



Community-Based Care Transitions Program Fact Sheet

In April 2011, the Center for Medicare and Medicaid Services (CMS) announced funding opportunities for acute-care hospitals with high readmission rates that partner with community based organizations (CBOs) or CBOs that provide care transition services to improve a patient's transition from a hospital to another setting, such as a long-term care facility or the patient's home. Created by Section 3026 of the Affordable Care Act, the Community-Based Care Transition Program (CCTP) provides funding to test models for improving care transitions for high risk Medicare patients by using services to manage patients' transitions effectively. Participants will use process and outcome measures to report on their results.

Background

Care transitions occur when a patient moves from one health care provider or setting to another. When people living with serious and complex illnesses move from the hospital to home or a nursing home, they may be at risk for readmission back to the hospital if they develop a complication. These complications are often preventable. Nearly one in five Medicare patients discharged from the hospital—approximately 2.6 million seniors—is readmitted within 30 days, at a cost of over \$26 billion every year.

CCTP supports the three-part aim of making health care safer, more reliable, and less costly for all Americans. This initiative is part of the Partnership for Patients, a public public-private partnership charged with reducing hospital-acquired conditions by 40 percent and hospital readmissions by 20 percent by 2013. The Department of Health and Human Services plans to invest up to \$1 billion in Affordable Care Act funds in the Partnership to reduce millions of preventable injuries and complications.

Who can participate?

CMS invites CBOs, or acute care hospitals that partner with CBOs, to submit an application describing the proposed care transition intervention(s) and people with Medicare who are at high risk of readmission in their communities.

CBOs must provide care transition services across the continuum of care and have a formal organizational and governance structure, including formal relationships with hospitals, other providers, and consumer representatives. Preference will be given to Administration on Aging (AoA) grantees who partner with multiple hospitals and practitioners to provide care transition interventions or entities that provide services to medically-underserved populations, small communities and rural areas.

What will participation require?

CBOs will be required to provide care transition services across the continuum of care, which may include at least one of the following:

- Care transition services that begin no later than 24 hours prior to discharge;
- Timely and culturally and linguistically competent post-discharge education to patients so they understand potential additional health problems or a deteriorating condition;
- Timely interactions between patients and post-acute and outpatient providers;
- Patient-centered self-management support and information specific to the beneficiary's condition; and,
- A comprehensive medication review and management, including—if appropriate—counseling and self-management support).

Applicants must explain how they will align their care transition programs with care transition initiatives by other payers in their communities, including Medicaid, Medicare Advantage, and private payers.

All awardees must agree to and sign terms and conditions governing their participation in the program prior to initiating their programs.

How long will CMS accept applications?

CMS will accept applicants and enroll participants on a rolling basis as funding permits. The program will run for 5 years. Participants will be awarded two-year agreements that may be extended annually through the duration of the program based on performance.

What does the application require?

Interested parties must submit a written proposal that addresses all of the evaluation selection criteria described in the solicitation on the CCTP web page at: <http://go.cms.gov/caretransitions>.

As part of the proposal, applicants must:

- Identify community-specific root causes of readmissions, define the target population, and strategies for identifying high risk patients;
- Specify care transition interventions and services that will address readmissions, including strategies for improving provider communications and improving patient activation;
- Describe how care transition strategies will incorporate culturally appropriate, beneficiary-centric, effective care transition approaches to reach ethnically diverse beneficiaries, and how other community and social supports will be incorporated to enhance beneficiaries' post-hospitalization outcomes;
- Provide an implementation plan with milestones;
- Provide a clear budget proposal, including a per eligible discharge rate reflecting direct costs for care transition services; and,
- Describe prior experience with managing care transition services and reducing readmissions.

What is the total funding allocation and how will participants be paid?

CMS was appropriated \$500 million in total funding for the CCTP for 2011 through 2015.

CCTP differs from a grant program in that it does not pay for administrative overhead and infrastructure costs. CBOs will be paid an all-inclusive rate per eligible discharge, determined based on the cost of care transition services provided at the patient level and systemic changes at the hospital level; however, the CBO will only be paid once per eligible discharge in a 180-day period of time for any given beneficiary.

How will CMS evaluate a CBO's performance?

CMS will evaluate and track CBO's targeted performance thresholds on quality and utilization measures such as focusing on 30-day all cause readmission rates, and will also monitor 90- and 180-day readmission rates, mortality rates, observation services, and emergency department visits to ensure that the program preserves or enhance the quality of care for Medicare beneficiaries while sustaining efforts to provide care transition interventions across different settings and result in greater program efficiency. Each CBO will be required to fully cooperate with the evaluation contractor and implementation and monitoring contractor. A CMS project officer will be assigned to all CBOs, and that project officer will serve as liaison to program and evaluation contractor staff. In addition, the project officer will provide technical consultation regarding program procedures and monitor CBO activities.

What resources and technical assistance will CMS provide?

Applicants are invited to contact Medicare Quality Improvement Organizations (QIOs) as they prepare their proposals. The QIOs' mission includes assisting communities in improving care transitions, whether they are new to this work or they have experience in improving care transitions and wish to apply to the CCTP.

QIOs' technical assistance capabilities include:

- Community-level readmissions data and trend analysis;
- Assistance with conducting a community-specific root cause analysis and in selecting the appropriate interventions;
- Helping recruit community partners, and,
- Other technical assistance on the CCTP application.

A roster of care transitions contacts for each of the country's 53 QIOs is available on the CCTP webpage (see the bottom of this factsheet for the web address). Additionally, a template for developing the CCTP budget is on the CCTP webpage.

CMS encourages all applicants to seek assistance from their State's QIO and learn more about how to improve care transitions through a comprehensive community effort at the QIO Integrating Care for Populations and Communities National Coordinating Center (NCC) at:

<http://www.cfmc.org/integratingcare/>.

For more information about the Community Based Care Transitions Program, visit

<http://go.cms.gov/caretransitions>.