Solicitation for Applications
Community-based Care Transitions Program

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 goals of the CCTP are to improve transitions of beneficiaries from the inpatient hospital setting to other care settings, to improve quality of care, to reduce readmissions for high risk beneficiaries, and to document measureable savings to the Medicare program. The CCTP is part of Partnership for Patients, 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.

Eligible entities for this program are statutorily defined under section 3026 of P.L. 111-148 (hereinafter referred to as the "Affordable Care Act") 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.

The CBOs will use care transition services to effectively manage transitions and report process and outcome measures on their results. CBOs will be paid on a per eligible discharge basis for Medicare beneficiaries at high risk for readmission, including those with multiple chronic conditions, depression, and cognitive impairments.

In selecting CBOs to participate in the program, the statute requires that preference be given to Administration on Aging (AoA) grantees that provide care transition interventions in conjunction with multiple hospitals and practitioners and/or entities that provide services to medically-underserved populations, small communities, and rural areas. In addition, consideration will be given to organizations that have established similar care transition interventions with State Medicaid programs and organizations that have established relationships with medical homes serving Medicare beneficiaries. Applicants are also encouraged to collaborate with Medicare Advantage plans and commercial health plans as part of a comprehensive all-payer approach to readmission reduction. The program will run for 5 years beginning April 12, 2011; however, applicants will be awarded 2-year agreements that may be extended on an annual basis for the remaining 3 years based on performance.

Applicants must identify root causes of readmissions and define their target population and strategies for identifying high risk patients. In addition to readmission reduction, a positive beneficiary-centered experience with the care transition process is an important CMS strategic goal. Applicants will also specify care transition interventions, including strategies for

improving provider communications in care transitions and improving patient activation. Applicants will describe how care transition strategies will incorporate culturally appropriate and effective care transition beneficiary-centric approaches to ethnically diverse beneficiaries, and how other community and social supports and resources will be incorporated to enhance the beneficiaries' post-hospitalization management outcomes. Lastly, applicants will be required to provide a budget, including a per eligible discharge rate for care transition services, provide an implementation plan with milestones, and demonstrate prior experience with effectively managing care transition services and reducing readmissions.

Community Care Transitions Program Website: To locate the CCTP webpage, go to http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1239313. Applicants are responsible for monitoring the website to obtain the most current information available.

Application: Interested parties must submit a written proposal that addresses all of the evaluation selection criteria described in this announcement. Proposals may not exceed 30 double-spaced pages with a minimum font size of 12. An application template is available online at: http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1239313. Please provide two hard copies and one electronic copy or CD-ROM of the full application. Proposals may not exceed 30 double-spaced pages with a minimum font size of 12. Please follow guidance in this solicitation for elements to include in the application, specifically those elements outlined in the selection criteria. Applicants may, but are not required to, submit a total of 10 copies to assure that each reviewer receive an application in the manner intended by the applicant (e.g., collated, tabulated, color copies). Hard copies and electronic copies must be identical. Applicants must designate one copy as the official proposal. Please provide two hard copies and one electronic copy or CD-ROM of the full application. A budgeting worksheet is available on our webpage for assistance in developing the required blended rate.

Application Due Date: Applications will be accepted and reviewed on a rolling basis. Acceptable applicants will be awarded on a first come, first serve basis as funding permits.

Mail or Deliver Applications: Applications may be mailed or hand-delivered to:

Centers for Medicare & Medicaid Services
Attention: Juliana Tiongson
7500 Security Boulevard
Mail Stop C4-14-15
Baltimore, Maryland 21244

Please note we are not able to accept applications by facsimile (FAX) transmission or by e-mail. Applicants will receive acknowledgement of receipt of their application.

CMS Contact: Juliana Tiongson at (410) 786-0342 or by e-mail at CareTransitions@cms.hhs.gov.

