

117TH CONGRESS
1ST SESSION

S. 1125

To recommend that the Center for Medicare and Medicaid Innovation test the effect of a dementia care management model, and for other purposes.

IN THE SENATE OF THE UNITED STATES

APRIL 14, 2021

Ms. STABENOW (for herself and Mrs. CAPITO) introduced the following bill;
which was read twice and referred to the Committee on Finance

A BILL

To recommend that the Center for Medicare and Medicaid Innovation test the effect of a dementia care management model, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Comprehensive Care
5 for Alzheimer’s Act”.

6 **SEC. 2. CMI TESTING OF DEMENTIA CARE MANAGEMENT.**

7 Section 1115A of the Social Security Act (42 U.S.C.
8 1315a) is amended—

9 (1) in subsection (b)(2)(B), by adding at the
10 end the following new clause:

1 “(xxviii) Furnishing comprehensive
 2 care management services to eligible indi-
 3 viduals with Alzheimer’s disease or a re-
 4 lated dementia through a Dementia Care
 5 Management Model, as described in sub-
 6 section (h).”; and

7 (2) by adding at the end the following new sub-
 8 section:

9 “(h) DEMENTIA CARE MANAGEMENT MODEL.—

10 “(1) DESCRIPTION OF MODEL AND REQUIRE-
 11 MENTS.—

12 “(A) IN GENERAL.—The Dementia Care
 13 Management Model described in this subsection
 14 is a model under which payments are made
 15 under title XVIII to eligible entities that fur-
 16 nish comprehensive care management services
 17 to eligible individuals with Alzheimer’s disease
 18 or a related dementia, in order to test the effec-
 19 tiveness of comprehensive care management
 20 services on patient health, care quality, and
 21 care experience, as well as on unpaid caregivers,
 22 and on reducing spending under title XVIII
 23 without reducing the quality of care.

24 “(B) VOLUNTARY PARTICIPATION.—Par-
 25 ticipation under the Dementia Care Manage-

ment Model shall be voluntary with respect to both eligible individuals and eligible entities.

“(C) IMPLEMENTATION OF DEMENTIA CARE MANAGEMENT MODEL.—

“(i) IN GENERAL.—The Secretary shall—

“(I) implement the Dementia Care Management Model as a stand-alone model;

“(II) incorporate the Dementia Care Management Model into the Primary Care First Model; or

“(III) incorporate the Dementia Care Management Model into—

“(aa) the Primary Care First Model; and

“(bb) the Direct Contracting Model.

“(ii) ADDITIONAL AUTHORITY.—In addition to the models described in subclauses (I) through (III) of clause (i), the Secretary may incorporate the Dementia Care Management Model into other existing coordinated care models established under title XVIII or under this section, in-

cluding accountable care organizations,
value-based purchasing arrangements, and
such other coordinated care models as the
Secretary determines to be appropriate.

“(2) COMPREHENSIVE CARE MANAGEMENT
SERVICES DEFINED.—In this subsection, the term
‘comprehensive care management services’ means
the following services furnished by an eligible entity
with respect to an eligible individual:

“(A) CONTINUOUS MONITORING AND AS-
SESSMENT.—An eligible entity shall regularly
assess and continuously monitor the following:

“(i) Neuropsychiatric symptoms, in-
cluding behavior, physical safety, and func-
tion of an eligible individual.

“(ii) Comorbidities.

“(iii) Financial resources and needs.

“(iv) Caregiver supports and re-
sources, including caregiver education,
training, and support.

“(v) The well-being of unpaid care-
givers of the eligible individual.

“(vi) Potential risks and harms of the
eligible individual’s home and environment

1 and the need for support for activities of
2 daily living.

3 “(B) ONGOING DEMENTIA CARE PLAN.—

4 An eligible entity shall develop and implement
5 an Alzheimer’s disease or related dementia care
6 plan, including advance care planning as appro-
7 priate, for an eligible individual. The care plan
8 shall include patient-centered goals for the eligi-
9 ble individual as well as goals for unpaid care-
10 givers of the eligible individual. Such care plan
11 shall be continuously evaluated and modified as
12 appropriate.

13 “(C) PSYCHOSOCIAL INTERVENTIONS.—An

14 eligible entity may implement psychosocial
15 interventions designed to prevent or reduce the
16 burden of cognitive, functional, behavioral, and
17 psychological challenges as well as the associ-
18 ated stress on unpaid caregivers of the eligible
19 individual.

