Everything You Wanted to Know to Successfully Apply to the Community-based Care Transitions Program (CCTP) by September 3, 2012
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Sarah Stout: Thank you. Good afternoon. Welcome to the "Everything You Wanted to Know to Apply to the Community-based Care Transitions Program by September 3, 2012" webinar.

I would like to start by introducing our speakers from the Centers for Medicaid & Medicaid Services. We have Juliana Tiongson, a Social Science Research Analyst and CCTP Program Lead at the CMS Center for Medicare & Medicaid Innovation. We also have Ashley Ridlon, Field Director for Care Transitions, Partnership for Patients, CMS Center for Medicare & Medicaid Innovation. And we also have on the line Dr. Paul McGann, who is the Co-Director for the Partnership for Patients, and I am going to start by turning it over to Dr. McGann.

Dr. Paul McGann: Thank you very much, and welcome, everyone. We're very excited at the enormous response we've had to this educational webinar, and we hope in the information that's to follow over the next little while that we'll illustrate our commitment to continuous quality improvement and continuous learning and the development of a robust learning community from coast to coast. I wanted to just take a couple of minutes to outline for everyone why we're excited about this and why we're pushing the Community-based Care Transitions as hard as we are.

As you know, in the Partnership for Patients, we have two goals for national quality improvement in hospital care. One is to reduce all hospital-acquired conditions in all payers and all hospitals by 40 percent by the end of December 2013. The second is to reduce 30-day readmissions by 20 percent by the end of December 2013.

For obvious reasons, our Partnership for Patients program is relying and looking upon the ACA Section 3026 Community-based Care Transitions Program as one of the most important interventions to help us achieve our second goal. This is really a historic program that's never before been done, anything like it, in the Medicare program. It's the first time in history that you, members of the provider community who know your communities, your organizations and your patients best, can define a new program benefit and price the benefit to work in your area.

This is really about coordination and cooperation, not just to improve care for individual patients, but coordination and cooperation among the major providers and community-based organizations in your area. Just like the Partnership for Patients, the Community-based Care Transitions Program is about developing new partnerships and reaching out to people in ways that haven't been done before to ensure in a patient-centered way that all of our patients get the best coordinated care we possibly can.

We are committed to developing and growing rapidly a big learning community. We already have 30 program agreements announced and many more on their way this summer, and we decided instead of the usual rolling application process that we were going to have one final big push to try to get this program up to a huge level, with the next application deadline being September 3.

What you're going to hear over the next hour or so is our best attempt to outline the program requirements and application requirements for you and to incorporate the learning that we've already experienced from the 30 communities that are out there. Our overall goal is all the same, and that is to work together in partnership to achieve better care for our patients at less cost. Let's start the program now.

Sarah Stout: Thank you, Dr. McGann, and now we'll turn it over to Juliana Tiongson.

Juliana Tiongson: Okay, thank you, Ashley. The Community-based Care Transitions Program created by Section 3026 of the Affordable Care Act provides funding to test models for improving care transitions to high-risk fee-for-service Medicare beneficiaries. As Dr. McGann mentioned, we are looking at a final review date of September 20 for calendar year 2012. The applications must be received by close of business on September 3 to be considered on this final review.

Next slide. Eligible applicants are statutorily defined as acute-care hospitals with high readmission rates in partnership with an eligible community-based organization, or community-based organizations that provide care transition services. It's important to note that there must always be a partnership between at least one acute-care hospital and one eligible community-based organization. Critical access hospitals and specialty hospitals are excluded as feeder hospitals for this program but could be part of the larger community collaboration, as can other downstream providers such as SNFs, home health providers, hospice and palliative care, social service providers and so on.

One very important point that I wanted to clarify is that acute-care hospital only has to be a high-readmission hospital on our high-readmission file if it is the primary applicant to the program. If a community -- if an eligible community-based organization is the primary applicant, they can partner with any acute-care hospitals in their community and come into the program that way.

So, there are really four main goals with the CCTP program, which is to 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; and to document measureable savings to the Medicare program.

So, CBOs, community-based organizations, are defined by the legislation as organizations that provide care transition services across the continuum of care through arrangements with subsection (d) hospitals. The key requirements to be an eligible CBO are that the CBO has a governing body that includes multiple healthcare stakeholders, including consumers; it is a legal entity with a tax ID number that can accept payment from CMS for services; and it's physically located in the community that it proposes to serve.

So, the possibilities are endless as to who could qualify for -- as a community-based organization, so long as these three criteria are met. And it's very important that applicants are clear and justify that they are an eligible CBO in their applications by laying out who their board -- governing board members are, what roles they fulfill in terms of the multiple healthcare stakeholder representation and the consumer representation, that they are physically located in

the community, and that they have previous care transitions experience, as well as a legal entity with a tax ID.

Lastly, we -- this is about community partnerships. We are not looking at closed systems to come in, meaning that the CBO falls under the same umbrella as the hospitals. So a hospital system that also has a home health agency under its umbrella and that's the totality of the partnership, that will not be accepted.

Next slide. So, some examples of entities that may be a community-based organization are Area Agencies on Aging, Aging and Disability Resource Centers, Federally Qualified Health Centers, coalitions representing a collaboration of community healthcare providers if a legal entity is formed. Again, it's critically important that it's the governing board of the organization that has the -- that meets the requirements, and it cannot be an advisory committee or advisory board that fulfills this requirement. Some postacute care providers may qualify with evidence that there is board representation that comes from outside of that provider entity. Because of the requirements, it's rare that a single provider qualifies. However, in some cases they do -- visiting nurse services, for example, sometimes have qualified in terms of their board representation.

Next slide. So, preferences that we give to applicants that are required by statute include applicants that participate in a program administered by the -- formerly the Administration on Aging, now the Administration for Community Living, to provide concurrent care transition interventions with multiple hospitals and practitioners. Also, some preference is given to applicants that propose to provide the services in medically underserved areas, small communities as well as rural areas. It's important that applicant substantiate these claims if they are seeking preference for a rural area or a medically underserved population, that they have some sort of official designation by HRSA or the Census or some other way to substantiate the claim.

Also wanted to point out that preference means all other things being equal these factors would improve an applicant's rating. It's not that extra points are given right off the bat because somebody meets one of these preferred criteria.

