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117TH CONGRESS
1ST SESSION

H. R. 2517

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 HOUSE OF REPRESENTATIVES

APRIL 14, 2021

Mr. HIGGINS of New York (for himself, Mr. LAHOOD, Mr. TONKO, and Mr. GUTHRIE) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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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.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Comprehensive Care for Alzheimer's Act''.

SEC. 2. CMI TESTING OF DEMENTIA CARE MANAGEMENT.

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

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

"(xxviii) Furnishing comprehensive care management services to eligible individuals with Alzheimer's disease or a related dementia through a Dementia Care Management Model, as described in subsection (h).''; and

(2) by adding at the end the following new subsection:

''(h) DEMENTIA CARE MANAGEMENT MODEL.—

''(1) DESCRIPTION OF MODEL AND REQUIREMENTS.—

''(A) IN GENERAL.—The Dementia Care Management Model described in this subsection is a model under which payments are made under title XVIII to eligible entities that furnish comprehensive care management services to eligible individuals with Alzheimer's disease or a related dementia, in order to test the effectiveness of comprehensive care management services on patient health, care quality, and care experience, as well as on unpaid caregivers, and on reducing spending under title XVIII without reducing the quality of care.

"(B) VOLUNTARY PARTICIPATION.—Participation under the Dementia Care Management 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 standalone 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 exist-

ing coordinated care models established under title XVIII or under this section, including 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 ASSESSMENT.—An eligible entity shall regularly assess and continuously monitor the following:

"(i) Neuropsychiatric symptoms, including behavior, physical safety, and function of an eligible individual.

"(ii) Comorbidities.

"(iii) Financial resources and needs.

"(iv) Caregiver supports and resources, including caregiver education, training, and support.

"(v) The well-being of unpaid caregivers of the eligible individual.

"(vi) Potential risks and harms of the eligible individual's home and environment and the need for support for activities of daily living.

"(B) ONGOING DEMENTIA CARE PLAN.—An eligible entity shall develop and implement an Alzheimer's disease or related dementia care plan, including advance care planning as appropriate, for an eligible individual. The care plan shall include patient-centered goals for the eligible individual as well as goals for unpaid caregivers of the eligible individual. Such care plan shall be continuously evaluated and modified as appropriate.

"(C) PSYCHOSOCIAL INTERVENTIONS.—An eligible entity may implement psychosocial interventions designed to prevent or reduce the burden of cognitive, functional, behavioral, and psychological challenges as well as the associated stress on unpaid caregivers of the eligible individual.

"(D) SELF-MANAGEMENT TOOLS.—An eligible entity shall provide self-management tools to enhance the skills of the unpaid caregiver of the eligible individual to manage the Alz-

heimer's disease or related dementia of the eligible individual and to navigate the health care system. Such tools shall include training and support for unpaid caregivers in managing the limitations of eligible individuals, including education, problem solving strategies, care navigation support, support after discharge from a hospital or nursing home, and decision-making support.

''(E) MEDICATION MANAGEMENT.—An eligible entity shall furnish evidence-based medication review and management services to an eligible individual, including polypharmacy management, using a planned process to reduce or stop medications that may no longer be of benefit or may be having adverse cognitive effects, prescribing approved medications, and enhancing adherence to appropriate medications.

''(F) TREATMENT OF RELATED CONDITIONS.—An eligible entity shall provide interventions to prevent or treat conditions related to the Alzheimer's disease or related dementia of the eligible individual, such as depression and delirium.

"(G) CARE COORDINATION.—An eligible entity shall provide ongoing care management services and shall coordinate services and supports among providers of services and suppliers, as well as social and community resources. Such services shall include necessary assistance for referrals to social and community-based organizations, collaboration with primary care providers and the interdisciplinary team of the eligible individual, and support for care transitions and continuity of care.

"(H) EXCLUSION OF PALLIATIVE CARE AND HOSPICE CARE.—Comprehensive care management services shall not include palliative care or hospice care.