20 “(D) SELF-MANAGEMENT TOOLS.—An eli-

21 gible entity shall provide self-management tools
22 to enhance the skills of the unpaid caregiver of
23 the eligible individual to manage the Alz-
24 heimer’s disease or related dementia of the eli-
25 gible individual and to navigate the health care

1 system. Such tools shall include training and
2 support for unpaid caregivers in managing the
3 limitations of eligible individuals, including edu-
4 cation, problem solving strategies, care naviga-
5 tion support, support after discharge from a
6 hospital or nursing home, and decision-making
7 support.

8 “(E) MEDICATION MANAGEMENT.—An eli-
9 gible entity shall furnish evidence-based medica-
10 tion review and management services to an eli-
11 gible individual, including polypharmacy man-
12 agement, using a planned process to reduce or
13 stop medications that may no longer be of ben-
14 efit or may be having adverse cognitive effects,
15 prescribing approved medications, and enhanc-
16 ing adherence to appropriate medications.

17 “(F) TREATMENT OF RELATED CONDI-
18 TIONS.—An eligible entity shall provide inter-
19 ventions to prevent or treat conditions related
20 to the Alzheimer’s disease or related dementia
21 of the eligible individual, such as depression
22 and delirium.

23 “(G) CARE COORDINATION.—An eligible
24 entity shall provide ongoing care management
25 services and shall coordinate services and sup-

1 ports among providers of services and suppliers,
2 as well as social and community resources.
3 Such services shall include necessary assistance
4 for referrals to social and community-based or-
5 ganizations, collaboration with primary care
6 providers and the interdisciplinary team of the
7 eligible individual, and support for care transi-
8 tions and continuity of care.

9 “(H) EXCLUSION OF PALLIATIVE CARE
10 AND HOSPICE CARE.—Comprehensive care man-
11 agement services shall not include palliative
12 care or hospice care.

13 “(I) OTHER SERVICES.—The Secretary
14 may require or permit other services, as appro-
15 priate.

16 “(3) ELIGIBLE ENTITY DEFINED.—In this sub-
17 section, the term ‘eligible entity’ means an entity,
18 such as a health system, hospital, physician or non-
19 physician group practice, multiple physician prac-
20 tices, a Federally qualified health center, a rural
21 health clinic, or an accountable care organization,
22 that—

23 “(A) is qualified to furnish comprehensive
24 care management services to an eligible indi-
25 vidual, and any unpaid caregiver of such eligible

1 individual, under the Dementia Care Manage-
2 ment Model either directly or through arrange-
3 ments with Medicare participating providers of
4 services and suppliers as well as social and com-
5 munity-based organizations;

6 “(B) is accountable for the quality of com-
7 prehensive care management services furnished
8 to an eligible individual under the model;

9 “(C) furnishes comprehensive care man-
10 agement services through an interdisciplinary
11 team that has at least 1 physician, physician
12 assistant, nurse practitioner, or advanced prac-
13 tice nurse who devotes 25 percent or more of
14 patient contact time to the evaluation and care
15 of patients with acquired cognitive impairment;

16 “(D) furnishes comprehensive care man-
17 agement services in a culturally appropriate
18 manner;

19 “(E) utilizes a comprehensive, person-cen-
20 tered care management approach;

21 “(F) furnishes wellness and healthcare
22 planning, including medication review and man-
23 agement;

24 “(G) supports family and caregiver engage-
25 ment;

1 “(H) provides access to a primary care
2 provider or a member of the interdisciplinary
3 team 24 hours a day 7 days a week;

4 “(I) has relationships with medical and
5 nonmedical community-based organizations that
6 support patients with Alzheimer’s disease or a
7 related dementia and their caregivers; and

8 “(J) meets such other requirements as the
9 Secretary may determine to be appropriate.

10 “(4) ELIGIBLE INDIVIDUAL DEFINED.—In this
11 subsection, the term ‘eligible individual’ means an
12 individual—

13 “(A) who—

14 “(i) is entitled to, or enrolled for, ben-
15 efits under part A of title XVIII and en-
16 rolled under part B of such title (including
17 such an individual who is a dual eligible in-
18 dividual described in subsection
19 (a)(4)(A)(iii)); and

20 “(ii) is not enrolled under part C of
21 such title or under a PACE program under
22 section 1894;

23 “(B) who has been diagnosed with a form
24 of dementia;

1 “(C) who has not made an election to re-
2 ceive hospice care; and

3 “(D) who is not a resident of a nursing
4 home.

5 “(5) PATIENT PATHWAYS.—

6 “(A) INITIAL PLACEMENT.—

7 “(i) PLACEMENT OF PATIENTS INTO
8 CARE PATHWAYS.—An eligible entity shall
9 assign an eligible individual to an appro-
10 priate pathway (as described in clauses
11 (ii), (iii), and (iv)) based on an assessment
12 of the clinical and financial status of the
13 eligible individual that is conducted not
14 later than 60 days after the eligible indi-
15 vidual is enrolled in the model.

