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alzheimer's association

The Honorable Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

September 6, 2013

Re: Notice of proposed rules, CMS-1600-P

Dear Administrator Tavenner,

Thank you for the opportunity to comment on the proposed "Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014" (CMS-1600-P).

The Alzheimer's Association® is the world's leading voluntary health organization in Alzheimer's care, support and research. Today, there are more than 5 million Americans living with Alzheimer's disease and other dementias. Alzheimer's is the sixth-leading cause of death in the United States, and the only cause of death among the top 10 without a way to prevent, cure or even slow its progression. According to a recent article in the *New England Journal of Medicine*, Alzheimer's is the costliest disease in the United States and is set to increase like no other. This year alone, Alzheimer's and other dementias will cost the United States an estimated $203 billion, including $142 billion paid by Medicare and Medicaid. By 2050, this number will grow to a projected $1.2 trillion.[1]

Specific Comments

We have the following comments with regard to the proposed regulations that are of specific concern to the Alzheimer's Association, as they will significantly affect beneficiaries with Alzheimer's disease and other dementias.

1. **Payment reforms such as Complex Chronic Care Management Services should include disease-specific considerations for beneficiaries with Alzheimer's disease and other dementias.**

   The Alzheimer's Association applauds the Centers for Medicare and Medicaid Services (CMS) for their recognition of care management as a critical component of primary care services and care coordination. Serious coexisting medical conditions are common in people with Alzheimer's disease and other dementias, often resulting in complex care plans. For example, individuals with Alzheimer's disease will often be afflicted with other serious medical conditions such as hypertension (66 percent), heart disease (30 percent) and diabetes (29 percent). Overall, at least 74 percent of individuals with Alzheimer's disease have at least one additional chronic condition. Furthermore, people with dementia are 5.5 times more likely to have at least six other chronic conditions than those without dementia. The inability to self-manage one's health due to dementia can exacerbate other existing chronic conditions and lead to costly hospitalizations. Data show that Medicare payments for individuals 65 and older with Alzheimer's or another dementia are nearly three times as high as payments for other Medicare beneficiaries who do not have dementia.[2]

[1] Alzheimer's Association. (2013). *2013 Alzheimer's Disease Facts and Figures, 41*
[2] Ibid.

The complex cognitive, functional and behavioral symptoms associated with dementia, as well as the progressive nature of Alzheimer's disease, greatly hinders the ability of those afflicted to care for themselves over time. Individualized care plans for this population should always include complex chronic care management. The Alzheimer's Association believes that for those with dementia, care plans need to be specifically tailored to accommodate individuals with cognitive impairment as even simple instructions can be misunderstood or forgotten. To best provide complex chronic care management services, both face-to face and non-face-to-face consultations should be made available to all beneficiaries with a diagnosis of Alzheimer's disease or another dementia, not just those who have additional chronic conditions. We are concerned that coinsurance liability on Alzheimer's beneficiaries for every non-face-to-face encounter required in the management of Alzheimer's disease will cause confusion and further burden individuals and families who already face high health care costs associated with the disease.

Further, the Alzheimer's Association believes any complex chronic care management for individuals with dementia must include the option for engagement of a caregiver in addition to the beneficiary receiving services. Impaired cognition and speech can make it difficult for individuals with the disease to remember physician advice or communicate changing care needs. Many individuals living with Alzheimer's disease rely on caregivers to assist with daily activities, manage care transitions between settings and advocate for medical assistance on their behalf. Evaluation of a North Dakota care consultation program for individuals with Alzheimer's and their caregivers revealed that involving caregivers in care management activities, such as the development of a care plan, led to $323,098 in savings during an 18-month period, 90 percent of which was due to reduced hospital care.[3] Furthermore, engaging caregivers who are not cognitively impaired in the management of complex chronic conditions, including Alzheimer's disease, will help to ensure follow-up on care instructions to make them more effective.

We agree that in order to receive reimbursement for complex chronic care management, physicians must be able to demonstrate a capability to provide them. We have concerns, however, with the suggestion that certification as a medical home might be sufficient to demonstrate these capabilities. The Alzheimer's Association supports the principles of patient-centered care models for individuals with Alzheimer's and other dementias. However, many standards for accreditation as a patient-centered medical home (PCMH) do not consider the needs of those with dementia. One of the hallmarks of a PCMH is the inclusion of care recipients in the development of a care plan. Individuals with Alzheimer's or other dementias may not be able to participate in the same capacity as individuals who are not cognitively impaired. Should accreditation as a PCMH be used as the standard for demonstrating the capability to provide complex chronic care management, we would encourage CMS to require accreditation bodies to include quality measures on dementia care as a standard for PCMH accreditation. Quality measures such as the ones created by the American Medical Association (AMA) would make existing standards more meaningful and relevant to those with Alzheimer's and other dementias.[4]

Finally, we believe that any determination regarding how practitioners should demonstrate their ability to provide complex chronic care management services should not restrict beneficiaries' right-to-choose their health care practitioners. Many individuals with Alzheimer's disease or other dementias reside in underserved communities where there may be limited health care resources. Further restrictions on where they can access services will only increase health care disparities.

