

118TH CONGRESS  
1ST SESSION

# H. R. 1637

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

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## IN THE HOUSE OF REPRESENTATIVES

MARCH 17, 2023

Mr. LAHOOD (for himself, Mr. COLE, Mr. TONKO, and Mr. HIGGINS of New York) 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.

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—

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

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

9 (2) by adding at the end the following new sub-  
10 section:

11 “(h) DEMENTIA CARE MANAGEMENT MODEL.—

12 “(1) DESCRIPTION OF MODEL AND REQUIRE-  
13 MENTS.—

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

1           “(B) VOLUNTARY PARTICIPATION.—Par-  
2           ticipation under the Dementia Care Manage-  
3           ment Model shall be voluntary with respect to  
4           both eligible individuals and eligible entities.

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

7                   “(i) IN GENERAL.—The Secretary  
8                   shall—

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

12                           “(II) incorporate the Dementia  
13                           Care Management Model into the Pri-  
14                           mary Care First Model; or

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

17                                   “(aa) the Primary Care  
18                                   First Model; and

19                                   “(bb) the Direct Contracting  
20                                   Model.

21                   “(ii) ADDITIONAL AUTHORITY.—In  
22                   addition to the models described in sub-  
23                   clauses (I) through (III) of clause (i), the  
24                   Secretary may incorporate the Dementia  
25                   Care Management Model into other exist-

1           ing coordinated care models established  
2           under title XVIII or under this section, in-  
3           cluding accountable care organizations,  
4           value-based purchasing arrangements, and  
5           such other coordinated care models as the  
6           Secretary determines to be appropriate.

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

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

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

18                       “(ii) Comorbidities.

19                       “(iii) Financial resources and needs.

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

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

1                   “(vi) Potential risks and harms of the  
2                   eligible individual’s home and environment  
3                   and the need for support for activities of  
4                   daily living.

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

15                  “(C) PSYCHOSOCIAL INTERVENTIONS.—An  
16                  eligible entity may implement psychosocial  
17                  interventions designed to prevent or reduce the  
18                  burden of cognitive, functional, behavioral, and  
19                  psychological challenges as well as the associ-  
20                  ated stress on unpaid caregivers of the eligible  
21                  individual.

22                  “(D) SELF-MANAGEMENT TOOLS.—An eli-  
23                  gible entity shall provide self-management tools  
24                  to enhance the skills of the unpaid caregiver of  
25                  the eligible individual to manage the Alz-

1 heimer’s disease or related dementia of the eli-  
2 gible individual and to navigate the health care  
3 system. Such tools shall include training and  
4 support for unpaid caregivers in managing the  
5 limitations of eligible individuals, including edu-  
6 cation, problem solving strategies, care naviga-  
7 tion support, support after discharge from a  
8 hospital or nursing home, and decision-making  
9 support.

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

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

1           “(G) CARE COORDINATION.—An eligible  
2           entity shall provide ongoing care management  
3           services and shall coordinate services and sup-  
4           ports among providers of services and suppliers,  
5           as well as social and community resources.  
6           Such services shall include necessary assistance  
7           for referrals to social and community-based or-  
8           ganizations, collaboration with primary care  
9           providers and the interdisciplinary team of the  
10          eligible individual, and support for care transi-  
11          tions and continuity of care.

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

16          “(I) OTHER SERVICES.—The Secretary  
17          may require or permit other services, as appro-  
18          priate.

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

1           “(A) is qualified to furnish comprehensive  
2 care management services to an eligible indi-  
3 vidual, and any unpaid caregiver of such eligible  
4 individual, under the Dementia Care Manage-  
5 ment Model either directly or through arrange-  
6 ments with Medicare participating providers of  
7 services and suppliers as well as social and com-  
8 munity-based organizations;

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

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

19           “(D) furnishes comprehensive care man-  
20 agement services in a culturally appropriate  
21 manner;

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



1           “(F) furnishes wellness and healthcare  
2           planning, including medication review and man-  
3           agement;

4           “(G) supports family and caregiver engage-  
5           ment;

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

9           “(I) has relationships with medical and  
10          nonmedical community-based organizations that  
11          support patients with Alzheimer’s disease or a  
12          related dementia and their caregivers; and

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

15          “(4) ELIGIBLE INDIVIDUAL DEFINED.—In this  
16          subsection, the term ‘eligible individual’ means an  
17          individual—

18                 “(A) who—

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

1           “(ii) is not enrolled under part C of  
2           such title or under a PACE program under  
3           section 1894;

4           “(B) who has been diagnosed with a form  
5           of dementia;

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

8           “(D) who is not a resident of a nursing  
9           home.

