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An Alternative Payment Model To Support Widespread Use Of Collaborative Dementia Care Models

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ABSTRACT The current US system of reimbursement for dementia care does not support the complex biospychosocial needs of families living with Alzheimer disease and related dementias. We propose an alternative payment system for dementia care that would provide insurance coverage for evidence-based, collaborative dementia care models. This payment model involves a per member per month payment for care management services that would target community-dwelling beneficiaries living with dementia and evidence-based education and support programs for unpaid caregivers. This payment model has the potential to align the incentives of payers and providers and create market demand for the implementation of collaborative dementia care models across the nation.

Millions of Americans are living with Alzheimer disease and related dementias.[1,2] They experience complex cognitive, functional, behavioral, and psychological challenges. Care for these people is often provided by family members and other unpaid caregivers in a community setting.[2,3] The behavioral and psychological symptoms of Alzheimer disease and related dementias (referred to here as “Alzheimer disease”) can negatively affect the well-being of both patients and unpaid caregivers, in addition to being associated with adverse health outcomes.[4,5] Americans living with Alzheimer disease have higher use of emergency department and inpatient services,[4,6] with care costing up to $56,000 per year.[7] Unpaid caregivers can spend hundreds of hours per month caring for loved ones with Alzheimer disease,[2,3] which can be stressful and result in poorer health.[8,9]

Innovators have developed several collaborative dementia care models to support the biopsychosocial needs of people living with Alzheimer disease and reduce the stress of and burden on their unpaid caregivers. Randomized controlled trials and other demonstration projects confirm the effectiveness of these models for improving health outcomes and reducing caregiver burden.[10–17] Unfortunately, the US health care system has failed to implement these models,[18] in part because the current system of reimbursement does not adequately support their delivery. In this article we describe the limitations of the current reimbursement system and propose an alternative payment strategy that would align the incentives of payers and providers and lend support for the wide dissemination of collaborative dementia care models.

Background

MINIMUM SPECIFICATIONS FOR CARE MODELS

Multiple clinical trials and demonstration projects have shown that improvements in the care of people with Alzheimer disease could be achieved through care models involving education and counseling, care management and coordination, and personalized care plans that are monitored and modified as needed.[10–17,19] Employing the essential elements (exhibit 1), these models improve care, delay transitions from the home to

EXHIBIT 1

Essential elements of the proposed collaborative dementia care model

Element	Description
Continuous monitoring and assessment	Continuously monitor and assess cognitive, functional, behavioral, and psychological needs as well as the level of unpaid caregiver stress
Ongoing care plan	Develop and implement a care plan, including advance care planning, that is regularly evaluated and modified as needed
Psychosocial interventions	Implement interventions aimed at preventing or reducing the burden of cognitive, functional, behavioral, and psychological challenges as well as unpaid caregiver stress
Self-management	Provide self-management tools to enhance the skills of the patient and unpaid caregiver in managing Alzheimer disease and related dementias and navigating the health care system
Medication management	Employ evidence-based medication management, including deprescribing medications with adverse cognitive effects; includes efforts to increase medication adherence
Treatment of related conditions	Take steps to prevent and treat conditions related to Alzheimer disease and related dementias, such as depression and delirium
Coordination of care	Coordinate transitional and other health care services across hospitals, nursing homes, and ambulatory care and community-based settings

SOURCE Authors' interpretation of essential elements demonstrated in clinical trials and demonstration projects. See Boustani MA, et al. Implementing innovative models of dementia care (note 10 in text); Callahan CM, et al. Effectiveness of collaborative care for older adults with Alzheimer disease in primary care (note 11 in text); Callahan CM, et al. Implementing dementia care models in primary care settings (note 12 in text); Jennings LA, et al. Quality of care provided by a comprehensive dementia care comanagement program (note 13 in text); Possin KL, et al. Development of an adaptive, personalized, and scalable dementia care program (note 14 in text); Samus QM, et al. A multidimensional home-based care coordination intervention for elders with memory disorders (note 15 in text); Thyrian JR, et al. Effectiveness and safety of dementia care management in primary care (note 16 in text); Vickrey BG, et al. The effect of a disease management intervention on quality and outcomes of dementia care (note 17 in text); and Bass DM, et al. A controlled trial of Partners in Dementia Care (note 19 in text).

nursing homes for people living with Alzheimer disease,[15] and reduce the burden on their unpaid caregivers.[11,16,17]

