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Senate Finance Subcommittee on Health Care
United States Senate

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Ranking Member
Senate Finance Subcommittee on Health Care
United States Senate

**American Geriatrics Society
Additional Comments on Alzheimer's Disease and Related Dementias¹
July 23, 2020**

GENERAL COMMENTS

With Congress's support, the Centers for Medicare and Medicaid (CMS) has created a series of benefits that can radically improve detection and care for people with dementia. The Annual Medicare Wellness Visit (AWV), the Alzheimer's and other dementia's care planning benefit, and payment for care management of complex patients. Together, these form a seamless pathway that would make a real difference if properly implemented, monitored, and tracked. As the Subcommittee's leaders have recognized, what is lacking is promotion and training for providing these services and for ways to coordinate and implement them in healthcare settings.

AGS is supportive of both S. 880, the "Improving Hope for Alzheimer's Act" (HOPE Act) and S. 1126, the "Concentrating on High-Value Alzheimer's Needs to Get to an End Act of 2019" (CHANGE Act). This document provides comments and input on each bill (see below) as well as comments on potential changes to the Programs of All-Inclusive Care for the Elderly (PACE) Program that would bolster the objectives of both bills.

Programs like Maximizing Independence at Home (Mind at Home), PACE, and Independence at Home all prioritize keeping patients at home. They are examples of approaches that potentially reduce use of acute care and nursing home care by providing a broad range of supportive health and social services in the community.² PACE provides excellent care for enrollees with dementia but is fairly costly and targets a somewhat more impaired population. For those who are less impaired, but whose trajectories are likely to decline (most with dementia), it would be possible to link a care manager/coordinator with either a day care center or home care team to improve care coordination and provide better care with the goal of improving the participant's overall health. An international example which emphasizes use of information technology is Pinetree Care Group in China.^{3,4}

In addition, we want to raise outstanding issues related to caregivers and home and community-based services that are not addressed in the HOPE or the CHANGE Acts. We raise these with the Subcommittee given our

¹ [AGS Senate Comment Opportunity – Dementia](#): Follow Up Conversation with Senate Finance Committee Staff

² Programs of All-Inclusive Care for the Elderly: <https://www.medicaid.gov/medicaid/long-term-services-supports/program-all-inclusive-care-elderly/index.html>; Mind-at-Home: <http://www.mindathome.org>; and Independence at Home <https://innovation.cms.gov/innovation-models/independence-at-home>

³ Widen, S. What Pinetree Can Teach Homecare Providers. (May 21, 2016). *Access Health International*. Available at: <http://archive.accessh.org/what-pinetree-can-teach-homecare-providers>

⁴ Wang, N. The Role of Home Service and Technology in Home Care for Frail Older Adults in Metropolitan Beijing. (July 1, 2017). *Innovation in Aging*. Available at: <https://doi.org/10.1093/geroni/igx004.3836>

experience with clinician education programs and belief that focusing on a broader audience will increase chances of success for these initiatives. AGS believes that improving the quality of life for Americans living with Alzheimer’s and related dementias in the community will require programs and enhanced support not only for health professionals, but also for caregivers, and home and community-based service providers. Some suggestions for the Subcommittee to consider to complement and strengthen the HOPE and the CHANGE Acts are:

- A pilot Special Needs Plan for those with dementia coupled with either a risk adjustment or a supplemental payment (e.g. \$400 per month) to address support needs;
- Mechanisms to increase enrollment of eligible Medicare-only individuals into PACE. PACE is a proven program that is available for both Medicare-only and individuals who are dually eligible for Medicare and Medicaid, but there are barriers that limit its reach, including how the premium is calculated for Medicare beneficiaries who are not eligible for Medicaid and are paying out of pocket.
- A respite care benefit that is available to caregivers;
- Tax credits, tools, and education for caregivers;
- Improving access to and affordability of long-term care insurance coverage;
- Paid family and medical caregiver leave that supports all caregivers who may need time to deal with their own family member’s serious illness.
- Guarantees of a living wage and career ladders for home care workers and personal care assistants.

S. 880, IMPROVING HOPE FOR ALZHEIMER’S ACT

General Comments

We appreciate the bill’s recognition of the cognitive assessment and care plan benefit as a crucial and underutilized component of improving dementia care. Primary care clinicians are the principal clinicians caring for people living with dementia (PLWD). Currently, however, it is very difficult for practitioners to provide the benefit effectively, and it does not adequately reimburse for the elements that are required. Utilization could improve with separate reimbursement for the diagnostic evaluation and follow-up care needed for someone who screens positive for cognitive impairment. In addition, it is important to establish incentives for health systems to implement programs to improve dementia detection and care, and to support them in implementing training and skills development programs, establishing meaningful connections with community-based service providers, and engaging primary care practices in these efforts.

