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To: California Medicare-Medicaid Plans

From: California Contract Management Team

Subject: Cal MediConnect Support for Enrollees with Alzheimer's Disease and Related Dementias - INFORMATIONAL

This informational bulletin provides information about prevalence, cost, and quality of care for Medicare-Medicaid enrollees, and reminds plans of contractual requirements for care coordination staff in dementia care management. Educational information in the bulletin was provided by the Alzheimer's: Greater Los Angeles.

California's Population of Duals with Alzheimer's Disease and Related Disorders

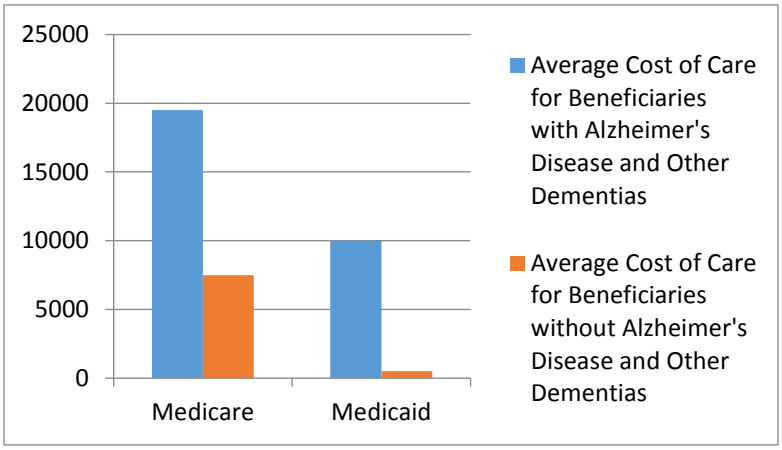
Alzheimer's disease currently afflicts 5.4 million Americans and over 600,000 Californians.[i] Prevalence estimates for those 65 years and older and dually eligible are 23%. Applying this prevalence to the CA Department of Health Care Services' estimate of dually-eligible Californians, Alzheimer's Greater Los Angeles estimates that almost 200,000 dual eligible beneficiaries in California, and 71,000 in Los Angeles county alone, have Alzheimer's disease or a related dementia.[ii] [iii] Hispanics and African Americans are one and a half to two times as likely to have Alzheimer's disease and other dementias.[iv] Alzheimer's and other dementias have enormous health and economic consequences for patients, their family caregivers, and society.

The California Contract Management Team wants to provide information on this population to the California Medicare-Medicaid Plans, draw attention to contractual language around dementia care, and plan for the March CMT plan calls focused on promising practices supporting this population.

Cost and Quality of Care

The costs of care for people with dementia are high for all payers, including Medicare, Medicaid, and private insurers.[v] [vi] [vii] [viii] [ix] [x] This is due, in part, to the fact that the presence of dementia significantly increases the likelihood for hospitalization and length of hospital stays, compared to people with the same serious medical conditions, but without dementia.[xi] Dementia is also an independent risk factor for nursing home admission in community-dwelling older adults, even when controlling for numerous co-morbidities.[xii] In addition, many people with dementia have multiple coexisting conditions: 60% have hypertension, 26% have coronary heart disease, 25% have stroke, and 23% have diabetes.[xiii] A recent study found that people with cognitive impairment and three additional chronic health conditions cost

Medicare an average of $50,000 per year.[xiv] As a result, beneficiaries with moderate to severe cognitive impairment, as shown in the chart below, cost Medicare three times more than other beneficiaries in the same age group; this difference is driven primarily by hospitalizations. They cost Medicaid 19 times more than other enrollees of the same age, largely due to nursing home utilization.[xv]



Complicating the picture for health plans is the fact that only 50% of people with a dementia receive a diagnosis, and only 50% of those people have that diagnosis recorded in the medical chart.[xvi]

All of these factors combine to mean:

- All plans serving older adults will have patients with dementia among their client population
- Many of these individuals will not enter the health plan's system with an accurate diagnosis, and therefore[xvii]:
    - They do not receive appropriate care for their cognitive symptoms
    - They do not receive appropriate care for their behavioral symptoms and may be prescribed non-preferred and potentially dangerous anti-psychotic medications
    - They do not manage their co-morbid chronic conditions well and may suffer undue burdens from these conditions
    - Their family/friend caregivers are not identified, assessed and supported so that they can maintain the patient in the preferred home and community settings

For these reasons, the CMT encourages plans to plan for and provide appropriate resources to support these enrollees. The CA MMPs are responsible for a wide range of services, supported by Medicare and Medicaid funding, and therefore Cal MediConnect offers plans the unique opportunity to meaningfully improve health outcomes and decrease costs for this population.

