ALZHEIMER'S FOUNDATION OF AMERICA

Charles J. Fuschillo, Jr.
President & Chief Executive Officer

June 22, 2015

The Honorable Johnny Isakson
The Honorable Mark Warner
Senate Finance Committee
The United States Senate
Washington, DC 20510

Dear Senators Isakson and Warner:

On behalf of the Alzheimer's Foundation of America (AFA), a nonprofit organization that unites more than 2,300 member organizations nationwide with the goal of providing optimal care and services to individuals confronting dementia, and to their caregivers and families, I appreciate the opportunity to provide input on ways to increase opportunities for person-centered care coordination, which has potential to both provide better outcomes and lower costs for individuals with chronic conditions, including many of those living with dementia.

The following are AFA's suggestions in regards to some of the questions you posed in your May 22nd letter to stakeholders:

- **Transformative policies that improve outcomes for patients living with chronic diseases either through modifications to the current Medicare Shared Savings ACO Program, piloted alternate payment models (APMs) currently underway at CMS, or by proposing new APM structures:**

  In 2014, AFA's released a report "Cost of Care: Quantifying Care-Centered Provisions of the National Plan to Address Alzheimer's Disease,"[1] which evaluates the costs and benefits associated with implementation of coordinated care delivery models, transitional care programs, and expanded caregiver supports in the 2012 National Alzheimer's Plan. AFA found enactment of these provisions could result in more than $110 billion in federal savings over 10 years.[2]

  Among the care models analyzed in the report are:

  Medical Homes

  The premise of the medical home model is that by providing coordinated, comprehensive and personalized care, medical homes will:

  - reduce the need for emergency room visits;
  - decrease hospital admissions (and readmissions);
  - shorten the average length of a hospital stay; and

[1] See, http://www.alzfdn.org/documents/Quantifying-Care-Centered-Provisions-of-the-National-Plan-to-Address-Alzheimers-Disease.pdf .
[2] *Ibid.*

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- eliminate unnecessary tests and procedures.

All of these elements would contribute to overall cost savings. Moreover, this model is likely to improve the person's health, quality of care, and satisfaction, as well as provide multiple benefits to family caregivers.

Medicare spends on average $20,638 per beneficiary with Alzheimer's disease compared to only $7,832 per beneficiary without Alzheimer's disease.[3] In a fully phased-in model of Medical Homes for those with dementia, reducing the need for intensive medical services could reduce in-patient hospitalization spending by approximately $2.5 billion in a given year. With the anticipated growth in the Medicare population of beneficiaries with Alzheimer's disease, reducing the need for hospitalization through Medical Homes could reduce costs by $39 billion over 10 years if fully implemented.[4]

Independence at Home (IAH) for People with Alzheimer's Disease

The Independence at Home (IAH) is a payment incentive and service delivery model that uses primary care teams led by physicians or nurse practitioners to deliver timely, in-home primary care.

Under the requirements of the IAH model, participating practices must assess the effects of timely, in-home primary care on health care costs, quality of care, and rates of preventable hospitalizations, hospital readmissions, and emergency department visits over a three-year period. To qualify for an incentive payment, the practice's expenditures for participating beneficiaries must be lower than the calculated target expenditure, which represents the expected Medicare fee-for-service expenditures of participating beneficiaries in the absence of the IAH.[5]

Currently, an estimated 300,000 nursing home residents have a diagnosis of Alzheimer's disease.[6] This represents approximately 6.7 percent of all Medicare beneficiaries with Alzheimer's disease, but 15.5 percent of all nursing home residents. Medicare spends an average of $18,353 annually on medical services per nursing home resident with Alzheimer's disease.[7] In contrast, Medicare spends an average of $1,401 annually on medical services per home health beneficiary with Alzheimer's disease.

IAH could offer savings in two ways. First, by allowing peoples with Alzheimer's disease to receive quality care at home, the number and percent of the nursing home population with Alzheimer's disease could be reduced. Second, coordinated in-home

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[3] The Scan Foundation Data Brief: Medicare Spending on Beneficiaries With Dementia (http://thescanfoundation.org/sites/thescanfoundation.org/files/1pg_databrief_no30_medicare_spending_on_beneficiaries_with_dementia.pdf).

[4] *Cost of Care Report*, p. 7.

[5] See, www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/Downloads/IAH_FactSheet.pdf for more information on the IAH demonstration project.