Next slide. So, we do have -- I alluded to this earlier -- we have a file posted on the CCTP program web page. It's our high-readmission hospital file. This goes through and lists out several hospitals I believe in every state, or almost every state, that fell in the fourth quartile for their state on two -- at least two out of three of the hospital compare measures. This is -- this file will not be updated. It was created when the program started. We are hoping that hospitals on this file will come in with partnerships to the program.

Another thing that has happened, though, is there's been some confusion that people think they must focus on these three conditions in their proposal, and that's not the case. It's just this is the data we had that was available, and that's why we used it to generate the high-readmission hospital file. But we are moving towards all-cause, 30-day all-cause readmissions. So it really is more important to do a thorough root cause analysis that's specific to your community. And I'm going to be turning it over to Ashley Ridlon now that's going to speak about that requirement.

Ashley Ridlon: Thank you, Juliana. We wanted -- so now you've heard a little bit about the sort of broad overview of the program. We wanted to talk a little bit about some of what we've learned in care transitions, because we're not starting from scratch. In the Community-based Care Transitions Program we are building on a lot of the great evidence-based models for improving care transitions that we know exist, and we're building on what communities have already learned in improving care transitions, that people are readmitted for a number of reasons, and sometimes the problems are occurring at the provider and patient level, and this results in unmanaged conditions worsening, use of suboptimal medication regimens and return to the emergency department.

Sometimes it's a system problem and there aren't standard and known processes that are known across care settings, or information is not appropriately and consistently transferred across settings, or patients are not activated, they're not confident of their next step in care during transfers. And we know that these factors, these drivers of readmissions can be really indicative of a problem at the community level. And ultimately they sort of boil down to the community lacking infrastructure for achieving common goals.

So, we have a model here, an example of using root cause analysis to drive your intervention selection. This is a very simplified model, but this is something that I'll talk about in a minute that QIOs, the Medicare Quality Improvement Organizations, can assist with. But this focuses on not just determining what the major high-risk diagnoses are, like heart failure, and you saw some of these earlier in our hospital compare measures. Heart failure, AMI and pneumonia are certainly some diagnoses that can result in readmissions. But here you see patient interviews were conducted for hospital patients who were readmitted. And some of the findings, it wasn't just about their diagnoses, it was about patients not understanding their medications, or not understanding what to do when there was a problem, and so they called 911 and came back to the emergency department.

So, in this case the intervention that was selected to target those drivers was the Care Transitions Intervention, the CTI program, and because it specifically targets patient activation, that very key component of a patient being confident about their next step in care, addresses patient engagement, addresses the knowledge that's gained from a personal health record, from adequate medication management, red flags and follow-up. So, in this example you're specifically tying those root causes that you've identified to the intervention to address those causes. And a root cause analysis is required in the application.

So, here is an example of a good list of some evidence-based interventions that are out there. This is from a Remington Report in January 2010, and it's available through the Colorado Foundation for Medical Care website. This is not all-inclusive. There are some other evidence-based interventions out there. But we wanted to provide this as a resource.

And this is a more comprehensive resource. Again, it's the Colorado Foundation for Medical Care. This is the QIO, the Quality Improvement Organization, that is in charge of improving care transitions in about currently 174 communities across the country. So this is their toolkit, and the website at the top of the page can provide some great resources for getting started, for convening members of your community and learning kind of who to bring to the table, how do you do that

root cause analysis, what kinds of interventions are best for targeting certain drivers, and has some really great tips on measurement. So, we highly recommend that you visit this toolkit.

So, additional requirements in the application -- we'll talk about each component of the application, beginning with the strategy and implementation plan. Again, it includes that community-specific root cause analysis. This recognizes that communities differ in their major drivers of readmission. We'll also talk about the organizational structure and capability requirement for the lead applicant and the partners in the community. We'll talk about previous experience, and, finally, we'll talk about the budget proposal.

In the implementation plan, we ask in the solicitation to include a very clear work plan with milestones; to identify the process for collecting, aggregating and reporting quality measure data to CMS; to describe how you will align your care transition programs with other care transition initiatives sponsored by other payers in the community; and to align -- to talk about the preference -- as Juliana mentioned earlier, if you're working in rural areas, small communities or serving medically underserved populations, do provide adequate evidence to support those claims. We talked about that a little bit earlier.

So, now we want to turn to our sites and ask them a couple of questions about their experience. So the first one is Donna Zaworski in Carondelet - Pima Council on Aging. So, Donna, we'd like to ask how you have aligned your care transitions efforts with other payers in your community.

Donna Zaworski: Great. Thank you. At Carondelet, back in 2010 yet we started our heart failure transition program, and after several months showed some very significant improvement. So we went to our managed care director and demonstrated these improvements so that as we have different contracts coming up for health plans, our managed care director is able to work it in as either a value-added or look at a potential carve-out for our care transitions work.

As we progress that into our CMS demonstration project here, we then worked with our own health plan, MercyCare, which is a Medicaid plan here in Arizona. And with that we've already had our medical home project established, so now we're looking at how we can expand this into a care transitions medical home, if you will, so that it would be part of that medical home process. So they are actually part of our community coalition that we have established for this -- for our program. And so they'll be a part of that whole process, and then we'll continue to work with our other access plans as well as with our other health plans, in general.

Dr. Paul McGann: Thanks so much, Donna. This is Paul McGann. I just want to highlight what just happened here. This is an approach to Affordable Care Act 3026 that is evolving as part of our learning community. So, what you just heard Donna describe is taking a standard Medicare demo targeted at Medicare beneficiaries, developing the infrastructure, getting the plan in place, getting the program and agreement developed, and then working with other organizations in her community to leverage the 3026 plan into other payers that weren't really envisioned at the beginning of the effort.

And this is what we mean by a learning community, and this is the exciting development and extension of a Medicare-based program and an illustration of how it can have wide impact in any

individual community with creative thought and good will and cooperation widespread throughout the entire community across payers. It's an excellent, excellent story, and we thank you for helping us learn that, Donna.

Donna Zaworski: Thank you.

Ashley Ridlon: Thank you, Donna, and thank you, Dr. McGann.

So, we'll go on to the next slide. This gives a couple of tips on the strategy. Again, you're describing your comprehensive root cause analysis, and you're including -- we call them downstream providers, because we're focusing on a hospital discharge. We recognize that downstream providers -- home health agencies, nursing homes, primary care providers and others -- are also upstream providers, and certainly we want you to know that we recognize that. But the point here is we want to make sure that all of the partners are included very explicitly. How are you coming together to manage this transition across all care settings that that patient encounters?

