFLUENCE	INFLUENCED, SHARED WITH OTHERS	OUTSIDE THE PRACTICE
• Acting on admission and discharge alerts the **same day or within 72hrs** • **Date-stamping receipt** of the notification and the discharge summary • **Completing and documenting medication reconciliation** • Delivering a qualifying **visit** or **telehealth** contact inside **30 days**, **recommended inside 14 days** • Billing the TRC codes in time, codes only apply for **less than 7 days** and **14 days for a TRC visit**	• Whether the hospital's ADT feed and discharge summary actually arrive, and **arrive complete** • **Health information exchange** participation • The plan's **Supplemental-data** handling and **medical-record** review • Caregiver availability for the **follow-up**	• **Who** gets admitted and **where** • The **composite calculation** and **clustering** • **CMS cut points** • The **Categorical Adjustment Index** • Which discharges fall into the plan's review sample

ABBREVIATIONS: ADT = admission, discharge, transfer; CMS = Centers for Medicare & Medicaid Services

AAVBC PERSPECTIVE

Transitions of Care includes **four separately assessed components**, each component with its own measurement window: **3 days, 3 days, 30 days, and 31 days.** Completing the engagement visit later in the 30-day window is associated with a higher likelihood of readmission, which can also affect other Star measures, including **PCR (all-cause readmissions).**

Completing each component earlier within its window may reduce this risk. Each hospitalization is scored **independently** on all four components, so a patient with multiple hospitalizations during the measurement period is scored multiple times.

Reviewing performance at the component level, in addition to the composite rate, can help a practice identify which specific component needs improvement.

MEASURE SPECIFICATION

HEDIS Episode-Based Composite Measure

The unit of measurement is the discharge, not the patient. A patient hospitalized three times generates three eligible events, each assessed on all four components.

ELEMENT	SPECIFICATION
Denominator	**Acute and nonacute** inpatient discharges between January 1 and December 1 of the measurement year, for patients age 18 or older.[1,2] The December 1 cutoff ensures every eligible discharge has its **full 31-day** medication reconciliation window inside the measurement year[2]
Numerator	**Each one of the four components is a separate rate:** the share of eligible discharges for which that activity was completed and documented inside its window.[1,2] The four components are **Notification of Inpatient Admission**, **Receipt of Discharge Information**, **Patient Engagement After Inpatient Discharge**, and **Medication Reconciliation Post-Discharge**. Full specifications for each are in the table below
Readmissions and transfers	A readmission or direct transfer within the 31-day period is collapsed into a single episode. The admission date of the first admission and the discharge date of the last discharge define the event. If the final discharge occurs after December 1, both discharges are excluded[1]
Exclusions	Patients in **hospice** or using hospice services at any time during the measurement year, and patients who died during the measurement year. Health plans with enrollment under 500, or 500–999 with measure reliability below 0.7, are excluded at contract level[1]
Data collection	**Hybrid**. Claims and encounter data are used to determine each component where available. The two notification components cannot be established from claims and instead require dated documentation in the outpatient record, identified through medical record review. Claims data alone undercount this measure[2]
Measurement window	January 1 – December 31, 2024 for the 2026 Star Ratings; eligible discharges end December 1[1,2]

ABBREVIATIONS: CMS = Centers for Medicare & Medicaid Services; NCQA = National Committee for Quality Assurance

Numerator Components

ELEMENT	SPECIFICATION
Notification of Inpatient Admission	Documentation of receipt of notification of the inpatient admission, from the day of admission through 2 days after **(3 days total)**. The notification must come from the hospital, an inpatient practitioner, or the emergency department. Typically communication/notifications are relayed through state level health information exchanges.Documentation that the patient or a caregiver informed the office **does not qualify**[2]

ELEMENT	SPECIFICATION
Receipt of Discharge Information	Documentation of receipt of discharge information, from the day of discharge through 2 days after **(3 days total)**. The information **must include all six required elements**: • the practitioner responsible for the inpatient stay • procedures or treatment provided • discharge diagnoses • the current medication list • test results or an explicit statement that no tests are pending • and post-discharge care instructions[2]
Patient Engagement After Inpatient Discharge	A qualifying patient engagement (an office visit, outpatient visit, home visit, or telehealth contact under the current specification), **within 30 days after discharge**. Contact on the day of discharge does not qualify[2]
Medication Reconciliation Post-Discharge	Medications reconciled by a prescribing practitioner, clinical pharmacist, physician assistant, or registered nurse, and documented in the outpatient record, from the date of discharge through 30 days after **(31 days total)**. A face-to-face visit is not required[2]

ABBREVIATIONS: CMS = Centers for Medicare & Medicaid Services; NCQA = National Committee for Quality Assurance

⚠ RED FLAG — PATIENT REPORTED NOTIFICATIONS

A patient or caregiver informing the practice of a recent hospitalization **does not satisfy either notification component.** The record must show **communication from the hospital, an inpatient practitioner, or the emergency department**, date-stamped inside the 3-day window.[2] **Practices relying on patient-reported notification alone will not meet this requirement**, even when the information is received and acted on clinically.