10          “(5) PATIENT PATHWAYS.—

11           “(A) INITIAL PLACEMENT.—

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

21           “(ii) PATHWAY FOR UNCOMPLICATED  
22           DEMENTIA DIAGNOSIS.—During the pre-  
23           ceding 12-month period, the eligible indi-  
24           vidual has not more than 1 unplanned in-

1 patient hospitalization or visit to a hospital  
2 emergency department.

3 “(iii) PATHWAY FOR DEMENTIA DIAG-  
4 NOSIS WITH ENHANCED CARE COORDINA-  
5 TION NEEDS.—During the preceding 12-  
6 month period, the eligible individual—

7 “(I)(aa) has 2 or more un-  
8 planned inpatient hospitalizations or  
9 visits to a hospital emergency depart-  
10 ment; or

11 “(bb) has a psychiatric hos-  
12 pitalization; and

13 “(II) has sufficient financial or  
14 caregiver resources (as determined by  
15 the Secretary).

16 “(iv) PATHWAY FOR DEMENTIA DIAG-  
17 NOSIS WITH COMPLEX CARE NEEDS.—Dur-  
18 ing the preceding 12-month period, the eli-  
19 gible individual—

20 “(I)(aa) has 2 or more un-  
21 planned inpatient hospitalizations or  
22 visits to a hospital emergency depart-  
23 ment; or

24 “(bb) has a psychiatric hos-  
25 pitalization; and

1                   “(II) has insufficient financial or  
2                   caregiver resources (as determined by  
3                   the Secretary).

4                   “(B) REGULAR PATIENT ASSESSMENTS  
5                   FOR APPROPRIATE PATHWAY.—

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

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

1 individual’s financial and caregiver re-  
2 sources applicable to each pathway.

3 “(iii) ENHANCED OR COMPLEX CARE  
4 NEEDS.—Each eligible individual enrolled  
5 in the pathway for dementia diagnosis with  
6 enhanced care coordination needs (as de-  
7 scribed in subparagraph (A)(iii)) or the  
8 pathway for dementia diagnosis with com-  
9 plex care needs (as described in subpara-  
10 graph (A)(iv)) shall be assigned to 1 of the  
11 2 pathways based on the eligible individ-  
12 ual’s financial and caregiver resources ap-  
13 plicable to each pathway.

14 “(6) QUALITY ASSESSMENT.—

15 “(A) IN GENERAL.—The Secretary shall  
16 specify appropriate measures to assess the qual-  
17 ity of care furnished by an eligible entity under  
18 the Dementia Care Management Model. Such  
19 measures shall include, as appropriate, meas-  
20 ures for clinical processes and outcomes, patient  
21 and caregiver experience of care, and utilization  
22 of services for which payment is made under  
23 the original medicare fee-for-service program  
24 under title XVIII, including measures for—

25 “(i) emergency department utilization;

- 1 “(ii) inpatient hospital utilization;
- 2 “(iii) documented advanced care plan;
- 3 “(iv) medication review;
- 4 “(v) screening for future fall risk;
- 5 “(vi) depression screening for care-
- 6 givers;
- 7 “(vii) caregiver stress assessment; and
- 8 “(viii) caregiver assessment of out-
- 9 comes.

10 “(B) REPORTING.—An eligible entity shall

11 submit data in a form and manner determined

12 by the Secretary on measures specified by the

13 Secretary.

14 “(C) PERFORMANCE ASSESSMENT.—In

15 order to assess the quality of care furnished by

16 an eligible entity under the model, the Sec-

17 retary shall establish—

- 18 “(i) quality performance standards;
- 19 and
- 20 “(ii) methodologies for quality per-
- 21 formance scoring and related payment ad-
- 22 justments.

23 “(D) STAKEHOLDER INPUT.—The Sec-

24 retary shall seek input from eligible entities on

1 final measure specifications, including appro-  
2 priate adjustment for patient preferences.

