

# Dementia Care Management: A Proposed Framework for an Alternative Payment Model



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## Background

The purpose of this proposal is to outline the Dementia Care Management (DCM) model, an alternative payment model (APM) with the goal of improving outcomes and reducing health care costs for Medicare beneficiaries with Alzheimer's disease and other forms of dementia. Given the increasing number of individuals diagnosed with dementia and the associated disease burden on not only patients but their caregivers as well, we believe the CMS Center for Medicare and Medicaid Innovation (CMMI) should move swiftly to implement and test a national APM aimed at addressing the unique challenges associated with dementia care. This proposed APM would be based on a collaborative and interdisciplinary dementia care model supported by innovative dementia-specific approaches to payment methodology, patient assessment and eligibility criteria, and other key design parameters.

Over 5 million individuals in the United States live with Alzheimer's dementia, almost all of whom are above the age of 65.<sup>1</sup> This figure is projected to reach nearly 14 million individuals in 2050. Health care costs are relatively high for this population; per-capita Medicare spending for individuals with Alzheimer's or other dementias exceeded \$25,200 in 2019, compared with more than \$7,700 for individuals without Alzheimer's or other dementias. The high costs are primarily a result of high rates of hospitalization, emergency department (ED) utilization, and skilled nursing facility (SNF) placements that are nearly four times the rate of the population without Alzheimer's or other dementias. Average per-person Medicaid spending across all seniors was also substantially higher (\$8,779 vs \$374), mainly due to greater utilization of long-term services and supports (LTSS).<sup>2</sup>

We believe adverse outcomes and high costs can, in part, be avoided by enabling patients and their caregivers to more seamlessly navigate their care with enhanced coordination across the many providers involved in the care of a patient with dementia and more timely access to care and interventions that reduce avoidable health care utilization. Such results have been demonstrated through previously funded CMMI projects on care management delivery, including the Eskenazi Health and Indiana University Center for Aging Research's Aging Brain Care (ABC) Medical Home program; the University of California, Los Angeles's (UCLA's) Alzheimer's and Dementia Care (ADC) program; and the University of California, San Francisco's (UCSF's) Care Ecosystem.

Furthermore, the high prevalence of comorbidities such as hypertension, heart disease, depression and diabetes among this population compounds the need for this approach as they complicate the process of providing care and treatment. Enhanced coordination can advance better outcomes in a range of practice settings, including for those patients with dementia cared for in small practices or by solo practitioners.

Despite mounting evidence supporting the success of care coordination models for dementia in integrated delivery systems and broader investment in Medicare APM primary care models, no current Medicare APM approach exists to specifically address the challenge of dementia care. Opportunities exist to build on the foundation of those models with a national approach that applies to a variety of practice settings.

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<sup>1</sup> Alzheimer's Association. 2020 Alzheimer's Disease Facts and Figures. *Alzheimer's Dement* 2020;16(3):391-460.

<sup>2</sup> *Ibid.*

## Overview

Primary care practices and practitioners are best positioned to serve as the “entry point” for screening and identifying dementia patients and referring them to a DCM program. Several DCM pilot interventions and studies currently exist.<sup>3</sup>

However, in the current health care environment, primary care practices have been hesitant and reluctant to develop or adopt DCM programs. These practices are often already operating “at the margin” and have valid concerns about the lack of appropriate reimbursements that are necessary for developing, implementing, and sustaining such programs. There are concerns that valuable DCM models will not develop organically due to the lack of sufficient reimbursement pathways.