Commonly Misunderstood

- Teams apply one deadline to all four components → **the windows for each component differ.** Three days for the two notification components, 30 days for engagement, 31 for reconciliation. The two short windows **close** before most practices know the event happened
- A follow-up visit on the day of discharge is assumed to count → **it does not.** Patient engagement starts the **day after discharge**[2]
- A billed TCM code is assumed to satisfy everything → **only if its own timing was met.** Transitional Care Management requires contact within 2 business days and a visit within **7 or 14 days**; a TCM code without documented timing does not rescue the components

- The composite is read as one number → **it is an average of four.** A health plan at 63% may be at 85% on reconciliation and 40% on admission notification. Focus on component-specific improvements[1]

HOW PERFORMANCE IS MEASURED

From Four Rates to One Score

Each eligible discharge, as defined in the Denominator specification, is assessed on all four components against the measurement windows defined for each component. Eligible discharges are drawn from the measurement year, which precedes the Star Ratings display year by approximately two years.[1] **Patient Engagement** and **Medication Reconciliation** can be established from qualifying claims, a visit claim, **CPT II 1111F**, or an eligible TCM code, or from the outpatient record at review. The two notification components exist only as dated documentation in the outpatient record

CMS averages the four component rates into a single health plan score, assigns measure Stars by clustering, and computes the composite's statistical uncertainty using a formula specific to this measure that accounts for how the four components correlate with one another.[1] The correlations are moderate: a health plan that reliably receives discharge information tends to also have been notified of the admission, while reconciliation performance moves semi-independently of both.[1]

The measure is included in the Part C Improvement Measure **(correlation 0.887)** and in the Categorical Adjustment Index.[1] It is **not** case-mix adjusted.[1]

CLINICAL PEARL — DIAGNOSE BY COMPONENT

The two notification components typically are most often not met for **information exchange reasons**: the non-current data feed, the fax or the date stamp, are all outdated and carry unnecessary administrative burden. The engagement and reconciliation components are most often not met for **access and workflow reasons**: scheduling, transportation, or staffing for outreach calls. These require different owners and different solutions, and the composite score alone cannot indicate which one applies. Request the **four component rates separately** before any intervention.

Internal Performance is not the Official Star Result

Internal dashboards can support care improvement, but they should be distinguished from the official CMS result because the populations, denominators and data pathways differ.

CALL IT THIS	WHICH MEANS
Official result	The contract-level result calculated and published by CMS using its **own data and methodology**

CALL IT THIS	WHICH MEANS
Internal proxy	An organization's internal estimate based on its own patient population and available records. Useful for improvement work, but **not equivalent to the official result**
Documentation completeness	How **consistently** the care delivered is identified in structured fields
Patient understanding	Whether patients leave encounters with a **clear understanding** of what care they received, supported by an accessible record

ABBREVIATIONS: CMS = Centers for Medicare & Medicaid Services
*Internal estimates should be labeled clearly and interpreted separately from the official CMS contract-level result because the populations, denominators, and measurement pathways differ

Adjustment and Comparability

Case-mix adjustment is a statistical method that accounts for differences in patient population characteristics, such as comorbidities or social risk factors, when comparing performance across providers. It is intended to prevent providers serving higher-need populations from being penalized relative to those serving lower-need populations.

This measure is **not** case-mix adjusted.[1]A practice serving patients with fewer supports at home, such as no caregiver available to answer the phone, or no transportation to the follow-up visit, is compared at the same rate as a practice whose patients face fewer of these barriers.

HIGH-YIELD INTERVENTIONS

Every component of this measure is time-sensitive. The two shortest windows **close within 72 hours** of events the practice did not schedule and may not know about. Improving performance on this measure, and improving outcomes for patients, depends first on **information exchange infrastructure** that identifies the event on the day it occurs, and second on timely completion of the required action.[2]

Health Information Exchange (HIE)

A Health Information Exchange (HIE) is a secure network that enables **same-day awareness of patient event**s. It links electronic health records across independent hospitals, clinicians, skilled nursing facilities, and payers, and transmits admission-discharge-transfer (ADT) alerts at the time a patient's status changes, rather than relying on claims data, which typically lags 30 to 60 days.

