

LONG-TERM CARE IN BRIEF: EXPLAINING THE MEDICARE COMMUNITY-BASED TRANSITIONS PROGRAM

HR 3590, Sec. 3026. Community-Based Care Transitions Program

The Patient Protection and Affordable Care Act (PPACA), signed into law on March 23, 2010, establishes a program designed to reduce hospital readmissions by implementing improved care transition services. The Community-Based Transitions program (HR 3590, Sec. 3026) encourages eligible hospitals and community-based organizations to work together to provide evidence-based care transition services to Medicare beneficiaries who are at a high risk for hospital readmission. The program is built largely upon the Centers for Medicaid and Medicare (CMS) Care Transitions Intervention program in which fourteen states contracted with CMS to reduce the number of hospital readmissions in older adults during the transition process.

Who can participate in the program? Eligible entities include hospitals with high readmission rates and community-based organizations that partner with such hospitals to provide care transitions services. If selected for participation by the Secretary, these entities will receive funding to provide improved transition services to qualifying, high-risk Medicare beneficiaries. Qualifying beneficiaries are those with an elevated risk for hospital readmissions due to either a diagnosis of multiple chronic conditions, or a diagnosis of other risk factors that make the individual particularly vulnerable throughout the transitions process. Applicable risk factors may include cognitive impairments, depression, a medical history of multiple readmissions, or any other chronic disease or risk factor as determined by the Secretary.

What are the application guidelines? To participate in the program, the hospital or community-based organization must submit an application to the Department of Health and Human Services in accordance with guidelines to be established by the Secretary. If the applicant is a hospital, then it must agree to enter into a partnership with a community-based organization in order to be considered for the program. The application itself must include a detailed intervention proposal, which may include programs designed: to provide care transition services for high-risk Medicare beneficiaries at least 24 hours before the individual is to be discharged; to provide the beneficiary with post-discharge assistance in recognizing and preventing a deteriorating condition; to ensure timely post-acute coordination between the beneficiary and the out-patient providers; to offer the beneficiary patient-centered self-management support; or to conduct comprehensive medication review and management.

How will the program operate? The Secretary will establish the program and provide funding to eligible hospitals and community-based organizations that will partner together to implement evidence-based care transitions services, with the goal of improving post-acute transition services for high-risk Medicare beneficiaries. In selecting participants, the Secretary will give priority to any hospitals or organizations that are either participating in a program administered by the Administration on Aging that provides care transitions or intervention services, or are otherwise providing services to medically underserved populations, small communities, and rural areas.



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What funding is available for the program? In order to carry out this program, the Secretary may transfer, from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, up to \$500 million to the CMS Program Management Account for the period of fiscal years 2011 through 2015. Any amounts transferred will remain available until expended.

IMPORTANT DATES

January 1, 2011 The program will be conducted for five years, beginning on this date. The Secretary may expand the duration and scope of the program.

FY 2011 - 2015 The program is funded