Medicare Community-Based Care Transitions Program

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Partnership for Patients

- Government-wide partnership with private sector
  - Prevent patients from getting injured or sicker
  - Help patients heal safely
- Focus on hospital-acquired conditions and readmissions
- http://www.healthcare.gov/center/programs/partnership/index.html

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Background

- Community-based Care Transitions Program builds on QIO work performed August 2008-July 2011
  - 14 communities
  - Efforts across the continuum to implement evidence-based care transitions, such as BOOST, Transitional Care Model, Care Transitions Intervention, RED, and others

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The Community–based Care Transitions Program

- Mandated by section 3026 of the Affordable Care Act
- Provides funding to test models for improving care transitions for high-risk Medicare beneficiaries

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Program Goals

- Improve transitions of beneficiaries from the inpatient hospital setting to home or other care settings
- Improve quality of care
- Reduce readmissions for high risk beneficiaries
- Document measureable savings to the Medicare program

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Eligible Applicants

- Statutorily defined as:
  - Acute care hospitals with high readmission rates in partnership with a community based organization
  - Community-based organizations (CBOs) that provide care transition services
- There *must* be a partnership between acute care hospitals and CBOs—neither can apply without the other

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Definition of CBO

- Community-based organizations that provide care transition services across the continuum of care through arrangements with subsection (d) hospitals

  - Whose governing bodies include sufficient representation of multiple health care stakeholders, including consumers.

Key Points

- CBOs will use care transition services to effectively manage transitions and report process and outcome measures on their results.
- Applicants will not be compensated for services already required through the discharge planning process under the Social Security Act and stipulated in the CMS Hospital Conditions of Participation.

Preferences

- Preference will be given to proposals that :
  - include participation in a program administered by the AoA to provide concurrent care transition interventions with multiple hospitals and practitioners
  - provide services to medically underserved populations, small communities and rural areas

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Considerations

- Applicants must address:
  - how they will align their care transition programs with care transition initiatives sponsored by other payers in their respective communities
  - how they will work with accountable care organizations and medical homes that develop in their communities

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Additional Information

- High-readmission hospitals are defined as those whose 30-day readmission rate falls in the fourth quartile for its state for at least two of the three Hospital Compare measures (AMI, HF, PNEU).
- Applicants are required to complete a root cause analysis.

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Payment Methodology

- CBOs will be paid a per eligible discharge rate
- Rate is determined by:
  - the target population
  - the proposed intervention(s)
  - the anticipated patient volume
  - the expected reduction in readmissions (cost savings)

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Performance Measurement

- Awardees will need to demonstrate reduced 30-day all-cause readmission rates
- Awardees will be required to attend up to 3 face-to-face learning collaboratives in Baltimore each year

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Expectations

- 300-500 hospitals participating in CCTP
- QIOs working with hospitals contemplating CCTP applications to conduct root cause analysis of readmissions
- CMS measuring readmission rates throughout delivery system—Medicare, Medicaid, ACOs, medical homes, etc.

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Conclusion

- The program solicitation is now available on our program webpage at http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1239313
- The program will run for 5 years with the possibility of expansion beyond 2015
- Please direct questions to CareTransitions@cms.hhs.gov

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