LIMITATIONS OF CURRENT REIMBURSEMENT The current system of reimbursement fails to reimburse providers for certain types of services and discourages providers from delivering others. Providers may be unlikely to provide certain (nonbillable) services required by the evidence-based models, such as counseling and problem-solving coaching for unpaid caregivers. The current system also does not pay for those services when they are provided by community-based organizations. Traditional fee-for-service payments apply only to physicians, nurse practitioners, clinical nurse specialists, and physician assistants, but many of the services required by collaborative dementia care models are more effectively and efficiently delivered by nurses, social workers, and community health workers. Furthermore, recently added billing codes for chronic care management do not fully encompass the breadth of the services included in collaborative dementia care models or are available for reimbursement only if a service is provided by a certified professional. Also, the codes do not adequately compensate providers for the time needed to meet the needs of more complex Medicare beneficiaries. For example, Healthcare Common Procedure Coding System code G0505 (for cognition and functional assessment) and its replacement as of January 2018 (*Current Procedural Terminology* [CPT] code 99483) are limited in scope: They allow providers to be reimbursed for assessment and care plan creation, but not for ongoing care management services suggested by evidence-based models.

The chronic care management codes (CPT codes 99490, 99487, and 99489) are intended to address ongoing care and may encompass activities such as maintaining a care plan, managing care transitions, ensuring the receipt of preventive care, and engaging both the patient and their unpaid caregiver.[20] However, current reimbursement for chronic care management does not align with evidence-based dementia care models. Specialists in Alzheimer disease care are not in a position to create the comprehensive plan of care covering all health issues that is required for chronic care management services, and only one practitioner (who must be licensed and is usually the primary care physician) may be paid for chronic care management services in a given month.[20] The services required by collaborative dementia care models can be time intensive but might not meet the chronic care management definition of *complex*, thereby limiting reimbursement to a level not commensurate with the time and effort invested. Furthermore, the administrative burden associated with chronic care management codes is extensive, and costs to document and bill for services may exceed the reimbursement benefit.

Proposed Payment Model

OVERVIEW We recommend that the Centers for Medicare and Medicaid Services (CMS) restructure payment to meet the care needs of people living with Alzheimer disease and their unpaid caregivers. We believe that this can be achieved by implementing a per beneficiary per month payment for comprehensive dementia care management services targeting community-living beneficiaries with Alzheimer disease and their unpaid caregivers and including all of the essential elements of the collaborative dementia care models. Payment would be in addition to evaluation and management codes for nondementia medical services and would require an initial cognitive and functional assessment (CPT code 99483) before payment could begin. The new payment system would replace codes for transitional care, advance care planning, and chronic care management for beneficiaries receiving this new benefit.

PURPOSE AND OBJECTIVES The ultimate goal of this model is to improve the experience of care, health, and well-being of patients and their unpaid caregivers as a result of management of the cognitive, functional, behavioral, and psychological needs of people living with Alzheimer disease; prevention and management of caregiver burden; coordination of care transitions and services among providers and community resources, including home and community-based services; and advance care planning and shared decision making.

CARE DELIVERY FRAMEWORK Operationally, an eligible provider of care for Alzheimer disease could be any entity (for example, a health system, medical group, or accountable care organization) that demonstrates the ability to supply all of the necessary services, either by directly providing them or by purchasing them from community-based organizations. Linkages between health care systems and community-based resources are often informal and tenuous; the proposed framework aims to support this crucial link and help patients and unpaid caregivers navigate it. Additionally, this model would encourage the development and use of stand-alone community-based organizations by establishing a mechanism to compensate them for providing geographically convenient and culturally matched services. The care provider would conduct ongoing communication and education with the patient and their unpaid caregiver regarding coordination of the care plan and care options. Finally, the care provider would be held accountable for the quality of all services, whether provided directly or indirectly. To assess the quality of the care provided, process and outcome measures could be used. Examples of measures effectively used in previously implemented care programs[10,13] include the frequency of repeat acute care visits, the prevalence and severity of behavioral and psychological symptoms of Alzheimer disease, and the level of unpaid caregiver stress. Together with assessments of patients' and unpaid caregivers' satisfaction, these metrics would serve to demonstrate the success of the program implemented by the care provider.