So, you'll talk about your results of your root cause analysis with data, and the interventions that you're choosing, so be very explicit about how you're tying your interventions back to your root cause analysis findings. You'll talk a little bit about -- this is explained in the solicitation -- you'll explain the root cause analysis methodology, so how do you do it? You may include claims data and interviews, focus groups. There's lot of different ways to do a root cause analysis. You'll want to explain the methodology and also the findings with data.

You want to show what your process will be for identifying the high-risk Medicare fee-for-service beneficiaries. You are defining who is high risk in your population based on the root cause analysis that you conduct. So you just need to be very clear on how will you identify and enroll these patients into the care transitions program in your community.

You'll talk about your intervention implementation strategy, including how the intervention you've selected or interventions you've selected will be integrated into the current discharge process without duplicating it. There are hospital discharge requirements for Medicare conditions of participation, and we want to make sure that we're certainly not duplicating existing processes, but we're working with them and leveraging and building on them.

So, with that, we will turn it over again to one of our communities who we have on the call today, the P2 Collaborative, and this question is for Sarah Rugnetta and Megan Havey. So, we wanted to ask how you conducted your community-specific root cause analysis in order to achieve a whole systems view across eight local community organizations and 10 hospitals in seven counties of western New York. So, Sarah or Megan, could you help us learn a little bit about that?

Sarah Rugnetta: Sure. This is Sarah. P2 Collaborative, as the regional community-based organization overseeing the application in our region, tried to support all of our hospitals and local community-based organizations with whom they are working, by providing templates that

they would use throughout the root cause analysis and also just being available to answer all of their questions.

We were incredibly lucky to have technical support from IPRO, which is our regional Quality Improvement Organization, as well as a local foundation called the Health Foundation for Western and Central New York. I would really recommend to any communities who are thinking about applying for the CCTP solicitation to reach out to your Quality Improvement Organizations, because they're incredibly helpful for the root cause analysis process as well as the entire application process.

So, first, P2 Collaborative held a regional meeting where we explained the process and we set a pretty aggressive timeline that any hospitals who wanted to participate would need to comply with. And then we met in each of the seven counties where we're -- where we were engaging the hospitals to explain the process in more detail, answer any questions, as well as providing them with those templates that we created.

That included templates for patient interviews that the hospitals would use, hospital chart reviews that they conducted, as well as partner surveys that we encouraged them to send out to any outside organizations from the hospital and local community-based organizations, and that included long-term care councils, home health agencies, health departments, skilled nursing facilities, adult protective services, and lots of other community-based organizations, to basically ask them targeted questions to find out where they perceived gaps in care transitions in their county.

Also, IPRO, that Quality Improvement Organization that we were working with, provided each of the hospitals with readmissions data specific to their hospital and helped to facilitate meetings with them to assist them as they analyzed trends in their hospital-specific data.

So, after each of the counties performed their own local root cause analysis, P2 collected their specific -- county-specific findings. And then we met with all of the hospitals and local community-based organizations as a region to analyze whether there were common trends in the gaps that they found in their counties. We found three, and then that informed our intervention that we chose, which was Dr. Coleman's Care Transitions Intervention, and then it also informed the target populations that each hospital chose to offer this intervention to.

Ashley Ridlon: Great. Thank you very much. And we'd also like to ask Walter Rosenberg from Age Options to discuss your community-specific root cause analysis.

Walter Rosenberg: Sure. Thanks. And our strategy was very similar to the P2 Collaborative. We also had quite an aggressive timeline, and I have to say in the entire application this was probably the most challenging component for us. It also ended up being really the most rewarding, for a number of reasons.

First of all, as was just mentioned, it's really important to help clarify that the intervention that you're selecting is appropriate for your geographic region. So definitely that's really a key thing. But also it really helped us to foster collaboration with the many partners that we had. We ended

up dividing our application into these so-called BRIDGE coordinating agencies. We ended up using the BRIDGE model, and we had several hospitals.

And so for each hospital, for each geographic area, we tried to take into account the perspectives of all the downstream providers, as you called them, Ashley. And so in order to do that, we tried to do a mix of both focus groups and interviews, and we used a root cause analysis template which we developed. And we really pulled it together from several different resources available online.

Our main strategy was try to use the Five Whys approach. So, the way this worked is we would put together -- we would pull together a particular provider and have a focus group with several of the employees from that organization, or maybe just a one-on-one interview, where we asked them to come prepared with 10 or more representative cases that had ended in a 30-day readmission. The kind of providers we met with were skilled nursing facilities, home health agencies, and the so-called care coordination units, which function in Illinois very much the way AAAs function in other states.

So, once we had the cases in front of us, we took into account a few of the common domains that were associated with readmissions, everything from discharge plan understanding, home health, activities of daily living, instrumental activities of daily living, financial situation, cognition, social support, caregiver support, ability to follow up on appointments, postdischarge appointments, self-management, patient activation, mental health, so really tried to get a broad spectrum of things.

And then, keeping all those domains in mind, we used the Five Whys approach, which basically said why did this particular individual readmit to the hospital? And then that answer, let's say, was they weren't able to get to their follow-up appointment. Why were they not able to get to their follow-up appointment? So that's the second why. And let's say their caregiver was burdened and they had no access to transportation. Usually their daughter takes them. So why was their caregiver burdened? Is that something we can intervene on? And if not, it's a bit of a decision tree, and then maybe something else could be done. You could tap into community resources. So this is a great way to get really to the root problem that ended up in a readmission.

So, once we did this with all of our agencies, we compared the results and used those to formulate our proposal.

Ashley Ridlon: Okay, thank you. And I have an additional question. You know, we get questions a lot here at CMS about the size of the community. So I wanted to follow up again with the P2 Collaborative, since given you do serve a large area with a number of partners in the community to ask what's your process for coordinating and integrating all of those partners and providing oversight on the intervention strategy across your expansive network?

Megan Havey: This is Megan Havey from P2 Collaborative. As Sarah mentioned, our root cause analysis identified three major findings. However, we were really intentional in building a great deal of flexibility into the proposal for each county to carry out the intervention in a way that made the most sense to them. This was really important, because we have a huge range in

size, capacity and experience with care transitions among each of our partners. Our partner hospitals, for instance, range from four beds to more than 100, and there's also a huge variation in how they operate. So, for instance, one of our hospitals found it was important to offer CTI to those being discharge from short-term rehab settings based on their findings from the root cause analysis.

