

Summary - Solicitation for Applications

Community-Based Care Transitions Program (CCTP) Overview

The Centers for Medicare & Medicaid Services (CMS) is accepting applications for participation in the Community-based Care Transitions Program (CCTP). 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. The CCTP is part of Partnership for Patients (PfP), a national patient safety initiative through which the Administration is supporting broad-based efforts to reduce harm caused to patients in hospitals and improve care transitions.

The goals of the CCTP are to:

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

In addition to readmission reduction, a positive beneficiary-centered experience with the care transition process is an important CMS strategic goal.

Eligible entities for this program are statutorily defined as subsection (d) hospitals with high readmission rates that partner with community-based organizations (CBOs) or CBOs that provide care transition services. CBOs are defined as community-based organizations that provide care transition services across the continuum of care through arrangements with subsection (d) hospitals and whose governing bodies include sufficient representation of multiple health care stakeholders, including consumers.

Applicants must:

- Identify root causes of readmissions
- Define their target population
- Define strategies for identifying high-risk patients
- Specify care transition interventions - including strategies for improving provider communications in care transitions and improving patient activation
- Describe how care transition strategies will incorporate culturally appropriate and effective care transition beneficiary-centric approaches to ethnically diverse beneficiaries
- Describe how other community and social supports and resources will be incorporated to enhance the beneficiaries' post-hospitalization management outcomes
- Provide a budget, including a per eligible discharge rate for care transition services
- Provide an implementation plan with milestones
- Demonstrate prior experience with effectively managing care transition services and reducing readmissions