Background

Hospitalizations account for approximately 33 percent of total Medicare expenditures and represent the largest program outlay.[1] A retrospective review of Medicare fee-for-service claims conducted by Jencks, et al., found that one-fifth of Medicare beneficiaries discharged from hospitals were readmitted within 30 days, and one-third were readmitted within 90 days.[2] While some of these hospital readmissions are planned and others are related to the follow-up treatment for specific conditions, Medicare beneficiaries are being increasingly readmitted for avoidable conditions indicative of poor quality of care. The Medicare Payment Advisory Commission estimated Medicare costs of approximately $15 billion due to readmissions, $12 billion of which is for cases considered preventable.[3] An avoidable or preventable readmission is considered to be an admission clinically related to the prior admission if there was a reasonable expectation that it could have been prevented by: (1) the provision of quality care in the initial hospitalization; (2) adequate discharge planning; (3) adequate post-discharge follow up; or (4) improved coordination between inpatient and outpatient health care teams.[4] Hospitals have traditionally served as the focal point of efforts to reduce readmissions by focusing on those components that they are directly responsible, including the quality of care during the hospitalization and the discharge planning process. However, it is clear that there are multiple factors along the care continuum that impact readmissions, and identifying the key drivers of readmissions for a hospital and its downstream providers is the first step towards implementing the appropriate interventions necessary for reducing readmissions.

The CMS is particularly concerned that increasing rates of avoidable hospital readmissions will also result in negative health outcomes for Medicare beneficiaries impacting their levels of safety and quality of care. The CCTP seeks to correct these deficiencies by encouraging a community to come together and work together to improve quality, reduce cost, and improve patient experience. In 2009, CMS began reporting on a quarterly basis the rate of readmissions for beneficiaries with the diagnoses of congestive heart failure (CHF), heart attack (AMI), and pneumonia (PNEU) on the Hospital Compare website http://www.medicare.gov/Hospital. CMS has also made a commitment to continually improve reporting to incorporate additional measures of readmission after CMS has sought endorsement by the National Quality Forum.

Prior to the passage of the Affordable Care Act, many efforts were underway targeting care transition processes to reduce hospital readmission rates and improve patient care coordination. Since August 2008, 14 Quality Improvement Organizations (QIOs) have participated in the 9th Statement of Work care transitions sub-national theme. CMS directed each of these QIOs to promote seamless transitions for a community of Medicare beneficiaries involving multiple provider settings in order to reduce unnecessary readmissions in selected communities. The

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[1] 2009 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

[2] Stephen F. Jencks, M.D., M.P.H., Mark V. Williams, M.D., and Eric A. Coleman, M.D., M.P.H. *Rehospitalizations among Patients in the Medicare Fee-for-Service Program,* N Engl J Med 2009; 360:1418-1428 April 2, 2009

[3] Medicare Payment Advisory Commission: Promoting Greater Efficiency in Medicare, Report to Congress, June, 2007.

[4] Norbert I. Goldfield et al. *Identifying Potentially Preventable Readmissions*, Health Care Financing Review, Fall, 2008.

QIOs have incorporated evidence-based care transition models in their work and have facilitated communities working together to address care transitions.

The CMS has also worked closely with the AoA, providing grants for the development of Aging and Disability Resource Center (ADRC) care transition programs. Since 2003, AoA and CMS have funded several initiatives related to improving the coordination of care transitions. AoA has recently published a program announcement to states that propose to strengthen the role of ADRC's implementing interventions to facilitate evidence-based care transition models and linking individuals and their caregivers to available long-term care services and supports in the community. Many area agencies on aging are also providing care transition services in their communities in partnership with QIOs in the care transitions theme and/or other providers.

For a comprehensive list of evidence-based care transition interventions, please refer to http://www.cfmc.org/caretransitions/files/Care_Transition_Article_Remington_Report_Jan_2010.pdf.

Some of the evidence-based care transition interventions funded by AoA and CMS include:

- **The Care Transitions Intervention (CTI)** **http://www.caretransitions.org/** is a 4-week hospital-based care transitions model that requires a Transitions Coach to: conduct an initial hospital visit and assessment, work with a patient to complete discharge preparation checklist, utilize a personal health record to help patients self-manage, provide medication management, conduct a coaching/role playing session for a patient's follow-up primary care appointment, and make three follow-up phone calls to the participant.