So, anyways, we were really intentional in building that flexibility into the proposal. And it's really made implementation quite interesting for us, because obviously we have to keep tabs on each of them and also kind of identify how we're going to build that unified message. So we have several ways that we try to do this on both a regional and then also a county-specific level.

Regionally, pretty quickly after receiving the award we went ahead and tried to develop a program-wide brand, something that would really unify all of our partners. We developed a name and a logo and several communications tools on how to introduce the program to patients that would really kind of make everyone feel like they were part of a bigger team.

And what's also been really essential to our program is that we developed -- we worked with a software company to develop a region-wide database which is able to collect and monitor data and produce necessary reports to CMS. This is also HIPAA-compliant, which has been really important for us in sharing -- corresponding about patients, eligible patients, appropriate patients in a way that we know is HIPAA-compliant.

And we also hold monthly steering committee meetings, which is largely big-picture reports to the administrators and folks higher up that helped us to develop the proposal initially, and then we also do monthly operations committee meetings, which is typically a similar message but being delivered to people who are really on the ground.

And in addition to that, probably the most time-consuming right now but also really essential piece that we're working on on a local level is that we hold weekly operations committee calls with each local county themselves. So that's really important for us, especially during this implementation time, to brainstorm areas and strategies that we can improve things and really hone in on some of the early successes and share that with the other counties.

Ashley Ridlon: Okay, thank you very much. We'll go on, and I know we'll have additional questions toward the end of this call that we can offer to those sites that are on the line to help us answer. So thank you very much.

Additional requirements for organizational structure include describing the financial, legal and organizational structure of the partnership between the hospital or multiple hospitals and the CBO. You have to -- you do need to describe the process for if and how CBO fees will be shared among the hospitals or other community providers. So, the fees are going through the community-based organization even if a high-readmissions hospital is the lead applicant on the proposal. However, those fees may be shared based on who is providing the services in the community. So, if you are sharing those fees, you do want to describe that in detail, and that's included in the application.

The application also requires an explanation of the internal monitoring processes for the management and delivery of the care transition services and protocols for detailing the financial controls for Medicare payments. And so for more detail on these organizational requirements, we'll direct you again to the solicitation for the program, but do pay very close attention to including all of these details in your organizational structure section of the application.

The application also asks that formal agreements are presented for all of the providers in the community, including nursing homes, home health agencies, primary care providers and others, who are identified as partners in the initiative. We've seen a number of different ways that communities have done this -- submitting MOUs or charters or data-sharing agreements or other forms of this. But you do need to have these formal agreements in place.

The applicant is asked to provide letters of support signed by the CFO, CEO and the operations manager for discharge or case management at each of the hospitals who are named as partners in the application. So you do want to make sure you have all three of those signatures on these letters of support.

The application requires justification that the CBO qualifies, so those requirements you heard earlier about being a legal entity, being located in the community and having that requisite board of multiple stakeholders. Just make sure you provide very clear information to support those eligibility requirements.

Also, if you're claiming those program preferences, working in rural or medically underserved areas, or letting us know who your high-readmissions hospitals are, or if you're part of a program that's funded under the Administration for Community Living, then please let us know, provide support, and describe what those preferences are that you meet.

So, clarity in your narrative is key. Don't make the panelists guess whether you're eligible or whether you're qualified. Be very clear about those requirements being met. Sometimes tables and charts will help to organize this information.

And I will turn it over to Juliana to discuss previous experience.

Juliana Tiongson: So, the third area that applicants are rated on is previous experience. This program is really meant to target organizations with past care transitions experience.

So, description of previous experience implementing care transitions interventions is really important in the application. You should include evidence on measurement strategies and outcomes of this work that you have completed, and also include relevant experience where longer term care coordination or disease management interventions focused around the hospital discharge or transition, because that is really the difference between this program. We're focused on those transitional periods. This program is not going to support your traditional ongoing chronic care coordination, ongoing disease management kind of an approach. So, if that is your past experience that you're citing, really zero in on how that relates to the transition period.

Provide any training, any information on training completed in any of the evidence-based care transitions interventions, when the training happens, how many people are trained, where it happens and so on and so forth. These interventions would include CTI, BOOST, RED, INTERACT, the Transitional Care Model -- there's a number of additional ones listed here -- TCAB, STAAR, BRIDGE, GRACE and so on.

And then, lastly, you can describe other efforts that have been implemented either by the CBO or their partner hospitals or other partners in their community coalition. This could include discharge process redesign or the use of electronic health information systems and tools, for example.

I'm going to ask Terry Levine, from the Delaware County Office of Services for the Aging, to describe the valuable previous experience that his organization had in care transitions that they brought to this program. Terry?

Terry Levine: Yes, hi. Thank you. Yes, from Delaware County, Pennsylvania, we're in southeastern Pennsylvania, immediately southwest of Philadelphia. We received a two-year federal grant through AOA and CMS. It's an aging and disability resource center evidence-based transition program. We partnered with Crozer-Keystone Health System. We had been with other partnerships in the past, other projects, very successful working with them. We chose Taylor Hospital in Delaware County, Taylor because of their admission rate involving seniors is 70 percent.

The model we used is Dr. Naylor's modified model for the Transitional Care Model, providing comprehensive discharge planning and assessment along with intensive in-home follow-up care by an advanced practice nurse, with the goal of the program is to decrease the rehospitalizations, significant savings to Medicare, more successful transitions from the hospital to the community.

In the hospital, the patient was provided with an assessment by an AAA assessor, also a regular home visit by the advanced practice nurse, ongoing telephone supports, engaging the ADRC partners, and a physician/nurse collaboration. The first year of the program was for patients 65 and older. The second year was 60 and older. To qualify for the program you had to have an inpatient order for diuretics. The patient usually had no or very limited family support, reoccurring emergency department visits. No dementia was included in the program.

Based on the outcome of the program -- the initial goal was to see in the two years which the program will end this September would be 235 patients, and as of now we have seen 393 patients. At the start of the program the readmission rate was 13 percent. Right now the readmission rate is 7.06 percent, so 92 percent of the patients in the program successfully without the 30-day readmission.

And then what would happen in the program, while the patient was being assessed and also followed by the advanced practice nurse, they would be involved in other (inaudible) agency programs as far as the options program, where they would get a care manager, also patients in the [aging waiver] program. Some patients went to the family caregiver program. And also some patients were referred to the Life at Home program.