Specific Comments

Page 2, Lines 10-20: Comprehensive Education Program

Recommendations: The legislation proposes a one-time educational initiative to inform physicians and practitioners that Medicare reimburses for comprehensive cognitive assessment and care planning services. The proposed program would cover appropriate diagnostic evaluations and explanations of the requirements for eligibility for such services. We note that the Alzheimer’s Association has a helpful educational toolkit that is focused on this topic: <https://alz.org/professionals/health-systems-clinicians/care-planning>.

One of the barriers in primary care practice to implementing the Alzheimer’s and Other Dementias Care Planning Service is that practices often have inadequate resources to fully implement and, as noted above, there is an additional barrier in terms of adequate training on how to administer validated screening and assessment tools. Additionally, CMS evaluates and modifies payment for services annually, which can result in changes to Medicare payment that then require updating of educational materials related to coding and payment and additional training of clinicians on how to implement codes. Further, as new clinicians enter the workforce, they will need access to this training. For these reasons, AGS recommends that Congress direct CMS to develop or contract development of a training program that is comprehensive and ongoing with the goal of reaching all clinicians using or planning to use this code. Such a program should include training on how to use validated tools for assessing cognition and how to use the results.

An additional barrier is that the majority of clinicians are now employees of health systems that largely dictate their schedules and pay. This leads to uneven uptake of both the Medicare AWV (see comments below regarding the CHANGE Act) and a lack of education programs for health systems administrators and decision-makers to help them understand the importance and value of these screenings, how they should be paid for, how to facilitate the process for providers, and what outcomes should be measured—all necessary components of implementing widespread improvements.

In light of this, the AGS recommends the following:

- Any training program should be ongoing and updated as changes are made to payment and/or to reflect advances in diagnosis (e.g. when new and better screening tools are validated and become available), treatment (both preventative and curative), and care. It should cover existing benefits for dementia screening, care management, and the Medicare AWV given that together, these benefits offer a potentially seamless pathway to care. There is a need to review and update payment training materials annually to be sure that they are aligned with the Medicare Physician Fee Schedule (MPFS) and to review other enduring materials at least every three years.
- Consideration should be given to expanding funding for the Geriatrics Workforce Enhancement Programs (GWEPs) administered by the Health Resources and Services Administration (HRSA) to increase the number of GWEPs that are providing training on Alzheimer’s and other dementias. Additional funding to individual GWEPs would also help them to meet this mandate.
- An educational program for key health systems decision-makers on the importance of screening older adults for cognitive impairment (and other screenings) would be valuable; how to optimize reimbursement, partnering with home and community-based providers, and restructuring practices so clinicians are supported in providing these services. Health systems should be incentivized to provide skills development and support restructuring of practices, so they are adequately resourced and positioned to support the provision of the services.

Page 3, Lines 13-14: Utilization Rates

Recommendation: Add “dementia” as follows:

- year, were furnished comprehensive Alzheimer’s disease and dementia care planning services for which payment was

S. 1126, CONCENTRATING ON HIGH-VALUE ALZHEIMER'S NEEDS TO GET TO AN END (CHANGE) ACT OF 2019

General Comments

Medicare AWW and Welcome to Medicare Visits [also referred to as Initial Preventive Physical Examination (IPPE)]: AGS supports use of an objective and validated screening tool to identify cognitive impairment. As a general matter, most clinicians have not received sufficient training on the importance of understanding a patient's cognitive status and do not understand the foundational impact of cognitive status on care to support healthy aging and maximize autonomy. In 2014 and 2019, the U.S. Preventive Services Task Force (USPSTF)⁵ found that there was 'insufficient evidence' to endorse universal screening and this continues to be an impediment to action and to generate a sense of urgency to act. The USPSTF acknowledges that use of validated cognitive assessment tools increases detection of impairment. They reason that there have been no clinical trials designed to identify clinical benefits of detection through screening, therefore there is a lack of evidence and more research is needed. They note that screening and early detection of cognitive impairment can allow for identification and treatment of reversible causes, and may help clinicians anticipate problems patients may have in understanding and adhering to medical treatment plans, and may also be useful by providing a basis for advance planning on the part of patients and families. These are all areas that require further investment in training and clinical practice facilitation.

An additional consideration is around when to start screening given the low prevalence of impairment at the usual Medicare enrollment age (65). Some specialists argue that this imposes an undue burden on health care providers, systems, patients, and families if prevalence is low in a population. For these reasons, AGS strongly recommends that there be no requirement in legislative language around screening being a part of both the IPPE and Medicare AWW. Whether a patient needs to be screened is a matter of clinical judgment and a decision that should be made by the clinician in consultation with the patient. Legislation can and should, however, support programs to improve clinician awareness, skills, and judgment regarding dementia detection and clinical systems to improve patient management over time.

Some argue against early detection in the Medicare AWW because of concern about risks of job loss and loss of insurance coverage if an individual is diagnosed with dementia. Although job loss is not an issue for retirees, who comprise most Medicare beneficiaries, this issue needs to be squarely addressed on behalf of younger beneficiaries who are still employed. (Interestingly, the advocacy community speaks to both the barriers to getting an early diagnosis and the stigma of being diagnosed early when a PLWD still want or need to be work.) As long as a PLWD is still able to work and carry out ordinary everyday functions, protection against job and insurance loss is important. When dementia progresses to a stage that prevents these activities, an early diagnosis allows a PLWD to access medical disability benefits rather than potentially being fired for poor performance due to undiagnosed cognitive impairment.

