DEPARTMENT OF HEALTH & HUMAN SERVICES
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**Office of Clinical Standards and Quality/Survey & Certification Group**

**Ref: S&C-12-23-ALL**

**DATE:** **March 16, 2012**

**TO:** State Survey Agency Directors

**FROM:** Director
Survey and Certification Group

**SUBJECT:** INFORMATION: Reducing Avoidable Hospitalizations among Nursing Facility Residents; State Survey Agency Director Role in Applications

**Memorandum Summary**

- **Reducing Hospitalizations among Nursing Home Residents:** On Thursday March 15, 2012 the Centers for Medicare & Medicaid Services (CMS) announced the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents, a new effort designed to improve care for people living in nursing facilities who are enrolled in Medicare and Medicaid.
- **Due Date for Applications:** CMS issued a Request for Applications on March 15, 2012. Organizations interested in participating in this initiative must submit an application by June 14, 2012.

*New Opportunity for Better Care for Nursing Facility Residents through Enhanced Coordination Efforts - New Initiative to Improve Care for Medicare-Medicaid Enrollees and Reduce Costly and Avoidable Hospitalizations*

On Thursday March 15, 2012 CMS announced the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents, a new effort designed to improve care for people living in nursing facilities who are enrolled in Medicare and Medicaid. The initiative aims to reduce costly and avoidable hospitalizations among nursing facility residents by funding organizations that would partner with nursing facilities to provide enhanced on-site services and supports to nursing facility residents. CMS commits up to $128 million to support a diverse portfolio of these evidence-based interventions.

The initiative will be run collaboratively by the CMS Medicare-Medicaid Coordination Office and the Center for Medicare and Medicaid Innovation, both created by the Affordable Care Act to improve the quality and costs of care in the Medicare and Medicaid programs.

Through this initiative, CMS will partner with independent organizations to improve care for long-stay nursing facility residents. These organizations will collaborate with nursing facilities and States to provide coordinated, person-centered care with the goal of reducing avoidable

hospital stays. Eligible organizations can include physician practices, care management organizations, and other public and not-for-profit entities.

Each organization will propose its own evidence-based intervention and improvement strategy. All participants will have staff on-site at nursing facilities to provide preventive services and improve coordination and communication among providers, helping to provide the resident with a more seamless transition between care settings.

Nearly two-thirds of nursing facility residents are enrolled in Medicaid, and most are also enrolled in Medicare. Many are enrolled in both programs. These Medicare-Medicaid enrollees are among the most vulnerable individuals served by the programs and generally have the most complex health care needs. Research on these enrollees in nursing facilities found that approximately 45% of hospital admissions among those receiving either Medicare skilled nursing facility services or Medicaid nursing facility services could have been avoided, accounting for 314,000 potentially avoidable hospitalizations and $2.6 billion in Medicare expenditures in 2005. This new initiative works to prevent potentially avoidable hospitalizations by providing better, more cost-effective care in nursing facilities.

CMS issued a Request for Applications on Thursday March 15; organizations interested in participating in this initiative must submit an application by Thursday June 14, 2012. More information about this initiative, including the Request for Applications, is available at http://Innovation.CMS.gov/initiatives/rahnfr, or by searching for CFDA 93.621 at www.Grants.gov.

Please note that applicants must include letters of support from the relevant State Medicaid Director and **State Survey & Certification Director**, and letters of intent from at least 15 nursing facility partners in the same State. Notices of Intent to Apply are due April 30, 2012.

The full text of this excerpted CMS press release (issued Thursday March 15) can be found at http://www.CMS.gov/apps/media/press/release.asp?Counter=4303. A media factsheet can be found at http://www.CMS.gov/apps/media/press/factsheet.asp?Counter=4304.

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***Additional Information of Relevance***

As part of the new healthcare law's policies to improve the quality of care available to people with Medicare and all Americans, on Wednesday March 14 CMS announced 23 additional participants in the *Community-based Care Transitions Program* (CCTP). These participants will join seven other community-based organizations already working with local hospitals and other healthcare and social service providers to support Medicare patients who are at high-risk of being readmitted to the hospital while transitioning from hospital stays to their homes, a nursing home, or other care setting.

CCTP is designed specifically to provide support for high-risk Medicare beneficiaries following a hospital discharge. These 23 sites will work with CMS and local hospitals to provide support

for patients as they move from hospitals to new settings, including skilled nursing facilities and home. Community organizations will help these patients stay in contact with their doctors to ensure their questions are answered and they are taking medications they need to help them stay healthy. This announcement will support more than 126 local hospitals and help more than 223,000 Medicare beneficiaries in 19 states across the country.

CCTP is part of the *Partnership for Patients*, a public-private partnership aiming to cut preventable errors in hospitals by 40 percent and reduce preventable hospital readmissions by 20 percent over a three-year period. Achieving these goals has the potential to save up to 60,000 lives, prevent millions of injuries and unnecessary complications in patient care, and save up to $50 billion for Medicare over ten years. To date, more than 8,000 partners have pledged their commitment to the aims of the *Partnership for Patients*, including more than 3800 hospitals.

As part of their two-year agreement with the CMS Innovation Center, each organization will be paid a flat fee for helping to coordinate patient care after a hospital stay for each Medicare beneficiary who is at high-risk for readmission to the hospital. The 23 sites will join the seven organizations announced in November 2011, bringing the total number of sites to 30. This is the second round of CCTP participants announced since the program was launched in April 2011.

More information on the CCTP is available at:
http://www.CMS.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1239313.

More information about the work the Department of Health and Human Services is doing to improve care for Medicare, Medicaid, and CHIP beneficiaries and, by extension, all Americans through the broader *Partnership for Patients* initiative is available at:
http://www.HealthCare.gov/PartnershipForPatients.

/s/
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management