REIMBURSABLE SERVICES To meet the requirements of the collaborative dementia care models, the following services would be reimbursed through the per beneficiary per month payment: the continuous assessment and monitoring of cognitive, functional, behavioral, and psychological symptoms of Alzheimer disease and associated unpaid caregiver stress, performed at least every four months in addition to an annual assessment (currently partially covered by CPT code 99483); the development, implementation, and continuous evaluation and modification of an Alzheimer disease care plan (and advance care planning), including patient- and unpaid caregiver–centered goals (currently partially covered by advance care planning, chronic care management, and evaluation and management codes); psychosocial interventions aimed at preventing or reducing the patient's symptoms and associated unpaid caregiver stress (not currently covered); training and support to enhance the unpaid caregiver's skills in managing the various limitations of their loved one living with Alzheimer disease, including education, problem-solving strategies, care navigation support, support after discharge from a hospital or nursing home, and decision-making support (not currently covered); medication management to reduce the burden of Alzheimer disease's cognitive, functional, behavioral, and psychological disabilities, including deprescribing of medications with adverse cognitive effects, prescribing medications approved by the Food and Drug Administration, and enhancing adherence to appropriate medications (currently partially covered by evaluation and management codes); the prevention and treatment of conditions related to Alzheimer disease, such as depression and delirium (currently partially covered by evaluation and management codes); and case management and coordination of services and supports among providers and community resources, including steps necessary to refer and connect patients to community-based organizations (for example, adult day care, homemaker services, volunteer services, and in-home respite care—many of which will also be covered under the new payment model through the care provider; currently partially covered by chronic care management codes), as well as after-hours access to a dementia care specialist who would be reimbursed for their time and services (not currently covered).

Treatment for chronic and acute conditions unrelated to Alzheimer disease would be reimbursed under the current payment system. The proposed new benefit would complement and facilitate—but not replicate—the care of other conditions.

The unpaid caregiver would receive covered support services regardless of their Medicare eligibility status. Providers of those services would be reimbursed as part of the benefit provided to the Medicare-eligible patient and would be billed as such. The services and support received by unpaid caregivers would ultimately translate into improved care for the patient with Alzheimer disease and thus would be appropriately reimbursed as part of the benefit. We envision that certain mental health–related services would be covered for unpaid caregivers, such as access to support groups and limited counseling. However, more intense psychiatric services (for example, ongoing psychotherapy and antidepressive medications) would not be covered, so as not to impose undue financial strain on the model.

ELIGIBILITY For beneficiaries and their unpaid caregivers to be eligible for this benefit, the person with Alzheimer disease would have to be enrolled in Medicare Parts A and B and could not be enrolled in a Medicare managed care plan (Part C). Furthermore, the patient must have a documented diagnosis of dementia. Eligible people would be either those with moderate to severe dementia (regardless of the level of stress that their unpaid caregiver experienced) or those with mild dementia whose unpaid caregiver had a high level of stress. This would ensure that only those in need of a heightened level of care management were included in the program. There exist numerous validated scales to stage the severity of Alzheimer disease and caregiver stress levels, including several currently employed by programs at Eskenazi Health in Indianapolis and at the University of California Los Angeles (UCLA)—such as the Mini-Mental Status Examination,[21] the Healthy Aging Brain Care Monitor,[22] and the Modified Caregiver Strain Index,[23] among others.[24,25] Eligibility would cease when a patient entered long-term nursing care, the Program of All-Inclusive Care for the Elderly, or hospice. Both the patient and the unpaid caregiver must agree to participate in the process to establish person-centered goals.

PAYMENT MODEL The payment model is grounded on three principles. First, the care provider should not be required to assume full risk for the patient: Payment for Alzheimer disease care services should supplement the existing fee-for-service structure. Second, the payment model should support the care provider's ability to determine the appropriate range of services and the appropriate amount, duration, and scope of the intervention necessary at any given time. Third, the structure of the payment model should minimize the administrative burden associated with documentation and reporting to ensure the quality of services without deterring care providers from participating in the program.

Therefore, we propose the following specifications for the payment model. First, reimbursement should be a fixed amount per beneficiary per month for providing services. Second, covered services should have no copayment or deductible. Third, covered services may be rendered by licensed or nonlicensed staff (the latter under the supervision of licensed staff), but all must be deemed competent in providing the collaborative dementia care models by the care provider, who must document the activities involved in providing and assessing such competency. Lastly, at least some portion of payment would be tied to performance on program-specific quality measures, in the mode of CMS's Merit-based Incentive Payment System. These measures would be process and outcomes based and would reflect multiple aspects of the program, including care quality, unpaid caregiver burden, and care coordination and management. The number and specifications of these measures would be developed in congruence with specialists in Alzheimer disease care.