2. Complex Chronic Care Management and the Annual Wellness Visit

The Alzheimer's Association is encouraged by the proposed requirement that a beneficiary must have received an annual wellness visit (AWV) in the prior 12 months in order for their practitioner to bill separately for

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[3] North Dakota Dementia Care Services Project:Contributing to health cost savings. (2011). *Rural Health Facts. Center for Rural Health, University of North Dakota School of Medicine & Health Sciences*

[4] The American Medical Association's dementia performance measure set can be found at http://www.ama-assn.org/apps/listserv/x-check/qmeasure.cgi?submit=PCPI.

complex chronic care management services. The AWV serves as an important tool for CMS to encourage beneficiary wellness and preventive care, including assessing for possible cognitive impairment. The detection of possible cognitive impairment is the crucial first step to obtaining a diagnosis of Alzheimer's disease or another dementia. In order to provide better medical care and outcomes for individuals with Alzheimer's and other dementias, possible dementia must first be detected, the type of dementia must then be diagnosed, care must be planned, and the diagnosis must be noted in the patient's medical record. Obtaining an appropriate diagnosis for dementia is also key to accessing available treatments, managing other chronic conditions and participating in clinical trials.

Despite this, more than half of individuals who meet the specific diagnostic criteria for dementia have never received a diagnosis. In addition, recent public health survey data from 22 states indicate that at least one-in-eight adults over age 60 had experienced confusion or memory loss in the previous year. Of those, less than 20 percent had discussed these problems with a health care provider.[5] By requiring beneficiaries to have had an AWV in the 12 months prior to receiving complex chronic care management services, CMS will encourage more practitioners to inform Medicare beneficiaries of this valuable benefit and improve assessment rates for possible cognitive impairment. We ask that CMS consider delineating that an objective tool must be used for cognitive assessment during the AWV unless both the beneficiary and an informant can confirm that no cognitive symptoms are evident. This request is consistent with recommendations put forth by the Alzheimer's Association in 2013[6] as well as the U.S. Department of Health and Human Services' *National Plan to Address Alzheimer's Disease*. For examples of appropriate tools, both the Alzheimer's Association[7] and the National Institute on Aging have identified brief cognitive assessment tools suitable for use during the AWV.

3. Proposed measures for the Physician Quality Reporting System

The Alzheimer's Association applauds CMS for retaining the dementia measures group in the Physician Quality Reporting System (PQRS) for 2014. The AMA dementia performance measures are a useful tool to help improve care outcomes for people with dementia.

In addition to those quality measures listed in the proposed rule, we would encourage CMS to also consider three additional measures: (1) a measure that requires physicians to assess cognitive impairment using a standardized assessment tool; (2) a measure that requires documentation of a diagnosis in the medical record; and (3) the American Medical Association's (AMA) dementia performance measure on palliative care counseling and advance care planning.

An assessment for cognitive impairment was a Physician Quality Reporting Initiative (PQRI) measure in 2008[8], but was retired on January 1, 2009.[9] As previously discussed, assessing for possible cognitive impairment is now a required element in the AWV for Medicare beneficiaries, and diagnosing Alzheimer's disease or other dementias is a crucial step in effective medical management.

To ensure communication across all medical settings, in the event Alzheimer's or another dementia is detected and a diagnosis is given, diagnosing physicians should be required to document the diagnosis in the medical record. The Advisory Council on Alzheimer's Research, Care, and Services echoed this sentiment in recent recommendations to the Department of Health and Human Services that included redesigning Medicare

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[5] Centers for Disease Control and Prevention. *Self-reported increased confusion or memory loss and associated functional difficulties among adults aged ≥60--21 states, 2011*. MMWR Weekly 2013; 62(18);345-50. Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6218a1.htm?s_cid=mm6218a1_w

[6] Cordell, et. al. (2013). Alzheimer's Association recommendations for operationalizing the detection of cognitive impairment during the Medicare Annual Wellness Visit in a primary care setting. *Alzheimer's & Dementia* 1-10

[7] Ibid.

[8] Centers for Medicare and Medicaid Services. (2007). *2008 Physician Quality Reporting Initiative Specifications Document.* Retrieved from http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/downloads/2008PQRIMeasureSpecs.pdf

[9] Centers for Medicare and Medicaid Services. (2011). *2011 Physician Quality Reporting Initiative Measure Specification Manual for Claims and Registry*. Retrieved from http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/downloads/2011_PhysQualRptg_MeasureSpecificationsManual_033111.pdf

benefits to ensure the documentation of a dementia diagnosis in a beneficiary's medical record. Documentation in the medical record ensures the diagnosis is communicated across care settings, and other health care professionals are informed and better positioned to provide high-quality care while managing other chronic conditions, medications and care transitions.

Comprehensive counseling and medical preference documentation are also important for individuals with Alzheimer's and other dementias as well as their families. In the late stages of the disease, affected individuals may no longer be able to articulate decisions and find themselves subject to unwanted or undesirable medical choices. Including AMA's palliative care counseling and advance care planning measure in the 2014 quality measures will encourage communication between the care recipient, family members and health care providers. It will also encourage documentation of an individual's medical preferences, which is critical information for health care providers as the disease progresses and care settings change. Lastly, counseling and advance planning will ease the burden on families and continue to enhance the quality of care for vulnerable, older individuals.

Thank you for the opportunity to comment on these proposed regulations and for working to achieve better quality of care for individuals with Alzheimer's disease and other dementias. Please contact Rachel Conant, Director of Federal Affairs at 202.638.7121 or RConant@alz.org if you have questions or if we can be of additional assistance.

Sincerely,

Robert Egge
Vice President, Public Policy
Alzheimer's Association