BHIP Provider/ Coding Support | FY26 V1

Transitions of Care

Measure Description:

- The percentage of inpatient discharges for members 18 and older that had documentation of receipt of notification of inpatient admission, receipt of discharge information, patient engagement after inpatient discharge, and medication reconciliation post-discharge.
- The measure reports four rates (notification of admission, discharge information, patient engagement, medication reconciliation), with payment tied to all four rates meeting thresholds under ACC Phase III RAE performance.
- This measure is identical to the CMS Adult Core Set (TRC-AD) specification, with focus on care coordination to reduce readmissions.
- Follow-up must occur within 30 days of discharge for engagement and reconciliation.
- Reportable via claims or EHR, with emphasis on timely communication between facilities and RAEs.

Numerator:

- Discharges with documentation of RAE notification of admission on the day of admission or following day (rate 1).
- Discharges with documentation of receipt of discharge information on the day of discharge or following day (rate 2).
- Discharges with patient engagement (e.g., office visit, home visit, telehealth) within 30 days after discharge (rate 3).
- Discharges with medication reconciliation on the date of discharge or within 30 days after discharge (rate 4).
- Rates calculated separately, with payment requiring all four to meet thresholds for effective transitions of care.

Denominator:

- All inpatient discharges for members ages 18 and older during the measurement year (CY2026), with discharges grouped by facility.
- Members must be enrolled in Medicaid on the discharge date to be included in the denominator.
- Excludes planned discharges for maternity or hospice (see Exclusions section).

Services to Support Transitions of Care:

- Inpatient facility notifications to RAEs for admission and discharge information sharing.
- Post-discharge follow-up visits, including office, home, or telehealth for patient engagement.
- Medication reconciliation services by pharmacists or care coordinators to review and update meds.
- Community care coordination programs for support in high-risk discharges (e.g., chronic conditions).
- Telehealth or virtual services for remote engagement and reconciliation in rural areas.

Best Practices:

- Establish protocols for facilities to notify RAEs of admissions on the day or next day per CMS guidelines, using secure portals or fax to ensure timely receipt.
- Ensure discharge information (e.g., meds, instructions) is sent to RAEs on the day or next day, using standardized templates to avoid delays.

More information can be found here: www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html

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- Schedule post-discharge engagement (visit or call) within 7–14 days for high-risk members, using the "Teach Back Method" to confirm patient understanding of care plan.
- Document all interactions in structured EHR fields, using CPT codes for visits to facilitate data capture and hybrid reporting.
- Partners with hospitals and community providers for seamless handoffs, targeting high-risk groups like those with multiple admissions.
- Conduct outreach to patients post-discharge via phone, text, or portal messages, offering home visits or telehealth to boost engagement rates.
- Common miss: Incomplete medication reconciliation — always use CPT 1111F in EHR to document and resolve discrepancies.
- Submit claims promptly with CPT codes to ensure activities are captured in administrative data, reducing the need for chart reviews during audits.
- Monitor performance using EHR dashboards or RAE reports to identify gaps in rates and target interventions (e.g., better notification for ED discharges).
- Collaborate with RAE quality teams for resources like discharge toolkits, training on coordination, or incentives to improve equity in transitions of access.

CY 2026 Payment Thresholds

Rate	Level	Required Rate	Payout %	Description
Notification of Admission	Basecamp	≥ [from guide, page 50 - use actual if available, e.g., 50%]	33%	Entry-level target; focus on facility protocols.
Notification of Admission	Tree Line	≥ [e.g., 70%]	67%	Mid-level target; emphasize timely communication.
Notification of Admission	Summit	≥ [e.g., 90%]	100%	High-performance target; use portals for automation.
Receipt of Discharge Information	Basecamp	≥ [e.g., 50%]	33%	Entry-level target; focus on standardized templates.
Receipt of Discharge Information	Tree Line	≥ [e.g., 70%]	67%	Mid-level target; ensure day-of receipt.
Receipt of Discharge Information	Summit	≥ [e.g., 90%]	100%	High-performance target; integrate with EHR.
Patient Engagement After Discharge	Basecamp	≥ [e.g., 40%]	33%	Entry-level target; focus on scheduling.
Patient Engagement After Discharge	Tree Line	≥ [e.g., 60%]	67%	Mid-level target; use telehealth.
Patient Engagement After Discharge	Summit	≥ [e.g., 80%]	100%	High-performance target; outreach for no-shows.

More information can be found here: www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html

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Medication Reconciliation Post-Discharge	Basecamp	≥ [e.g., 50%]	33%	Entry-level target; focus on pharmacist involvement.
Medication Reconciliation Post-Discharge	Tree Line	≥ [e.g., 70%]	67%	Mid-level target; document in EHR.
Medication Reconciliation Post-Discharge	Summit	≥ [e.g., 90%]	100%	High-performance target; use tools for reconciliation.

For the full list of codes, please see Appendix A on following page.

More information can be found here: www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html

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Appendix A

Codes to InPatient Discharges (Denominator- UBREV)	
Code	**Description**
0100-0101	All inclusive room and board plus ancillary
0110-0114	Private room - medical/surgical/GYN

Codes for Patient Engagement (CPT/HCPCS)	
Code	**Description**
99201-99215	Office or other outpatient services
99381-99397	Preventive medicine services
G0402	Welcome to Medicare visit
G0438	Annual wellness visit, initial
G0439	Annual wellness visit, subsequent
99495-99496	Transitional care management services

Codes for Medication Reconciliation (CPT/HCPCS)	
Code	**Description**
1111F	Discharge medications reconciled with the current medications in outpatient medical record
99495	Transitional Care Management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge)
99496	Transitional Care Management services with high medical decision complexity (face-to-face visit within 7 days of discharge)

Codes for Hospice Exclusions (UBREV)	
Code	**Description**
0651	Hospice routine home care (per diem)
0652	Hospice continuous home care (per hour)
0655	Hospice inpatient respite care (per diem)
0656	Hospice general inpatient care (non-respite) (per diem)
0657	Hospice physician services
0658	Hospice room and board nursing facility (per diem)
0659	Hospice other (per diem)

More information can be found here: www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html