Everything You Wanted to Know to Apply to the Community-based Care Transitions Program by September 3, 2012

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Why Our BIG PUSH for Many, High-Quality Applicants to the CCTP Program by September 3, 2012,

is Important

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The Community–based Care Transitions Program (CCTP)

- The CCTP, created by section 3026 of the Affordable Care Act, provides funding to test models for improving care transitions for high risk Medicare beneficiaries.

- Our last application review date for CY 2012:
  - **September 20, 2012 -** Applications must be received by September 3rd to be considered for this review.

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Program Goals

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

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Eligible Applicants

- Are statutorily defined as:
  - Acute Care Hospitals with high readmission rates in partnership with an eligible community-based organization
  - Community-based organizations (CBOs) that provide care transition services
- There must always be a partnership between at least one acute care hospital and one eligible CBO
- Critical access hospitals and specialty hospitals excluded as feeder hospitals but could be part of the larger community collaboration

Definition of CBO

- Community-based organizations that provide care transition services across the continuum of care through arrangements with subsection (d) hospitals
  - Governing body with multiple health care stakeholders, including consumers
  - Legal entity with taxpayer ID number - for example, a 501(c)3) - so they can be paid for services they provide
  - Physically located in the community it proposes to serve
- A self-contained or closed health system does not qualify as a CBO

Examples of entities that may be a CBO

- Area Agencies on Aging (AAAs)
- Aging and Disability Resource Center (ADRCs)
- Federally Qualified Health Centers (FQHCs)
- A coalition representing a collaboration of community healthcare providers - if a legal entity is formed
- Some post-acute care providers may qualify – with evidence that there is board representation that comes from outside of that provider entity

Preferences

- Preference will be given to proposals that:
  - Include participation in a program administered by the AoA (ACL) to provide concurrent care transition interventions with multiple hospitals and practitioners
  - Provide services to medically-underserved populations, small communities and rural areas
- Preference means that all other things being equal, these factors can improve applicant's rating by panel

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Additional Considerations

- "High-readmission hospital" defined as having 30-day readmission rate on at least two of the three hospital compare measures (Acute Myocardial Infarction [AMI], Heart Failure [HF], Pneumonia [PNEU]) in the fourth quartile for its state
  - You can find this data at: http://www.cms.gov/DemoProjectsEvalRpts/downloads/CCTP_FourthQuartileHospsbyState.pdf
  - The data covers 30 day readmission rates for hospitalizations that occurred between July 2006 and June 2009

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Why are people readmitted?

Provider-Patient interface

Unmanaged condition worsening
Use of suboptimal medication regimens
Return to an emergency department

Unreliable system support

Lack of standard and known processes
Unreliable information transfer
Unsupported patient activation during transfers

No Community infrastructure for achieving common goals

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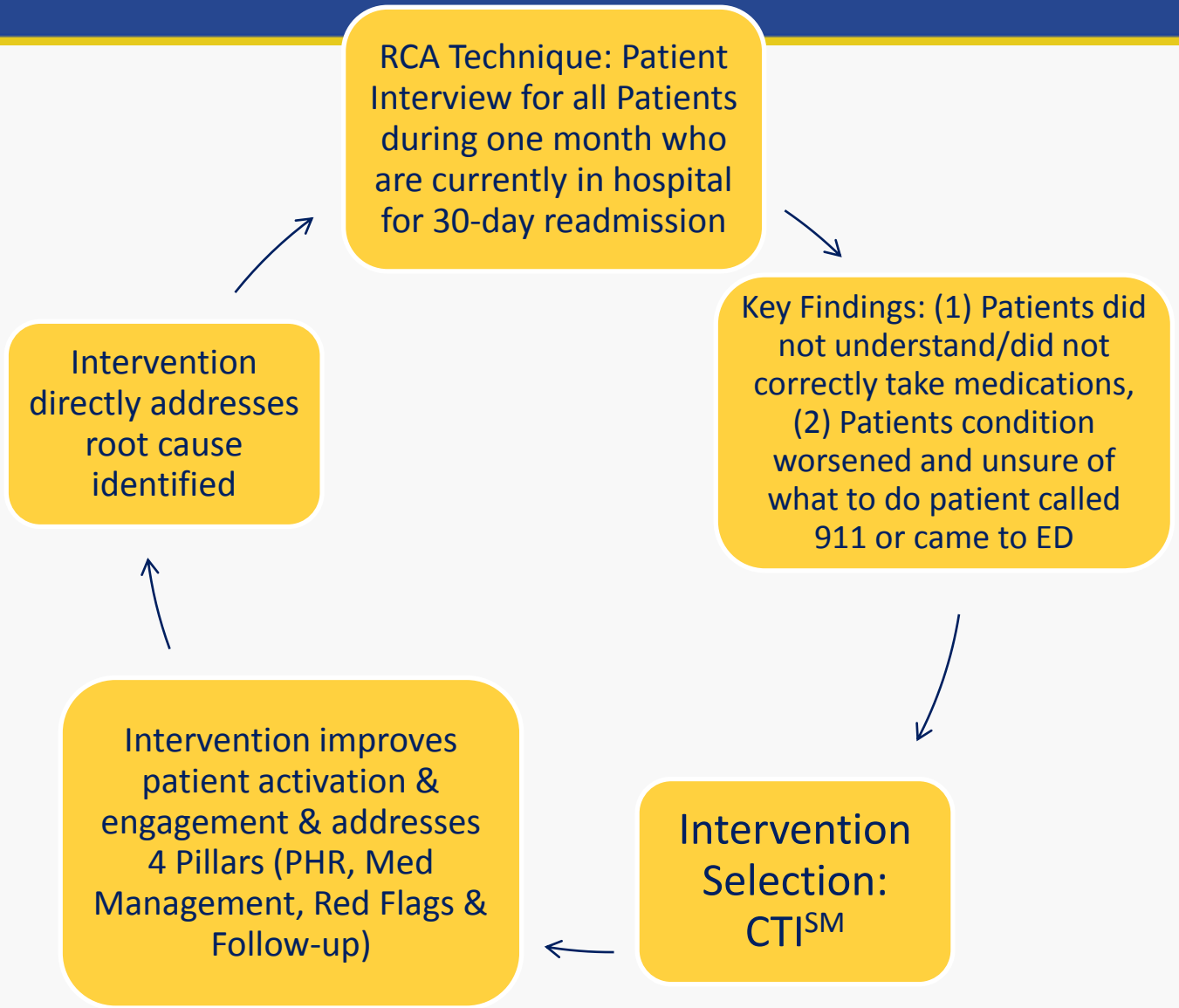
Using Root Cause Analysis to Drive Intervention Selection