In developing a proposed DCM APM, we used the DCM pilots as a foundation and sought to build upon, enable, and sustain the success of these models by including an alternative payment mechanism. The proposed DCM APM contains the following key elements:

- ✓ **Coordinated Care Management** — utilizing an interdisciplinary care team with dementia care management expertise that works collaboratively with primary care physicians.
- ✓ **Outcomes-Based Approach** — assessing performance on meaningful utilization and patient and caregiver outcome measures demonstrating the values of the DCM model services and interventions.
- ✓ **Innovative Payment Methodology** — shifting away from the traditional fee-for-service (FFS) payment model to provide additional support and resources necessary for caring for this high-needs patient population, with a potential for shared savings or quality performance bonus.
- ✓ **Widespread Adoption** — providing flexibility so the model could be adopted by all practice types (including, small, community health clinic, and rural practices as well as larger, integrated systems) to increase patient access to valuable services.
- ✓ **Patient Care Innovations** — increasing access to care and resources for individuals with dementia.
- ✓ **Caregiver Innovations** — focusing on enhancements and waivers necessary to support patients and their caregivers in maintaining their independence in a setting of their preference.

## DCM — Alternative Payment Model

We believe the DCM APM has the potential to improve medical outcomes for patients with Alzheimer’s and other forms of dementia, improve the quality of life for patients and their caregivers, and produce net savings to the Medicare program. Upon demonstrating improved outcomes and savings, the DCM APM could become a mandatory model and a permanent part of the Medicare program.

What follows are the specific components of how we recommend a DCM APM be structured.

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<sup>3</sup> CMMI has funded such pilots, including the University of California, Los Angeles’s (UCLA’s) Alzheimer’s and Dementia Care (ADC) program, and the University of California, San Francisco’s (UCSF’s) Care Ecosystem.

## Practice Eligibility Criteria

Practices would have to meet the following requirements to participate in the DCM model:

- ✓ Be practitioners in good standing with CMS
- ✓ Have or have access to an interdisciplinary team (IDT) with “expertise in dementia care management” where at least one individual who is part of the IDT meets the criteria for being a dementia specialist
  - Expertise in dementia care management can be satisfied with the inclusion of a physician (neurologist, geriatrician, primary care practitioner, or psychiatrist), physician assistant (PA), and/or advanced practice nurse (APN) that meets the criteria for being a dementia specialist<sup>4</sup>
- ✓ Utilize a comprehensive, person-centered care management approach (including assessment of patients’ needs for social services)
- ✓ Perform wellness and health care planning, including medication review and management
- ✓ Have the capacity to support family and caregiver engagement
- ✓ Provide 24/7 access to a member of the DCM care team or primary care provider
- ✓ Can fulfill dementia care management services described in the care model section below
- ✓ Have relationships with medical and non-medical community-based organizations that provide support services for patients with dementia and/or their caregivers

## Patient Population

Medicare beneficiaries with any form of dementia, at any stage, will be eligible for care under the new DCM model. While different dementias differ in some manifestations, all represent acquired cognitive deficits sufficient to interfere with function. Alzheimer’s disease, the most common form of dementia, affects the regions of the brain responsible for memory, thinking, and behavior; related forms of dementia include vascular dementia, dementia with Lewy bodies, and frontotemporal lobar degeneration. Individuals with dementia experience substantial cognitive decline over a long period of time and many ultimately require a nursing home level of care as their condition progresses and as caregivers lose the ability to provide necessary services to them. Individuals with Alzheimer’s disease shift to more advanced phases over time due to the progressive nature of the disease. During these later stages, mortality risk increases.<sup>5</sup> Related dementias have similar progressive characteristics.

As diagnosis requires a clinical evaluation, many individuals in the early stages of the disease are unaware they have it. Frequently, individuals with Alzheimer’s and other dementias have other chronic conditions and/or early symptoms may be mistakenly attributed to cognitive changes associated with normal aging—factors that complicate medical initial diagnosis and subsequent treatment.

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<sup>4</sup> Defined as a practitioner that “devotes 25% or more of patient contact time to the evaluation and care of acquired cognitive impairment.” See, Rabinovici GD, et al. “Association of Amyloid Positron Emission Tomography With Subsequent Change in Clinical Management Among Medicare Beneficiaries With Mild Cognitive Impairment or Dementia,” *JAMA* 2019;321(13):1286-1294.

