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NATIONAL TRANSITIONS OF CARE COALITION

COMMUNITY-BASED CARE TRANSITIONS PROGRAM

The Community-Based Care Transitions Program (CCTP) was created by Affordable Care Act and provides funding to local community-based organizations (CBOs) to test models for improving care transitions from hospitals to other settings of care.

The role of CBOs is critical, as the program creates a bridge between acute care and home and community-based care. In creating the program, Congress recognized the failures of our current system to adequately care for patients moving between care settings, which create serious patient safety, quality of care and health outcome concerns. In addition, poor transitions in care also lead to significant financial burdens for patients, payers, and taxpayers. Nearly one in five Medicare patients discharged from a hospital—approximately 2.6 million seniors—are readmitted within 30 days, at a cost of over \$26 billion every year. Of those additional expenditures, an estimated \$12 billion was spent on readmissions that could have been prevented.¹



There are many evidence-based care transitions interventions that have led to documented improvements in both health outcomes and reduction in costs to the health care system.² CCTP seeks to foster the use of these and other evidence-based care models in order to improve the quality of care and reduce readmissions rates for high-risk fee-for-service Medicare beneficiaries, and to document measurable savings to the Medicare program.

1. The Community Based Care Transitions Program: The Centers for Medicare & Medicaid Innovation. Web. Center <http://innovation.cms.gov/initiatives/CCTP/>
2. <http://www.ntocc.org/Portals/o/PDF/Resources/TangibleSavings.pdf>

Current Status

The CCTP is run through the Center for Medicare and Medicaid Innovation. Initially, \$500 million was authorized over five years for eligible community-based organizations (CBOs) that partner with acute-care hospitals to provide care transition services to manage Medicare patients' transitions and improve their quality of care. Unfortunately, in March 2013 appropriators stripped \$200 million from the program. This occurred at the eleventh hour without sufficient congressional consideration.

To date, there are 102 CCTP sites in 40 states across the country aiming to provide 700,000 Medicare beneficiaries with critical care transitions services.

Many participating sites are seeing significant progress in effectively managing the transitions of high-risk beneficiaries and are achieving positive results from their interventions to assist high-risk Medicare patients with care transitions. For example, one CCTP program implemented a telephonic-based, social worker-led interdisciplinary team to intervene with high-risk beneficiaries following hospital discharge. Over 14 months, this model successfully decreased 30 day readmissions by 24.7 percent for approximately 1,400 patients in the host university medical center. In addition, one CCTP recently reported an overall 30-day readmission rate of less than 10 percent for patients who completed CCTP services administered through the program, as compared to a baseline of all Medicare patients in that same service area of nearly 19 percent.

While these initial successes demonstrate the power of improving care transitions and the important strides the CCTP is making, there are several challenges with the implementation of the program that are proving to be barriers to more consistent progress across all of the CCTP sites.

Challenges

As detailed above, while many CCTP sites are seeing positive results in reducing readmissions and improving patient outcomes, some sites are having difficulty meeting the 20 percent readmissions reduction requirement within the designated two-year time frame. This is due to a number of challenges including:

1. **LOW ENROLLMENT:** Many sites are having difficulties meeting their enrollment benchmarks, which in turn has a direct, adverse impact on the targeted readmissions measure. This is a result of:
 - **Confusion regarding CCTP and other ACA programs.** Many hospitals perceive that their participation in other CMS-sponsored payment demonstrations, such as bundled payment or shared savings programs, precludes them from partnering with CBOs under the CCTP program. Although CMS has stated that qualifying hospitals participating in other programs are not excluded from the CCTP, further education is needed. Without active engagement in the partnership by the hospital, a CBO cannot achieve the CCTP goals, as they won't be able to identify and enroll the most appropriate patients, which is obviously an enrollment challenge.
 - **Lack of an adequate ramp-up period.** It takes time to cultivate a relationship between a CBO and their partner institution or hospital. Many CBOs participating in the CCTP set up brand-new organizational structures, as was directed by CMS to meet program requirements, and it took time and resources to acquire the technical systems for data collection and reporting. Furthermore, CMS does not make any distinction between large and small CCTP sites, in terms of the speed at which they could ramp-up operations.

Possible Solutions

- CMS should work with local stakeholders to further educate hospitals and other partner institutions about the CCTP and participating CBOs.
- For those hospitals that are participating in other demonstrations, CMS should provide clarity around the issue of how payments made to a CBO participating in the CCTP would interact with their partner hospital's potential shared savings from reduced readmissions.
- Require a more formal partnership between 102 CCTP sites and their respective Hospital Engagements Networks, so that the role and engagement level of participating hospitals is made explicit.

2. AGGRESSIVE TIME FRAME: CMS requires sites to meet the 20 percent readmissions reduction for high-risk Medicare patients serviced across all partner hospitals within the initial two-year performance period, with the option of extending that agreement if the program meets this objective. Yet many sites have experienced administrative barriers that have delayed implementation of the program, including:

- **Lag in real-time data from CMS.** The lack of timely data has forced many sites to create their own local data reporting systems and processes to guide their programmatic efforts while they wait for official results from CMS. This duplication has proved costly and has taken time away from service delivery and targeting more patients for CCTP. Until recently, CMS did not allow the Quality Improvement Organizations (QIOs) to provide data support to CCTP sites.
- **Upfront costs.** Given the draw-down reimbursement structure of the CCTP, sites are responsible for the majority of the up-front costs associated with the start-up of the program including technical training, staffing, and other administrative costs, creating a huge financial burden on the CBOs. This, in turn, makes it more difficult to expand enrollment. For example, the sooner you hire more transitions coaches, the higher you can boost your enrollment. However, if you have to ramp up hiring more slowly to keep pace with reimbursements, it hinders the ability to meet the enrollment benchmarks.

Possible Solutions

- CMS should allow more time for the CCTP sites to both ramp up their enrollment and continue to implement the appropriate systems to achieve readmissions targets.

3. INAPPROPRIATE PERFORMANCE MEASURE: CMS requires sites to meet the 20 percent readmissions reduction targets for the total high-risk fee-for-service beneficiary population served across all partner hospitals in the initial two-year performance period, regardless of whether these patients are enrolled in the CCTP. For example, if a CCTP site is targeting beneficiaries with three specific health conditions to enroll into the program, the performance measure would comprise more than just that targeted group, including all high-risk Medicare patients served across all partner institutions in the calculation. We feel it is important that sites be held accountable only for those patients that are targeted by the program. It is important to note that Secretary of Health and Human Services has the flexibility in how the readmissions target is structured, as there was no specific readmissions reduction target language included in Section 3026 in the Affordable Care Act, which authorized the CCTP.

Possible Solutions

- CMS should provide a more appropriate performance measure to hold sites accountable for both improving health outcomes and reducing readmissions of the targeted population. Rather than a 20 percent reduction in overall Medicare readmissions, the reduction should be measured only with patients who were eligible to participate in the CCTP program.

For More Info:

AMY GOTWALS 📧 Chief, Public Policy and External Affairs, n4a, agotwals@n4a.org, 202.872.0888

LINDSAY PUNZENBERGER 📧 Policy Director, National Transitions of Care Coalition, lpunzenberger@vennstrategies.com, 202.466.8700