- **The Transitional Care Model (TCM)** **http://www.transitionalcare.info/** is a 1 to 3 month hospital-based care transitions model that requires a Transitional Care Nurse to do the following: conduct an initial hospital visit and assessment (and subsequent home visits each week for a month), conduct detailed assessment of patient's ability to complete activities of daily living and independent activities of daily living, provide medication management, coach patient for follow-up primary care visit and accompany them to primary care visit, and conduct follow-up phone calls for each week there is not a home visit.

- **Project BOOST** **Society of Hospital Medicine | Quality Initiatives for Hospitalized Patient Care** is a toolkit for improving hospital discharge, including screening/assessment tools, discharge checklist, transition record, teach-back process, risk-specific interventions and written discharge instructions. Project Boost strives to reduce avoidable 30-day readmissions, improve patient satisfaction, improve communication between hospital and outpatient physicians, and ensure that high risk patients are identified and specific interventions are offered to mitigate their risk.

- **Re-engineered Discharge (RED)** **http://www.bu.edu/fammed/projectred/index.html** strives to minimize post-discharge hospital utilization by using a standardized discharge

intervention that includes patient education, comprehensive discharge planning, and post-discharge telephone reinforcement.

- **Transforming Care at the Bedside (TCAB)** http://www.ihi.org/IHI/Programs/StrategicInitiatives/TransformingCareAtTheBedside.htm is a set of hospital interventions built around four themes: 1) safety and reliability; 2) care team vitality; 3) patient-centeredness; and 4) increased value. The four core elements of the intervention are: 1) enhanced admission assessment for post-discharge needs; 2) enhanced teaching and learning; 3) patient and family-centered handoff communication; and 4) early post-acute care follow-up.

The CCTP builds upon these earlier efforts by pairing an ongoing payment mechanism with care transition interventions to reduce readmission rates in hospitals, especially hospitals with high readmission rates, while maintaining or improving quality of care.

Eligible Applicants

The CMS invites CBOs or acute care hospitals with high 30-day readmission rates that partner with CBOs to submit an application describing the proposed care transition intervention(s) and targeted Medicare population at high risk of readmission in its community. Consideration will be given to hospitals whose 30-day readmission rate on at least two of the three hospital compare measures (AMI, HF, PNEU) falls in the top quartile for its state.[5] Consideration will also be given to CBOs working with multiple high readmission hospitals in a community. Eligible acute care hospitals, defined as those subject to subsection 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)), must be located in one of the 50 states or the District of Columbia and do not include psychiatric hospitals, rehabilitation hospitals, children's hospitals, cancer hospitals, or long-term acute care hospitals which have an average inpatient length of stay of greater than 25 days.

Eligible CBOs are those that provide care transition services across a continuum of care through arrangements with subsection (d) hospitals and whose governing body includes sufficient representation of multiple health care stakeholders, including consumers. The CBOs may be characterized as physician practices, particularly primary care practices, a corporate entity that has a separate quality improvement organization (QIO) contract with CMS under Part B of title XI of the Act, in situations that will not result in or create the appearance of a conflict of interest between the QIO's review tasks under title XI and the corporate entity's role as a CBO, an ADRC or area agencies on aging, or other appropriate organization that meets the requirements outlined in section 3026(b)-(1) and (c)-(2)-(A)-(ii). CBOs must have a formal organizational and governance structure including formal relationships with hospitals and other providers along the continuum of care.

[5] Please refer to appendix B on the CCTP webpage to determine whether your institution's rate falls within the 4th quartile of your state on any of the condition-specific measures.

As required by section 3026 of the Affordable Care Act, proposals must address how the CBO will use care transitions models and processes that may include at least one of the following features:

- Initiating care transition services no later than 24 hours prior to discharge (**NOTE**: Application should be specific as to the particular care transition services to be provided);
- Providing timely, culturally, and linguistically competent post-discharge education regarding symptoms that may indicate additional health problems or a deteriorating condition;
- Providing assistance to ensure timely and productive interactions between patients and post-acute and outpatient providers;
- Providing patient-centered self-management support and relevant information specific to the beneficiary's condition; and
- Conducting comprehensive medication review and management (including, if appropriate, counseling and self-management support).

