There Is More to the Story on CCTP

Statement by n4a CEO Sandy Markwood on the Community-Based Care Transitions Program (CCTP)

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Recently the Department of Health and Human Services (HHS) released a privately contracted evaluation of the Community-Based Care Transitions Program (CCTP). Kaiser Health News reported on this evaluation in an article titled, “Health-Law Test to Cut Readmissions Lacks Early Results” published on January 14, 2015, but both the evaluation and the article paint an incomplete picture of the CCTP, which is funded by the Patient Protection and Affordable Care Act (ACA) and aimed at reducing preventable 30-day hospital readmissions in targeted, high-risk Medicare populations. Instead of relying solely on early results from a HHS-contracted evaluation, judgment on overall program performance must take a long-term view and consider a greater number of compounding factors.

Area Agencies on Aging (AAAs) and other Community Based Organizations (CBOs) participating in the CCTP and contracting through the Center for Medicare and Medicaid Services (CMS) Innovation Center are a key part of an important paradigm shift in the health care delivery model. This shift—aimed at achieving the triple aim of better care for patients, better health for communities at a lower cost—requires changes within a historically rigid and resistant medical model of health care delivery to realize and respond to the fact that, once released from the hospital, the critical support for an individual’s health and recovery happens at home and in communities.

CBOs—particularly AAAs with a decades-long history of efficiently and cost-effectively delivering home and community-based services to older adults and people with disabilities—are key partners in achieving such monumental change. Furthermore, a large-scale shift as outlined in and required by the ACA, cannot possibly occur without significant investment in and support from the federal government—in this case from CMS through the Innovations Center.
An essential component to overall program success for an initiative as ambitious and innovative as the CCTP requires long-term, flexible and responsive reflection and evaluation of participant performance. These key considerations were missing in the early program evaluation cited within the article. Both publications did note that the current evaluation was preliminary and based only on several months of initial available data gathered from less than half of the total number of sites ultimately participating in the five-year-long initiative.

Unfortunately, juxtaposing the current program status—that 29 of the total 101 CCTP-funded sites have withdrawn or been ended—with the very early results outlined in the evaluation—only four of the 48 sites achieved the readmissions goals set by CMS—fails to accurately account for the lessons learned, successes experienced, and money and lives saved by CCTP activities.

As n4a, in partnership with the National Transitions of Care Coalition (NTOCC), noted in a March 2014 white paper outlining the early challenges of CCTP participants, there are significant concerns that CCTP sites themselves are aware of and have proactively addressed. An unforeseen and last-minute 40 percent cut in the program’s budget from Congress; significant lag time in beneficiary data; ill-defined readmissions and enrollment metrics; considerable and non-reimbursable program start-up costs averaging over $165,000 per site; lack-of buy-in and communications challenges with partner hospitals; unclear performance expectations; and an overly ambitious ramp-up time prescribed did not position CCTP sites for immediate success.

Despite these challenges, many CCTP sites are experiencing successes in reducing readmissions and, more importantly, positively affecting patient lives. In October 2014, n4a surveyed 92 CCTP sites either led by or partnering with local AAAs. Eighty-two sites responded and the results of this survey begin to paint a different and much more optimistic picture of CBO and AAA-directed care transitions activities.

While the n4a survey delved into and recognized all of the challenges reported in the 2014 white paper, it also asked CCTP sites to detail whether they were experiencing success, how they were internally measuring their successes, if they were demonstrating Medicare cost savings, and if they planned to continue care transitions activities beyond the lifespan and footprint of the CMS-funded CCTP.

The results speak for themselves. The CMS-defined measure of CCTP site success is largely based on a 20 percent all-cause reduction in hospital readmissions, a metric that has been expanded since the first sites were contracted and repeatedly questioned in independent evaluations of appropriate and accurate readmissions measures. n4 asked those sites that had fallen below this particular measure whether they were still demonstrating positive results as evaluated internally. More than 95 percent of respondents indicated their programs were achieving positive results in reducing readmissions despite falling short of this benchmark. Furthermore, 93 percent of those sites falling short of the technical benchmark for success were still demonstrating cost savings to Medicare—in many cases totaling millions of dollars.
Nearly half of all agencies no longer funded through CCTP were still engaged in care transitions activities funded through private health care companies or non-profits, which demonstrates the market value of this work. Additionally, 87 percent of respondents said that they anticipated continuing care transitions activities beyond the CCTP program based on the program’s need and outcomes.

If we are to truly change the health care delivery model to better connect an acute-care system to a post-acute HCBS system to increase patient safety, improve quality of care and reduce health care costs, CMS should adjust the program guidelines and metrics to allow for the true testing and recalibration that is inherent in innovation. To support this paradigm shift, CMS should invest in the start-up and full program costs; allow flexibility to ensure investments build infrastructure and support partnerships to reach patients where they want to be served; as well as evaluate programs on responsive, not rigid, performance metrics that accommodate both lessons learned and reflect the time it takes to create an efficient and cost-effective system.

Basing the future value of an unprecedented and complicated program on a preliminary and incomplete evaluation that demonstrates limited initial success has the potential to hamstring current and future local innovations that are demonstrating life-changing success through this program. More importantly, however, failing to provide a balanced and comprehensive picture of CCTP challenges and successes undermines the very goal of CMS’s Innovation Center and the triple-aim mission of the ACA.