



National Advisory Committee On Rural Health and Human Services



Rural Challenges for HHS in Implementing the Community-Based Care Transitions Program (CCTP)

White Paper March 2011

Editorial Note: In 2012, the National Advisory Committee on Rural Health and Human Services will focus on the rural implications of key provisions from the Patient Protection and Affordable Care Act through a series of white papers with policy recommendations that will be sent to the Secretary of the U.S. Department of Health and Human Services.

INTRODUCTION

Section 3026 of the Patient Protection and Affordable Care Act authorizes HHS to provide grants through the Community-Based Care Transitions Program (CCTP). These grants offer the promise of improving care quality and reducing costs for Medicare through more effective management of beneficiaries' post-discharge care and avoidance of preventable readmissions. Although such interventions may be especially important to beneficiaries residing in rural areas—where care may be less available or require lengthy travel—the current demonstration program appears to restrict many rural areas from participating. In particular, it is regrettable that the authorizing statute for the program references only Section 1886(d) hospitals, thereby excluding Critical Access Hospitals as applicants since they are authorized under Section 1820 of the Social Security Act.

The National Advisory Committee on Rural Health and Human Services has reviewed the CCTP program and recommends a number of steps to more effectively and equitably assess those proposals that might be submitted for CCTP funding from rural areas. At the same time, the Committee encourages the Centers for Medicare and Medicaid Services (CMS) to more formally include additional provisions for inclusion of rural demonstrations through its Center for Medicare and Medicaid Innovation (CMMI).

These grants have the potential to broadly inform future CMS policy. The Committee urges CMS to give careful attention to rural-based models and ensure that rural providers are part of the overall award pool so that any future policy that emerges from these demonstration grants will take into account both urban and rural considerations.

Recommendations

1. The Committee recommends that in preparing guidance for the grant reviewers that CMS give strong consideration to whether the project gives evidence of good working relationships among the following partners: rural health clinics, principal rural or urban referral center(s), PPS hospitals, critical access hospitals, Aging and Disability Resource Centers, Area Agencies on Aging, home health agencies, skilled nursing facilities.
2. The Committee recommends that project proposals, especially those in rural areas, address at least three of the five interventions.
3. The Committee also recommends that attention be given to proposals that offer a comprehensive transitions approach that is more likely to be sustainable upon the conclusion of demonstration funding.
4. The Committee recommends that CMS include grant reviewers who have rural health experience in order to ensure a fair and unbiased review.
5. The Committee recommends that the CCTP (or future CMMI projects) give increased weight to applications that serve the dually eligible population.

GRANT REVIEW

Review of CCTP grant proposals should be attentive to several recommendations to ensure that demonstration projects serving rural beneficiaries receive a fair evaluation. One difficulty facing prospective rural applicants is the lack of clarity in the guidelines about the geographic scope of a project and the nature of the entity that can sponsor the project.¹ We strongly believe that entities will need to incorporate a partnership with regional reach in order to encompass the significant number of rural AMI, heart failure and pneumonia readmissions that are needed to evaluate the utility of evidence-based models, and yet suggested structures offered through the FAQ seem to restrict their participation. In some rural regions, the beneficiary population tends to rely on a limited set of agencies and providers that may constitute a relatively self-contained definable “care community or market.” The Committee recommends that in preparing guidance for the grant reviewers that CMS give strong consideration to whether the project gives evidence of good working relationships among the following partners: rural health clinics, principal rural or urban referral center(s), PPS hospitals, critical access hospitals, Aging and Disability Resource Centers, Area Agencies on Aging, home health agencies, skilled nursing facilities.

It is possible that CCTPs might inadvertently contribute to fragmentation of transition related activities rather than to increased coordination of existing community and regionally-based resources. This is especially likely to occur if a transition project limits its attention to only one or two of the five recommended transition interventions suggested in the program guidelines. The Committee recommends that project proposals, especially those in rural areas, address at least three of the five interventions.

The Committee also recommends that attention be given to proposals that offer a comprehensive transitions approach that is more likely to be sustainable upon the conclusion of demonstration funding. Such a proposal may actually offer a blueprint for creation or absorption of additional activities that strengthen various components of the CCTP entity. For example, attention might be given to the ability of CCTP activities to contribute to and draw upon the efforts of rural health clinics to become CMS tier 1 or even tier 2 certified medical homes with the capability to link patients with community based services, emphasize preventive services, and maintain up-to-date care plans. Likewise, effective participation of hospital, primary care, and home health providers in any future accountable care organization (ACO) would be enhanced by a strong CCTP partnership.

OTHER CONSIDERATIONS

Demonstration programs can be costly in time and effort for a limited set of organizations and community and regional leaders. This is especially true in rural areas. Any number of new initiatives calling for exchange navigators, information technical assistance specialist, community health workers, medical home certification, and accountable care organizations may place tremendous additional strain on rural health and human services leadership capacity and stretch an already short supply of health care workers to a dangerous point. The Committee believes it is important that those who review the applications for the CCTP understand that the unique structure of the rural health care delivery system. In other words, the reviewers need to understand that the rural health care delivery system is not a smaller version of urban and suburban systems. It may not have the same breadth of physical or human service infrastructure. The Committee recommends that CMS include grant reviewers who have rural health experience in order to ensure a fair and unbiased review.

¹ The Frequently Asked Questions page on the CCTP page of the CMS website provides more information on those entities that are eligible to participate:

<https://questions.cms.hhs.gov/app/answers/list/kw/Community%20Based%20Care%20Transition%20Program>

Also, implicit in some of the Committee's previous recommendations and rationales is that the CCTP program and future CMMI grant programs should be both integrative and inclusive of long recognized and increasingly costly challenges in health and human services. This is particularly true for the dual eligible population, which is a major driver of health care costs. In rural areas, those who are dually eligible for both Medicare and Medicaid make up 12.4 percent of the beneficiary population compared to 10.5 percent in urban areas. The Committee recommends that the CCTP (or future CMMI projects) give increased weight to applications that serve the dually eligible population.