<sup>5</sup> Information about the distribution by disease stage and transition rates can be found in an analysis of the Canadian Study of Health and Aging cited by the Lewin Group in an analysis of the projected population with Alzheimer’s. See, Graham, J, et al. “Prevalence and Severity of Cognitive Impairment With and Without Dementia in an Elderly Population,” *Lancet* 1997;349(9068):1793-1796; and Alzheimer’s Association. *Changing the Trajectory of Alzheimer’s Disease: A National Imperative*, Appendix A. Available at <https://alz.org/media/Documents/trajectory-report-appendix-a.pdf>.

Patient eligibility criteria for the DCM model are designed to target a range of patients, including those with early- to late-stage dementia, in primary care and community settings. The following criteria will be used to determine the appropriate pathway for patients upon enrollment in the DCM model.

### **Initial Patient Eligibility and Pathways**

Eligible beneficiaries for the DCM model would generally be:

- ✓ Medicare FFS beneficiaries, including those receiving care in Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs);
- ✓ With one or more of the following diagnoses: ICD F01-F03, F10.27, G30.0-G30.9, G31.09, G31.01, and G31.83).
- **Exclusions:** Beneficiaries who are in long-term institutional care, PACE, or hospice will be excluded

Patients would be identified for the DCM model using the claims-based criteria. Determination of the appropriate pathway will be dependent upon evaluation of the patient's clinical status as well as financial and/or caregiver resources. An initial caregiver and/or resources evaluation must be performed within 60 days of identification of a patient with a dementia diagnosis to tier patients into the pathways.<sup>6</sup>

#### **Pathway 1: Beneficiaries with a Diagnosis of Dementia, Uncomplicated**

- ✓ Beneficiary is diagnosed with a form of dementia, as evidenced through Medicare FFS claims data within the past 12 months
- AND**
- ✓ Has 0-1 unplanned hospitalizations or visits to the emergency department (ED) within the past 12 months

#### **Pathway 2: Beneficiaries with Dementia and Enhanced Care Coordination Needs**

- ✓ Beneficiary is diagnosed with a form of dementia, as evidenced through Medicare FFS claims data within the past 12 months
- AND**
- ✓ One of the following:
  - Has 2 or more unplanned hospitalizations or visits to the emergency department (ED) within the past 12 months
  - OR**
  - Has a psychiatric hospitalization within the past 12 months
- AND**
- ✓ Has sufficient financial and/or caregiver resources