And as far as the satisfaction surveys, we contracted out with the Philadelphia Health Management Corporation, where at the end of the program patients were contacted with the survey, and based on the surveys, some of the surveys were like 93 percent patients felt satisfied that their follow-up care questions were answered; 90 percent medications were explained to them; 92 percent of the patients felt that they were given name and numbers of the doctors to see and what to do in case -- with their health situation; 98 percent included that they learned to balance their daily activities with periods of rest.

And to date with the grant, the grant was a $400,000 two-year grant, and to date possibly the Medicare savings are approximately $3 million. So we're confident that the program is very successful, and in our program that we're doing now we're building on that model to roll out with the other hospitals.

Juliana Tiongson: Thank you so much. That was great.

I'm now going to move on to talk about the budget, which is the last section that's rated in the proposals. And, as Ashley mentioned earlier, we cannot pay for services that are already required and stipulated in the CMS Conditions for Participation under the usual discharge planning function. So, it's very important that what you're proposing is clearly additive to what is already required of the discharge planning process.

Another important point that can't be said too many times is that this is not a grant program, although a lot of applicants to this program are used to applying for grants, and I think that's what makes this budget particularly difficult for people to get their arms around. This is not a grant program. We are testing a payment for a service, which is care transitions to high-risk Medicare beneficiaries. So we are looking to really limit the dollars paid to the cost of the direct service that the beneficiaries are receiving.

Under this program the community-based organizations will bill CMS monthly for care transitions services that were provided in the previous month and are paid the per-eligible discharge rate that is established in the final program agreements between CMS and the applicants.

We do acknowledge that there may be regional and other reasons for variations in the rates. So, the rates will vary from program to program. Based on all the applications and all the awards that have been made to date and everything we've seen, I can tell you that if your per-eligible discharge rate is not under $400, you're likely to be outside of the competitive range for this program.

So, again, you want to include when putting together your budget the costs of direct service, such as the FTEs for the coaches, if you're doing a coaching model. We need to have clear information on number of FTEs that are being covered, caseloads that those FTEs are anticipated to manage. Besides the budget worksheet, we also need to have an extensive budget narrative that explains all the costs and goes to explaining the numbers provided in the budget worksheet.

Okay. Yes, there is a minor error I noticed in the slide here. The last bullet point should be -- should say, "You should not use $9,600." This should have been in the pitfall slides that are coming up later, but it got misplaced. We provided at CMS to applicants $9,600 as the average cost of a readmission. That is only used in the budget worksheet when multiplying times the number of anticipated averted readmissions to come up with a projected savings. That should not be used as a starting point for developing your per-eligible discharge rate.

Next slide. If you are proposing multiple models, you would want to have a separate column or row for each model proposed, and the anticipated number of individuals that will be impacted by that intervention, model equalling intervention or service.

You would then come to a weighted average when developing your blended per-eligible discharge rate. So we have an example here with three different models, three different cost models. Three is probably a systems redesign at the hospital level, with Models 1 and 2 being a more high-touch, coaching type of intervention.

But oftentimes people don't do a weighted average, and oftentimes applicants propose multiple evidence-based interventions but there's duplication, because the same people are getting multiple interventions that have some of the same components to them. So we really need to have that fleshed out very clearly as to why one would propose multiple interventions. And, similar to how your intervention is not duplicative of the discharge process, you need to be crystal clear on how your interventions are acting synergistically and are not duplicative and are not in conflict with one another.

I'm going to call on Andrea Ramirez, from Project Amistad, to speak about effectively blending two evidence-based models to avoid this issue. Andrea?

Andrea Ramirez: Hi. Good morning, everyone. My name is Andrea Ramirez. I'm the Director of the Aging and Disability Transportation Resource Center in El Paso, Texas, and I'm the principal design leader of our CCTP.

During the brainstorming and researching phase of really preparing the proposal I had the opportunity to conduct various root cause analysis with the partner hospitals and in the community setting, to include chart reviews and surveys, patient interviews, and was able to identify the root causes and drivers that were contributing factors that led to the high readmission rates for our community along with who our targeted patients would be. And so I had the great opportunity to work with TMS, the Quality Improvement Organization that many of you have mentioned today.

In doing so, they introduced me to various eclectic models that were evidence-based, such as Care Transitions Intervention, Project BOOST, BRIDGE, the 11 components of the Reengineering Discharge Process in Track 2, etc. And so I then proceeded to work with our hospital partners just to find out what discharge model they were working with. And so three of the five hospitals that we had partnered with had just actually implemented the Reengineering Discharge Process, RED. And I started working very closely with the administrative directors of quality improvement within the facilities.

I was then invited to attend weekly evidence-based action team meetings that consisted of the lead cardiologists, four nurses, case managers. There were data analysts there, and, of course, the director of quality improvement. I then became familiar with the Reengineering Discharge Process and noted that and really surprised that out of all of the components that most of the hospitals were really only using two or three out of those components.

And so the action team would then meet monthly with corporate management on strategies to how to avoid unnecessary readmits for core measures, and they also would meet quarterly and have best practice meetings. And so they would invite me to those meetings. And so I was able to really understand where they were coming from within the hospital setting and knowing it was very important as being the community care transitions lead that I would have to know what would be the best bridge for us.

And so during the process I completed the Readiness Assessment Tool for Care Transitions Interventions. But I involved the hospital partners, because I wanted to make sure that they were involved in the models that we chose. And so we traveled to Dallas and we received training in Care Transitions Interventions by Dr. Coleman and his staff.

Really, prior to receiving the official training we were still not sure what model we wanted to implement. We still felt like we needed to do more research. And so after receiving the official training our care transitions collaborative, which consists of 18 healthcare stakeholders and community stakeholders, we then all agreed to continue utilizing all 11 components of Project RED within the hospital settings and then to implement CTI, Care Transitions Interventions, for our community care transitions model. And then we all sat around and developed a logic model for our care transitions program.

Really, the hospitals at large were making strides in their discharge process for -- mostly for the core measures of heart failure and AMI patients. For example, they made sure that in every chart, in every patient chart the PCP that the patient was being assigned to after discharge was written in the chart, the appointment date and time were there, the address to location of the PCP. All heart failure/AMI patients were receiving two follow-up calls within 72 hours from a software system called Conifer that the hospitals had purchased just to ensure that the patient transitioned in the community setting and making sure that if there were any issues addressed that those were taken care of by the nursing staff.