Despite these caveats, the AGS believes it is important to significantly incentivize IPPE and AWW for Medicare beneficiaries given their importance to understanding and tracking an older adult's health over time. It is important to keep detection of cognitive impairment a key required element of these visits. Further research is

⁵ U.S. Preventive Services Task Force. Cognitive Impairment in Older Adults: Screening. (February 25, 2020). Available at: <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/cognitive-impairment-in-older-adults-screening>

needed to ensure that clinicians have the tools and resources needed to act on a positive screen for cognitive impairment. This will require investments in home and community-based services, re-designing primary care practices, supporting administrative as well as clinical pathways, and ensuring that clinicians have the competence and skills to detect and act appropriately on evidence of cognitive impairment in their patients.

Recommendations:

- Based on our experience with the telehealth waivers from CMS related to COVID-19, we recommend that practices be allowed to continue to offer the AWV virtually as well as in person.
- The National Institute on Aging (NIA) should invest in validating available cognitive assessment tools for use in telehealth.
- Direct the U.S. Department of Health and Human Services (HHS) and/or NIA to invest in research to determine whether early detection of dementia using a screening approach improves patient, family, and clinician decision making and reduces burdens and costs for patients and caregivers. This would develop the evidence base that has been missing since the USPSTF first addressed the question 17 years ago.

SPECIFIC COMMENTS

Page 6 (Line 21) through page 7 (Line 2), Recommended screening tools

Recommendation: The NIA does not currently endorse specific screening tools. Further, the selection of screening tools depends on a variety of factors, such as the setting, target population age and demographics, language, and expertise of the administrator. For these reasons, AGS strongly recommends against including language that requires clinicians to use a prescribed or specific set of tools or to begin screening at a certain age.

Page 7, Lines 15-21: Referral for diagnostic services

Recommendation: strike “including amyloid positron emission tomography,”; strike “other” as follows:

- “(i) appropriate Alzheimer’s disease and dementia diagnostic services, ~~including amyloid positron emission tomography, and other~~ medically accepted diagnostic tests that the Secretary determines are safe and effective;
- **Rationale:** The accuracy of amyloid positron emission tomography (PET) scan is questionable—it has weak clinical diagnostic and prognostic value in individuals, and it is not covered by Medicare. We recommend that legislative language not include a reference to any specific tests or screening instruments and give flexibility to the Secretary which reflects the evolving science.

Page 7, Lines 22-24: Referral to a specialist for diagnosis and treatment

Comment: This provision stands in tension with a public health approach to dementia/cognitive impairment that sees personal and population health as the most important goals of detection and care, requires the involvement of a specialist (only for specific issues affecting a minority of patients), and does not always require any kind of neuroimaging.

Page 8, Line 4: Referral to clinical trials

Comment: Referral to clinical trials is one potential outcome for early detection but this would be a difficult task for primary care clinicians given that most are nowhere close to trial sites and access for their patients is far from assured even if referred. Additionally, clinicians in primary care practices do not have the time to discuss the pros and cons of specific clinical trials and legislation should not place this additional burden on the Medicare AWW.

Page 8, Line 22 to Page 9, Line 18: Medicare Quality Payment Program

Comments: Careful consideration should be given to existing quality metrics and whether there is a need for additional quality metrics. Metrics should not be focused on increasing the rate of screening but rather on the quality of subsequent care provided to patients who screen positive. It would be inappropriate to include a measure of referral to clinical trials as a metric that impacts Medicare payment. Quality payments to incentivize the detection and diagnosis of Alzheimer's and related dementias are important for public health and health care planning but should also be linked to provision of appropriate care planning and delivery.

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) PROGRAM

PACE provides wraparound health and social services for older adults who need support for one or more functional activities of daily living in order to remain in their homes. It offers a successful general delivery model for service design that should be adapted and implemented by health systems in collaboration with CMS and community-based older adult services organizations. At the conceptual level, PACE is a structure for providing the kind of care dementia patients need.

However, its current organizational and funding model may be a barrier for individuals who are not dually enrolled given costs and difficulty in finding a program in their state (currently only 22 states have PACE, and for those that do, sites are few). For older adults enrolled in PACE, all services are provided via the PACE program. There are restrictions on individual choice which may be an additional barrier to enrollment. Only 22 states have currently active PACE programs with most enrollees being dually eligible. Presumably, a major impetus for developing PACE beyond its original iteration (as On Loc in San Francisco) was to eliminate the need for nursing home placement solely due to poverty.

If the PACE funding model could be separated from the delivery model and consideration be given to the affordability of the premium for individuals who meet all criteria but who are not Medicaid eligible, and the PACE organization be a partnership between a health system and a consortium of community-based organizations, the overall concept could transform dementia care in the community for all older adults living with dementia.