CMS Table of Interventions

http://www.cfmc.org/integratingcare/files/Care_Transition_Article_Remington_Report_Jan_2010.pdf

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http://www.cfmc.org/integratingcare/toolkit.htm

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Scroll over each sign to find more information.
For additions and edits to the toolkit, please contact the National Coordinating Center.

Application Requirements

- Strategy and Implementation Plan
  - Includes a Community Specific Root Cause Analysis (RCA)
- Organizational Structure and Capabilities for the applicant and its partners
- Previous Experience
- Budget Proposal

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Implementation Plan

- Implementation work plan with milestones
- Identify process for collecting, aggregating, and reporting quality measure data to CMS
- Description of how the applicant will align its care transition programs with care transition initiatives sponsored by other payers in their respective community
- Applicants claiming preference for working in rural areas, small communities, or serving medically- underserved populations should provide evidence to support that claim

Strategy

- Description of a comprehensive community specific root cause analysis including incorporating downstream providers as appropriate
- Results of the root cause analysis are used to drive selection of the target population and the interventions
- Clear process for identifying high risk Medicare FFS beneficiaries to be targeted
- Intervention implementation strategy- including how the intervention will be integrated into the discharge process without duplicating it

Organizational Structure

- Description of the financial, legal, and organizational structure of the partnership between the hospital and the CBO
- Process for if and how CBO fees will be shared among hospitals and/or other community providers
- Explanation of internal monitoring processes for the management and delivery of care transition services
- Include protocols detailing financial controls for Medicare payments

Capabilities

- Formal agreements are presented for all downstream providers (such as nursing homes, home health agencies, primary care providers) identified as partners in the initiative
  - For example, MOUs, Charters, Data-Sharing Agreements
- Applicant provides letters of support signed by the CFO, CEO, and operations manager for discharge/case management at each hospital named as a partner in the application.
- Justification for applicant to qualify as a CBO
- Support for claiming program preferences as noted above
- Clarity in your narrative is key – don't make panelists guess whether you are eligible/qualified. Tables and charts can help to organize information.

Previous Experience

- Description of previous experience implementing care transitions interventions
  - Includes evidence on the measurement strategies and outcomes of this work
  - Specify where longer-term care coordination or disease management intervention focused around the hospital discharge/transition
- Training completed in any of the evidence based care transitions interventions (e.g., CTI, BOOST, RED, INTERACT, TCM, TCAB, STAAR, H2H, BRIDGE, GRACE)
- Description of other efforts to reduce readmissions
  - May include discharge process redesign or the use of electronic health information systems and tools.

Budget Guidance

- CBOs will not be paid for discharge planning services already required under the Social Security Act and stipulated in the CMS Conditions of Participation
- This is not a grant program; do not structure your budgets as you would a grant.
- Under this program, CBOs bill monthly for care transitions services they provide and are paid the per-eligible discharge rate per final program agreement. CMS acknowledges that there may be regional and other reasons for variations in the rates.
- CBOs may only include the direct service costs for the provision of care transition services to high risk Medicare beneficiaries
- Do not use the average cost of a hospital admission/readmission ($9600) as a starting point for developing proposed rate

Budget Guidance (continued): Blended Rate Calculation

Model	Model Rate	% of Target Population	# Targeting	Total Amount
Model 1	$194.44	50%	336	$65,331.84
Model 2	$138.89	30%	201	$27,916.89
Model 3	$3.33	20%	134	$446.22
TOTALS		**100%**	**671**	**$93,694.95**

Blended Rate =

Total Amount ($93,694.95) / Total # Targeted (671) = $139.63

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Payment Methodology

- CBOs will be paid a per-eligible discharge rate
- Rate is determined by:
  - the target population
  - the proposed intervention(s)
  - the anticipated patient volume
  - the expected reduction in readmissions (cost savings)
- Rate will not support ongoing disease management or chronic care management, which generally require a PMPM fee.