Heart failure and AMI patients received maybe a total of five follow-up calls, and a weight scale is needed when you blended the CTI model with the Project RED. But for the patients that have other diagnosis, the CTI coach will then ensure components of RED are being provided by the presenting and presented in the discharge checklist, making sure that the patient is activated and ensure that the follow-up appointment has been made, or making sure that the patient has accessible transportation to and from the doctor's office, making sure that the prescription has been picked up or delivered, and really just link them to all the social services available in the community setting.

By having the Amistad Care Transitions team be really familiar with what the hospital model was, Project RED, but just really being trained and well versed in CTI, it then reinforced that synergistic rather than duplicative process. The coaches were able to identify maybe what components of RED were being used and weren't being used and really advocated for the patient to make sure that the hospital staff were really being accountable and really vice versa, because a lot of the hospital staff had been trained on CTI already, so it was really about accountability.

When the coach begins a CTI model and introduces it, they also introduce something called the discharge checklist along with the patient health record in the hospital setting, and if the patient caregiver is not able to complete the discharge checklist then the coach will activate or empower the patient to take a proactive approach in the hospital setting, and so then the hospital discharge planner's case managers, since they're also familiar with CTI, that would just facilitate the whole discharge process, and then in the end we just -- we're really seeing how we're able to improve healthcare in our community. We're really able to see the safer transition here in our community.

Every month we meet with the downstream providers, and we meet them within the hospital settings, and we have meetings. And something else we've noticed is that some of our skilled nursing facilities have actually started utilizing Interact, too. And so there's a lot of cooperation, there's a lot of coordination, and it's just been very enlightening for us here in El Paso, Texas. Thank you.

Juliana Tiongson: Thank you, Andrea. That was very helpful.

I'm going to turn to the next slide now. So, the payment methodology for the CCTP is that CBOs will be paid a per-eligible discharge rate, and, as we said, this rate will vary from community to community. But some of the factors that determine the rate are the target population, or -- I'm sorry, the target population, the proposed intervention or interventions, the anticipated patient volume -- how many lives you have to spread your cost over, the expected reduction in readmissions -- the cost savings to the Medicare program. We do need to anticipate that there will be significant savings generated by your program in order to move forward with your proposal.

Again, I mentioned this earlier, but the rate will not support an ongoing disease management or chronic care management program, which generally requires a per member per month fee. Just wanted to clarify here that we state in the solicitation that applicants or program participants will be paid once -- no more frequently than once every 180 days for the same beneficiary. That does not mean that we're expecting applicants or looking for applicants to serve beneficiaries for 180-day period and basically frontload a per member per month disease management type fee, frontload that into a per-eligible discharge rate.

We chose the 180 days because with one of the most condensed evidence-based care transitions services, the Eric Coleman CTI, that is a 30-day intervention, that has been found to have lasting effects five months after its completion. So, some of the other interventions do go on longer than 30 days of the evidence-based ones, but that's why we picked the 180 days. Just wanted to clarify that, because it has led to some confusion.

Next slide. We're just going to go over some pitfalls to avoid quickly. Some of these have already been touched on. But these are common reasons why applicants score low during our review process with the technical expert panels.

The applicant CBO does not meet the eligibility requirements to be a CBO, or it is unclear to the reviewers. This happens when board members and their affiliations are not explicitly identified; the CBO appears to be part of a closed health system -- I mentioned that earlier; audit reports are not completed, not provided or are incomplete.

Lack of a community-specific root cause analysis -- we really need to see that a robust community-specific root cause analysis was completed that then ties back to the intervention selection and the targeting strategy for the high-risk Medicare beneficiaries.

So, I spoke to the next bullet already.

Letters of support or appropriate signatures are missing from the application. At a minimum, we need letters of commitment from all of the partner organizations identified and letters of commitment signed from each hospital partner by the CFO, CEO and head of discharge planning or case management.

Oftentimes the budget worksheet is completed but there's no budget narrative to go along with it explaining what patient-level services the fee covers, or what is making up that end per-eligible discharge rate.

Some additional pitfalls with regard to the strategy and implementation: failure to provide a comprehensive implementation timeline; staffing and training -- this also speaks to the organizational structure and capabilities. We need to know who is trained so far, what kind of training they have, how many staff will still require training, when will that be accomplished, and how?

There are also often problems with overly broad or subjective targeting. So, although the goal is to reduce 30-day readmissions, all-cause 30-day readmissions by 20 percent across the total Medicare fee-for-service population at your partner hospitals, and that's stated explicitly in the program agreements -- we do have a blank program agreement available for viewing on our CCTP program web page -- it is very important that we are only targeting the high-risk subgroup of the total fee-for-service population with this service, because if we're targeting people that would not have been readmitted without the service, then we're not going to be achieving savings.

Sometimes the targeting is not fully addressed or described.

Sometimes there's a risk screening assessment tool but it is not provided, or it is not evidence-based. It's always important to provide copies of any tools that you plan to use, and those can be included in the supplemental sections.

Proposing a hybrid model that has not been tested -- this is the common problem. People will take bits and pieces out of these various evidence-based models, put them together and propose moving forward with that, when they have not piloted it in their community and cannot demonstrate that it would be effective. So, the panelists do prefer people using evidence-based models, and, certainly, if it isn't, something that has already been piloted and you can show us that it appears to be effective in your community.

Again, proposing multiple interventions, you need to be clear that they do not conflict with each other or are not duplicative -- for example, discharge advocates with Project RED scheduling appointments for beneficiaries being discharged from the hospital and then also proposing to have CTI working with that same group of people, where the idea is to activate the patient, have them set up their own follow-up physician appointment and have a productive doctor's visit. You can see how those things could be in conflict, because the one intervention is on patient activation and getting them to role play and set up the appointment and what they're going to say to their doctor, and then the other one is scheduling the appointment for them. So, sometimes when people try and put in too many interventions and it's not clear if they're going to the same group of people or different groups of people that leads to problems and low scores, ultimately.

In terms of organizational structure, unclear relationships between partner organizations; fee-sharing arrangements that are not adequately described -- we did speak to this earlier. CBOs may share fees, but we need to know what is being shared, with whom and for what services.

Board of directors not listed and/or no consumer representation -- this goes back to the eligible CBO requirements.

Excessive lead time to get started -- we expect applicant to be able to get started within three months of notification of award, if not sooner. I mean, three months is pushing the envelope, because this program targets organizations that already have experience, and we're expecting them to be able to hit the ground running, if you will. So, when there are no operational protocols in place, when it said they're in development and a whole host of people need to be trained and hired and agreements are not -- formal agreements are not in place, such as MOUs, it gives us great pause.

