Care-transition fumbles highlight CMS' reform challenges

By Melanie Evans | April 28, 2015

In Cincinnati, a former pharmaceutical marketer is working alongside nurses and social workers to encourage Medicare patients to accept help as they leave the hospital so they can avoid a repeat visit. The marketer's sales savvy turned out to be a crucial element in getting patients to participate, thus reducing readmissions.

The Council on Aging of Southwestern Ohio's project, part of the CMS Innovation Center's five-year Community-based Care Transitions Program, needed to rapidly enroll Medicare patients to keep its CMS contract. The national demonstration program was launched in 2012 and will spend up to $300 million enlisting community agencies to work with hospitals to help patients build skills and find resources to prevent repeat hospital visits. The CMS Innovation Center had targeted area agencies on aging to participate.

“We were being too nice about allowing people not to sign up,” said Ken Wilson, vice president of operations for the Council on Aging of Southwestern Ohio in Cincinnati. So the agency revised the job description for recruiters to hire more persuasive staff, including the former pharmaceutical marketer. Enrollment jumped from 64% to 98% of eligible patients.

Others didn't do so well. Of 101 participating agencies, roughly one-quarter withdrew or had their contract terminated after the first two-year contract. Wilson's agency survived the cut. "The sites that were not extended failed to achieve performance targets," the center said in a written statement. There are 72 agencies still participating.

The demonstration's objective was a 20% reduction in the 30-day all-cause readmission rate for all patients in traditional Medicare for hospitals in the initiative. Separately, agencies also were required to reduce 30-day all-cause readmissions for high-risk patients and hit target volume for enrollment to show a steady trend toward targets. Agencies are paid an all-inclusive rate for serving eligible patients during a 180-day post-discharge period.

But an evaluation conducted for the Innovation Center by the consulting firm Econometrica found just four of 47 agencies studied succeeded in reducing readmission rates against a comparison group.

The Innovation's Center's negative evaluation of the Community-based Care Transitions Program's results and the contract terminations have been criticized by some researchers and advocates for community-based care. They say the Innovation Center used unrealistic performance targets and evaluated results too early in the program, using a flawed measure of readmissions. "It's really too early to tell," said Sandy Markwood, CEO of the National Association of Area Agencies on Aging.

The controversy underscores the challenge CMS officials face as they seek to simultaneously evaluate multiple payment and delivery reform demonstrations aimed at reducing costs and improving quality of care. These include Medicare accountable care organizations, bundled-payment initiatives, and patient-centered medical-home initiatives, all of which the CMS has targeted for rapid expansion.
These payment and delivery system experiments, established and funded under the Innovation Center that was created by the Affordable Care Act, are seen as central to the healthcare reform law's goal of improving quality of care and reducing costs. The law allows the HHS secretary to implement successful demonstrations in the Medicare program at large, without congressional approval. But results from the demonstrations are emerging more slowly than many experts had hoped, and their results have been mixed so far.

Paul Ginsburg, director of public policy for the University of Southern California's Schaeffer Center for Health Policy and Economics, said evaluating a demonstration is complicated when multiple interventions are underway to reduce readmissions. That is the case with the Community-based Care Transitions Program, which is being used at the same time as multiple other national and local efforts are being implemented to prevent repeat hospital visits.

"Doing a number of things to reach the same goal makes your evaluation process far more challenging if not impossible," Ginsburg said.

Dr. Joanne Lynn, director of the Altarum Institute's Center for Elder Care and Advanced Illness, called the measure used to track readmissions in the Community-based Care Transitions Program demonstration "seriously flawed." She called the preliminary evaluation of the program "dramatically uninsightful." Lynn worked with San Diego County's Health and Human Services Agency in California to develop that agency's successful bid to join the demonstration program. The agency survived the cut and its program continues.

Lynn said one methodological problem is that the evaluators used a hospital's ratio of readmissions to admissions to track progress. But that ratio won't change if community-based assistance reduces both admissions and readmissions. She urged the Innovation Center to instead measure readmissions at the participating hospital against the rate in the larger community.

A spokeswoman for the Innovation Center said no one was available for an interview to discuss these issues.

Quality experts have debated the best way to measure readmission rates. Each approach has limits and strengths, depending on its purpose, said Dr. Ashish Jha, a health policy professor at Harvard University who studies quality of care. Measuring a hospital's ratio of readmissions to admissions is better for evaluating programs designed to prevent readmissions, he said, while population-based measures are better for evaluating programs designed to reduce admissions generally.

Current and former participants in the program described the Community-based Care Transitions Program's performance targets as daunting, and said it took a lot of investment and hard work to launch such a project. Not all succeeded as quickly as necessary, they said. Area agencies on aging needed time to build relationships with leaders and discharge planners at hospitals that would provide patient referrals. Community care coordinators needed training to gain access to patients' medical records. Some programs needed time to coordinate access to data. Some area agencies on aging lacked experience in billing Medicare, so they struggled to submit claims to the agency.

Just getting off the ground was a challenge, Markwood said.

The CMS Innovation Center encouraged area agencies on aging to apply, and they each invested an average of $165,000, according to a survey last October of 82 participating agencies. Nearly all reported that they failed to meet the program's targets for reducing readmissions. But they generally said they had achieved some positive results for patients.

Markwood urged Innovation Center officials to be less rigid in evaluating progress. "In any innovation there needs to be some flexibility," she said.
The Metropolitan Area Agency on Aging in North St. Paul, Minn., withdrew voluntarily. The agency worked to reduce readmissions at two Twin Cities hospitals but did not enroll enough Medicare patients, said Dawn Simonson, the agency's executive director. Patients who worked with her agency's transition coaches had fewer readmissions, she said. The agency currently is in talks with a hospital that may invest to finance the project.

Jonathan Lavin, CEO of AgeOptions, Oak Park, Ill., said his aging agency struggled to get the attention of hospital partners that were simultaneously involved in other delivery reform efforts. "Everybody just acknowledged that there were too many things going on," he said.

Lavin met with Dr. Patrick Conway, the Innovation Center's chief, and Kathy Greenlee from the U.S. Administration on Community Living, to try to convince them to renew his agency's contract. He argued that his agency had sharply increased patient enrollment with six months left in its two-year contract. The pitch failed. "We didn't have a performance record that I would claim was outstanding," he acknowledged. "We were moving along. When we finally figured out what they wanted, we just went into full gear and were able to turn around the productivity."

He considers the program a missed opportunity to demonstrate to healthcare providers the value of community-based support.

Even agencies that got their contracts renewed by the CMS described the performance targets as unattainable. Nick Macchione, deputy chief administrative officer for the Health and Human Services Agency County in San Diego County, called the requirement to have the program up and running in three months "delusional."

His agency succeeded in meeting that startup requirement at one health system. But it needed another 1½ months to start enrollment at a second system. "It was a colossal feat," he said, comparing it to "giving birth to a porcupine."

It also took time for hospitals to see the value of the Community-based Care Transitions Program. "That was the big ah-ha," Macchione said. "They started to see that (what happened) outside the walls of the hospital was equally as important as the quality of the care inside the hospital."