Pitfalls to Avoid: Common Errors

- The applicant CBO does not meet the eligibility requirements to be a CBO or it is unclear.
  - Board members and their affiliations are not identified
  - CBO appears to be part of closed hospital-system
  - Audit reports are not completed or are incomplete
- Lack of a community-specific RCA.
- The RCA is present, but the methodology for targeting high risk beneficiaries and the selected interventions proposed are not tied back to the community specific RCA.
- Letters of support or appropriate signatures are missing from the application.
- Budget narrative is unclear. What patient-level services does the fee cover?

Pitfalls to Avoid: Strategy & Implementation

- Insufficient detail
  - **Implementation timeline** (Hint: tables are helpful, and the sooner you are prepared to begin implementation, the better)
  - **Staffing and training**: Who is trained so far? What kind of training, and how many staff? Who/how many do you still need to train, when, and what kind?
- Overly broad and/or subjective targeting
- Population targeting not fully addressed
- Readmission risk assessment screening tool not fully described, provided or is not evidence-based
- Proposing a hybrid model that has not been tested
- Proposing multiple evidence-based interventions that lack integration, appear duplicative, and may be in conflict with one another

Pitfalls to Avoid: Organizational Structure

- Unclear relationship between partner organizations
- Fee-sharing arrangements not adequately described
- Board of Directors not listed and/or no consumer representation
- Excessive lead-time to get started
  - Hiring / training
  - Agreements not finalized
  - Operational protocols in development

Pitfalls to Avoid: Previous Experience

- Insufficient detail with previous experience/ pilot programs
  - Population, intervention, duration, outcomes, lessons learned
  - Show us the data - all of it (e.g., not just final readmission rate of target population after intervention, but how much did all-cause readmissions go down both in target population and overall in hospital/community, and include both rate and counts)
- Broader experience ***is*** taken into account, but applicant should provide transferrable features

Pitfalls to Avoid: Budget

- Proposing a PMPM instead of a per-eligible discharge rate
- Populating the budget worksheet with numbers and failing to provide narrative/justification for numbers elsewhere
- Basing eligible discharge rate on 100% participation
- Using unreasonable assumptions for readmissions avoided, which also inflates savings estimates.

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Pitfalls to Avoid: Budget

- Building a budget as a grant and including costs for training, evaluation, office supplies and equipment, project directors, administrative support and so on
- Payments between providers for referrals
- Incentive payments to providers for good will, cooperation, and promotion
- Duplication of services or lack of clarity around how services are distributed among normal discharge planning activities and staff, and what additional services are being provided among hospital, CBO, other partner staff

CCTP is Key in Partnership for Patients Readmissions Aim

Aim	National Baseline, 2010	2013 Target
20% Reduction in 30-day All-Cause, All-Payer Readmissions	14.4 %, based on 32.9 million admissions in 2010	11.5%, based on 32.9 million admissions (or approx. 947,106 readmissions averted, 548,437 of which in Medicare)

Key Thoughts and Requests from the Partnership for Patients

1. Focus on effective targeting to reduce more readmissions
2. Collaborate with other payers, including Medicaid, Medicare Advantage, Medicaid Managed Care. While CCTP can only directly support the Medicare transitions, aim to serve *all* high risk patients and help these other payers achieve better quality outcomes at lower costs.
3. Build strategic partnerships with others in your community who can bridge gaps – ultimately creating "economies of scale" and allowing multiple providers and patients to tap into learning and other shared resources.
4. CMS would like to double or triple the impact of this program – the goals are far too important not to reach for the stars!

Community-Based Care Transitions - Your QIO Can Help!

- Community Coalition Formation
- Community-specific Root Cause Analysis
- Intervention Selection and Implementation
- Assist with Application to Formal Care Transitions Program

For assistance please locate your QIO care transitions contact at: http://cfmc.org/integratingcare under “Contact Us”

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Useful Care Transitions Links

LEARN:

- **QIO National Coordinating Center:** www.cfmc.org/integratingcare
- **ACL:** http://www.adrc-tae.org/tiki-index.php?page=CareTransitions
- **CCTP Site Summaries:** http://innovations.cms.gov/initiatives/Partnership-for-Patients/CCTP/partners.html

APPLY:

- **CCTP:** http://innovations.cms.gov/initiatives/Partnership-for-Patients/CCTP

- **QIO Help: See "Toolkit" at CFMC.org and Contact Your QIO Directly at** http://www.cfmc.org/integratingcare/files/ICPC%20Aim%20Lead%20Contacts_022712.pdf

Thank you.

For CCTP Specific Questions, E-mail Us:

CareTransitions@cms.hhs.gov

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