Pitfalls on the budget -- I already spoke to the first one; already spoke to the second bullet here, making sure you need to include a narrative to go along with your budget worksheet.

Okay, another big problem is basing eligible discharge rate on 100 percent participation among your eligible population. You have to take into account that not everybody will participate or accept the intervention being offered.

Using unreasonable assumptions for readmissions avoided, which also inflates savings estimates -- based on our previous experience, most notably with the QIO [9.] Scope of Work Care Transitions Pilot in nine -- I'm sorry, in 14 states, we believe that a 20 percent reduction is reasonable over a two-year period. And so when people propose that they're going to reduce readmissions by much higher percentages -- we do here at CMS have a standardized form, a budget form that we run everybody through that looks at a 20 percent reduction on their total fee-

for-service population across all their partner hospitals to see if in fact the program is expected to generate savings.

Just wanted to mention, this is where that last bullet on the previous slide should have been that says do not use $9,600 as your starting point for developing your per-eligible discharge rate.

Just getting down to the end of the pitfalls here, with previous experience, provide us all the information you have, any data, and not just pieces of it, not just the final readmission rate of the target population after the intervention, but everything that goes along with that. We can't just have one piece of information out of context and not know how many people participated in the program, how it compared to those that didn't participate and so on.

Broader experience is taken into account but needs to really drill down on how it relates to that transitional period, as I mentioned earlier.

Okay, I'm not going to spend too much time on this last one with budget. I think these are pretty clear pitfalls to avoid, and I've touched on most of these points already. But these are ways to get a low score, so you want to pay attention to these pitfall slides.

I'm going to turn it over to Ashley, that's going to talk about the -- how this fits in with a broader Partnership for Patients initiative.

Ashley Ridlon: Thanks, Juliana. As you heard at the very beginning of this webinar from Dr. Paul McGann, who's the Co-Director of the Partnership for Patients, the Community-based Care Transitions Program is key for the Partnership for Patients in achieving its readmissions aim. So, here is the readmissions aim -- a 20 percent reduction in 30-day all-cause, all-payer readmissions across the country.

And what that means in terms of the numbers is that in 2010 we had a rate across all payers of 14.4 percent readmissions, and that was based on 32.9 million admissions that occurred in 2010, so our target for 2013 is a rate of about 11.5 percent readmissions. That's still based on the same admission number. And if you look at a reduction in the count, a 20 percent reduction in the count of readmission, it's about 947,106 readmissions that we need to avert over this three-year period, so 548,437 of those are in Medicare.

So it's a huge goal. It's a bold goal. But we believe it's important, and we appreciate all of the great work that's going on out there across the country toward achieving this aim.

The Partnership for Patients has some requests and some thoughts for this community involved in care transitions. We've talked a lot about focusing on effective targeting so that you can make your program more effective at reducing readmissions. Again, we're measuring all-cause readmissions. The CCTP focuses on Medicare fee-for-service beneficiaries, but we also would like to see as much collaboration as possible with other payers.

You heard on this call from some sites that are successful doing that, reaching out to private health insurance companies, Medicare Advantage, Medicaid, managed care, even state Medicaid

programs. So, while CCTP can only pay for those Medicare beneficiaries, aim to serve all of the high-risk patients in those communities and kind of have an all-payer approach so that you can help those -- you can help more patients, but you can also help those other payers achieve better quality outcomes at lower costs. So it really is a win for everyone.

Think about building strategic partners with others in your community who can help to bridge the gaps. You heard about some of the entities that may not qualify for this program. For instance, if you're a critical access hospital we can't pay directly for the discharges from those hospitals, but you can be a part of the broader community effort. So think about who to partner with in your community that helps to fill in those gaps. So, you're creating economies of scale. You're allowing multiple different kinds of providers and multiple patients across a community to benefit from this program. There will be lots of learning and other shared resources that occur in the community, and so those partnerships are critically important.

Again, we can't stress enough your Quality Improvement Organization can help with this. They can help choose those partners to be effective in your community. They can help with root cause analysis, intervention selection and assisting with your application. You can find a care transitions point of contact for each of the 53 QIOs across the country at this link on the CFMC website under Contact Us. So we strongly encourage you to reach out to them if you have not already.

Here are some additional links: the QIOs; the Administration for Community Living has an excellent toolkit, as well. You can go to the CCTP website at the Innovations Center website and see -- we encourage you to look at these partner one-pagers. There's a one-pager on each of the 30 sites we've announced publicly, and it talks a little bit about what they're doing. So it kind of gives you an idea of the scope of the program and how each of these sites did it.

To apply -- this is very important -- at the Innovations Center website there is the solicitation and the application, the budget worksheet. Any information that you need to know will be on this website.

And, again, we have the link to the QIO points of contact for you.

If you have additional questions, I know we'll open it up here for the last 10 minutes or so of the call for some questions. We have some questions in the chat room that we'll try our best to answer. If we don't answer all of them we'll try our best to answer them following the call. But for additional questions please email caretransitions@cms.hhs.gov.

So now I think we'll go into the Q&A portion of our call.

Sarah Stout: Great. There are two ways you can ask a question. You can ask a question over the phone by pressing *0 and give the operator your name and the organization you are calling from. You can also ask a question by clicking on the red Q&A button at the bottom of the webinar console. And we can get started by addressing a couple of the questions that have come in through the Q&A.

The first is does the CBO have to provide the care management services itself, or can one of its healthcare partners provide the service under contract with the CBO?

Juliana Tiongson: Hi, this is Juliana at CMS, and it is possible that a CBO could use subcontractors to provide the direct service. I know that many Area Agencies on Aging have that as their model for their home- and community-based services that they provide through their Medicare waiver programs, for example. And if that is a group's model it is possible that that could work.

Sarah Stout: Great. Another question that came in through the Q&A, can costs for a project manager be included in the per-beneficiary reimbursement rate?

Juliana Tiongson: This is Juliana again, at CMS. Some costs can. We again want to focus on paying for those FTEs that are actually delivering the services to the beneficiaries. What we cannot support is a project director, a project manager, a clinical supervisor, basically multiple levels of management. That is more consistent with a grant program structure, and that is not something we can support. But clearly we understand that there has to be some supervisory or overall managing component to the people providing the direct services.

Sarah Stout: Okay. Operator, do we have any questions that have come in over the phone?