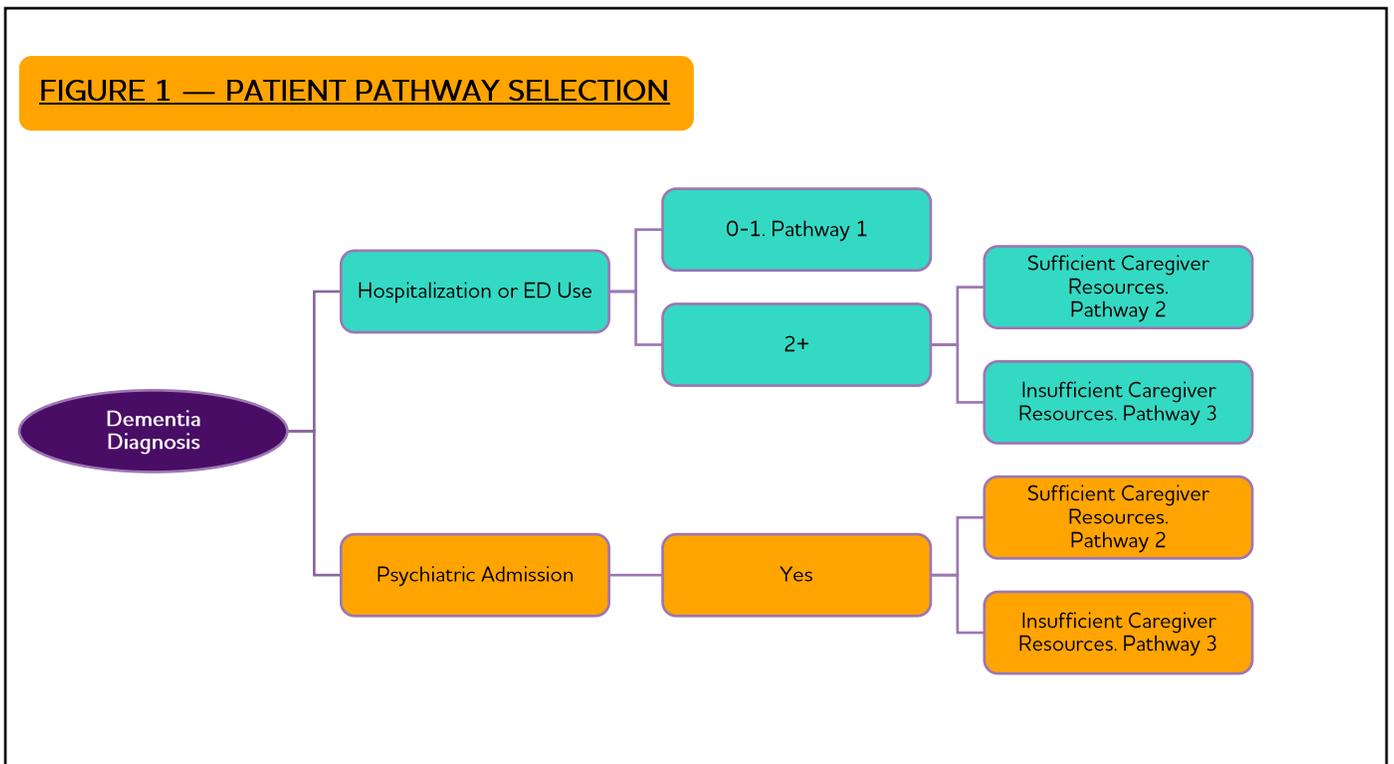
#### **Pathway 3: Beneficiaries with Dementia or Cognitive Impairment and Complex Care Needs**

- ✓ Beneficiary is diagnosed with dementia or cognitive impairment, as evidenced through Medicare FFS claims data within the past 12 months
- AND**

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<sup>6</sup> Determination of the patient's financial and/or caregiver resources would be determined using a recommended evaluation tool. The Association does not recommend a specific tool at this time and is developing an evaluation tool for consideration for inclusion in the model.

- ✓ One of the following:
  - Has 2 or more unplanned hospitalizations or visits to the emergency department (ED) within the past 12 months
  - OR**
  - Has a psychiatric hospitalization within the past 12 months
- AND**
- ✓ Has insufficient financial and/or caregiver resources



**Regular Patient Assessments for Appropriate Pathway**

Prior CMMI pilots have demonstrated that the DCM framework proposed here can reduce hospitalizations, emergency department visits, and nursing home placement, thus reducing overall costs. However, no DCM model can change the degenerative nature of dementia and the ultimate progression of the disease. While high-cost health events can be reduced with a well-run DCM model, eventually persons with dementia will need increased assistance with activities of daily living (ADLs), and their care will become more complicated. In addition, the capacity of a patient’s caregiver can change over time particularly if the primary caregiver is a spouse.

As a result, patients with dementia who are initially enrolled in Pathway 1 will be assessed annually and those who have increased ADLs will be transitioned to Pathway 2 or 3, depending on financial and caregiver resources, as outlined above. For those patients enrolled in Pathway 2 or 3, an annual reassessment of their caregiver resources will be undertaken to determine in which of the two Pathways they will be enrolled for the following year.