In Florida, this network is the **Florida HIE**, governed by the **Agency for Health Care Administration (AHCA)** and modernized through a partnership with **CRISP Shared Services** to strengthen real-time tracking, consent management, and statewide interoperability. This infrastructure is not specific to Florida. Most states operate their own HIE. In states that currently do not, including **Iowa, New Hampshire, and Wyoming**, hospitals route ADT data through national exchange networks such as **CommonWell, Carequality, and eHealth Exchange**, operating under the **ONC's TEFCA framework**, or through commercial ADT alert vendors.

Three components determine whether an alert is actionable by a practice:

- **Automated trigger.** The discharging facility's EHR generates the ADT message when the patient's status changes. Hospitals are required to send this notification as a **Medicare Condition of Participation.** No request from the practice is required, it should be provided from the hospital
- **Clinical content.** The message includes the **discharge summary, medication list, and diagnoses**, the same data medication reconciliation and the TCM visit require
- **Routing to a monitored queue.** An alert that is delivered to an inbox that is not checked daily is not considered a true notification. It must be routed to a named owner.

Phase 1 - Build Once

ACTION	WHEN/WHO	WHY IT MATTERS FOR THIS MEASURE
Implement real-time ADT alerts from regional hospitals and the HIE, routed into a worked task queue	**Week 1** Automated, Practice leadership, then care coordinator	Hospitals **must** send electronic patient event notifications as a Medicare Condition of Participation.[8] Claims feeds can lag by weeks

Phase 2- Runs on Every Discharge (Day 0–14)

ACTION	WHEN/WHO	WHY IT MATTERS FOR THIS MEASURE
Date-stamp receipt of the admission notification and the discharge summary in the outpatient chart the day each arrives, and check the summary against the six required elements	**Day 0–2 of each event** Automated(Health Information Exchange) MA or care coordinator	The notification components are scored based on the date stamp. A summary filed without the pending-tests statement fails at review, even if it is present in the chart[2]
Tier the day's discharges by risk level, and open a standard transitions note that identifies every downstream task, including scheduling the transitional care management visit within 7 to 14 days	**Day 1** MA, from the ADT list, or Health Information Exchange	**Tiering establishes the order in which discharges are contacted.** A single shared note keeps all four component deadlines visible in one place

ACTION	WHEN/WHO	WHY IT MATTERS FOR THIS MEASURE
Pharmacist or trained nurse completes telephone medication reconciliation on days 2–3, comparing the discharge list against the outpatient list and calling the pharmacy to confirm pickup	**Days 2–3** Clinical pharmacist or RN	Telephone follow-up with medication reconciliation after discharge reduced 30-day readmissions by **9.9 percentage points** (odds ratio 0.57) in a controlled evaluation,[9] and pharmacist-led reconciliation programs reduced post-discharge emergency department visits by roughly **28%** in meta-analysis.[10] This step also provides the engagement visit with a verified medication list
Book the follow-up contact before the patient leaves the hospital, or during the first outreach call. Telehealth and home visits qualify	**By day 7** Care coordinator books; clinician delivers	Timely outpatient follow-up is associated with roughly **21% lower 30-day readmission risk** in pooled analyses,[7] and multihospital care-transition bundles cut rehospitalization by 13.6% relative.[11] Booking early provides time to reschedule a cancellation without missing the window
Run eligible discharges through the Transitional Care Management structure: interactive contact within 2 business days, and a visit within 7 or 14 days depending on complexity	**Each discharge** Named owner for the 2-day contact	TCM's built-in deadlines require the engagement and reconciliation components to occur within their windows. **This depends on a named owner for the 2-business-day contact**; without one, the code cannot be billed

ABBREVIATIONS: ADT = admission, discharge, transfer; HIE = health information exchange; MA = medical assistant; RN = registered nurse; TCM = Transitional Care Management

Phase 3 - Ongoing Backstop

ACTION	WHEN/WHO	WHY IT MATTERS FOR THIS MEASURE
Reconcile chart documentation against submitted codes weekly, including completed reconciliations with 1111F and TCM notes and their documented timings	**Weekly** Quality staff with the biller	If **medication reconciliation or a TCM visit** is completed but not coded or submitted correctly, it will not appear in the patient's claims data, only a chart review would catch it. **Weekly claims reconciliation** identifies these gaps while the claim can still be corrected[2]

Risk Stratification — Who to Reach First

TIER	CRITERIA	RESPONSE
Tier 1:High risk	**Polypharmacy** (5+ chronic medications), high LACE score (≥10), heart failure, COPD, age 85 or older, or known cognitive impairment	**Outreach within 24–48 hours**; pharmacist-led reconciliation call. **Visit within 7 days**, delivered ASAP
Tier 2:Standard risk	**Moderate-risk** chronic disease admissions, or no designated caregiver, or low-risk elective surgical discharges with reliable home support	**Outreach within 72 hours**. Engagement call or portal check-in confirming medication understanding and the scheduled visit; involve a case manager or social worker where a caregiver is missing. **Visit booked for days 7–14** (standard TCM timing). Escalate to Tier 1 handling if the check-in surfaces new risk