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, as well as those proposals that provide services to medically-underserved populations, small communities and rural areas. Consideration will be given to physician practices, particularly primary care practices, that meet the statutory definition of a CBO and to programs who have established relationships with State Medicaid programs for care management and who have relationships with primary care medical homes. Where proposals reference the applicant's participation in existing care management or primary care medical home programs that may relate to Medicare beneficiaries, the proposal should describe how such services would be coordinated and payment under the CCTP would not result in recipients receiving payment from multiple sources for the same services.

Applicants must address how they will align their care transition programs with care transition initiatives sponsored by other payers in their respective communities, including Medicaid, Medicare Advantage, and the private sector. Awardees are expected to work closely with accountable care organizations and medical homes that develop in their communities as we believe it is ultimately the responsibility of the delivery system to manage care transition and the services needed to support them. All awardees must agree to and sign terms and conditions governing their participation in the program prior to their start in the program.

Beneficiary Eligibility and Enrollment

All Medicare fee-for-service beneficiaries admitted at participating subsection (d) hospitals and deemed at high risk for readmission based upon the applicant's root cause analysis or other accepted methodology for targeting beneficiaries at high risk for readmission are potentially eligible to receive care transition services through the program. Because the majority of beneficiaries with multiple chronic conditions will have higher than average HCC risk scores, as long as programs target beneficiaries with multiple chronic conditions, they will capture these beneficiaries and need not calculate individual HCC scores. We will also review applicants proposed targeting criteria to ensure that high risk beneficiaries are being targeted as opposed to being excluded We have access to data to determine whether the targeted diagnoses carry high

HCC scores or not. We do require, however, that each applicant identify its target population and/or screening methodology and expected patient volume in its proposal. A root cause analysis and review of historical readmission data specific to the applicant will be necessary to develop a care transitions strategy capable of correcting deficiencies in the current system. Applicants must describe how the implementation of the proposed care transition interventions will be integrated with the hospital discharge planning process. Applicants will not be compensated for services that are already required through the discharge planning process under section 1861 (ee) of the Social Security Act, and as stipulated in the CMS Conditions of Participation. In general, we expect targeted beneficiaries to include those with multiple chronic conditions, depression, cognitive impairments, or a history of multiple admissions. Applicants should describe how their targeting methods address these beneficiaries. For additional background on sizing your target population, please refer to the *New England Journal of Medicine* article and the Medicare Payment Advisory Commission report referenced on pages 2 and 3 of this solicitation, respectively.

Medicare Payment for Program Participants

The CBOs will be paid an all-inclusive rate per eligible discharge. Applicants are required to build a per eligible discharge rate and must consider the following regarding their pricing in their application for this program:

- The cost of care transition services provided at the patient level (e.g., coaching, medicine reconciliation).
- The costs of implementing broader systemic changes at the hospital level (e.g., Project Boost, RED).

The applicant will develop a blended rate based on the interventions proposed, the anticipated volume for each of the interventions, and the duration of the interventions. For the convenience of applicants, a template for developing the budget is available on the CCTP webpage. The proposal should be designed to reduce readmissions, thereby reducing Medicare expenditures over the program period.

The CBOs will submit invoices to CMS on a monthly basis to receive payment for care transition services rendered in the previous month. CBOs will not be paid a per eligible discharge rate more than once in a 180-day period for the same beneficiary under any circumstance.

Implementation

The CMS will award an implementation and monitoring contract to monitor performance, aggregate quality measures, validate monthly invoices, and measure savings based on established targets for reduction in readmissions. The implementation and monitoring contractor will provide CMS and program awardees with quarterly monitoring reports. These reports will track 30-day all cause readmission rates, emergency department visits, observation services, follow-up physician visits, and mortality rates.

In addition to the implementation and monitoring contract, CMS will award a technical assistance contract to support participating hospitals and CBOs through a series of learning

collaboratives. Program awardees will be required to attend a minimum of three meetings per year and, if identified as a top performer for the quarter, present their model to the larger group for possible adoption. Program awardees are expected to learn, adjust, and share strategies and approaches as new best practices are discovered to achieve the optimal results from care transitions. Also, program awardees are expected to try new and innovative approaches, learn from successes and failures, and continually seek improved results.

