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VIA ELECTRONIC DELIVERY

June 23, 2015

The Honorable Orrin Hatch
Chairman
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Johnny Isakson
United States Senate
131 Russell Senate Office Building
Washington, DC 20510

The Honorable Mark Warner
United States Senate
475 Russell Senate Office Building
Washington, DC 20510

Dear Chairman Hatch, Ranking Member Wyden, Sen. Isakson and Sen. Warner:

On behalf of the more than five million Americans currently living with Alzheimer's and dementia and the estimated 15 million more family caregivers, I thank you for your bipartisan commitment to improve care for patients navigating chronic illnesses. The aging of our nation combined with an inadequate – or virtually non-existent – system to manage and support older persons navigating multiple chronic conditions makes this issue one of tremendous importance to our nation's health and fiscal futures. It is my sincerest desire that your bipartisan effort will bear fruit, and USAgainstAlzheimer's looks forward to working with you and your colleagues to achieve this aim. I am pleased to provide some initial thoughts from USAgainstAlzheimer's as to policy reforms the Finance Committee can consider to strengthen and modernize Medicare policies and benefits for those beneficiaries navigating Alzheimer's and dementia. I look forward to your reaction to these ideas, and to discussing more fully.

Problem: The under-diagnosis of patients with Alzheimer's and dementia which hinders the ability to treat and support patients and their family caregivers. Secondly, this leads to under-reporting and inaccurate estimates as to the extent of the Alzheimer's and dementia burden on our people and healthcare system.

Proposed Solution: Significantly expand adoption of the Medicare Annual Wellness (AWV) visit. Require documentation of, and use of a standardized assessment tool for, the currently-required cognitive impairment detection component of the AWV. Also encourage the physician community to develop a professional protocol for the detection, diagnosis and post-diagnostic support for those determined to have a cognitive impairment.

According to the most recent data, less than half of primary care patients with diagnosable dementia receive such a diagnosis. In establishing the Annual Wellness Visit via the Affordable Care Act, Congress

clearly sought to address this problem by including detection of any cognitive impairment as a required component of the visit. But despite this requirement, evidence suggests this provision is being underutilized. To address this problem, USAgainstAlzheimer's recommends that the Centers for Medicare & Medicaid Services build upon the comprehensive recommendations issued earlier this year by the Gerontological Society of America (GSA) Workgroup on Cognitive Impairment Detection and Earlier Diagnosis to increase the use of the cognitive assessment component of the AWW. Specifically, we would encourage CMS, working through the Center for Medicare and Medicaid Innovation, to develop a phased implementation program focused on achieving the goals noted above around greater use of the cognitive detection tool and follow-on diagnostic and post-diagnostic services to those beneficiaries determined to have cognitive impairment or a form of dementia.

Problem: High Costs Associated with Medicare and Medicaid Beneficiaries with Alzheimer's, particularly costs associated with institutional care.

Solution: Implement within the Medicare population evidence-based caregiver support interventions to improve beneficiary outcomes and enable them to be cared for in the home setting for longer periods of time. Provide Medicare with flexible authorities to enter into pay-for-performance or other innovative finance mechanisms with private service providers and financial service firms who deliver evidence-based programs that deliver improved health outcomes while reducing costs of care for those with dementia.

Much of the cost of Alzheimer's and dementia to federal health programs is driven by Medicaid spending on long-term care, particularly costly institutional care. A population that is largely unprepared or underprepared with long-term care insurance or other resources to pay for such care will only further exasperate an already taxed system. While we all hope that the development of disease-modifying, curative or preventive therapies will address this problem, the reality is that tens of millions of Americans are already living with Alzheimer's and dementia or will develop this disease before this time and will thus require supportive services. Thankfully, evidence-based programs including an initiative developed by the Department of Veterans Affairs known as the Resources for Enhancing Alzheimer's Caregivers Health or REACH program, have been demonstrated to be effective in improving the health and well-being of caregivers and enabling them to better care for the person with dementia. Both REACH and a similar program known as the New York University Caregiver Initiative or NYUCI provide caregivers with between four to six support sessions to help them better understand and navigate the many challenges they will face. The programs then offer the caregiver a second "maintenance" phase where additional supports are provided as needed. Both of these initiatives have been developed and evaluated over a lengthy period of time, and both have achieved documented successes in reducing caregiver burden and delaying costly residential admissions.

For the REACH program, caregivers experienced reduced depression and frustrations as well as a decrease in the number of hours spent providing care each day. The program was so successful that VA has rolled it out nationwide. The NYUCI has been evaluated over more than two decades going back to 1987. Analysis of the program has found that it was able to delay patient admission to a nursing home by an average of 557 days – more than a year and-a-half – compared to the control group. With one year of care in a semi-private nursing home exceeding \$80,000, this delay would result in significant savings to payers, including Medicaid. Six states have implemented the NYUCI model with the longest-running program operating in Minnesota. According to a May 2014 analysis by Act on Alzheimer's, more widespread implementation of the model in Minnesota to serve more caregivers could result in net

savings to the state ranging from \$61.8 million to \$250.6 million over 15 years, depending on the percentage of the caregiver population reached.

These findings suggest that evidence-based interventions targeted toward the caregiver of a Medicare beneficiary impacted by Alzheimer's or related dementias could yield measurable results in terms of improved health outcomes and reduced federal healthcare costs. I recognize that delivering services to the caregiver rather than the beneficiary is not typical for the Medicare program. At the same time, given the nature of Alzheimer's and dementia and its impact on the patient, addressing caregiver stress, anxiety and other burdens is of demonstrable benefit to the beneficiary with the disease as well.

Given the data that exists today, USAgainstAlzheimer's recommends that Congress amend the Social Security Act to establish an Alzheimer's and Dementia Caregiver Support benefit available to persons who receive a diagnosis of Alzheimer's or related dementias. The benefit package should be informed by the evidence-based programs cited above. Within three years of the implementation of the benefit, CMS should submit a report to Congress summarizing the impact of the benefit on the following areas:

- Impact of the quality of life and care of beneficiaries with dementia, including ability of the beneficiary to be cared for in their home;
- Impact on the health, well-being and quality of life of caregivers who are also Medicare beneficiaries;
- Impact on the institutional care costs of the Medicaid program; and
- Impact on reducing 30-day preventable hospital admissions, readmissions and other quality and efficient measures.

Related to this topic, I am also aware of promising models that have sharply reduced hospital utilization, particularly use of the emergency department, as well as preventable readmissions among patients with Alzheimer's and dementia residing in long-term care settings. Given the significant multiplier effect of Alzheimer's and dementia on costs of chronically ill Medicare and Medicaid beneficiaries, additional research to validate and scale up such interventions should be another priority. Relatedly, I would encourage you to strongly consider innovative financing tools, such as pay-for-success instruments, whereby such successful interventions could be rapidly scaled in a way where government only pays for demonstrated health outcomes and financial returns. Such care-oriented interventions appear to be ripe for such attention given the ability to benchmark performance against the status quo and the ability to measure impact over a relatively brief period of time.

I thank you, again, for your leadership in taking on this most important set of issues and for seeking broad-based public comment, and I look forward to working with you to advance this effort going forward. Should you have any questions or want to meet on these issues, please feel free to reach out to my office at any time to set up a discussion.

Sincerely,



George Vradenburg