Contractual Requirements

CMS and DHCS recognized the high prevalence and impact of Alzheimer's and related dementias on the dually-eligible population, as well as the opportunities to improve care and control costs that an integrated care model offers. With that in mind, CMS and DHCS incorporated care coordination and

staffing requirements into the design of the Cal MediConnect demonstration. Section 2.10.10 of the three-way contract requires plans to include specially designated care coordination staff in dementia care management. These staff shall have expertise in understanding dementia symptoms and progression, understand and manage behaviors and communication challenges caused by dementia, provide supports to manage care giver stress, and coordinate community resources for both enrollees and caregivers. The CMT urges the MMPs to plan more broadly and work to ensure that all workforce are trained in dementia, have a basic level of knowledge of dementia, and understand the needs of both enrollees and caregivers. Given workforce turnover, it is important that plans provide regular dementia care training opportunities to ensure the care coordination workforce maintains skills in dementia care management.

The state provided additional guidance via DPL 13-002 to include dementia screening as one of the required health risk assessment components. Individuals with Alzheimer's disease are under-diagnosed and often do not receive appropriate post-diagnostic care. Plans must not assume that patient medical records will accurately and consistently identify the presence of a cognitive impairment. ICD 10 codes may only identify a quarter of members with Alzheimer's or related dementia.[xviii]

Several sections of the three-way contract identify plan responsibilities for identifying and engaging caregivers in care coordination, with the enrollee's consent, including in the health risk assessment (Section 2.8.2.2.2), development of the interdisciplinary care plan, and participation in the interdisciplinary care team (Section 2.5.1.8.2). DPL 13-002 further notes that plans must develop a process describing how the MCP will identify care needs in order to develop an individual care management and care coordination that includes the need for caregiver support and respite.

CMT Plan calls

The CMT will use the March CMT calls discuss each plans approach for designated care coordination in three areas:

- Workforce training and assignment to high risk enrollees
- Screening for dementia among enrollees
- Identifying and supporting caregivers

Additionally, please provide the CMT with written responses to the below questions by **Friday, March 24, 2017.**

1. Please describe your process for training designated staff in dementia care management (also called "dementia care specialists"). Please address the below questions:
    a. How many care coordinators are currently trained in dementia care management (both internal and vendor care coordination staff)?
    b. How often are staff members trained?
    c. Please describe your training materials. Do they include the following elements?
        - Does your training provide education on the understanding the major elements of dementia, along with its symptoms and progression?
        - Does your training provide education for care coordinator in how to manage behaviors and problems caused by dementia?

- Does your training provide education to alleviate caregiver stress from managing a family member with dementia?

d. If the training was conducted by a vendor, please provide a summary of the training, topics covered, duration, and if there were certifications given.

2. Please provide two case studies of your members with dementia care and how their conditions have been managed by a dementia trained care coordinator in the last year.
   - 250-500-word summary of case
   - HRA and ICP may be included
3. What community resources are you providing or directing your enrollees and caregivers to? When did you last update this list of resources?
4. Have you worked with the Alzheimer's Association or any other organizations regarding training or referrals?

Additional Resources

- The National Institute on Aging has posted online a searchable database of 116 instruments to detect cognitive impairment in older adults [https://www.nia.nih.gov/research/cognitive-instrument].
- The Alzheimer's Association also provides guidance and access to tools at www.alz.org/health-care-professionals/cognitive-tests-patient-assessment.
- The Gerontological Society of America Workgroup on Cognitive Impairment, Detection, and Earlier Diagnosis report provides guidance on both assessment tools and on the elements of a comprehensive assessment protocol within which these tools should be used. www.geron.org .
- Alzheimer's Greater Los Angeles has trained over 300 care managers in the Cal MediConnect health plans to use the AD8, a brief, validated, telephone questionnaire for cognitive screening. That tool can be found at: www.alzgla.org/professionals .
- Caregiver Assessment Resources can be found at:
  - Alzheimer's Greater Los Angeles: www.alzgla.org/professionals
  - The Rosalynn Carter Institute: www.rosalynncarter.org/caregiver_intervention_database
- Family Caregiver Education Resources can be found at:
  - Alzheimer's Greater Los Angeles: www.alzgla.org
  - The Rosalynn Carter Institute: www.rosalynncarter.org/caregiver_intervention_database
  - Administration on Community Living: www.acl.gov/Get_Help/Help_Caregivers/Index.aspx
  - Family Caregiver Alliance: www.caregiver.org/californias-caregiver-resource-centers
  - Alzheimer's Association: www.alz.org

PROMISING PROGRAMS

A recent study of Indiana University's *Aging Brain Care Program* demonstrates the potential of a dementia capable comprehensive case management program to dramatically alter both the individual's health outcomes and the financial impact of providing care to this population. Patients receiving comprehensive case management had an annual net cost savings of up to $2856 with 53% of those savings coming from reduced inpatient expenses.[xix]

These results are further substantiated by the ongoing *UCLA Alzheimer's and Dementia Care Program*. Again using a comprehensive case management model, the pilot project has achieved significant positive outcomes for patients and caregivers, including patients who exhibited fewer behavioral symptoms and caregivers who reported higher feelings of self-efficacy and lower rates of depression.[xx]

