PROPOSAL TO IMPROVE ACCESS FOR MEDICARE BENEFICIARIES WHO ARE LIVING WITH CHRONIC CONDITIONS

Introduction

Alzheimer's disease is a chronic, neurodegenerative condition that affects more than 5 million U.S. citizens over the age of 65. (1) These individuals are Medicare beneficiaries who need access to any and all treatments that are available to help minimize symptoms and suffering, while enabling optimal functioning throughout the course of the disease. Since Alzheimer's currently has no known cure, any intervention which can slow progression and minimize the expression of symptoms must be made accessible to all Medicare beneficiaries.

In 2010, the NIH presented its findings of all research for the previous decade that might have shed light on factors that increase or decrease the development of cognitive decline and Alzheimer's disease. Currently available pharmaceutical interventions were not found to be effective, with any statistical significance. The only factor that was found to be helpful, with a 'high degree of strength' in the science behind its study, was the non-pharmacologic intervention of **cognitive training**. (2)

On October 16, 2012, Attorneys from the Center for Medicare Advocacy, Vermont Legal Aid and the Centers for Medicare & Medicaid Services (CMS) agreed to settle the "Improvement Standard" case, *Jimmo v. Sebelius. [3]* CMS was ordered to revise the Medicare Benefit Policy Manual and other Medicare Manuals to correct all suggestions that Medicare coverage is dependent on a beneficiary "improving." New policy provisions will state that skilled nursing and **therapy services necessary to maintain a person's condition can be covered by Medicare**.

- As advocates, beneficiaries, and their families have long known, the Improvement Standard has harmed thousands of older and disabled Medicare beneficiaries who need skilled care to maintain their conditions. **Among those most affected are those with chronic conditions**. The effects of the Improvement Standard on beneficiaries with chronic conditions is underscored by the organizations that joined individual Medicare beneficiaries in challenging the Improvement

Standard in *Jimmo* -the National Multiple Sclerosis Society, Parkinson's Action Network, Paralyzed Veterans of America, the Alzheimer's Association, United Cerebral Palsy, and the National Committee to Preserve Social Security and Medicare. (3)

The Jimmo Settlement was said to "clarify Medicare's long-standing policy that when skilled services are required in order to provide care that is reasonable and necessary to prevent and slow further deterioration, coverage cannot be denied based on the absence of potential for improvement or restoration."

Cognitive Training and Treatment for Chronic Neurodegenerative Conditions

Cognitive training is currently a service that can be provided by psychologists, under the CPT code of 97532- Development of Cognitive Skills. In addition to the 2010 NIH report stating the effectiveness of cognitive training to reduce risk of cognitive decline, multiple other studies in recent years have validated the intervention's effectiveness to not only improve cognitive and independent function, but to 'prevent and slow further deterioration'. (4-22) In accordance with the guidelines of the CMS 'Jimmo Settlement', this intervention must be provided to Medicare beneficiaries who are suffering from a chronic neurocognitive condition. (23) In addition to the Public Health mandate to do so, the potential cost savings to Medicare would be dramatic.

However, due to the fact that LCD Manuals put forth by various Medicare Carriers (MAC's) offer confusing and often limiting language re the use of mental health professionals who can provide this service, the availability of treatment for older adults with Alzheimer's disease and other causes of dementia has been limited. Some of the history of confusing and discrepant guidance and language has been summarized in a document prepared by the Minnesota Hospital Association, entitled: "Direct Supervision of Outpatient Services". (24)

- Hospital outpatient therapeutic services have always been provided by licensed, skilled professionals under the overall direction of a physician and with the assurance of rapid assistance from a team of caregivers, including a physician, should an unforeseen event occur. While hospitals recognize **the need for direct supervision for certain outpatient services that pose high risk or are very complex**, [in some documents] CMS's policy [can be interpreted as applying] to even the lowest risk services. (24)

The direct supervision provision for outpatient settings was created to support physician extenders, by allowing the auxiliary staff working in the physician's office to personally perform certain services that were both integral and incidental to the care of the patient. **The supervision rule only had to do with availability during an emergency**. Over the years, we have seen many variations on the language (paraphrasing - "in the office suite and able to respond in case of an emergency", "in the office suite and able to respond within 3 minutes in case of an emergency"), etc.. But
such level of supervision had/has little to do with academic medical supervision or training, and in fact, the "emergency" language has almost entirely disappeared from the LCD's.
Cognitive rehabilitation should pose no physical risk to the patient and requires little oversight beyond establishment of the plan of care and periodic care plan oversight when provided by a qualified practitioner "incident to" the services of a clinical psychologist. General supervision, such as that required for other rehabilitation services (OT/PT, for instance) in "all other settings" (LCD 26884), is surely the appropriate level. We ask that CMS clarify this position.

Cost Savings to Medicare

If each older adult in need of treatment to improve cognitive function and stabilize and slow any further deterioration in function could receive said treatment, cost savings to the Medicare program would be quite significant.

For instance, the annual Medicare overall medical cost for ADRD (Alzheimer's disease and related dementia) patients is approximately $4,000 higher than for the average Medicare beneficiary who does not carry a diagnosis of cognitive impairment. (24, 25, 26) With more than 5+ million older adults in the U.S. carrying an Alzheimer's diagnosis (1), if all patients had access to treatment that is known to improve, stabilize and/or slow further deterioration, Medicare could see an annual savings of up to $20 billion.

Secondary cost savings

The 5+ million patients who suffer from ADRD are supported by approximately 15.7 million family and other unpaid caregivers. (1) One third of these individuals are themselves, over age 65, Medicare recipients, and reportedly present a burden of their own in an additional healthcare costs of $9,733 billion. (1)

When the costs of medical care for caregivers, lost wages, etc. are added in, the Alzheimer's Association reports that in 2015, Alzheimer's and other dementias will cost the nation $226 billion.

Also, without the ability to provide general v. direct supervision, significant cost to the provider is added just as the availability of a clinically effective service is threatened. Whether the cost is absorbed by the provider, passed through to the patient or included in the cost reporting of a facility, it increases the cost of healthcare to all consumers.

In sum: The ambiguous requirement for a physician to be present in order for healthcare providers who are licensed and trained to conduct cognitive training is a seriously limiting factor to access of treatment for the 5+ million Medicare beneficiaries who could benefit from non-pharmaceutical treatment for Alzheimer's and other forms of cognitive impairment. The result of this reduced access to appropriate medical care is: decreased independence and quality of life for millions of older adults; $ billions of lost Medicare dollars; and a profound impact on the emotional and physical health of caregivers, resulting in additional $ billions in Healthcare costs, at least 1/3 of which are Medicare dollars.

We propose that Medicare be directed to clarify the guidelines for supervision in the case of cognitive training to that of general supervision as a safe and adequate level of supervision for this particular intervention. Implementation of this directive would greatly improve accessibility of one of the only proven treatments to diminish symptomatology and improve the course and quality of life for the 5+ million U.S. Medicare beneficiaries suffering with Alzheimer's disease, and thus provide a necessary Public Health as well as economic benefit.

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