



THE HOSPITAL & HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA

June 22, 2015

United State Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510-6200
Submitted electrically to: chronic_care@finance.senate.gov

SUBJECT: Chronic Care Reform Comments

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson and Senator Warner:

On behalf of The Hospital & Healthsystem Association of Pennsylvania (HAP), which represents approximately 240 member institutions, we appreciate the opportunity to provide input to inform your policy discussions about improving outcomes for patients with chronic conditions.

During June of 2010, the Pennsylvania Health Care Cost Containment Council (PHC4) issued a [report](#) that highlighted challenges for Pennsylvania in addressing chronic health conditions. The report, which focused on four chronic conditions—diabetes, asthma, chronic obstructive pulmonary disease and heart failure—cited the following:

- More than 60 percent of the state's population suffers from a chronic condition, and almost 70 percent of all deaths are caused by chronic disease.
- Chronic disease patients account for 80 percent of all health care costs and hospitalizations, 76 percent of all physician visits, and 91 percent of all filled prescriptions.
- The vast majority of the hospitalizations for the four conditions were considered potentially avoidable, and more than a quarter of the patients admitted for one of the four conditions were readmitted for the same condition within one year.
- Medicare and Medicaid were the primary payers for 87.3 percent of heart failure hospitalizations, 83.7 percent of chronic obstructive pulmonary disease (COPD) hospitalizations, 70.8 percent of diabetes hospitalizations, and 66 percent of asthma hospitalizations.
- Extrapolating the average Medicare payment for diabetes, asthma, COPD, and heart failure to all 2007 Medicare hospitalizations, total Medicare payments for hospitalizations for these four conditions is estimated at \$615 million.
- The annual economic impact of chronic disease on the commonwealth due to productivity loss and treatments is estimated to reach \$170.2 billion by 2023.

Directly and indirectly, collectively and individually, a great deal of the delivery system reform efforts in Pennsylvania are geared at tackling chronic conditions. Signature efforts by Pennsylvania hospitals have been addressing readmissions and promoting care transitions.

Readmissions and Care Transitions

HAP's work through the Pennsylvania Hospital Engagement Network (PA-HEN) and participating hospitals—a three-year contract under the Centers for Medicare & Medicaid Services' Partnership for



Patients initiative—reduced preventable harm and all-cause hospital readmissions in the state. The federal funding enabled HAP to provide training, tools, consulting, and collaborative support to address quality and patient safety in Pennsylvania hospitals. Through PA-HEN leadership and the significant accomplishments of participating hospitals and health systems, all-cause harm was reduced by 37 percent, and all-cause readmissions were reduced by 26 percent¹. PA-HEN's efforts resulted in an avoidance of more than 136,000 harm events and an estimated cost avoidance of nearly \$700 million in Pennsylvania.

Supported by the work of PA-HEN, Pennsylvania hospitals and health systems have adopted numerous best practices to reduce readmissions, including:

- Developing successful patient-centered discharge programs that improve patient and family understanding of care instructions provided at the time of discharge.
- Incorporating health literacy, which means an understandable explanation of a patient's condition and follow-up care.
- Using “teach back” models, which involve having patients repeat discharge and care information.
- Identifying better ways to share information with a patient's other health care providers to ensure that there is a clear care plan. This includes information needed during transitions to other care settings, such as nursing homes, rehabilitation facilities, or home care.

To augment those efforts, through PA-HEN, HAP created the first statewide hospital association patient and family engagement advisory council comprised of caregivers, patients, their families, and community members. The council has guided HAP's efforts in providing training and collaborative forums across the state.

All of this work has contributed to a significant decline in hospital readmission rates for the same condition for COPD and congestive heart failure (CHF) as shown in a [recently released PHC4 report](#) analyzing data from January 2013 through August 2014. Of the four conditions analyzed in the report—abnormal heartbeat, COPD, CHF, and diabetes—medical management—none showed a statewide increase for readmissions for the same condition within 30 days.

The PHC4 report provides important insight into the cause of readmissions and the connections between readmissions and chronic conditions. For the four chronic conditions studied, the report breaks out the rate of readmissions for the same condition as compared to the rate of readmissions for “any reason.” More often than not, readmissions are unrelated to the condition that originally led to hospitalization. For example, 22.3 percent of patients originally hospitalized for CHF were readmitted within 30 days for “any reason.” However, only 7.7 percent of these readmissions were due to CHF. The majority of these patients were readmitted for reasons other than CHF.