"(I) OTHER SERVICES.—The Secretary may require or permit other services, as appropriate.

"(3) ELIGIBLE ENTITY DEFINED.—In this subsection, the term 'eligible entity' means an entity, such as a health system, hospital, physician or non-physician group practice, multiple physician practices, a Federally qualified health center, a rural health clinic, or an accountable care organization, that—

''(A) is qualified to furnish comprehensive care management services to an eligible individual, and any unpaid caregiver of such eligible individual, under the Dementia Care Management Model either directly or through arrangements with Medicare participating providers of services and suppliers as well as social and community-based organizations;

''(B) is accountable for the quality of comprehensive care management services furnished to an eligible individual under the model;

''(C) furnishes comprehensive care management services through an interdisciplinary team that has at least 1 physician, physician assistant, nurse practitioner, or advanced practice nurse who devotes 25 percent or more of patient contact time to the evaluation and care of patients with acquired cognitive impairment;

''(D) furnishes comprehensive care management services in a culturally appropriate manner;

''(E) utilizes a comprehensive, person-centered care management approach;

"(F) furnishes wellness and healthcare planning, including medication review and management;

"(G) supports family and caregiver engagement;

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

"(I) has relationships with medical and nonmedical community-based organizations that support patients with Alzheimer's disease or a related dementia and their caregivers; and

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

"(4) ELIGIBLE INDIVIDUAL DEFINED.—In this subsection, the term 'eligible individual' means an individual—

"(A) who—

"(i) is entitled to, or enrolled for, benefits under part A of title XVIII and enrolled under part B of such title (including such an individual who is a dual eligible individual described in subsection (a)(4)(A)(iii)); and

"(ii) is not enrolled under part C of such title or under a PACE program under section 1894;

"(B) who has been diagnosed with a form of dementia;

"(C) who has not made an election to receive hospice care; and

"(D) who is not a resident of a nursing home.

"(5) PATIENT PATHWAYS.—

"(A) INITIAL PLACEMENT.—

"(i) PLACEMENT OF PATIENTS INTO CARE PATHWAYS.—An eligible entity shall assign an eligible individual to an appropriate pathway (as described in clauses (ii), (iii), and (iv)) based on an assessment of the clinical and financial status of the eligible individual that is conducted not later than 60 days after the eligible individual is enrolled in the model.

"(ii) PATHWAY FOR UNCOMPLICATED DEMENTIA DIAGNOSIS.—During the preceding 12-month period, the eligible individual has not more than 1 unplanned in-

patient hospitalization or visit to a hospital emergency department.

"(iii) PATHWAY FOR DEMENTIA DIAGNOSIS WITH ENHANCED CARE COORDINATION NEEDS.—During the preceding 12-month period, the eligible individual—

"(I)(aa) has 2 or more unplanned inpatient hospitalizations or visits to a hospital emergency department; or

"(bb) has a psychiatric hospitalization; and

"(II) has sufficient financial or caregiver resources (as determined by the Secretary).

"(iv) PATHWAY FOR DEMENTIA DIAGNOSIS WITH COMPLEX CARE NEEDS.—During the preceding 12-month period, the eligible individual—

"(I)(aa) has 2 or more unplanned inpatient hospitalizations or visits to a hospital emergency department; or

"(bb) has a psychiatric hospitalization; and

''(II) has insufficient financial or caregiver resources (as determined by the Secretary).

''(B) REGULAR PATIENT ASSESSMENTS FOR APPROPRIATE PATHWAY.—

''(i) IN GENERAL.—After determination of the initial pathway, at a frequency to be determined by the Secretary, but not less than once per year, an eligible entity shall reassess the pathway determination of each eligible individual enrolled under the model.

''(ii) INCREASED ADL LIMITATIONS.—Each eligible individual enrolled in the pathway for uncomplicated dementia diagnosis (as described in subparagraph (A)(ii)) who has had increased limitations in performing activities of daily living since the prior assessment shall be assigned to 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)), depending on the eligible

individual's financial and caregiver resources applicable to each pathway.