Operator: Yes, we'll go to the line of Daphne Van Tiem, with the Prince William Area. Please go ahead.

Daphne Van Tiem: Yes, a couple of things. I wasn't aware or made aware that there are more slides to this webinar. Are they at the Innovations Center website?

Ashley Ridlon: This is Ashley at CMS. I know we will be posting the slides if not already at the Innovations Center website, so if you didn't receive them prior to the call or through registration we will be posting them. It's at innovations.cms.gov, at the CCTP site. In fact, I will reverse the slide here -- innovations.cms.gov/initiatives/partnership --

Daphne Van Tiem: Okay, so it's innovations.cms.gov.

Ashley Ridlon: That's right. The slide that you currently see, the middle link under Apply is the link where the webinar will be located. We do require a bit of time to transcribe the call today, to get the audio file and the transcript online, but we'll try to get the -- go ahead and get the slides up today and then hopefully in the next week or so get the audio file and transcript up, as well.

Daphne Van Tiem: Okay. And you also mentioned a Care Transitions website.

Ashley Ridlon: Yes, this is a page within the Innovations Center --

Daphne Van Tiem: Okay, I can find it, then. That's no problem.

Ashley Ridlon: It is specific to the Community-based Care Transitions Program.

Daphne Van Tiem: And I have one final question. I need to learn a lot more about the Coleman process. Where would I find information on that?

Ashley Ridlon: I would -- we certainly recommend the QIOs to talk about interventions specifically.

Daphne Van Tiem: Okay.

Ashley Ridlon: And the QIO link that you see here, I would also stress they offer learning sessions on the second and fourth Thursday of each month from 3:00 to 4:00 p.m. Eastern. In fact, there's one this afternoon that's focused on home health. That's at 3:00 to 4:00 p.m. Eastern time, and it's at that CFMC.org/integratingcare website. And you can also look through their archived learning sessions, and there are excellent webinars on all of the evidence-based interventions, or just about all the evidence-based interventions, including the Care Transitions Intervention, the Coleman model.

Daphne Van Tiem: Okay. And you said that was the CFMC website?

Ashley Ridlon: That's right. CFMC, Colorado Foundation for Medical Care.

Daphne Van Tiem: Okay.

Ashley Ridlon: CFMC.org/integratingcare.

Daphne Van Tiem: Thank you so much.

Ashley Ridlon: Thank you.

Sarah Stout: Great. And we have another question from the chat room. Are coaching costs reimbursable if the patient is discharged to a skilled nursing facility?

Juliana Tiongson: This is Juliana at CMS again. What initiates the eligibility is that a high-risk beneficiary is admitted and discharged from a partner acute-care hospital. If they're being discharged for short-term rehab at a skilled nursing, they can be included, and we encourage CBOs to work with beneficiaries across the continuum of care, which may include multiple interventions -- I'm sorry, multiple transitions, such as hospital to SNF to home, not always just hospital to home.

Ashley Ridlon: And this is Ashley. I would just add one point to that. I think certainly the Care Transitions Intervention, the CTI model, is something that is designed to allow patients to help manage their own care. So it's something to consider if a patient is a long-term care resident and may not be able to use all of the tools of the CTI intervention effectively, the managing their own care and being activated to have physician follow-up visits and manage their medications, etc. Then CTI may not be the best model for them. Certainly CTI focuses more on patients that are going to the home. So that's something to think about. You certainly want to look at where your

discharges are going or where your readmissions are coming from and include that as part of your root cause analysis so that when you're choosing the interventions you're picking the intervention strategy that's best for your patient population.

Sarah Stout: Okay. And another chat room question. What is the threshold in percentage terms defining a hospital as a high-readmission facility?

Juliana Tiongson: This is Juliana at CMS. I don't -- I can't speak to that exactly. Instead of -- I know this was done some time ago, and I think it might vary. But the way it's -- what we did was divide all the Subsection (d) hospitals, or all those reporting into Hospital Compare that were Subsection (d) hospitals in a particular state into four quartiles based on their readmission rates for those three Hospital Compare conditions, the fourth quartile being the worst, meaning that they had the highest readmission rate for those conditions in their state. And then we looked at that. It's divided up [the file] by those that are in the fourth quartile for two out of three conditions and those for three out of three conditions. So, we did it on a state level so that there would be hospitals identified in every state instead of looking at it in a more national level.

Sarah Stout: Okay. I think we have time for one or two more questions. Operator, do we have any other questions on the phone?

Operator: Yes, we'll go to the line of [Christina Burke], with [K&M] Enterprises.

Christina Burke: Yes, thank you very much. I noticed that there are two hospitals on the high-risk hospital list that are located in Puerto Rico, but there are 40 QIOs, which sort of implies 50 states. So I'm wondering if the U.S. Commonwealth of Puerto Rico is eligible to apply.

Juliana Tiongson: This is Juliana at CMS, and, unfortunately, this program, the CCTP, does not extend to the U.S. territories.

Christina Burke: Okay.

Sarah Stout: Okay, we have another question from the chat room. Can a CBO be in more than one application if they service that community?

Juliana Tiongson: This is Juliana again. This is not something that we encourage. We will look at it on a case-by-case basis, but there would have to be some compelling reason for us to accept that sort of arrangement.

Sarah Stout: Okay. Another question from the chat room. Is it possible to forge a partnership between one hospital and several community-based organizations?

Juliana Tiongson: No, that wouldn't be -- well, okay, I have to be careful about this one. We wouldn't want -- okay, in an application there should be a lead CBO and at least one acute-care hospital. If we're not talking about a rural area there should -- there needs to be multiple acute-care hospitals, unless there is some kind of really compelling justification like the QIO ran data

analysis showing that, although there is a second acute-care hospital 20-some miles away, the largest volume is serviced by that one hospital.

So, what I'm saying is there should be multiple hospitals except in rural areas and one lead community-based organization. Now, there can be some other community-based organizations that are like subcontractors to that lead CBO. But we wouldn't want to create a situation where multiple community-based organizations were competing for the same patient population at the same hospitals.

Sarah Stout: Great. And I think that's all the time we have for questions.

Juliana Tiongson: Okay. And, so, we didn't have as much time as we hoped for for questions, so please send in your questions to caretransitions@cms.hhs.gov. That is our resource mailbox, and we will be sure and get back to you through that vehicle if you didn't have a chance to answer -- to ask your question here today.

Sarah Stout: Great. And I think that concludes our webinar today. Thank you, everybody, for signing in.