[6] This figure represents an estimate for 2013, based on data from the Centers for Disease Control and Prevention and the National Nursing Home Survey, available at: www.cdc.gov/nchs/fastats/alzheimr.htm.

[7] *Id.*

care could provide efficiencies in care delivery (as in the Medical Home provisions) through a centralized medical provider.

Reducing the number of nursing home residents with Alzheimer's disease by just 10 percent would reduce Medicare spending by approximately $800 million in a given year.[8] Over 10 years, this cost saving increases to approximately $11.4 billion. In addition, efficient in-home care could reduce unnecessary spending on medical services rendered when the beneficiary receives care in a medical facility. Reducing office visits and hospitalizations could reduce the need for unnecessary tests and services.

Since the vast majority of people with Alzheimer's disease are in non-nursing home settings, estimates indicate that Medicare spending could decrease by approximately $1.5 billion in a given year. This translates to $18.4 billion in cost savings over 10 years, given the current growth rate in services and in the number of people diagnosed with Alzheimer's disease. In total, the fully-implemented IAH program could reduce Medicare spending by approximately $30 billion over 10 years.[9]

- **Reforms to Medicare's current fee-for-service program that incentivize providers to coordinate care for patients living with chronic conditions:**

  Increase Access to Home Care and Care Management for Medicare Beneficiaries with Dementia

  Benefits under federal health programs for long-term care for individuals with Alzheimer's disease are extremely limited. To qualify for Medicare home health services, a beneficiary must have a "skilled need." In the earlier stages of Alzheimer's disease, individuals, while struggling with cognitive impairment, safety issues and greater dependence, often lack this "skilled need" and, therefore, are excluded from receiving services such as home health aides. As the disease progresses, people increasingly need assistance with activities of daily living (ADLs).

  Medicare should allow greater case management for beneficiaries diagnosed with Alzheimer's disease who have difficulty with one or more ADLs, as well as access to home- and community-based services, despite not falling into the current statutory definition of "skilled need" and, therefore, not "homebound" for the purpose of qualifying for the Medicare home health benefit.

  Specifically, such a redesigned Medicare home care benefit would: 1) extend "homebound" status to all Medicare beneficiaries with Alzheimer's disease who need assistance with one of more ADLs; 2) assign a case manager to Medicare beneficiaries with Alzheimer's disease to coordinate care services and ensure smooth transitions across care settings and make health assessments of family caregivers.

  Integration and coordination of long-term care services will lower overall costs of treating Medicare beneficiaries with Alzheimer's disease. It also will reduce incidences

[8] *See,* Cost of Care Report, p. 8-9.
[9] *Id.*

of hospitalizations as a result of beneficiaries failing to take prescribed medication or by being unsafe in their environment. Further, access to home care services will provide respite for family caregivers, allowing them to better balance caregiving with their professional and other family responsibilities. This will allow the caregiver to remain financially productive and in the workforce while lowering their health care costs and increasing their overall well-being.

AFA urges that Congress establish an Alzheimer's disease benefit that expands access to home care services and care managers under the federal health programs, including fee-for-service Medicare.

Access to Adult Day Services for Medicare Beneficiaries

Adult day services provide a coordinated program of professional and compassionate services for cognitively or functionally-impaired adults, including people with dementia, in a community-based group setting. Services are designed to provide social services to adults who need supervised care in a safe place outside the home during the day. Such an option is also cost effective since the daily fees for adult day services, while varying depending upon services provided, is $61 per day (includes 8-10 hours on average) compared to an average rate for home health aides of $19 per hour.[10]

AFA recommends Congress establish an adult day services a benefit under the Medicare program for beneficiaries with dementia who have difficulties with one or more ADLs. Such programs provide socialization and stimulation to people with Alzheimer's disease and provide respite to family caregivers. They also provide family caregivers an avenue to maintain a worker/caregiver balance, which may enable them to stay economically productive in the workforce while serving as primary caregivers.

- **The effective use, coordination and cost of prescription drugs:**

  Value-based health care can enable patients to gain access to, and support in using, needed medications, and can do so while simultaneously lowering cost growth and achieving the quality benchmarks.

  Medication, however, cannot be viewed as a siloed expense item in a value-based environment. It needs to be integrated so that the cost offsets and quality benefits resulting from optimized pharmaceutical use can be recognized and calculated. In addition, medication therapy management (MTM) cannot be undertaken as a one-size-fits-all approach. The role, impact and characteristics of MTM will vary by condition.