## Care Model Components

The DCM model would consist of the following key components:

- ✓ Development and continued modification, as necessary and appropriate, of a dementia care plan
  - To include: patient assessment including neuropsychiatric symptoms including behavior, physical safety and function; caregiver wellbeing assessment; advanced care planning; managing other comorbidities and acute care; financial resources and needs assessment
- ✓ Evidence-based medication management plan
  - To include: polypharmacy management; de-prescribing of medications with adverse cognitive effects; prescribing approved medications; ensuring medication adherence
- ✓ Evaluating patient financial and/or caregiver supports and resources
  - To include: caregiver education and training and support
- ✓ Care coordination and navigation services
  - To include: referrals to social and community-based services; collaborating with the primary care provider and team; supporting care transitions and continuity of care
- ✓ Environmental and behavioral safety and needs assessment
  - To include: assessment of patient home/environment to identify potential risks and harms as well as supports necessary for ADLs, may be done in-person or remotely (telephonically or electronically)

Given variations in complexity as well as patient and caregiver needs, the specific services will need to be tailored on an individual case-by-case basis. The services provided would not include palliative or hospice care, which would continue to be billed separately.

## Provider Payments

On average, based on the experience of existing programs, administering a dementia care management program costs \$500-\$1200 per patient per year, and this does not include initial start-up costs. With consideration of the additional start-up costs and investments, we propose the following reimbursement for patients in each of the following pathways.

- Pathway 1: \$175 per beneficiary per month (PBPM)
- Pathway 2: \$200 PBPM
- Pathway 3: \$225 PBPM

The amounts above would only be for the dementia care management services provided under the DCM model, including services currently provided under the Transitional Care and CCM codes, as well as CPT code 99483, Cognitive Assessment and Care Plan Services. Practices would continue to receive FFS reimbursement for other clinical services. There would also be a shared savings or quality bonus payment approach based on performance in certain quality measures as discussed in the following section.

## Quality Component

The DCM model would include a small, focused set of quality measures that reflect the unique clinical characteristics of a dementia care management program. The measure set proposed below for illustrative purposes includes two service use outcome measures (rates of ED and inpatient hospital use), three clinical process measures, and three survey-based caregiver outcome measures. The service use

measures could be calculated using Medicare claims data; the clinical process measures would be selected from those that are approved for use in the Medicare Quality Payment Program; and the caregiver outcomes measures could be gathered from short surveys.<sup>7</sup>

Quality Measures for Consideration <sup>8</sup>
<ul style="list-style-type: none"><li>• Emergency Department Utilization (Visits) Rate (NCQA/HEDIS)</li><li>• Inpatient Hospital Utilization (Discharges) Rate (NCQA/HEDIS)</li><li>• Documented Advanced Care Plan (NQF 0326)</li><li>• Medication Review (HEDIS)</li><li>• Falls: Screening for future fall risk (NQF 0101)</li><li>• Depression Screening for Caregiver</li><li>• Caregiver Stress Assessment</li><li>• Caregiver Assessment of Outcomes</li></ul>

Final specifications for each measure, including appropriate risk adjustment for measure benchmarks and performance, would need to be developed and mutually agreed upon by program participants and CMS. For performance measurement, the rates for inpatient hospital and ED use should be compared only with rates for a clinically, demographically, and geographically similar control group. The specifications of those measures should also include adjustment to the extent feasible to reflect care choices that are consistent with patient preferences, such as the use of advance directives.

Due to the complexity of factors affecting patients with dementia (e.g., comorbidities, financial resources, caregiver supports, socioeconomic status, etc.) we would recommend a quality bonus payment approach rather than a shared savings approach.

## Waivers and Beneficiary Enhancements

The innovations of the DCM model would be centered around the patient and caregiver supports that are essential for an effective dementia care management program. We propose initial waivers and beneficiary enhancements for consideration, building on those currently offered under the Next Generation Accountable Care Organization (ACO) model:

- ✓ Coordinated Care Reward or Gift Cards for patients who “successfully” participate in the program
- ✓ Cost-sharing support for beneficiaries
- ✓ Caregiver supports waiver
- ✓ Telehealth services waiver
- ✓ Payments and/or cost sharing support for community-based organization (CBO) non-medical services; for example, caregiving services, respite care, adult day care, counseling service, etc.