The information and learnings culled from CMS' monitoring contract and the learning collaboratives will be used to improve the program on an ongoing basis and to spread the learnings across program participants. Eligible organizations are encouraged to check the CCTP website at http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1239313 for updated information before submitting their application.

Evaluation

To assess the impact of the program, CMS will conduct a formal and concurrent evaluation of each CBO's performance. In addition to tracking 30-day all cause readmission rates, the evaluation will also monitor 90- and 180-day readmission rates, mortality rates, observation services, and emergency department visits to ensure that the program does not result in any unintended adverse consequences. Each CBO will be required to fully cooperate with the evaluation contractor and implementation and monitoring contractor. A CMS project officer will be assigned to all CBOs, and that project officer will serve as liaison to program and evaluation contractor staff. In addition, the project officer will provide technical consultation regarding program procedures and monitor CBO activities.

The CMS expects the additional payment under the program will sustain efforts to provide care transition interventions across different settings and will result in greater program efficiency, as well as improved quality of care and health outcomes for Medicare beneficiaries. An independent evaluation will be conducted for this program to evaluate the feasibility and cost effectiveness of this additional per eligible discharge payment designed to reduce readmission rates at hospitals, while improving the quality of care for Medicare beneficiaries and providing the necessary support and resources for their caregivers. As part of CMS' ongoing effort to align its measurement and evaluation efforts across programs, the primary measures selected to evaluate the CCTP will be based on measures used for hospital performance. Applicants will be awarded 2-year participation agreements. Those awardees that achieve targeted performance thresholds on quality and utilization measures and demonstrate financial sustainability may be extended on an annual basis for the remaining 3 years of the program.

The CBOs and hospitals will be measured on the following:

1. Outcome Measures
    - 30-Day Risk Adjusted All Cause Readmission Rate (currently being developed)
    - 30-Day Unadjusted All Cause Readmission Rate
    - 30-Day Risk Adjusted AMI, HF, and PNEU Readmission Rates

2. Process Measures
    - Primary Care Provider follow-up within 7 days of discharge
    - Primary Care Provider follow-up within 30 days of discharge

In addition to outcome and process measures, CBOs will be asked to administer a questionnaire that will incorporate items derived from the following sources:

3. HCAHP Items
    - Percentage of patients over 65 years who rate hospital performance as meeting HCAHPS performance standard for information about medicines.
    - Percentage of patients over 65 years who rate hospital performance as meeting HCAHPS performance standard for discharge information
    - The Care Transitions Measure 3-item version
    - The Patient Activation Measure 13-item version

Selection

Applications will be accepted and participants enrolled on a rolling basis beginning April 12, 2011, and continue as funding permits. Applicants will be evaluated on multiple criteria including the proposed per eligible discharge rate for care transition services, implementation plan with milestones, as well as demonstrated prior experience with effectively managing care transition services and reducing readmissions. The program will run for 5 years. The Secretary may extend or expand the program beyond the 5 years if the program demonstrates financial sustainability by reducing Medicare expenditures and does not reduce quality.

Selection Criteria and Weights

Applications will be scored based on responsiveness to the following evaluation criteria and weights.

Strategy and Implementation Plan (30 points)

An applicant's strategy should be based upon the results of a root cause analysis. Describe targeted population and provide a rationale for choosing your proposed population. Describe plan for identifying those beneficiaries that meet target criteria. Will the hospital refer beneficiaries to the CBO within 24 hours of admission or will the CBO staff be provided access to the hospital census data on a daily basis and identify targeted beneficiaries? Will screening tools be employed as a way to identify eligible beneficiaries in need of transition services or as a means for selecting the most appropriate care transition interventions? If screening tools are to be employed, please describe the selected tools. Applicants are encouraged to use tools with documented validity and reliability. Describe plan to reduce hospital readmissions including one or more care transition interventions and the anticipated proportion of the target population that will receive each intervention. Consideration will be given to applicants proposing care transition models detailed in this announcement. If alternate models are proposed, applicants must justify with documentation the evidence that the proposed models can, in fact, reduce hospital readmissions while maintaining or improving quality of care. Applicants must describe

how the implementation of the proposed care transition interventions will be integrated with the hospital discharge planning process. Provide an implementation plan with milestones clearly defined. Describe the process for collecting, aggregating, and reporting quality measures and monthly intervention data to the CMS implementation/monitoring contractor. Describe how you will align with other payers in your community working on related initiatives. Applicants involving a partnership of a CBO and multiple hospitals, especially multiple hospitals in the top quartile for their state on 30-day readmission measures, will be given consideration. Applicants that partner with AoA grantees and those that provide services to medically-underserved populations, small communities, and rural areas will be given preference.

