The Role of Medicare's Annual Wellness Visit in the Assessment of Cognitive Health
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Dementia and mild cognitive impairment (MCI) are widely considered under-diagnosed, with some estimates suggesting that between 15 and 40% of dementia cases and an even higher share of MCI cases are undiagnosed (Taylor et al., 2009; Amjad et al., 2018). Clinical diagnosis often occurs late in the disease trajectory, hindering timely treatment of reversible causes of memory loss. Late diagnosis also complicates a patient's need to develop clear and consistent medical, legal, and financial plans.

Medicare payment policy for the routine assessment of cognitive impairment in the primary care setting is a potentially potent tool to improve early detection. As part of a new benefit created under the Affordable Care Act (ACA), Medicare now covers an Annual Wellness Visit (AWV) that requires, among other things, an assessment to detect cognitive impairment. Providers are given little guidance on how to do this assessment beyond "direct observation" and, if appropriate, a "brief validated structured cognitive assessment."[1] This assessment is just one of many required components of the AWV, which should include a health risk assessment, an enumeration of current providers and medications, a depression screening, more routine height and weight measurement, and so on. Importantly, providers bill Medicare for the visit as a whole and are not required to submit documentation of specific details of the visit.

Perhaps not surprisingly, anecdotal evidence suggests that many physicians do not follow the AWV structure. Providers are more inclined to discuss issues such as the management of high blood pressure or vaccinations at the expense of screening for memory loss or depression.[2] In addition, most providers, who are reimbursed on a fee-for-service basis and thus get paid irrespective of outcomes, do not face strong incentives to ensure follow-up testing is performed if a cognitive test reveals memory deficits.

A few recent studies have analyzed take-up of the AWV benefit (Ganguli et al. 2017), its relationship to use of preventive services and depression screening (Jensen et al. 2015; Pfoh et al. 2015), and its correlation with measures of cognitive care (Fowler et al. 2018; 2019 Alzheimer's Disease Facts and Figures Special Report on Detection in the Primary Care Setting). Yet, our understanding of whether the AWV has increased assessment for cognitive impairment in the Medicare population; how assessments get done; and what happens if someone shows signs of impaired cognition is extraordinarily limited. The proposed pilot will seed a broader project to fill in the gaps in our understanding of the AWV and the required cognitive assessment component of this visit. The specific aims of the broad project are to:

Aim 1: Characterize who gets a cognitive assessment in Medicare during an AWV

Aim 2: Determine why some beneficiaries get screened while others do not

Aim 3: Describe health care service use after a beneficiary screens positive for cognitive impairment

Aim 4. Develop and test a nudge to improve take-up and/or targeting of cognitive assessments to appropriate demographic groups

Aim 1 is the basis of the pilot while the full set of aims will constitute a 5-year R01 to be submitted to NIA. To achieve aim 1, we will bring together data from numerous sources: beneficiary reports, Medicare claims, and medical records. First, we will collect new data on whether current Medicare beneficiaries have received an AWV and, if so, whether the visit included a cognitive assessment such as a "word recall test" or a "backwards counting task." To capture this data, we will collaborate with a survey to be fielded in late spring (PI: Barcellos) in the Understanding Americans Study and YouGov about seniors' experience with Medicare. Second, using Medicare claims available at USC's Schaeffer Center, we will analyze recent data on Medicare provider billing for the AWV. Finally, we will develop a partnership with a health system to analyze their electronic health records (EHR) with the goal of describing the content of an AWV. We have leads at two systems (AltaMed, the largest independent Federally Qualified Health Center in the US, and Keck Medicine). The pilot funds will be used to cover RA time for the analysis of the datasets described above and for the development of a health system partnership.

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[1] See page 5 of this learning tools for providers https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AWV_Chart_ICN905706.pdf

[2] See testimony before the US Senate Special Committee on Aging https://www.aging.senate.gov/imo/media/doc/SCA_Ayati_01_24_18.pdf