Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, Maryland 21244–1850  
June 9, 2017

Dear Administrator Verma,

The Alzheimer’s Association appreciates the opportunity to comment on the proposed changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System for Fiscal Year (FY) 2018.

The Alzheimer’s Association is the leading voluntary health organization in Alzheimer’s disease care, support, and research. Today, there are more than 5 million Americans living with Alzheimer’s, and it is the only cause of death among the top 10 without a way to prevent, cure, or even slow its progression. As the size and proportion of the United States population age 65 and older continue to increase, the number of Americans with Alzheimer’s and other dementias will grow. Caring for individuals with Alzheimer’s disease will cost an estimated $259 billion in 2017 with Medicare and Medicaid bearing $175 billion--67 percent--of that figure. Thus, we encourage the Centers for Medicare & Medicaid Services (CMS) to consider the following comments to improve care for this growing population of beneficiaries.

**Long-Term Care Hospital Quality Reporting Program (LTCH QRP)**

We appreciate CMS’s recognition of both the prevalence and impact of cognitive impairment in and across settings: Due to their impaired memories and judgment, beneficiaries with cognitive impairment cannot manage their co-occurring conditions. We are grateful to CMS for its continuing work to improve the quality of beneficiary care.

We also appreciate CMS’s statement that skilled therapy can help beneficiaries with dementia. In light of CMS’s ongoing efforts to comply with the *Jimmo v. Sebelius* settlement terms, this is a meaningful acknowledgement and we encourage CMS to continue to communicate the importance of skilled therapy to beneficiaries with degenerative conditions.
CMS also states that some symptoms may be managed with pharmacotherapy. We note for CMS’s consideration that we continue to support the appropriate use of medications when behavioral and psychological symptoms of dementia (BPSD), such as agitation, aggression, and hallucinations, pose a greater risk to individuals and families living with dementia than the medications. For the more common occurrences of BPSD, however, non-pharmacologic interventions should be a first-line alternative to pharmacologic therapies. We refer CMS and post-acute providers to the Alzheimer’s Association position statement on BPSD.¹

**LTCH QRP Quality Measures under Consideration for Future Years**

The Alzheimer’s Association supports the inclusion of Experience of Care and Advance Care Plan measures. We note the following for CMS’s consideration as it develops and implements each measure.

With regard to an advance care plan, the current National Quality Forum-endorsed measure includes two distinct elements: an advance care plan and a surrogate decision maker. While we support the underlying intention—to capture the percentage of individuals with advance care plans and surrogates—these are not and should not be alternatives to each other. We believe capturing these percentages separately would better serve CMS’s purpose. In future years, the Association respectfully suggests that the National Quality Forum and CMS replace the current single measure with two measures:

**Advance Care Plan:** Percentage of patients aged 65 years and older who have an advance care plan documented in the medical record and documentation in the medical record that the advance care plan was discussed and distributed to the patient and/or a designated surrogate decision maker.

**Designated Surrogate Decision Maker:** Percentage of patients aged 65 years and older who have a designated surrogate decision maker documented in the medical record or documentation in the medical record that the patient did not wish or was not able to name a surrogate decision maker.

The Alzheimer’s Association also appreciates CMS’s continuing efforts to reduce inappropriate antipsychotic use in persons with dementia. As noted above, antipsychotic medications have been used appropriately and inappropriately to address BPSD and we believe that non-pharmacologic interventions should be first-line alternatives to pharmacologic therapies. However, the Association continues to support the appropriate use of medications when BPSD pose a greater risk to individuals and families living with dementia than the medications.

Persons with dementia and families acknowledge the potential benefits of appropriately-used antipsychotics, even if the medication does not have an FDA-approved indication for their symptoms. They report that such medications can ease paranoia or anxiety and can alleviate the rage some people experience, keeping them and others safe and allowing them to remain in their homes. These medications may calm an agitated person for a few hours, allowing him or her to attend an adult day program, granting a caregiver a few hours of respite. Many persons with dementia and their families can make informed choices regarding the use of antipsychotic medications. Any measure should account for this informed

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The Alzheimer’s Association supports the proposed tools to assess beneficiaries with cognitive impairment for the purpose of data collection, including the Brief Interview for Mental Status (BIMS). However, we respectfully disagree with CMS’s contention that cognitive function is relatively stable and, therefore, the BIMS only need be assessed at admission. Alzheimer’s and related dementias are degenerative diseases that progress over time and can change a person’s behavior and function from day to day. If the agency’s goal is to capture the most accurate data that will ultimately result in better care, CMS should consider requiring administration of the BIMS at both admission and discharge.

Finally, the Alzheimer’s Association supports the Behavioral Signs and Symptoms data elements. While we understand it is an established, tested set of elements in use, we respectfully request that CMS explain the specific exclusion of wandering from them. Wandering is a prominent safety concern for many individuals with Alzheimer’s or other dementias: six in ten people with Alzheimer’s disease will wander. If this data set is intended to capture the unrecognized needs and care preferences of beneficiaries with cognitive impairment including dementia, CMS should consider including a wandering element or capturing this information in another manner.

Thank you for the opportunity to comment. The Alzheimer’s Association would be glad to serve as a resource to CMS as it considers these important issues and how they relate to individuals living with Alzheimer’s and related dementias. Please contact Laura Thornhill, Manager of Regulatory Affairs, at 202-638-7042 or lthornhill@alz.org if you have questions or if we can be of additional assistance.

Sincerely,

Robert Egge
Executive Vice President, Government Affairs