This data strongly suggests that socioeconomic factors and health care disparities may contribute to repeated readmissions for the same chronic conditions. For example, low-income patients who

¹ Results reported December 1, 2014, are interim and subject to final verification by CMS. The analyses upon which this document is based were in part funded and performed under contract number HHSM-500-2012-00022C, entitled “Hospital Engagement Contractor for Partnership for Patients Initiative.”

qualified for Medicaid coverage had higher readmission rates for all four chronic conditions studied than patients with Medicare or commercial health coverage.

HAP believes that hospitals can play a significant role in improving care to patients living with chronic diseases and reducing the growth of Medicare spending through targeted efforts to address readmissions. That said, readmissions measures must recognize patient characteristics beyond those of medical diagnosis, age, and gender that greatly affect health status. **In order to be successful in tackling readmissions resulting from chronic conditions, hospital interventions must account for socioeconomic realities facing the patient, and policies that leverage quality improvements through payment incentives and penalties must adjust for socioeconomic factors.**

Other initiatives taking place at the state level in Pennsylvania merit consideration for how federal policy can best build upon and support innovative, multi-stakeholder collaborations.

Super-Utilizers

Throughout Pennsylvania, hospitals and health systems have initiated super-utilizer initiatives, which focus on health care management for people whose complex medical problems and quality-of-life issues make them disproportionately heavy, repeat users of expensive health care services. This population of patients is largely comprised of individuals facing multiple chronic conditions.

Pennsylvania has [identified super-utilizers](#) as those patients with five or more admissions to a Pennsylvania general acute care hospital during fiscal year 2014. Nearly 50 percent of super-utilizer admissions in Pennsylvania, according to 2012 data, were paid through Medicare and/or Medicaid, including care for individuals that are dually eligible. Fourteen percent, or \$545 million, of Medicare payments for inpatient stays were for super-utilizers, and 17 percent, or \$216 million, of Medicaid payments.

Key elements of super-utilizer programs have included data sharing to target utilization, partnerships with community organizations to address social and other non-health needs, case management to promote effective treatment, and alternative payment mechanisms.

Patient-Centered Medical Homes

During 2013, the commonwealth engaged in a process of reviewing innovation efforts across the state and developed a [State Health Care Innovation Plan](#). The state has received a second grant through the State Innovation Models (SIM) initiative and will continue to work to advance innovative care delivery models and payment methodologies.

One initiative that served as a foundation in Pennsylvania's 2013 Innovation Plan for work to address chronic care was [Pennsylvania's Chronic Care Initiative \(CCI\)](#)—a multi-payer, collaborative initiative leveraging public and commercial payers to train primary care practices in the patient-centered medical home. Pennsylvania was one of eight states that participated in CMS' [Multi-Payer Advanced Primary Care Practice \(MAPCP\)](#) demonstration project starting in 2012, which included Medicare as a participating payer. Under the program, a monthly care management fee is provided for primary care patients receiving care from advanced primary care practices.

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Similar to programs focused on super-utilizers, key elements of Pennsylvania's Chronic Care Initiative include using health information technology to allow for data sharing, collaborative learning between providers, care coordination through practice-based management of high-need patients, and new payment incentives through shared savings.

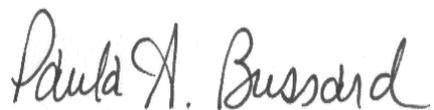
Common threads throughout the initiatives discussed above include:

- **Leveraging technology and data sharing to most effectively care for patients.**
- **Supporting collaboration between a broad spectrum of health insurers, health care providers, and community organizations.**
- **Deploying a case management approach that ensures proper transitions of care, addresses socioeconomic barriers impacting health outcomes, and promotes patient empowerment.**
- **Establishing appropriate payment mechanisms that reflect the intensity and scope of services provided.**

On behalf of the hospital community in Pennsylvania, we express our appreciation for your dedicated focus on identifying avenues to improve care for those with chronic conditions. Pennsylvania hospitals have embraced this imperative both from the perspective of serving our patients and communities, and in light of the fiscal impact. We look forward to continued work with the committee to identify policy solutions to address the needs of those with chronic conditions.

Thank you for your consideration of HAP's input. If you have any questions or would like additional information, please contact [Laura Stevens Kent](#), vice president, federal advocacy, at (202) 863-9287.

Sincerely,

A handwritten signature in black ink, reading 'Paula A. Bussard'. The signature is written in a cursive, flowing style.

Paula A. Bussard
Chief Strategy Officer