  Composite risk can be used to identify patients who are candidates for MTM strategies to watch for drug-drug, drug-disease, or polypharmacy concerns. In each circumstance where there are condition-specific incentives to achieve economic savings, there should also be a quality metric to detect under-use of pharmaceuticals.

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[10] The MetLife Market Survey of Adult Day Services & Home Care Costs, MetLife Mature Market Institute®, in conjunction with LifePlans, Inc., www.MatureMarketInstitute.com, September 2007.

For making this important transition, the following implementation considerations must be considered:

- Proactively consider medications an essential part of the full spectrum of condition management, and not just an expense or care silo.
- The role, impact, and characteristics of medication therapy management will vary by condition, and a "one size fits all" approach will not yield optimal clinical or economic outcomes
- Composite risk can be used to identify patients who are candidates for medication management strategies to watch for drug-drug, drug-disease, or polypharmacy concerns.
- In each circumstance where there are condition specific incentives to achieve economic savings, there should also be a quality metric to detect underuse.[11]

In addition, functional outcome measures being considered for inclusion in the calendar year (CY) 2016 Inpatient Rehabilitation Facility (IRF) prospective payment system (PPS) and the CY'16 Skilled Nursing Facility (SNF) PPS are physical in nature and include metrics addressing 30 day acute hospital readmissions, self-care and mobility, falls, and pressure ulcers. While ambulation is an important for many patients with neurologic conditions, cognitive and behavioral improvements are equally important and may be vital to improving quality of life and community engagement.

Beneficiaries with chronic underlying neurologic conditions, like dementia, may experience cognitive and behavioral symptoms that inhibit social interactions that can aid in quality chronic care management and favorable health outcomes. AFA, therefore, urges Congress to further define the term "function" in a way that encompasses the breadth of challenges that most of these patients face and include quality metrics that move beyond physical markers.

- **Ideas to effectively use or improve the use of telehealth and remote monitoring technology:**

With development of innovative health care technologies and implementation of new care delivery and payment models, connected care is offering new and more efficient ways to furnish health care to patients. Indeed, through connected care, health care providers can remotely communicate with their clients and other health care providers across care settings through tablets, laptops, and smartphones, patients and their caregivers can be more engaged in the delivery of their own care, and those with limited access to care providers can be treated in less costly and more convenient care settings, such as their homes or local senior center. In fact, replacing in person acute care

[11] See, *Role of Pharmaceuticals in Value-Based Healthcare: A Framework for Success* (www.ajmc.com/journals/issue/2012/2012-7-vol18-n7/Role-of-Pharmaceuticals-in-Value-Based-Healthcare-A-Framework-for-Success#sthash.NACugt2x.dpuf).

services with telehealth visits reimbursed at the same rate as a doctor's office visit could save the Medicare program an estimated $45/visit.[12]

Yet, because of geographic and site restrictions, Medicare beneficiaries who live in medically underserved urban areas or are homebound are unable to benefit from connected care. There is no coverage for about 80 percent of Medicare beneficiaries who live in the areas of the country that are not considered "rural." To illustrate this point, in 2009, there were more than 43 million Medicare beneficiaries, yet only 14,000 received telehealth services.[13]

AFA recommends Congress lift geographic and originating site restrictions from the Medicare fee-for-service telehealth benefit. Eliminating these restrictions would enable Medicare beneficiaries to receive connected care services in less costly settings, ensure fair access to connected care services for all beneficiaries, regardless of whether they live in rural or metropolitan areas, and improve care coordination and outcomes for those Medicare beneficiaries living with dementia and their family caregivers.

- **Options for empowering Medicare patients to play a greater role in managing their health and meaningfully engaging with their health care providers:**

  Care Planning Act

  Establishing a new transitional care benefit through hospice for Medicare beneficiaries will ensure individuals living with dementia and their families have access to new valuable end-of-life services, including: palliative care consultation services; care planning services; counseling for individual and family members; discussions regarding the availability of supportive services including information on advanced directives and other end-of-life planning tools; encouragement of patient-centered care; family conference services; respite services; and caregiver training.

  For the millions of Americans with Alzheimer's disease or a related dementia, advance directive planning services are essential. Such services will not only help improve quality of life, but will also help to reduce the stigma and fear of facing end-of-life issues in general.

