

Centers for Medicare & Medicaid Services
National Conference on Care Transitions
Friday, December 3, 2010

Juliana Tiongson:

Thank you, Linda. And thank you all for joining us today to learn about this very exciting opportunity for acute care hospitals and community-based organizations.

The Community-based Care Transitions Program, otherwise known as the CCTP, mandated by Section 3026 of the Affordable Care Act, provides funding to test models for improving care transitions for high-risk Medicare beneficiaries.

CMS is concerned, along with MedPAC and many of you participating in our meeting today, that increasing rates of avoidable hospital readmissions will result in negative health outcomes for Medicare beneficiaries, impacting our levels of safety and quality of care. The CCTP seeks to correct these deficiencies by encouraging communities to come together and work together to improve care transitions and improve patient experiences during those critical times. The CCTP program goals are to improve the transitions of beneficiaries from the inpatient hospital setting to other care settings. Sorry,

we're having a little bit of technical difficulty. OK, thank you.

So, the slides do not advance on their own. So, back to the program goals.

The first goal and these are in a particular order is to improve the transitions of beneficiaries from the inpatient hospital setting to other care settings, or to home; improve quality of care; reduce readmissions for high-risk beneficiaries; and document measurable savings to the Medicare Program.

And although the legislation only requires reducing readmissions while maintaining quality of care, we have set the bar higher and we are striving to really improve the quality of care for the beneficiaries.

And in terms of documenting measurable savings to the Medicare Program, the legislation stipulates that in order for the program to be extended or expanded beyond the five years, the Secretary has to determine that it is a financially sustainable program, meaning that it's reduced Medicare expenditures. So that of course is also another goal.

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Eligible applicants – eligible applicants are statutorily defined as acute care hospitals with high readmission rates in partnership with community-based organizations, or community-based organizations that provide care transition services.

In either of these cases, there must be a partnership between the acute care hospitals and the community-based organizations. We know that medicine is a team sport and requires strong partnerships in order to achieve both improved quality and cost savings.

The definition of CBO – this is the statutory definition of CBOs – is 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. We do intend to be flexible to the extent possible when determining who is a community-based organization as long as they do meet this statutory definition and they are based in the community where they will serve.

Some of the key points are that the CBOs will use care transition services to effectively manage transitions and report process and outcomes measures on the results. Applicants will not be compensated for services already required through the Social Security Act or the CMS Conditions of Participation. And lastly, applicants will be required to participate in ongoing learning collaboratives.

One thing that we are going to be doing is we're going to be having learning – a technical assistance learning contractor who's facilitating ongoing meetings with all participants, ongoing in-person meetings and these probably would occur quarterly. And it's a model that's been used effectively at other agencies to spread the learnings early and often and disseminate methods that are working. It could be adopted by other participants.

The requirements of what we would expect to see – some of the things we would expect to see in people's interventions, and these are outlined in the statute as well is, initiating care transition services no later than 24 hours prior to discharge, providing timely, culturally, and

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linguistically competent post-discharge education, ensuring timely and productive interactions between patients and providers, and providing comprehensive medication review and management, and providing patient-centered self-management support.

The preferences. Preferences as outlined in the statute must be given to applications that include participation in a program administered by the Administration on Aging, or programs that provide services to medically underserved populations, small communities, or folks in rural areas. Physician group practices, particularly primary care practices, we will be giving consideration to as well, as we believe that it is ultimately the responsibility of the delivery system to absorb these – the provision of these services, the care transition services. Some application guidance. We are requiring that applicants do their homework and complete a thorough root cause analysis to inform them of factors that may be specific to their communities that are resulting in high readmission rates. The proposals must specify how the root causes will be addressed.

And we are also asking applicants to describe how they will work with accountable care organizations and medical homes that develop in their communities, and how they will align their care transition programs with related initiatives that are being carried out by other payers, including Medicaid, Medicare Advantage and the private sector.

OK. So, a program solicitation will be announced shortly in the Federal Register. We are striving to have that announced by the end of this month, which after which time, we will accept applications on a rolling basis.

And we have our program web page address up there as well as in your notebooks. And any questions, because we are on a very tight time schedule today, any questions that don't get answered, please send them in to the Care Transitions mailbox and we will answer your questions. Thank you very much.