ABBREVIATIONS: COPD = chronic obstructive pulmonary disease; TCM = Transitional Care Management

QUALITY OUTCOME — MEDICATION RECONCILIATION REDUCES READMISSIONS

In a health system evaluation, pharmacist-led medication reconciliation after discharge reduced 7-day readmissions from **4% to 0.8%**.[12] Reconciliation identifies medication discrepancies, such as an incorrect refill, a duplicated prescription, or a medication that was never picked up, while each can still be corrected by phone rather than requiring hospital admission.

COMMON PITFALLS AND PRACTICAL FIXES

FAILURE MODE	WHY IT HAPPENS	WHAT PREVENTS IT
Learning about the admission from claims	**Claims data is typically not available until several weeks after the event.** A practice relying on claims alone will not learn of the discharge until after the two 3-day windows have already closed	**Real-time ADT and HIE feeds, worked daily.** Hospitals are required to send the notifications;[8] the practice is responsible for routing them to a location that is **checked daily**

FAILURE MODE	WHY IT HAPPENS	WHAT PREVENTS IT
Treating a patient's call as notification	A patient informing the practice of a hospitalization is clinically meaningful, but **it does not satisfy the specification's notification requirement**	Route the patient's call to clinical follow-up, and **separately confirm notification** from the hospital, practitioner, or ED. Date-stamp that confirmation in the chart[2]
Filing the discharge summary without checking it	Filing a scanned face sheet closes the task in the EHR queue, so **the six required elements are not reviewed**	**A six-element checklist at intake.** A summary that does not address pending tests fails the component. Request the missing element from the discharging facility within the 3-day window[2]
"Medications reviewed" as the reconciliation note	The reconciliation was completed, but the note does not document the comparison between the discharge and outpatient medication lists, so it cannot be credited	**Document the reconciliation using a standard statement:** the discharge medication list was compared and reconciled against the current outpatient list, with the date and the reconciling clinician's credential recorded[2]
Booking the engagement visit for day 28	The 30-day window is scheduled as the target date rather than the outer limit, leaving no time to reschedule a cancellation	Book **high-risk patients within 7 days** and **medium- to lower-risk patients within 14 days.** This allows a cancellation to still be rescheduled within the window, and follow-up is more clinically valuable when completed earlier[7]
Billing TCM without meeting the deadlines	TCM requires **two separate deadlines** under one code: an interactive contact within 2 business days and a visit within 7 to 14 days. Missing either deadline results in an incomplete measure	A **named owner for the 2-day contact**, and scheduling the TCM visit within **72 hours of discharge** so a cancellation can still be rescheduled before day 15. Weekly reconciliation of TCM claims against documented contact and visit dates before submission

ABBREVIATIONS: ADT = admission, discharge, transfer; ED = emergency department; EHR = electronic health record; TCM = Transitional Care Management

Where the Line Sits

The following **do not** satisfy the follow-up requirement, regardless of how they are documented:

- **A contact made only to satisfy the requirement, without clinical information.** For example, a voicemail or portal message asking the patient to call the office, with no clinical information and no returned call

- **Billing a transitional care service without completing the required review.** For example, submitting the TCM code because the visit date has passed, without completing the required medication reconciliation or complexity review
- **Reconciling medications using the discharge summary alone.** For example, comparing the discharge list to the chart without confirming with the patient what medications are currently being taken, discontinued, or not filled
- **Recording a follow-up as complete when the patient could not be reached.** For example, documenting an unsuccessful contact attempt as a completed follow-up, instead of recording it as unsuccessful and reattempting

CLINICAL PEARL — WHY THE WINDOW IS THIS SHORT

These follow-up windows are aligned with the period when patients are at the **highest risk**. **Post-discharge deterioration and medication errors** are most common in the **first few days** after discharge. The short windows are designed to identify and address these risks while intervention is still effective.

