

117TH CONGRESS
1ST SESSION

S. 1692

To provide better care and outcomes for Americans living with Alzheimer’s disease and related dementias and their caregivers, while accelerating progress toward prevention strategies, disease modifying treatments, and, ultimately, a cure.

IN THE SENATE OF THE UNITED STATES

MAY 19, 2021

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

A BILL

To provide better care and outcomes for Americans living with Alzheimer’s disease and related dementias and their caregivers, while accelerating progress toward prevention strategies, disease modifying treatments, and, ultimately, a cure.

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; TABLE OF CONTENTS; FINDINGS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Concentrating on High-Value Alzheimer’s Needs to Get
6 to an End (CHANGE) Act of 2021”.

1 (b) TABLE OF CONTENTS.—The table of contents for
2 this Act is as follows:

Sec. 1. Short title; table of contents; findings.

Sec. 2. Cognitive impairment detection benefit in the Medicare annual wellness visit and initial preventive physical examination.

Sec. 3. Medicare quality payment program.

Sec. 4. Report to congress on implementation.

3 (c) FINDINGS.—Congress finds the following:

4 (1) It is estimated that 6,200,000 Americans
5 age 65 and older are living with Alzheimer’s disease
6 in 2021. More than 1 in 9 people age 65 and older
7 has Alzheimer’s. By 2050, the number of Americans
8 age 65 and older with Alzheimer’s dementia is pro-
9 jected to reach 12,700,000.

10 (2) Alzheimer’s disease disproportionately im-
11 pacts women and people of color.

12 (3) Almost two-thirds of Americans with Alz-
13 heimer’s disease are women.

14 (4) According to the Centers for Disease Con-
15 trol and Prevention, among people ages 65 and
16 older, African Americans have the highest prevalence
17 of Alzheimer’s disease and related dementias (13.8
18 percent), followed by Hispanics (12.2 percent), and
19 non-Hispanic Whites (10.3 percent), American In-
20 dian and Alaska Natives (9.1 percent), and Asian
21 and Pacific Islanders (8.4 percent). This higher
22 prevalence translates into a higher death rate—Alz-
23 heimer’s deaths increased 55 percent among all

1 Americans between 1999 and 2014, while the num-
2 ber was 107 percent for Latinos and 99 percent for
3 African Americans.

4 (5) Currently available data shows that about
5 half of individuals age 65 and older with mild cog-
6 nitive impairment (MCI)—roughly 5,000,000 Ameri-
7 cans—have MCI due to Alzheimer’s disease. Ap-
8 proximately 15 percent of individuals with MCI de-
9 velop dementia after 2 years and 32 percent develop
10 Alzheimer’s dementia within 5 years’ follow-up.

11 (6) Addressing modifiable risk factors such as
12 physical activity, smoking, education, staying socially
13 and mentally active, blood pressure, and diet might
14 prevent or delay up to 40 percent of dementia cases.

15 (7) An early, documented diagnosis, commu-
16 nicated to the patient and caregiver, enables early
17 access to care planning services and available med-
18 ical and nonmedical treatments, and optimizes pa-
19 tients’ ability to build a care team, participate in
20 support services, and enroll in clinical trials.

21 (8) Alzheimer’s exacts an emotional and phys-
22 ical toll on caregivers, resulting in higher incidence
23 of heart disease, cancer, depression, and other health
24 consequences.

1 (9) More than 11,000,000 Americans provide
 2 unpaid care for people with Alzheimer’s or other de-
 3 mentia and provided nearly \$257,000,000,000 in un-
 4 paid care to people living with Alzheimer’s and other
 5 dementias in 2020.

6 (10) In 2021, it is estimated that Alzheimer’s
 7 and related dementias will have cost Medicare and
 8 Medicaid programs \$239,000,000,000. By 2050, it
 9 is estimated that these direct costs will increase to
 10 as much as \$1,100,000,000,000.

