

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

Linda Magno:

Good morning everyone. I'm Linda Magno, Director of the Medicare Demonstrations Program Group at the Centers for Medicare and Medicaid Services. And I'd like to welcome you all this morning to CMS' National Conference on Care Transitions.

We're very excited with many of you attending this conference in person. We're expecting more of you. We've had to increase the size of the conference and very excited also that there are nearly a thousand people participating in the conference by audio.

So, why are we here today? I'm going to spend just a very brief period of time, we've got a lot of ground to cover. But we're here today because hospitalizations account for about 33 percent of total Medicare expenditures and represent the largest single program outlay.

And the recent review of Fee-For-Service claims found that 1/3 of Medicare beneficiaries – 1/5, I'm sorry, of Medicare beneficiaries who are hospitalized and that's nearly 2-1/2 million beneficiaries were readmitted to

hospitals within 30 days of discharge, and nearly 1/3 were readmitted within 90 days.

The Medicare Payment Advisory Commission in 2007 estimated that Medicare spends approximately \$15 billion on readmissions into that \$12 billion that is – for cases that are considered to be preventable.

But as significant as the economic costs of readmissions and their impact on the Medicare budget are – we must keep in mind that preventable rehospitalizations represent a failure of our health care system to provide care that is safe and effective, efficient, and patient-centered. This is the failure that we must work to address, because we can and because it's the right thing to do for our patients, or in the case of the Medicare Program, our beneficiaries.

Since August 2008, quality improvement organizations in 14 states have worked to develop community-based care interventions, community-wide programs to improve care interventions as part of the QIO's 9th Scope of Work. In addition, CMS has also worked closely with the Administration on Aging to

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provide grants for the development of Aging and Disability Resource Center care transition programs.

AoA recently awarded 16 grants to states to coordinate and continue to encourage evidence-based care transition models.

So, our goal today is to share learnings from these projects so that we might build upon these efforts to improve care transitions and reduce avoidable rehospitalizations of Medicare beneficiaries and by spillover of these programs and their affects on all other patients.

In the Affordable Care Act, Congress has given us two powerful tools to focus our attention on preventing rehospitalizations. First of all, funding, specifically \$500 million in Section 3026, the Community-Based Care Transitions Program, for CMS to pay for interventions to improve care transitions among Medicare beneficiaries. And secondly, beginning in 2013, penalties to hospitals with high readmission rates.

We hope that today's conference serves as a useful forum for health care providers and for community-based

organizations to learn about some of the care transition models and interventions that have been used in a variety of programs and settings, including the work of the QIO program during the past 2-1/2 years around the country, and hope that it is a useful guidance regarding how best to lay the foundation for the successful implementation of such interventions.

We'll start out today by having Juliana Tiongson, Project Lead on Community-based Care Transitions Program, provide an overview of that program. In the interest of leaving the maximum amount of time for our speakers, I'm not going to provide speaker's bios as they can be found in your notebooks, at the end of the presentation session and just before the tab listing in-person participants of today's conference.

At the end of each agenda segment, there will be a brief opportunity for participants to ask questions. We will first take questions from those attending the conference in person. As time allows, those participating by phone will also be given an opportunity to ask questions.

If you are unable to ask a question due to time

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limitations, please email your questions or comments to the CMS Care Transitions mailbox at caretransitions@cms.hhs.gov. We'll see that flashed up on the screen later.

Note that today's event is being recorded and transcribed and an audio download of the conference will be available on the CMS Care Transitions web page in the coming weeks. For those of you participating by telephone, you can find today's presentations on the CMS Care Transitions web page. It has a URL is too long for me to read, but you should have received at least one email reminder of that web page from CMS over the past week.

So, with that, I would like to introduce Juliana Tiongson of CMS. Thank you.