  AFA urges Congress to pass S. 1549, the Care Planning Act, which establishes an advanced care planning benefit for Medicare beneficiaries with chronic conditions.

  REACH II

  Resources for Enhancing Alzheimer's Caregiver Health II (REACH II) is a multicomponent psychosocial and behavioral training intervention for caregivers of individuals with Alzheimer's disease or a related dementia. The intervention is designed to reduce caregiver burden and depression, improve caregivers' ability to provide self-care,

[12] See, Yamamato, D., *Assessment of the Feasibility and Cost of Replacing In-Person Care with Acute Care Telehealth Services* (December, 2014)(www.connectwithcare.org/wp-content/uploads/2014/12/Medicare-Acute-Care-Telehealth-Feasibility.pdf).

[13] *Id.*

provide caregivers with social support, and help caregivers learn how to manage difficult behaviors in care recipients.[14]

REACH II participants are provided with educational information, skills to manage care recipient behaviors, social support, cognitive strategies for reframing negative emotional responses, and strategies for enhancing healthy behaviors and managing stress. Methods used in the intervention include didactic instruction, role-playing, problem-solving tasks, skills training, stress management techniques, and telephone support groups.[15]

Findings from REACH II studies show improvements across many areas. Caregivers reported less "burden" and depression, and improved emotional well-being overall. They also reported gains in the areas of self-care and healthy behaviors, social support, and management of a loved one's problem behaviors that result from Alzheimer's disease. Plus, they gained up to two hours a day of time that was not consumed with caregiving duties.[16]

AFA encourages nationwide adoption of the REACH II program for all Medicare/Medicaid beneficiaries who have dementia and one ADL limitation.

- **Ways to more effectively utilize primary care providers and care coordination teams in order to meet the goal of maximizing health care outcomes for Medicare patients living with chronic conditions:**

  While most current models of care coordination focus on primary care and acute care, a more fully-integrated care coordination model that includes LTSS would improve on primary/acute care models by capitalizing on homecare workers providing essential long-term care services and coordinating individual care on a frequent and face-to-face basis.

  In an enhanced care coordination model, the homecare worker would fill two additional essential roles: 1) participating as part of the multidisciplinary care team including responsibilities for regular communication with care managers; and 2) expanding their range of services beyond assistance with ADLs to include training in care strategies, behavioral interventions and patient assessment.

  This regular and intensive contact means a homecare worker is likely to notice subtle changes in condition that another member of the care team —say, a doctor, in the course of a brief office visit—perhaps would not notice. This extensive contact also likely means a homecare worker builds a unique relationship of trust with the individual and their family caregivers.

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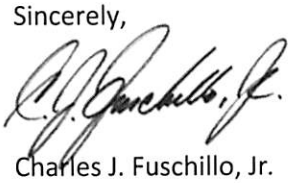
[14] *Resources for Enhancing Alzheimer's Caregiver Health II, National Registry of Evidence-based Programs and Practices*, (http://nrepp.samhsa.gov/Index.aspx).
[15] *Ibid.*
[16] *Translation of a Dementia Caregiver Support Program in a Health Care System—REACH VA*, JAMA Internal Medicine, February 28, 2011 Vol. 171, No. 4 (http://archinte.jamanetwork.com/article.aspx?articleid=226705).

Homecare workers can serve as a conduit sharing information with the care manager(s) that is crucial for minimizing decline and addressing exacerbations of conditions—information that would likely not otherwise come to the attention of the care manager or other providers. Similarly, if additional dementia training is provided, the homecare worker can take any emergent issues identified by care managers into account when delivering care. This can help prevent health and social issues from worsening to the point of requiring otherwise unnecessary services, and is likely to result in better health and social outcomes and lower expenditures.

AFA calls on CMS to support care coordination models, including additional dementia care training to homecare workers, that capitalize on homecare workers to lower care costs—especially hospitalizations and nursing home stays—and, therefore, has significant promise to bend the medical cost curve, as well as improve health outcomes for people with Alzheimer's disease and their family caregivers.

Again, thank you for your leadership in looking at policy solutions that incorporate innovative and creative care delivery models for persons with chronic conditions. AFA looks forward to working with you and other stakeholders as legislation is being developed. Feel free to contact me or Eric Sokol, AFA's vice president of public policy, at esokol@alzfdn.org if you have questions or need further information.

Sincerely,



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