BARRIERS AND EVIDENCE-BASED SOLUTIONS

Patient-side

BARRIER	HOW IT SHOWS UP	WHAT HELPS
Medication confusion at home	Patients are discharged with new, changed, and discontinued medication orders in addition to their existing regimen. Roughly a quarter of discharge medication changes are not followed within 30 days[6]	**A structured call in the first week** that includes a brown-bag medication review, active verification of each medication by name and purpose, an explicit list of discontinued medications, and teach-back confirmation[9]
No transportation to get to the visit	A booked follow-up visit is **cancelled due to lack of transportation**, and the cancellation occurs after day 30. Patients in rural areas may face long travel distances to a qualifying visit	**Telehealth and home visits count toward the engagement component.**[2] Offer these options at the time of booking rather than only after a missed visit, and use plan-provided transportation benefits where available

BARRIER	HOW IT SHOWS UP	WHAT HELPS
Cognitive impairment, no caregiver	The patient is unable to track multiple new instructions and may not recall the outreach call, which can result in **missed engagement and unreconciled medications**	With patient consent, **include the caregiver in the discharge plan**, on the reconciliation call and at the visit, and provide a single simplified written plan. When no caregiver is available, involve a case manager early
Premature Discharge	An expedited discharge can leave patients unclear on instructions. Unplanned early discharge is an established contributor to poor transitional care outcomes[13]	The first outreach call should address this by reviewing warning symptoms in plain language, clarifying when to call the practice versus seek emergency care, and confirming that equipment and services arranged at discharge have been delivered[13]

ABBREVIATIONS: ED = emergency department

CLINICAL PEARL — THE STOP-LIST

Patients generally start new medications correctly, since the new bottle and instructions provide a clear prompt. **Discontinuing a prior medication is more often missed**, since there is no equivalent prompt at home. The stop-list should be **reviewed explicitly**, both during the reconciliation call and at the visit.[6]

System and Workflow

BARRIER	HOW IT SHOWS UP	WHAT HELPS
Notification never arrives	ADT connections are often set up one hospital at a time, so coverage is limited to connected facilities. **Out-of-area** and **out-of-network** admissions are **frequently missed**	**Connect through the regional HIE** rather than establishing individual connections with each hospital where possible,[8] and audit the feed quarterly to identify which facilities' discharges are reaching the queue and which are appearing **only in claims**

BARRIER	HOW IT SHOWS UP	WHAT HELPS
Unstructured, incomplete summaries	**Direct communication** between hospital and primary care clinicians occurs in a small minority of discharges, and summaries may lack test results and pending items[5]	Establish **Collaborative care agreements** with high performing hospitalists **Standardized, electronically transmitted discharge summaries improve timeliness and completeness.**[5] Apply the six-element checklist on documentation and request any missing elements from the discharging facility **within the same week**
No clear assignment of handoff	**Fragmented roles** between hospital and community teams, and inside the practice, leave reconciliation and follow-up without a clearly assigned owner[13]	**One named coordinator per day's discharge list**, defined roles for each checkpoint, and a shared transitions note that provides the next owner with **full context**[13]
Discharge Summary does not arrive before the TRC visit	Hospitalist dictates discharge summary late, varying hospital policies on data dissemination	**Establish agreements with specific hospitalist groups or care teams** to manage the practice's patient population, and provide a **written directive** to the emergency department and hospital administration outlining discharge summary timing requirements

ABBREVIATIONS: ADT = admission, discharge, transfer; HIE = health information exchange

Disparity Gaps Requiring Targeted Action

The **composite rate** is the single overall score for this measure, calculated by averaging the four component rates. Because this measure is **not case-mix adjusted**, differences in post-discharge support are reflected directly in performance. **A practice's overall composite score can appear acceptable while specific patient populations perform far worse on individual components.** Examine the four component rates **separately** by race, ethnicity, language, dual-eligible status, rurality, and cognitive status to identify these gaps.

POPULATION SEGMENT	PATIENT IMPACT	INTERVENTIONS
Black patients	Timely follow-up visits after discharge are scheduled and completed **less often than for White patients**	**Patient navigation**, using a trained navigator, ideally culturally concordant, who books the follow-up visit before discharge and provides proactive reminders, has been shown to narrow racial disparities in timely follow-up care[14]
Dual-eligible patients	A higher chronic disease burden, combined with limited pharmacy access, unstable housing, and transportation barriers, can **delay every post-discharge step**	**Fully integrated Dual-Eligible Special Needs Plan models of care**, using interdisciplinary teams with supplemental transportation, food, and housing supports, are associated with **lower 30-day readmissions** than non-integrated coverage.[15] Medication home delivery and synchronization can address limited pharmacy access
Rural and cognitively impaired patients	Distance to a qualifying visit, combined with cognitive limitations or the absence of a caregiver, makes **the 30-day engagement component the most likely to fail**	**Intensive telemedicine transitions-of-care clinics**, using home monitoring and caregiver-facilitated video visits, have proven feasible and reduced acute care use in rural Appalachian populations.[16] Telehealth counts toward this component and **should be established as the default pathway for rural patients**[2]

