Florida Health Networks
Wellness Solutions in Your Neighborhood

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

Dear Senators Hatch, Wyden, Isakson and Warner,

The gift of longevity is slowly changing the way we deal with health in the constantly growing Medicare population. The Chronic Care model clearly demonstrate that if we want to change health outcomes, we need to change the way we deliver care. The Senate Finance Committee knows well the facts and figures. And, it is great that a Chronic Care Workgroup has been established.

Chronic conditions are expensive because usually they cannot be controlled only with clinical interventions; management of chronic conditions requires an activated patient able to become partner in care by changing the way they stay active, eat healthy, manage their medication, manage stress, and work with health care provider during ups and downs of the disease. If we continue to focus innovations on changing medical practice without changing practices to teach patients to become experts in chronic care management, we are bound to fail.

People, especially those with chronic conditions, spend 99% of their time outside of the health care system. Florida Health Networks (FHN), an organization created by the Health Foundation of South Florida, to support the delivery and quality improvement of community-based programs offered by Florida's network of Aging and Disability Resource Centers, work hard to activate and empower people living with multiple chronic conditions to improve their health and maintain independence.

Access to chronic-disease self-management education is critical in order to achieve reductions in health care utilization and, higher quality of life for older adults with multiple chronic conditions. There has been very little focus by health plans, including Medicare and Medicaid, on the role of individuals in proactively managing their health and taking more responsibility for improving behaviors that will result in improved health outcomes and costs.

Health Foundation of South Florida invested in 2008 over 8 million dollars in grants to community-based organizations offering evidence-based programs to older adults. Florida International University School of Public Health tracked outcomes and we have seen these programs as the best option for empowering Medicare beneficiaries to not only play a greater role in managing their health but also engage more meaningfully with their health care providers. As a result the Health Foundation of South Florida is committed to continue building the capacity of Florida's aging network to develop sustainable wellness and prevention programs in an accountable care community model. These program are proven, but need to be integrated with clinical services and sustained with established CMS codes for reiumbursement.

It is important to build a system of care that incorporates evidence-based programs, properly targeted to those that need it, in order to optimize population health. These programs need the legitimacy of being official and appropriate expenses within the health care system. FHN joins the Evidence-Based Leadership Council in our support of the following recommendations:

1. **Include CDSME in new Medicare billing codes for complex chronic care.**
    - Medicare billing codes for Chronic Care Management (CCM) services should include the provision of CDSME. Since the vast majority of chronic condition management takes place outside of the health care setting, providers, including community-based providers, should be able to bill for those patients who attend CDSME workshops either in-person or online.
2. **Conduct a new CMMI demonstration on Integrated Self-Care Planning (ISP).**
    - CMMI should be directed to develop and test Integrated Self-Care Planning (ISP), in which primary care and community service providers collaborate and integrate support to help older adults and their caregivers reach personal goals for aging well,. This new process would bring together older adults, caregivers, primary care providers, and aging network providers so they have a shared pathway to managing each person's chronic conditions.
3. **Fund a Medicare Demonstration Modeled after the Medicaid Incentives for Prevention of Chronic Diseases Program.**
    - A similar program to the Medicaid Incentives for Prevention of Chronic Disease should be designed and funded, targeting high risk beneficiaries, including dual eligibles (Medicare/Medicaid beneficiaries). Properly constructed based on recent learnings, evidence-based interventions and incentives to promote healthy aging and behavior change for this population has great potential to reduce Medicare spending and improve lives.

We strongly urge the Chronic Care Workgroup to also support the following recommendations to reduce costs and improve care for Medicare beneficiaries with multiple chronic conditions:

1. **Strengthen the annual Medicare wellness visit to better promote healthy aging.**
    - Improve requirements for screenings and referrals to CDSME and falls prevention interventions, including specific protocols, recommended best processes and practices, and use of CDC's STEADI tool.
    - Develop billing codes for falls risk assessments and patient activation assessments
    - Develop standards for post-visit follow-up to better ensure compliance with the including dual eligible. Evidence-based interventions and incentives to promote healthy aging and behavior change for this population has great potential to reduce Medicare spending and improve lives.
2. **Add second falls as a Hospital Readmissions Reduction Measure**
    - A measure should be added to the Hospital Readmissions Reduction Program - a second fall could incur fractures, brain injuries and other injuries resulting from a fall and is a sign of high risk and need for post-acute community care transitions coaching in the home.
3. **Provide assistance to states on how to incorporate evidence-based healthy aging programs within their Medicaid programs.**
    - The Medicaid Innovation Accelerator Program could provide a platform to deliver technical assistance on these issues to states. Several states have successfully incorporated evidence-based healthy aging programs within their Medicaid programs. Some have included CDSME in HCBS waiver programs; others have sought to include these programs within Medicaid managed care and duals integration demonstrations.

Thank you for consideration of these recommendations that will empower Medicare beneficiaries with chronic conditions to live with more dignity and independence, having their health self-management needs met reliably and well, both in the health care setting and in their communities.

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(on behalf of undersigned organizations)

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Florida Health Networks

Alliance for Aging, Inc. Miami, FL

Aging and Disability Resource Center of Broward County, Inc.

Your Aging and Disability Resource Center/Area Agency on Aging Palm Beach, Treasure Coast, Inc.

Senior Resource Alliance, Orlando

Area Agency on Aging of Pasco-Pinellas, Inc. St. Petesburg

Elder Options, Gainesville

Northwest Florida Area Agency on Aging, In. Pensacola

Area Agency on Aging for Southwest Florida, North Fort Myers

Senior Connection Center, Tampa

ElderSource, The Area Agency on Aging of Northeast Florida, Jacksonville

Area Agency on Aging for North Florida, Inc. Tallahassee