11 **SEC. 2. COGNITIVE IMPAIRMENT DETECTION BENEFIT IN**
 12 **THE MEDICARE ANNUAL WELLNESS VISIT**
 13 **AND INITIAL PREVENTIVE PHYSICAL EXAM-**
 14 **INATION.**

15 (a) ANNUAL WELLNESS VISIT.—

16 (1) IN GENERAL.—Section 1861(hhh)(2) of the
 17 Social Security Act (42 U.S.C. 1395x(hhh)(2)) is
 18 amended—

19 (A) by striking subparagraph (D) and in-
 20 serting the following:

21 “(D) Detection of any cognitive impairment or
 22 progression of cognitive impairment that shall—

23 “(i) be performed using a cognitive impairment
 24 detection tool identified by the National Institute on
 25 Aging as meeting its criteria for selecting instru-

1 ments to detect cognitive impairment in the primary
2 care setting, and other validated cognitive detection
3 tools as the Secretary determines;

4 “(ii) include documentation of the tool used for
5 detecting cognitive impairment and results of the as-
6 sessment in the medical record of the patient; and

7 “(iii) take into consideration the tool used, and
8 results of, any previously performed cognitive im-
9 pairment detection assessment.”;

10 (B) by moving subparagraphs (G) and (H)

11 two ems to the left;

12 (C) by redesignating subparagraph (I) as

13 subparagraph (J); and

14 (D) by inserting after subparagraph (H)

15 the following new subparagraph:

16 “(I) Referral of patients with detected cognitive
17 impairment or potential cognitive decline to—

18 “(i) appropriate Alzheimer’s disease and
19 dementia diagnostic services, including amyloid
20 positron emission tomography, and other medi-
21 cally accepted diagnostic tests that the Sec-
22 retary determines are safe and effective;

23 “(ii) specialists and other clinicians with
24 expertise in diagnosing or treating Alzheimer’s
25 disease and related dementias;

1 “(iii) available community-based services,
 2 including patient and caregiver counseling and
 3 social support services; and

4 “(iv) appropriate clinical trials.”.

5 (2) EFFECTIVE DATE.—The amendments made
 6 by paragraph (1) shall apply to annual wellness vis-
 7 its furnished on or after January 1, 2022.

8 (b) INITIAL PREVENTIVE PHYSICAL EXAMINA-
 9 TION.—

10 (1) IN GENERAL.—Section 1861(ww)(1) of the
 11 Social Security Act (42 U.S.C. 1395x(ww)(1)) is
 12 amended by inserting “detection of any cognitive im-
 13 pairment or progression of cognitive impairment as
 14 described in subparagraph (D) of subsection
 15 (hhh)(2) and referrals as described in subparagraph
 16 (I) of such subsection,” after “upon the agreement
 17 with the individual,”.

18 (2) EFFECTIVE DATE.—The amendments made
 19 by paragraph (1) shall apply to initial preventive
 20 physical examinations furnished on or after January
 21 1, 2022.

22 **SEC. 3. MEDICARE QUALITY PAYMENT PROGRAM.**

23 Not later than January 1, 2022, the Secretary of
 24 Health and Human Services shall implement Medicare
 25 policies under title XVIII of the Social Security Act (42

1 U.S.C. 1395 et seq.), including quality measures and
2 Medicare Advantage plan rating and risk adjustment
3 mechanisms, that reflect the public health imperative of—

4 (1) promoting healthy brain lifestyle choices;

5 (2) identifying and responding to patient risk
6 factors for Alzheimer’s disease and related demen-
7 tias; and

8 (3) incentivizing providers for—

9 (A) adequate and reliable cognitive impair-
10 ment detection in the primary care setting, that
11 is documented in the electronic health record of
12 the patient and communicated to the patient;

13 (B) timely Alzheimer’s disease diagnosis;
14 and

15 (C) appropriate care planning services, in-
16 cluding identification of, and communication
17 with patients and caregivers regarding, the po-
18 tential for clinical trial participation.

19 **SEC. 4. REPORT TO CONGRESS ON IMPLEMENTATION.**

20 Not later than 3 years after the date of the enact-
21 ment of this Act, the Secretary of Health and Human
22 Services shall submit to Congress a report on the imple-
23 mentation of the provisions of, and amendments made by,
24 this Act, including—

- 1 (1) the increased use of validated tools for de-
2 tection of cognitive impairment and Alzheimer's dis-
3 ease;
- 4 (2) utilization of Alzheimer's disease diagnostic
5 and care planning services; and
- 6 (3) outreach efforts in the primary care and pa-
7 tient communities.

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