DOCUMENTATION REMINDER — THE DATE STAMP

For **Notification of Inpatient Admission** and **Receipt of Discharge Information**, the reviewer needs proof of when the document was received. Most EHR and HIE feeds automatically record the date and time these documents are received; **confirm this date is visible in the chart**. For anything received outside of this automated process, such as a fax or scanned document, **record the receipt date manually the same day**, since these cannot otherwise demonstrate the 3-day window was met.[2]

CLINICAL CONTEXTS AND APPLICATIONS

Clinical Contexts

CONDITION OR SITUATION	WHY THIS MEASURE MATTERS HERE	WHAT TO WATCH FOR
Heart failure	The highest-volume source of discharge medication changes, including diuretic dose adjustments, new guideline-directed agents, and discontinued duplicate medications. This population also experiences the **fastest post-discharge deterioration**[7]	**Same-week pharmacist or physician reconciliation, early weight and symptom check** at the engagement visit, and explicit confirmation of which **pre-admission medicines were stopped**
COPD exacerbation	Steroid tapers and inhaler regimen changes are **commonly misunderstood without structured review**, and a missed follow-up window is poorly tolerated in this population[7]	Confirm **inhaler technique and the taper schedule** at the engagement contact. Use reconciliation to identify errors in device use and dosing changes
Stroke	**New cognitive and functional deficits** can make a standard office visit insufficient and self-managed follow-up unrealistic[7]	**Caregiver-involved engagement**, using a home visit or facilitated telehealth, and antithrombotic and anticoagulation reconciliation with **the stop-list stated to both patient and caregiver**
Polypharmacy and geriatric complexity	Patients on multiple chronic medications carry the highest risk that a discharge discrepancy results in readmission. A substantial share of readmissions in this population are attributable to medication problems[17]	Tier 1 outreach, a brown-bag medication reconciliation, regimen simplification where possible, and **screening new orders against high-risk medication classes for older adults**

ABBREVIATIONS: COPD = chronic obstructive pulmonary disease

Patient Journey

BEAT	CONTENT
Presents as	A patient in his **late sixties** with **hypertension** and **type 2 diabete**s is discharged home after a **two-day admission** for an **acute heart failure exacerbation**. His home **lisinopril** was stopped and **sacubitril/valsartan** started; his spouse manages his medications
What happens	The **ADT discharge alert** fires the **same afternoon**, and receipt is logged the same day; the MA opens the transitions note to begin working the case. The discharge summary arrives by HIE the next morning and is checked against the six elements- it states no tests are pending. On day 2 the pharmacist calls: the line-by-line review finds the old **lisinopril** still in the nightstand rotation alongside the new agent. She states the stop-list explicitly to patient and spouse and confirms the new prescription was picked up
Outcome	The overlap is resolved by phone before it causes the hypotensive fall it was building toward. A telehealth engagement visit on **day 10** confirms the regimen is understood and stable, the clinician documents the dated reconciliation against the discharge list, and **1111F** goes out on the claim
Follow-up	**All four components are met with three weeks of window to spare.** The team's next stop is the condition-track heart failure guidance for the longer-term titration plan

ABBREVIATIONS: ADT = admission, discharge, transfer; HIE = health information exchange; MA = medical assistant
Note: Case is illustrative and is not a reported individual case

Companion Guides – Making Connections

GUIDE	WHEN TO REACH FOR IT
Plan All-Cause Readmissions QRG (C18)	**Reach for this guide when a readmission has already happened, or when you need to explain why one occurred.** A failure in this measure often causes the problem the other measure tracks: a late alert, a skipped medication reconciliation, or a follow-up visit that happens too late can lead directly to a readmission. **The same ADT alerts and first-week contact prevent both problems**
Medication Reconciliation Post-Discharge QRG (C17)	**Reach for this guide when you need the reconciliation component on its own, separate from the rest of C20.** It is a standalone Star measure through SY2026. **After SY2026, this measure is retiring**, and the reconciliation work will be counted inside **C20** instead
Follow-up after ED Visit QRG (C21)	**Reach for this guide when the triggering event is an emergency department visit instead of a hospital discharge**, especially for patients with **multiple high-risk chronic conditions**

GUIDE	WHEN TO REACH FOR IT
Heart Failure QRG	**Reach for this guide when the patient has heart failure.** It is the condition where **transitions fail fastest** and **where reconciliation evidence is strongest**