16 “(ii) PATHWAY FOR UNCOMPLICATED
17 DEMENTIA DIAGNOSIS.—During the pre-
18 ceding 12-month period, the eligible indi-
19 vidual has not more than 1 unplanned in-
20 patient hospitalization or visit to a hospital
21 emergency department.

22 “(iii) PATHWAY FOR DEMENTIA DIAG-
23 NOSIS WITH ENHANCED CARE COORDINA-
24 TION NEEDS.—During the preceding 12-
25 month period, the eligible individual—

1 “(I)(aa) has 2 or more un-
 2 planned inpatient hospitalizations or
 3 visits to a hospital emergency depart-
 4 ment; or

5 “(bb) has a psychiatric hos-
 6 pitalization; and

7 “(II) has sufficient financial or
 8 caregiver resources (as determined by
 9 the Secretary).

10 “(iv) PATHWAY FOR DEMENTIA DIAG-
 11 NOSIS WITH COMPLEX CARE NEEDS.—Dur-
 12 ing the preceding 12-month period, the eli-
 13 gible individual—

14 “(I)(aa) has 2 or more un-
 15 planned inpatient hospitalizations or
 16 visits to a hospital emergency depart-
 17 ment; or

18 “(bb) has a psychiatric hos-
 19 pitalization; and

20 “(II) has insufficient financial or
 21 caregiver resources (as determined by
 22 the Secretary).

23 “(B) REGULAR PATIENT ASSESSMENTS
 24 FOR APPROPRIATE PATHWAY.—

1 “(i) IN GENERAL.—After determina-
 2 tion of the initial pathway, at a frequency
 3 to be determined by the Secretary, but not
 4 less than once per year, an eligible entity
 5 shall reassess the pathway determination
 6 of each eligible individual enrolled under
 7 the model.

8 “(ii) INCREASED ADL LIMITATIONS.—
 9 Each eligible individual enrolled in the
 10 pathway for uncomplicated dementia diag-
 11 nosis (as described in subparagraph
 12 (A)(ii)) who has had increased limitations
 13 in performing activities of daily living since
 14 the prior assessment shall be assigned to
 15 the pathway for dementia diagnosis with
 16 enhanced care coordination needs (as de-
 17 scribed in subparagraph (A)(iii)) or the
 18 pathway for dementia diagnosis with com-
 19 plex care needs (as described in subpara-
 20 graph (A)(iv)), depending on the eligible
 21 individual’s financial and caregiver re-
 22 sources applicable to each pathway.

23 “(iii) ENHANCED OR COMPLEX CARE
 24 NEEDS.—Each eligible individual enrolled
 25 in the pathway for dementia diagnosis with

enhanced care coordination needs (as described in subparagraph (A)(iii)) or the pathway for dementia diagnosis with complex care needs (as described in subparagraph (A)(iv)) shall be assigned to 1 of the 2 pathways based on the eligible individual's financial and caregiver resources applicable to each pathway.

“(6) QUALITY ASSESSMENT.—

“(A) IN GENERAL.—The Secretary shall specify appropriate measures to assess the quality of care furnished by an eligible entity under the Dementia Care Management Model. Such measures shall include, as appropriate, measures for clinical processes and outcomes, patient and caregiver experience of care, and utilization of services for which payment is made under the original medicare fee-for-service program under title XVIII, including measures for—

“(i) emergency department utilization;

“(ii) inpatient hospital utilization;

“(iii) documented advanced care plan;

“(iv) medication review;

“(v) screening for future fall risk;

1 “(vi) depression screening for care-
2 givers;

3 “(vii) caregiver stress assessment; and

4 “(viii) caregiver assessment of out-
5 comes.

6 “(B) REPORTING.—An eligible entity shall
7 submit data in a form and manner determined
8 by the Secretary on measures specified by the
9 Secretary.

10 “(C) PERFORMANCE ASSESSMENT.—In
11 order to assess the quality of care furnished by
12 an eligible entity under the model, the Sec-
13 retary shall establish—

14 “(i) quality performance standards;
15 and

16 “(ii) methodologies for quality per-
17 formance scoring and related payment ad-
18 justments.

19 “(D) STAKEHOLDER INPUT.—The Sec-
20 retary shall seek input from eligible entities on
21 final measure specifications, including appro-
22 priate adjustment for patient preferences.

23 “(7) PAYMENTS.—

24 “(A) IN GENERAL.—Under the Dementia
25 Care Management Model, the Secretary shall

1 establish payment amounts for care manage-
2 ment services furnished to eligible individuals,
3 including initial investment costs. Such
4 amounts shall reflect start-up costs and initial
5 investments incurred by an eligible entity in es-
6 tablishing the Dementia Care Management
7 Model.