''(iii) ENHANCED OR COMPLEX CARE NEEDS.—Each eligible individual enrolled 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;

"(vi) depression screening for caregivers;

"(vii) caregiver stress assessment; and

"(viii) caregiver assessment of outcomes.

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

"(C) PERFORMANCE ASSESSMENT.—In order to assess the quality of care furnished by an eligible entity under the model, the Secretary shall establish—

"(i) quality performance standards; and

"(ii) methodologies for quality performance scoring and related payment adjustments.

"(D) STAKEHOLDER INPUT.—The Secretary shall seek input from eligible entities on

final measure specifications, including appropriate adjustment for patient preferences.

''(7) PAYMENTS.—

''(A) IN GENERAL.—Under the Dementia Care Management Model, the Secretary shall establish payment amounts for care management services furnished to eligible individuals, including initial investment costs. Such amounts shall reflect start-up costs and initial investments incurred by an eligible entity in establishing the Dementia Care Management Model.

''(B) CAPITATED BASIS.—Payments under the Dementia Care Management Model shall be made on a capitated basis, such as a per-member, per-month payment, or such other similar payment mechanisms that the Secretary determines to be appropriate. Payments shall vary based on the assigned pathway of each patient as described in paragraph (5).

''(C) QUALITY BONUS.—Under the Dementia Care Management Model, additional payments shall be made to any eligible entity for quality bonuses based on the performance of

the eligible entity in providing quality care (as determined under paragraph (6)).

''(D) ZERO COST-SHARING.—An eligible individual shall not be liable for any cost-sharing, including deductibles, coinsurance, or copayments, for care management services for dementia care furnished to such eligible individual under the model.

''(E) SUPPLEMENTAL TO PAYMENTS FOR COVERED SERVICES.—Payments made under the model shall be in addition to any payments for items or services not provided under the model for which payment may be made under title XVIII for services furnished to such eligible individuals.

''(F) NONDUPLICATION.—Payments for care management services furnished to eligible individuals under the Dementia Care Management Model may not duplicate payments for services furnished to such eligible individuals for which payments are made under the original medicare fee-for-service program under title XVIII.

''(8) WAIVERS.—The Secretary shall waive provisions of this title, and title XVIII, to permit an eli-

gible entity operating a Dementia Care Management Model to provide the following:

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

"(B) CAREGIVERS.—Supports for caregivers.

"(C) TELEHEALTH.—Telehealth services without regard to geographic or other originating site limitations under section 1834(m).

"(D) SERVICES FROM COMMUNITY ORGANIZATIONS.—Payments, cost-sharing support, or both, for nonmedical services furnished by community-based organizations, such as limited caregiving services, respite care, adult day care counseling services, and such other services as the Secretary determines to be appropriate.

"(9) MODIFICATIONS FOR APPLICATION IN THE PRIMARY CARE FIRST AND DIRECT CONTRACTING MODELS.—

"(A) IN GENERAL.—Except as provided under subparagraph (B), if the Secretary elects to incorporate the Dementia Care Management Model into the Primary Care First Model, the

Direct Contracting Model, or both, as provided for under paragraph (1)(C)(i), the Secretary shall maintain the requirements of this subsection.

''(B) PERMISSIBLE MODIFICATIONS.—The 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 mem-

bers 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 payments are made under title XIX, in a similar manner to the manner in which payments are made under title XVIII under the Dementia Care Management Model described in this subsection, to eligible entities that furnish comprehensive care management services to individuals who are eligible for medical assistance under a State plan under title XIX (or a waiver of such a plan) with Alzheimer's disease or a related dementia, in order to test the effectiveness of comprehensive care management services on patient health, care quality, and care experience, as well as on unpaid caregivers, and on reducing spending under title XIX without reducing the quality of care.''.

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