Within the Cal MediConnect Program, with funding from the U.S. Administration for Community Living, California's Department of Aging, Alzheimer's Greater Los Angeles and other Alzheimer's groups have designed and implemented a program to improve and better coordinate dementia care. The *Dementia Cal MediConnect Project* provides:

- Care manager training and support
- Caregiver education and respite care
- Support services through referrals to local Alzheimer's
- Technical assistance to create improved systems of care within the health plans

Program evaluation data from the UCSF Institute for Health and Aging suggests that this intervention is succeeding in achieving more dementia capable systems of care that are helping the health plans to improve screening for cognitive impairment, develop systems to identify, assess, and support family/friend caregivers, establish workflow processes for connecting families to a trained Dementia Care Specialist, and adopt a referral program so that families are connected to home and community-based services.[xxixxii]

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[i] 2016 Alzheimer's Disease Facts and Figures. *Alzheimer's & Dementia* (2016); 12(4):17, 20.

[ii] *Medi-Cal/Medicare Dual Eligibility by Age by County January 2013*. Research and Analytical Studies Branch; California Department of Health Care Services.

[iii] Beneficiaries Dually Eligible for Medicare and Medicaid Databook. *Medicare Payment Advisory Commission report*, (January 2015):35.

[iv] Ibid:19.

[v] Bharmal et al. Incremental Dementia-Related Expenditures in a Medicaid Population. *American Journal of Geriatric Psychiatry* (January 2012); 20(1):73-83.

[vi] Bynum J.P. et al. The Relationship Between a Dementia Diagnosis, Chronic Illness, Medical Expenditures, and Hospital Use. Journal of the American Geriatric Society (February 2004); 52(2):187-94.

[vii] Fortinsky, Fenster, & Judge. Medicare and Medicaid Home Health and Medicaid Waiver Services for Dually Eligible Older Adults: Risk Factors for Use and Correlates of Expenditures. The Gerontologist (2004) 44 (6):739-749.

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[ix] Langa K.M., Foster N.L., Larson E.B. Mixed Dementia: Emerging Concepts and Therapeutic Implications. Journal of the American Medical Association (2004); 292(23):2901-2908.

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[xi] Op Cit. Bynum J.P. et al. (February 2004).

[xii] Gaugler J.E., Duval S., Anderson K.A., Kane R.L. Predicting Nursing Home Admission in the U.S.: A Meta-analysis. BMC Geriatrics (2007); 7(13).

[xiii] Bynum J. P. Characteristics, Costs, and Health Service Use for Medicare Beneficiaries with a Dementia Diagnosis: Report 1. Dartmouth Institute for Health Policy and Clinical Care (2009).

[xiv] 2016 Alzheimer's Disease Facts and Figures. *Alzheimer's & Dementia* (2016); 12(4):45.

[xv] Arrighi H.M., Neumann P.J., Lieberburg I.M., Townsend R.J. Lethality of Alzheimer Disease and its Impact on Nursing Home Placement. *Alzheimer Disease and Associated Disorders* (2010); 24(1):90-5.

[xvi] Chodosh J., Petitti D. B., Elliott M., Hays R. D., Crooks V. C., Reuben D. B., Galen Buckwalter J. and Wenger N. Physician Recognition of Cognitive Impairment: Evaluating the Need for Improvement. *Journal of the American Geriatric Society* (July 2004); 52(7):1051-1059.

[xvii] Chodosh J, Pearson M.L., Connor K.I., et al. A Dementia Care Management Intervention: Which Components Improve Quality? *American Journal of Managed Care* (2012); 18:85–94.

[xviii]Chodosh, J., Petitti, D. B., Elliott, M., Hays, R. D., Crooks, V. C., Reuben, D. B., Galen Buckwalter, J. and Wenger, N. Physician Recognition of Cognitive Impairment: Evaluating the Need for Improvement. *Journal of the American Geriatric Society* (July 2004); 52(7):1051-1059.

[xix] Indiana University Aging Brain Care Program. Malaz Boustani. Presentation before NAPA Advisory Committee Meeting (August 2016).

[xx] The UCLA Alzheimer's and Dementia Care Program. Lee Jennings, Zaldy Tan, David Reuben. Presentation before NAPA Advisory Committee Meeting (August 2016).

[xxi] Hollister, B. and Chapman, S. Dementia Care Coordination Workforce and Practices in Seven Duals Demonstration States. San Francisco, CA: UCSF Health Workforce Research Center on Long-Term Care (2015).

[xxii] Resources for Integrated Care: *Applying Promising Practices To Advance Care Of Medicare-Medicaid Enrollees With Dementia* Webinar https://resourcesforintegratedcare.com/GeriatricCompetentCare/2017_GCC_Webinar_Series/Applying_Promising_Practices (February 2017)