8 “(B) CAPITATED BASIS.—Payments under
9 the Dementia Care Management Model shall be
10 made on a capitated basis, such as a per-mem-
11 ber, per-month payment, or such other similar
12 payment mechanisms that the Secretary deter-
13 mines to be appropriate. Payments shall vary
14 based on the assigned pathway of each patient
15 as described in paragraph (5).

16 “(C) QUALITY BONUS.—Under the Demen-
17 tia Care Management Model, additional pay-
18 ments shall be made to any eligible entity for
19 quality bonuses based on the performance of
20 the eligible entity in providing quality care (as
21 determined under paragraph (6)).

22 “(D) ZERO COST-SHARING.—An eligible in-
23 dividual shall not be liable for any cost-sharing,
24 including deductibles, coinsurance, or copay-
25 ments, for care management services for de-

1 mentia care furnished to such eligible individual
2 under the model.

3 “(E) SUPPLEMENTAL TO PAYMENTS FOR
4 COVERED SERVICES.—Payments made under
5 the model shall be in addition to any payments
6 for items or services not provided under the
7 model for which payment may be made under
8 title XVIII for services furnished to such eligi-
9 ble individuals.

10 “(F) NONDUPLICATION.—Payments for
11 care management services furnished to eligible
12 individuals under the Dementia Care Manage-
13 ment Model may not duplicate payments for
14 services furnished to such eligible individuals
15 for which payments are made under the original
16 medicare fee-for-service program under title
17 XVIII.

18 “(8) WAIVERS.—The Secretary shall waive pro-
19 visions of this title, and title XVIII, to permit an eli-
20 gible entity operating a Dementia Care Management
21 Model to provide the following:

22 “(A) BENEFICIARY REWARDS.—Gift cards
23 or other rewards for patients who successfully
24 participate in the program (as determined by
25 the Secretary).

1 “(B) CAREGIVERS.—Supports for care-
2 givers.

3 “(C) TELEHEALTH.—Telehealth services
4 without regard to geographic or other origi-
5 nating site limitations under section 1834(m).

6 “(D) SERVICES FROM COMMUNITY ORGA-
7 NIZATIONS.—Payments, cost-sharing support,
8 or both, for nonmedical services furnished by
9 community-based organizations, such as limited
10 caregiving services, respite care, adult day care
11 counseling services, and such other services as
12 the Secretary determines to be appropriate.

13 “(9) MODIFICATIONS FOR APPLICATION IN THE
14 PRIMARY CARE FIRST AND DIRECT CONTRACTING
15 MODELS.—

16 “(A) IN GENERAL.—Except as provided
17 under subparagraph (B), if the Secretary elects
18 to incorporate the Dementia Care Management
19 Model into the Primary Care First Model, the
20 Direct Contracting Model, or both, as provided
21 for under paragraph (1)(C)(i), the Secretary
22 shall maintain the requirements of this sub-
23 section.

24 “(B) PERMISSIBLE MODIFICATIONS.—The
25 Secretary may adjust the requirements of this

subsection to the extent necessary to ensure consistency of the Dementia Care Management Model with the Primary Care First Model, the Direct Contracting Model, or both, with respect to—

“(i) any eligible entity, including beneficiary alignment thresholds;

“(ii) any eligible individual;

“(iii) capitated payments; and

“(iv) quality-bonus payments.

“(C) CONSULTATION WITH STAKEHOLDERS.—Prior to making any adjustment under subparagraph (B), the Secretary shall consult with appropriate stakeholders and patient advocacy organizations.

“(10) OUTREACH TO UNDERREPRESENTED MINORITY POPULATIONS.—An eligible entity shall carry out public outreach and education efforts, including the dissemination of information, for members of underrepresented minority populations regarding participation in the Dementia Care Management Model to ensure diversity in the patient population of such model.

“(11) OPTION TO EXPAND TO MEDICAID.—The Secretary may design a model under which pay-

1 ments are made under title XIX, in a similar man-
2 ner to the manner in which payments are made
3 under title XVIII under the Dementia Care Manage-
4 ment Model described in this subsection, to eligible
5 entities that furnish comprehensive care manage-
6 ment services to individuals who are eligible for med-
7 ical assistance under a State plan under title XIX
8 (or a waiver of such a plan) with Alzheimer’s disease
9 or a related dementia, in order to test the effective-
10 ness of comprehensive care management services on
11 patient health, care quality, and care experience, as
12 well as on unpaid caregivers, and on reducing spend-
13 ing under title XIX without reducing the quality of
14 care.”.

○