ABBREVIATIONS: ED = emergency department; QRG = Quick Reference Guide

DOCUMENTATION THAT SUPPORTS CARE

Documentation that Reflects the Care

- This measure can be completed through documentation. Two of the four components, **the admission notification and the discharge summary**, exist only as dated documentation. The other two, **medication reconciliation and the follow-up (engagement) visit**, are counted through claims that the documentation supports. **The care and the documentation of it are separate requirements**; either one missing means the component is not credited[1,2]
- **The date information was obtained is a distinct data element.** For the notification components, the reviewer is confirming when the practice received the information[2]
- **Reconciliation documentation must describe the specific action taken:** the discharge list compared against the current outpatient list, what changed, and who performed the comparison, including credential
- Where a component has been met, **the claim should reflect it**: **CPT II 1111F** for a completed reconciliation, or **TCM codes 99495** (moderate complexity, visit within 14 days) and **99496** (high complexity, visit within 7 days), where the interactive contact and visit timing are documented

What Belongs in the Record

The six required elements:

- The name of the provider responsible for the patient's care during the inpatient stay
- Services or treatments provided during the stay
- Diagnoses at discharge
- Test results, or an explicit statement that results are pending, or that none are pending
- The current medication list
- Directions for follow-up care to the PCP or ongoing care provider

ELEMENT	WHAT TO RECORD
The episode, anchored	**Admission date, discharge date, and discharging facility, in the outpatient note**. This ensures the record connects to the **correct denominator event**
Notification receipt	**Date-stamped entry showing when and from whom the admission notification arrived** (hospital, inpatient practitioner, or ED). Patient and caregiver reports noted **separately** as clinical context[2]
Discharge information receipt	**Date-stamped receipt, with the six required elements confirmed present** (including the explicit pending-tests statement) and a request logged for anything missing[2]
The engagement contact	**Modality** (office, home, telehealth), date, and clinician confirming it occurred after the discharge date and inside **30 days**[2]
The reconciliation	Date performed, the explicit comparison statement, each discrepancy addressed by name, the updated medication list, and the performing clinician's credentials[2]
Barriers and follow-up	**The specific barrier where a step is delayed** (unreachable, no transport, no caregiver) with a named owner and next contact date, this differentiates an in-progress episode from an abandoned one. A barrier is not an exclusion from the measure

ABBREVIATIONS: ED = emergency department

Clinical Documentation Optimization – SOAP

This measure requires documentation of care, not just the care itself. If a task is completed but not documented with the required details, what was done, what changed, and who did it, it does not count toward the measure. The note below is an example that includes those details, based on the heart failure discharge example.

S — Subjective

Patient seen by synchronous video for post-hospital follow-up after an inpatient stay for **acute heart failure exacerbation** (admitted and discharged this month; facility named in chart). Reports **no increased dyspnea, orthopnea, or leg swelling** since discharge. Spouse present; home weight log reviewed, **no gain over 2 lb**. Reports some initial confusion about whether to continue the prior blood pressure medicine, resolved on the pharmacist call.

O — Objective

Home blood pressure log stable on the new regimen. Discharge summary received and reviewed, dated within **2 days of discharge**; summary states no laboratory or imaging results pending.

A — Assessment

Heart failure exacerbation, resolved, status post recent hospitalization. Medication regimen changed at discharge — prior ACE inhibitor discontinued, sacubitril/valsartan initiated. No transportation or support barriers; spouse manages medications.

P — Plan

Discharge medication list compared and reconciled against the current outpatient medication list; discontinuation of the prior ACE inhibitor confirmed with patient and spouse, new agent tolerated. Updated medication list provided and teach-back completed. Follow-up with cardiology in 2 weeks. Reconciliation performed by the undersigned on today's date; **CPT II 1111F** submitted with this encounter.

Documentation Examples

Complete — administrative reception

"*[Date-stamped] Electronic ADT alert received from [hospital] indicating patient admitted [date]. Filed to chart, routed to PCP.*" … "*[Date-stamped] Discharge summary received via HIE from [discharging practitioner]. Contains discharge diagnoses, procedures, current medication list, post-discharge instructions, and statement that no test results are pending. Filed to chart.*"

Complete — the reconciliation entry

"*Reviewed the hospital discharge medication summary dated [date]. Compared and reconciled the discharge medications against the current outpatient medication list. Discontinued [prior medicine] as instructed at discharge; continued all other listed medications; updated list given to patient and spouse, who verbalized understanding of the changes. Reconciliation completed [date] by [name, credential].*"

Not enough — Incomplete

"*Records received from hospital. Chart updated.*" "*Patient seen for follow-up after hospital stay, feeling better.*" "*Medications reviewed, no issues, continue current regimen.*" — *no receipt dates, no six-element confirmation, no comparison statement, no credential. Each component these entries were meant to support fails at review, and the next clinician inherits none of the episode.*

DOCUMENTATION REMINDER — DOCUMENT THE DAY OF THE EVENT

Every element in this measure requires a dated entry within a **short window**. The EHR **automatically records the date and time an entry is created**, and does not allow that date to be changed to an earlier one. An entry written at the end of the week cannot show that a 3-day window was met, because the system records the actual, later entry date, not the date of the event. To meet this requirement, enter the documentation on the **same day** the event happens, and state clearly what was done.