Organizational Structure and Capabilities (25 points)

Present evidence that the applicant is capable of implementing and managing intervention strategies for the target population. If the eligible entity is a subsection (d) hospital, provide a description of the financial, legal, and organizational structure of the partnership between the hospital and the CBO. If the eligibility entity is a CBO, documentary evidence of a formal agreement between a CBO and eligible subsection (d) hospital(s) in a geographically contiguous area is required. If additional local health care providers are included in the proposed effort, formal agreements with them are also required. Describe how CBO fees will be shared with the hospital or other community providers if that is the applicant's intent. Consideration will be given to CBOs who partner with multiple high readmission hospitals in their community.

Applicants must present operational protocols that detail internal monitoring processes for 1) the management and delivery of care transition services, and 2) financial controls for Medicare payments. For each hospital named in the application, applicants must provide letters of support from the chief financial officer, chief executive officer, and applicable operations managers responsible for the discharge and care transitions.

Previous Experience (20 points)

Applicants must describe their experience providing care transition management services. To whom were the services provided? How were the services funded? What interventions were deployed? Has the applicant received formal training on any of the care transition services it proposes to use? If so, please specify the date, location, and training provided. If possible, please provide evidence demonstrating the success of current or past care transition efforts provided by the applicant. Consideration will be given to applicants that have direct experience providing care transition services to the fee-for-service Medicare population. Applicants are encouraged to describe any broader experience they may have in reducing readmissions such as system redesign at the hospital level and use of electronic health information systems and tools.

Budget Proposal (25 points)

Applicants must provide justification and rationale for the proposed per eligible discharge payment rate for care transition services to include a budget and narrative with sufficient documentation to justify the proposed rates. The budget worksheet available on the CCTP website should be used to arrive at a blended rate. Using the budgeting worksheet provided, the

applicant must develop a blended rate based on the interventions proposed, the anticipated volume for each of the interventions, and the duration of the interventions. In addition, applicants must provide a total "not to exceed" budget for participation in the program. Applicants must explicitly state their assumptions regarding overall participation rates, rationale and projections of the readmissions to be avoided, and overall reduction in readmission rates achievable. Applicants must justify their blended rate by comparing it with their anticipated savings achieved through reduced hospital readmissions, emergency department visits, and observation stays. Applicants may use $9,600 as the average cost of a hospital admission or readmission for their calculations. Applicants whose not-to-exceed rate is greater than the total savings anticipated based on proposed volume will not be evaluated favorably. If the applicant is participating in an existing care management or primary care medical home program serving fee-for-service Medicare beneficiaries, the proposal must describe how such services would be coordinated and payment under the CCTP would not result in recipients receiving payment from multiple sources for the same services.

Collection of Information Requirements

This information collection requirement is subject to the Paperwork Reduction Act of 1995. This specific collection is approved under the Office of Management and Budget control number 0938-1124 entitled "Medicare Community-based Care Transitions Program Application." Applicants must submit the Medicare Community-based Care Transitions Program Application to be considered for this program.

Statutory Authority

Section 3026 of the Affordable Care Act directs the Secretary to establish a 5-year community-based care transitions program for eligible entities beginning January 1, 2011. Applicants for the program must provide a detailed proposal for a care transitions intervention that may include at least one of the following areas: initiating care transition services no later than 24 hours prior to discharge; providing timely post-discharge education regarding symptoms that may indicate additional health problems or a deteriorating condition; providing assistance to ensure timely and productive interactions between patients and post-acute and outpatient providers; providing self-management support and relevant information specific to the beneficiary's condition; conducting comprehensive medication review and management. The program may be continued and expanded beyond the 5 years if it demonstrates financial sustainability by reducing Medicare spending and maintains or improves quality.