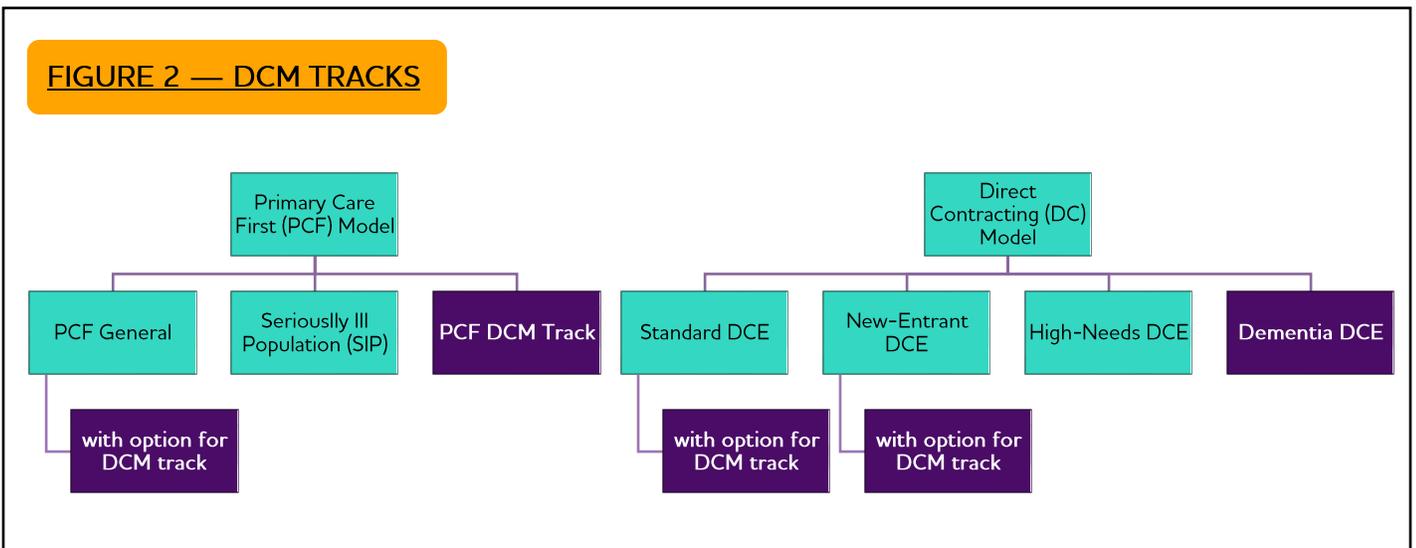
<sup>7</sup> For example, the model could use the quality of life and caregiver burden surveys used in the Care Ecosystem (see Possin, et al. “Effect of Collaborative Dementia Care via Telephone and Internet on Quality of Life, Caregiver Well-being, and Health Care Use: The Care Ecosystem Randomized Control Trial,” JAMA Intern Med 2019;179(12):1658-1667.) or those used in the UCLA ADC program (see Reuben DB, et al. “Patient and Caregiver Benefit From a Comprehensive Dementia Care Program: 1-Year Results From the UCLA Alzheimer’s and Dementia Care Program,” J Am Geriatr Soc. 2019;67(11);2267-2273.).

<sup>8</sup> Additional information on the Depression Screening for Caregivers measure is available here: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4552396/>; <https://link.springer.com/article/10.1046/j.1525-1497.2001.016009606.x>; and on the Caregiver Assessment of Outcomes measures is available here: <https://www.ncbi.nlm.nih.gov/pubmed/23244818>; <https://academic.oup.com/gerontologist/article/41/5/652/596578>.