Discussion

Although clinical trials have demonstrated the effectiveness of collaborative dementia care models, the current payment system cannot support the essential elements of the models. Therefore, the only solution is to develop an alternative payment model that would create a market demand for the collaborative dementia care models and incentivize providers to offer the services demonstrated to improve patient care and caregivers' well-being.

The impact that this model would have on Medicare costs is unknown. However, improvements in care coordination and efficiency, combined with the reduction in fee-for-service care use, could offset the additional cost of the per beneficiary per month payment. At Eskenazi Health, a collaborative dementia care model produced risk-adjusted cost savings per patient of $3,474 (53 percent of which came from reduced inpatient spending). After the cost of the program was accounted for, net cost savings were estimated to be $2,856 per patient.[26] At UCLA, a comprehensive dementia care comanagement program reduced per patient costs by an average of $2,404 per year, with an estimated net savings of $1,136 per patient per year.[27] Until details of the per beneficiary per month payment are finalized, it is impossible to forecast the model's precise financial impact.

Though creating market demand is essential to encourage the widespread adoption of collaborative dementia care models, others have accurately pointed out that the implementation of new care models faces challenges related to financial resources, space constraints, and resistance to change, to name a few.[12] We believe that a payment system that adequately reimburses providers for the necessary care and reflects evidence-based practices will address many of the usual barriers and incentivize providers and administrators to implement collaborative dementia care models.

The Department of Health and Human Services' Physician-Focused Payment Model Technical Advisory Committee has established criteria for evaluating alternative payment model proposals.[28] Exhibit 2 provides a list of the criteria with a description of how our model proposes to address them. In general, our model encourages value over volume, provides flexibility, encourages greater care coordination, and allows for patient (and unpaid caregiver) choice.

Currently, CMS is promoting the Comprehensive Primary Care Plus medical home model,[29] which seeks to improve primary care using a multipayer system to promote flexibility and innovation, as well as continuity of care and coordination. The Comprehensive Primary Care Plus model is available only in selected states, and its structure does not align with the essential elements of the collaborative dementia care models. Our proposed model is similar to Comprehensive Primary Care Plus in that it includes care management fees, fee-for-service reimbursement, and performance-based incentives. However, our proposal goes beyond the scope of Comprehensive Primary Care Plus by providing support for the unpaid caregivers.

Conclusion

Given the overwhelming evidence of the effectiveness of collaborative dementia care models, it is crucial to support their implementation through an appropriate payment system that ac-

EXHIBIT 2

Physician-Focused Payment Model Technical Advisory Committee criteria and aspects of the proposed collaborative dementia care model that address them

Criterion	Model aspect
Value over volume	Supports forgoing unnecessary (and frequently harmful) screening or treatment options and focuses on symptom management and the enhancement of quality of life, resulting in lower overall cost
Flexibility	Assesses patient or unpaid caregiver goals to create a personalized, comprehensive dementia care plan that is routinely reviewed and updated as needed
Quality and cost	Intended to improve health care quality for both patient and unpaid caregiver; may reduce inpatient and long-term nursing home costs
Payment methodology	Per beneficiary per month payment for comprehensive dementia care management services
Scope	Directly addresses several issues with current payment policies; expands upon the Comprehensive Primary Care Plus model
Ability to be evaluated	Several measures of patient experience of care, clinical outcomes, and cost
Integration and care coordination	Directly supports case management and coordination of care transitions and services, including home and community-based services
Patient choice	Involves patient- and unpaid caregiver–centered goals, shared decision making
Patient safety	Designed to encourage patient and unpaid caregiver to seek care and make it less likely that they will undergo unnecessary or harmful screenings or treatments to focus on symptom management and enhancement of quality of life; also intended to avoid using dangerous medications in dementia patients
Health information technology	Encourages use of case management software to enhance coordination and communication and to allow for personalization of care monitoring

SOURCE Authors' analysis of information from Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Physician-Focused Payment Model Technical Advisory Committee (note 27 in text); and of how the proposed collaborative dementia care model addresses each criterion.

knowledges the roles of unpaid caregivers and allows providers to coordinate and manage care for their patients living with Alzheimer disease and related dementias. We believe that the payment model proposed here would provide the needed support and ultimately lead to improved care and well-being of patients with Alzheimer disease and their unpaid caregivers. ■

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