One Status, Clearly Stated

Most records collapse several genuinely different situations into "done" or "not done," and the outreach that follows is wrong for most of them.

STATUS	WHAT IT MEANS, AND WHAT FOLLOWS FROM IT
Admitted, notification received	**Source and date recorded.** The windows for the remaining three components begin at discharge, not at admission

STATUS	WHAT IT MEANS, AND WHAT FOLLOWS FROM IT
Discharged	The 3-day window for discharge information, the 30-day window for engagement, and the 31-day window for medication reconciliation all begin. Outreach tiering begins the same day
Discharge information received, complete	All **six required elements confirmed** and automatically dated upon receipt. This component is met if received within 3 days of discharge
Discharge information incomplete or absent	**Document what is missing**, who was asked to provide it, and when, within the 3-day window
Outreach in progress	Attempts logged with dates and numbers tried. If the patient remains unreachable after multiple attempts, document it as a **barrier**
Engagement completed	**Document the modality, date, and clinician.** Confirm the engagement occurred after the day of discharge and within 30 days
Reconciliation completed	Document the date, the comparison statement, discrepancies resolved, the clinician's credential, and the submitted code
Patient declined follow-up	Document the **specific concern**, the clinical advice given, and that further outreach remains available
Episode collapsed, re-admitted	A readmission or transfer within **31 days** combines into one episode, defined by the first admission date and the last discharge date. Discharge-based windows restart from the **final discharge**[1]

KEY TAKEAWAYS

1. **This measure has four separately assessed components with three different windows**

   3 days, 3 days, 30 days, and 31 days, averaged into one composite score.[1,2]

2. **No component in this measure can be completed after its window closes**

3. **This measure's windows correspond to the period when post-discharge adverse events are most common**[4,6]

4 **Learning that the admission or discharge occurred is the primary obstacle for most practices, utilize automated health exchange infrastructure**

5 **The two notification components require real-time ADT and HIE alerts**

Claims data is not timely enough to meet either 3-day window.[3,9]

6 **A patient-reported hospitalization does not satisfy the notification requirement**

A visit on the day of dischargedoes notsatisfy the engagement requirement. The phrase "medications reviewed" does notsatisfy the reconciliation requirement.

7 **Record the date the notification or discharge summary is received, the same day it arrives**

Verify each discharge summary against the six required elements.

8 **Telephone medication reconciliation in the first week after discharge is associated with a 9.9 percentage-point reduction in 30-day readmissions in a controlled evaluation**[9,10]

9 **Book the engagement visit for days 7 to 14**

Telehealth and home visits qualify, and early booking allows time to reschedule a cancellation.

Changes to Monitor

Current as of 2026-08-20.

CHANGE	GOOD PRACTICE
Measure status	**Transitions of Care continues as a Part C Star measure.** The standalone Medication Reconciliation Post-Discharge measure (C17) is removed from the Star Ratings beginning Star Year 2027. Reconciliation work then earns Star credit only through this measure's component. Confirm measure status against the CMS measure list each cycle[18]

CHANGE	GOOD PRACTICE
Rating-year methodology	Cut points reset annually through clustering and are not guaranteed to repeat; revalidate cut points, Categorical Adjustment Index treatment, and Improvement Measure inclusion **(correlation 0.887 for 2026)** each new cycle[1]
Component specification	NCQA HEDIS Volume 2 for the current measurement year is the citation of record for component windows, eligible engagement modalities, eligible reconciling clinicians, and the six discharge-information elements. **Reconfirm each element annually** — industry analyses report an expanded eligible pharmacist type for MY2027 and proposed (not finalized) **MY2028** changes that would shorten the engagement and reconciliation windows to **14 days** and add a long-term-institution exclusion[2]
Reporting pathway	NCQA is reported to be developing an electronic (ECDS) version of this measure with testing from 2026 toward a possible MY2029 transition. If finalized, the documentation-dependent components would shift toward **structured data exchange**. Confirm against NCQA publications before revising workflow guidance[2]
Coding and payer handling	Confirm current **CPT II** and **TCM code handling**, and each plan's supplemental-data acceptance, before each measurement year
Internal tools and templates	**Review ADT feed coverage, the transitions note template, tier criteria, and dashboard definitions** annually, and label any retained prior-year cut points or windows as outdated

ABBREVIATIONS: ADT = admission, discharge, transfer; CPT = Current Procedural Terminology; ECDS = Electronic Clinical Data Systems; NCQA = National Committee for Quality Assurance; TCM = Transitional Care Management

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