

June 16, 2015

Senate Finance Committee Chronic Care Workgroup
US Senate
Washington, D.C.

Dear Senators Hatch, Wyden, Isakson and Warner,

As you have noted in your stakeholder letter dated May 22, 2015, there are increasing numbers of people in the United States with chronic disease. It is the leading cause of death and disability in the U.S. and account for over 79% of the nation's health care spending. As has been noted by the Senate Finance Chronic Care Workgroup, we need to find ways to provide high quality of care at greater value and lower cost without adding to the deficit.

In North Carolina, the burden of chronic health conditions are costly. According to the Division of Aging and Adult Services, annual health care expenditures reach \$3.4 billion to treat older adults with multiple chronic conditions. It cost more than \$500 million to treat hypertension, diabetes and arthritis. Nearly 90% of people age 65 and better have at least one chronic health condition and more than 77% have multiple health conditions. The average adult age 55-65 with at least one chronic health condition spent nearly \$7,400 on health care costs in 2006. The average 75 year old has three chronic health conditions and takes five prescription drugs. Older adults with five chronic conditions have an average of 37 doctor visits and 50 separate prescriptions each year. By 2050, it is expected that between 20-30% of all Americans will have diabetes.

Older adults with chronic conditions face a number of barriers in terms of coping with their illness and optimizing their health, which include the lack of social support, low skill levels for symptom management, and low confidence in their abilities to manage their conditions (self-efficacy). Self-management is heralded as a key component in the improvement of health outcomes associated with chronic disease. According to the Institute of Medicine, self-management is defined as "the tasks that individuals must undertake to live well with one or more chronic conditions". There has been very little focus by health plans, including Medicare and Medicaid, on the role of the individual in proactively managing their health conditions and taking more responsibility for improving their personal behaviors that will result in improved health outcomes and lower costs.

The Administration for Community Living and the Centers for Disease Control and Prevention have provided funding to support state and community-based organizations in expanding chronic disease self-management education and infrastructure to support the dissemination of these programs. Evidence-based program providers such as regional Area Agencies on Aging (AAA) are moving from grants and foundation support to working to make programs such as Chronic Disease Self-Management Program (CDSMP) and A Matter of Balance (MOB), part of medical care costs. These programs directly enhance health, improve quality, and reduce inappropriate service use. AAAs have made great strides with sustaining programs by developing strong links with health care providers and community based supports.

The North Carolina Senior Tar Heel Legislature (NCSTHL) is urging Chronic Care workgroup support for Medicare beneficiaries to have access to evidence based self-management programs for chronic disease, pain management, fall prevention and physical activity which will result in improved quality of care, improved disease management and lower per capita costs. In particular, we are asking you to support Medicare funding the Stanford Chronic Disease Self-Management Program (CDSMP) and A Matter of Balance (MOB), for older adults with chronic disease.

CDSMP is one of the most well-known and researched evidence-based programs. The program is very widespread in North Carolina and serves as a good model for people with multiple chronic conditions, as research studies have demonstrated positive changes in self-efficacy, health behaviors, physical and

psychological health status, and symptom management as well as reducing per capita costs of health care with an approximate 2:1 return on investment in the first year as noted in a national study published in 2013. This equates to a potential net savings of \$364 per participant and a national savings of \$3.3 billion if 5% of adults with one or more chronic conditions are reached. These programs should be a patient covered benefit provided to patients and integrated with care traditionally given by health care providers.

MOB is a falls prevention program that has proved successful in North Carolina. Falls are the number one cause of injury and death among people 65 and better and leads to 25,000 hospitalizations and 200,000 emergency department visits annually. According to the North Carolina Department of Public Health, the total hospital fees in North Carolina's 65+ population in 2011 was \$562 million. According to a 2013 Centers for Medicare Services report to Congress shows that return on investment for MOB workshops showed a \$938 reduction in total medical costs savings per year (\$517 reduction in in unplanned hospital expenditures, \$234 reduction in skilled nursing facility costs and \$81 reduction in home health coats.)

CDSMP, MOB and other evidence-based programs can address a number of the areas you have asked for input on in the stakeholder letter. These programs will improve the health and quality of life for Medicare beneficiaries with multiple chronic conditions. For example, individuals are more likely to effectively use of their prescription drugs and understand their importance. These programs are the best option for empowering Medicare patient to play a greater role in managing their health and meaningfully engaging with their health care providers. This will meet the goals of primary care providers and care coordination teams to maximize the health care outcomes for Medicare patients living with chronic conditions.

Having a policy that allows for any person with chronic illness to attend an evidence-based self-management program will be transformative and the Chronic Care Workgroup can recommend that all Medicare Advantage Programs, ACO Programs, CMS piloted alternate payment models (APMs) and Patient Centered Medical Homes make these programs available to their population with chronic disease. The STHL urges the Chronic Care Workgroup to recommend CDSMP and MOB be provided by community-based organizations to all health care providers, organization and systems as the fundamental self-management approach for Medicare beneficiaries with one or more chronic diseases.

Sincerely,

Charles (Chuck) Youse

Speaker

North Carolina Senior Tar Heel Legislature