3 “(7) PAYMENTS.—

4 “(A) IN GENERAL.—Under the Dementia  
5 Care Management Model, the Secretary shall  
6 establish payment amounts for care manage-  
7 ment services furnished to eligible individuals,  
8 including initial investment costs. Such  
9 amounts shall reflect start-up costs and initial  
10 investments incurred by an eligible entity in es-  
11 tablishing the Dementia Care Management  
12 Model.

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

21 “(C) QUALITY BONUS.—Under the Demen-  
22 tia Care Management Model, additional pay-  
23 ments shall be made to any eligible entity for  
24 quality bonuses based on the performance of

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

3 “(D) ZERO COST-SHARING.—An eligible in-  
4 dividual shall not be liable for any cost-sharing,  
5 including deductibles, coinsurance, or copay-  
6 ments, for care management services for de-  
7 mentia care furnished to such eligible individual  
8 under the model.

9 “(E) SUPPLEMENTAL TO PAYMENTS FOR  
10 COVERED SERVICES.—Payments made under  
11 the model shall be in addition to any payments  
12 for items or services not provided under the  
13 model for which payment may be made under  
14 title XVIII for services furnished to such eligi-  
15 ble individuals.

16 “(F) NONDUPLICATION.—Payments for  
17 care management services furnished to eligible  
18 individuals under the Dementia Care Manage-  
19 ment Model may not duplicate payments for  
20 services furnished to such eligible individuals  
21 for which payments are made under the original  
22 medicare fee-for-service program under title  
23 XVIII.

24 “(8) WAIVERS.—The Secretary shall waive pro-  
25 visions of this title, and title XVIII, to permit an eli-



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

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

7 “(B) CAREGIVERS.—Supports for care-  
8 givers.

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

12 “(D) SERVICES FROM COMMUNITY ORGA-  
13 NIZATIONS.—Payments, cost-sharing support,  
14 or both, for nonmedical services furnished by  
15 community-based organizations, such as limited  
16 caregiving services, respite care, adult day care  
17 counseling services, and such other services as  
18 the Secretary determines to be appropriate.

19 “(9) MODIFICATIONS FOR APPLICATION IN THE  
20 PRIMARY CARE FIRST AND DIRECT CONTRACTING  
21 MODELS.—

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

1 Direct Contracting Model, or both, as provided  
2 for under paragraph (1)(C)(i), the Secretary  
3 shall maintain the requirements of this sub-  
4 section.

5 “(B) PERMISSIBLE MODIFICATIONS.—The  
6 Secretary may adjust the requirements of this  
7 subsection to the extent necessary to ensure  
8 consistency of the Dementia Care Management  
9 Model with the Primary Care First Model, the  
10 Direct Contracting Model, or both, with respect  
11 to—

12 “(i) any eligible entity, including bene-  
13 ficiary alignment thresholds;

14 “(ii) any eligible individual;

15 “(iii) capitated payments; and

16 “(iv) quality-bonus payments.

17 “(C) CONSULTATION WITH STAKE-  
18 HOLDERS.—Prior to making any adjustment  
19 under subparagraph (B), the Secretary shall  
20 consult with appropriate stakeholders and pa-  
21 tient advocacy organizations.

22 “(10) OUTREACH TO UNDERREPRESENTED MI-  
23 NORITY POPULATIONS.—An eligible entity shall  
24 carry out public outreach and education efforts, in-  
25 cluding the dissemination of information, for mem-

1       bers of underrepresented minority populations re-  
2       garding participation in the Dementia Care Manage-  
3       ment Model to ensure diversity in the patient popu-  
4       lation of such model.

5               “(11) OPTION TO EXPAND TO MEDICAID.—The  
6       Secretary may design a model under which pay-  
7       ments are made under title XIX, in a similar man-  
8       ner to the manner in which payments are made  
9       under title XVIII under the Dementia Care Manage-  
10      ment Model described in this subsection, to eligible  
11      entities that furnish comprehensive care manage-  
12      ment services to individuals who are eligible for med-  
13      ical assistance under a State plan under title XIX  
14      (or a waiver of such a plan) with Alzheimer’s disease  
15      or a related dementia, in order to test the effective-  
16      ness of comprehensive care management services on  
17      patient health, care quality, and care experience, as  
18      well as on unpaid caregivers, and on reducing spend-  
19      ing under title XIX without reducing the quality of  
20      care.”.

○