GOLD COAST HEALTH PLAN TOTAL Care ADVANTAGE℠

2026 Measurement Year

STAR MEASURE: PLAN ALL-CAUSE READMISSION (PCR)

Measure Steward: National Committee for Quality Assurance

Gold Coast Health Plan Total Care Advantage's (HMO D-SNP) goal is to help its providers gain compliance with their annual Managed Care Accountability Set (MCAS)/Centers for Medicare & Medicaid (CMS) Star measure scores by providing guidance and resources. This tip sheet provides the key components to the Star measure, *"Plan All-Cause Readmission (PCR)."*

Measure Description: This measures the percentage of plan members 18 years of age and older discharged from a hospital stay who were readmitted to a hospital within 30 days, either for the same condition as their recent hospital stay or for a different reason.

Measure Specification:

- Denominator (Index Stay) includes acute inpatient or observation hospital admissions in the measurement year with a discharge on or between Jan. 1 and Dec. 1 of the measurement period.
  - The index stay must end in a discharge to the community or non-acute setting
- Numerator (Readmission) includes those index stays that are followed by an unplanned readmission within 30 days of discharge (for any diagnosis).
  - The readmission must be to an acute inpatient facility

Data Collection Method: Administrative[1]

PCR – Clinical Code Set:

- For billing, reimbursement, and reporting of services completed, submit claims timely with the appropriate medical codes for all clinical conditions evaluated and services completed.
  - Index hospital stays are identified from UB revenue codes on hospital facility claims.
    - UB Revenue codes used to identify inpatient stays between Jan. 1, 2026, to Dec. 1, 2026.

      0100, 0101, 0110, 0111, 0112, 0113, 0114, 0116, 0117, 0118, 0119, 0120, 0121, 0122, 0123, 0124, 0126, 0127, 0128, 0129, 0130, 0131, 0132, 0133, 0134, 0136, 0137, 0138, 0139, 0140, 0141, 0142, 0143, 0144, 0146, 0147, 0148, 0149, 0150, 0151, 0152, 0153, 0154, 0156, 0157, 0158, 0159, 0160, 0164, 0167, 0169, 0170, 0171, 0172, 0173, 0174, 0179, 0190, 0191, 0192, 0193, 0194, 0199, 0200, 0201, 0202, 0203, 0204, 0206, 0207, 0208, 0209, 0210, 0211, 0212, 0213, 0214, 0219, 1000, 1001, 1002

    - UB revenue codes used to identify observation stays between Jan. 1, 2026, to Dec. 1, 2026.

      0760, 0762, 0769
  - Providers determine coding accuracy through their clinical documentation
    - Document clear, complete, and specific notes that include diagnoses and comorbidities for conditions evaluated and treated.
    - Differentiate planned versus urgent admissions in supporting documentation.
    - Ensure all chronic conditions are accurately documented in the medical record.

Medical Record Should Include:

- Key areas to document in the medical record to support / supplement the accuracy of hospital facility claims.
  - Diagnosis specificity: The exact reason for admission and all active conditions
  - Planned versus urgent admission: Note if the admission / procedure was scheduled or emergent
  - Comorbidities: Document and code (using the most specific ICD-10 codes) all comorbidities including the below that have a high-impact on the PCR measure:
    - Congestive heart failure (CHF)
    - Chronic kidney disease (CKD)
    - Chronic obstructive pulmonary disease (COPD)
    - Diabetes (type 1 or 2)
    - Hypertension

- Cancer
- Obesity
- Cerebrovascular disease
- Liver disease
- Mental health disorders

Exclusion Criteria – Members with any of the following conditions are excluded from the MAD measure:

- Members in hospice or using hospice services anytime during the measurement year.
- Members with acute hospitalizations for the following reasons:
  - Principal diagnosis of pregnancy on the discharge claim
  - Principal diagnosis of a condition originating in the perinatal period on the discharge claim
  - Planned admissions for:
    - Chemotherapy maintenance
    - Principle diagnosis of rehabilitation
    - Organ transplant
    - Potentially planned procedure without a principal acute diagnosis
- Exclude the hospital stay if the direct transfer's discharge date occurs after Dec. 1 of the measurement year.
- Members who died during the inpatient stay.

Best Practices:

- Use the Inovalon® Provider Enablement Quality Gaps Insights to identify members with risk for readmission.
  - Attempt multiple outreach efforts to members who are at risk for readmission.
  - For members at risk of readmission, provide:
    - Medication reconciliation
    - Self-management training for members and caregivers to help members identify when/how to manage acute symptoms and when to seek timely care from their PCP
    - Regular follow-up appointments
- Once notified of an admission, reach out to the hospital's discharge team to share the member's baseline health status, medication list, and any known social needs that could impact discharge planning.
  - Coordinate with the discharge team to ensure the member has a clear, written, and easy-to-understand plan that covers all aspects of their post-hospital care.
- Contact the member by phone within two to three days of discharge to check on their condition, address any questions, and ensure they have understood their care plan.
- If a follow-up was not scheduled while member was still in the hospital, schedule a follow-up visit for within seven days of discharge.
  - Reserve appointment slots for members who are discharged from the hospital, so they can be seen within seven days of discharge
- During the initial follow-up, perform a thorough medication reconciliation. Review and reconcile the member's new and existing medication lists to avoid issues with adherence or interactions.
- Use the "teach-back" method to confirm the member and/or caregiver understands their medications and care plan by asking them to repeat key information in their own words.
- Ensure discharged members understand their local community support resources.
- Refer for Transitional Care Management.
  - Total Care Advantage's Care Management Team is made up of registered nurses, care management coordinators, and social workers who are ready to help Total Care Advantage members manage their health and provide transitional care management services (structured support for 30 days post-discharge).
    - Total Care Advantage Care Management referrals can be made by submitting the referral form available on the GCHP website or by contacting the Care Management Team by phone or email.
      - Care Management Contact: 1-805-437-5656
      - Care Management Email: CareManagement@goldchp.org
      - English Referral Form: Click Here
      - Spanish Referral Form: Click Here

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- Members with multiple comorbidities are expected to be readmitted at a higher rate. Ensure all conditions are appropriately identified in the member's medical record and claims.
- Ensure your documentation is clear and concise.
- Use proper coding for conditions evaluated and services provided.

[1] Measures reported using the *administrative* data collection method report on the entire eligible population and use only administrative data sources (e.g. claims, encounter, lab, immunization registries) to evaluate if services were performed.