## Integration with Existing APMs

The proposal outlined here is for a distinct new alternative payment model for dementia care management, nationally available and open to all practices. Alternatively, to encourage initial adoption and interest — or as a first step — the DCM APM could be developed as part of an existing CMMI model. Ideal models for consideration for this approach would be the Primary Care First (PCF) and Direct Contracting (DC) APMs. We believe the DCM model aligns with the goals of those programs and could seamlessly build on their existing framework.

**FIGURE 2 — DCM TRACKS**



### DCM Track Within Primary Care First (PCF) Model

Figure 2 illustrates two ways a DCM model could be integrated into the existing PCF model. It could be a stand-alone track solely for individuals with dementia. Or, patients with dementia enrolled in the General PCF model could be carved out to receive the additional services described in this proposal. The stand-alone track within the PCF model would essentially be the same as the DCM APM proposed here, except the underlying requirements of the PCF model for patient participation would also need to be met. For a carve-out within the existing model, we would recommend the following modifications to our proposal:

- ✓ *Lower capitated payment.* The efficiencies the practice would already have in place to participate in the overarching PCF model could lower the marginal costs of the patients with dementia. Thus, while practices would receive an additional payment for those in the DCM track on top of the underlying PCF payment — to accommodate the higher costs and increased level of services provided — it would not need to be as much as proposed above.
- ✓ *Retaining the PCF quality-based payment.* We would recommend including the dementia-specific quality measures proposed above. However, performance on the DCM quality measures would serve as a “gateway” for receiving the PCF quality payment. That is, practices would need to meet minimum performance thresholds for the dementia quality measures prior to being able to earn the quality-based payment under the overarching PCF model.

## DCM Track Within Direct Contracting (DC) Model

Figure 2 illustrates three ways a DCM model could be integrated into the DC APM: as a fourth type of Direct Contracting Entity (DCE) focusing solely on patients with dementia, or as a carve-out in Standard and/or New Entrant DCEs.

### Dementia DCE

For the stand-alone track, we would propose mimicking the High Needs DCE. The High Needs DCE eligibility requirements would need to be met, both for practices and patients, in addition to the dementia care management eligibility criteria proposed above. In addition, the beneficiary alignment thresholds of the High Needs DCE would apply. For this model, we would also recommend the following modifications to our DCM proposal:

- ✓ *Limiting participation to those in Pathways 2 and 3.* Because a High Needs DCE focuses on Medicare beneficiaries with the most complex care needs, patients with dementia who fall within Pathway 1 would not be eligible for enrollment in this model.
- ✓ *Use of Primary Care Capitation.* Rather than a per beneficiary per month capitated payment, we would propose using the Direct Contracting Model's Primary Care Capitation reimbursement methodology, with the following adjustments: (a) adding the following to the services included in the Primary Care Capitation: psychotherapy add-on services, cognitive assessment comprehensive care planning, and non-face-to-face prolonged services before or after direct face-to-face patient contact; and (b) increasing the payment from 7% of the estimated total cost of care to 9%-11% to ensure that the payment is sufficient to meet the needs of patients with dementia and that providers have the appropriate and necessary upfront cash flow.

### Dementia Carve-Out

For Standard and New Entrants DCEs, we would propose a dementia care management track for those entities that are interested in providing an extra focus on their patients with dementia. For this DCM carve-out, we would recommend the following changes to our proposal:

- ✓ *Limiting participation to those in Pathway 1.* These are the patients with dementia who, while still having a need for proper dementia care management, have the least complicated cases of dementia, which is more consistent with the overall patient population of Standard and New Entrant DCEs. However, we would propose that a DCE have at least 250 such patients in order to participate in the carve-out.
- ✓ *Use of Primary Care Capitation.* The capitated payment would be the same as outlined above for the stand-alone Dementia DCE. This means that Standard and New Entrant DCEs that opt for the Total Care Capitation would not be eligible to participate in the dementia carve-out.