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Guiding an Improved Dementia Experience

Request for Applications

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Model Summary

This Request for Applications (RFA) introduces the Guiding an Improved Dementia Experience (GUIDE) model, a new Center for Medicare and Medicaid Innovation (Innovation Center) model from the Centers for Medicare & Medicaid Services (CMS). The GUIDE Model will test whether providing an alternative payment methodology for participating dementia care programs to deliver a package of care management and coordination, caregiver education and support, and GUIDE Respite Services to Medicare beneficiaries with dementia and their caregivers¹ reduces expenditures while preserving or enhancing quality of care.

The GUIDE Model is designed to enhance quality of care by improving quality of life for people with dementia and reducing burden and strain on their caregivers. It is expected to reduce Medicare and Medicaid expenditures primarily by preventing or delaying long-term nursing home stays, and secondarily by reducing hospital, emergency department, and post-acute care utilization.

The GUIDE Model is a key deliverable from President Biden’s April 2023 Executive Order on Increasing Access to High-Quality Care and Supporting Caregivers, as well as key goals of the National Plan to Address Alzheimer’s Disease.

Key Model Elements:

- **Scope and Duration:** The GUIDE Model will be an 8-year voluntary model that is offered nationwide, and will run from July 1, 2024 through June 30, 2032 (“Model Performance Period”). The GUIDE Model will have two participant tracks, one for established dementia care programs and one for new dementia care programs. The first performance year for the established program track will begin on July 1, 2024. The new program track will have a one-year pre-implementation period that begins on July 1, 2024, and its first performance year will begin on July 1, 2025.
- **Participants:** GUIDE Participants will be Medicare Part B-enrolled providers or suppliers (excluding durable medical equipment (DME) and laboratory suppliers) that establish Dementia Care Programs (“DCPs”) to provide ongoing, longitudinal care to people with dementia (“GUIDE Participant”). A GUIDE Participant must participate in the GUIDE Model under a single, Medicare Part B-enrolled Taxpayer Identification Number (TIN) that is eligible to bill for Medicare Physician Fee Schedule (PFS) services. A GUIDE Participant must meet the care delivery requirements described in the “Care Delivery” section of this RFA but may choose to partner with other organizations, including both Medicare-enrolled providers and suppliers and non-Medicare enrolled entities, such as community-based organizations, to meet these requirements.

¹ For purposes of the GUIDE Model, the term “caregiver” is defined as a relative, or an unpaid nonrelative, who assists the beneficiary with activities of daily living and/or instrumental activities of daily living. Depending on the beneficiary’s need, the assistance may be episodic, daily, or occasional.

- **Beneficiary Eligibility and Beneficiary Alignment:** Eligible beneficiaries will be community-dwelling² Medicare FFS beneficiaries, including beneficiaries dually eligible for Medicare and Medicaid, who have dementia. Beneficiaries will be aligned to GUIDE Participants through a voluntary alignment process in which they are informed about the GUIDE Model and consent to receive services from a specific GUIDE Participant. Aligned beneficiaries will maintain freedom of choice with respect to their physicians or practitioners.
- **Model Tiers:** Beneficiaries will be assigned to one of five model tiers based on the complexity of their needs, and, if applicable, their caregiver needs. Model services, care intensity, and payment will vary by model tier. GUIDE Participants must re-assess each beneficiary at least once per year, and CMS may re-assign beneficiaries to a different model tier based on the results of the re-assessment.
- **Care Delivery:** The GUIDE care delivery approach includes 1) a standardized package of services that GUIDE Participants must provide to beneficiaries and their caregivers (as applicable to individual beneficiary and caregiver needs) (“GUIDE Care Delivery Services”); 2) an interdisciplinary care team to deliver these services; and 3) a standardized training requirement for care navigators who are part of the interdisciplinary care team. GUIDE Care Delivery Services encompass nine care delivery domains: comprehensive assessment, care planning, ongoing monitoring and support, medication reconciliation and management, 24/7 access to a care team member or helpline, care coordination and transitional care management, referrals and coordination for services and supports, caregiver education and support, and GUIDE Respite Services. The interdisciplinary care team must include, at a minimum, a “care navigator,” and a clinician with “dementia proficiency” who is eligible to bill Medicare Part B evaluation and management services (E/M).³ The terms “care navigator” and “dementia proficiency” are defined in the section titled “Care Team Requirements.”
- **Performance Measurement:** CMS plans to measure GUIDE Participant performance on five performance measures, including quality, patient experience, utilization, and cost metrics: Use of High-Risk Medications in Older Adults; Quality of Life Outcome for People with Neurological Conditions; Caregiver Burden; Total Per Capita Cost; and Long-Term Nursing Home Stay rate. The caregiver burden and long-term nursing home stay rate are new metrics that will be developed for use in the GUIDE Model.
- **Per Beneficiary Per Month Payment:** GUIDE Participants will be able to bill Medicare for a per beneficiary per month Dementia Care Management Payment (“DCMP”). CMS will pay the DCMP

² For the purposes of the GUIDE Model, the term “community-dwelling” is defined as living in a personal home, assisted living facility, group home, or other community setting. A beneficiary will still be considered community-dwelling for the purposes of the model if they are admitted to an acute care hospital or receive post-acute care in skilled nursing facility. A beneficiary will no longer be considered community-dwelling if the person becomes a long-term nursing home resident, defined as having a nursing home stay that is not covered under the Medicare skilled nursing facility benefit.

³ See “Care Delivery” section for more detailed criteria for the care navigator role and the definition of “dementia proficiency”.

to GUIDE Participants for furnishing the GUIDE Care Delivery Services to aligned beneficiaries (with the exception of GUIDE Respite Services, which will be paid for under a separate payment). The GUIDE Participant’s DCMP amount will depend on the aligned beneficiary’s model tier; each of the five model tiers will have a different DCMP rate. The DCMP will be adjusted by a performance-based adjustment tied to the five model performance metrics, as well as a health equity adjustment. The health equity adjustment will increase the DCMP paid to the GUIDE Participant for low-income aligned beneficiaries from underserved communities and it will decrease the DCMP paid to the GUIDE Participant for higher income aligned beneficiaries from more advantaged communities. The health equity adjustment is intended to provide an incentive for GUIDE Participants to deliver care to beneficiaries from underserved communities. The GUIDE Model is not a total cost of care model and GUIDE Participants may continue to bill for all services not included in the DCMP under traditional Medicare FFS.

- **Payment for GUIDE Respite Services:** GUIDE Participants will be able to bill the Innovation Center for up to \$2,500 per aligned beneficiary per year for GUIDE Respite Services. Only certain aligned beneficiaries will be eligible for GUIDE Respite Services (see *Requirements for Aligned Beneficiaries to be Eligible to Receive GUIDE Respite Services* under the “Respite Payment” section of this RFA). GUIDE Participants must offer in-home GUIDE Respite Services but may also choose to offer adult day center and facility-based respite.
- **Health Equity:** To address disparities in dementia care, GUIDE Participants will be required to develop and implement a Health Equity Plan that identifies disparities in outcomes in their patient populations and strategies to reduce these disparities over the course of their participation in the GUIDE Model. GUIDE Participants will also be required to collect and report data on beneficiaries’ sociodemographic characteristics and health-related social needs (though beneficiaries will always have the option to opt out of sharing their data). This data will help GUIDE Participants identify and address disparities within their patient population and track their progress towards health equity goals over time.
- **Data Reporting and Sharing:** In addition to the sociodemographic and health-related social needs data described above, GUIDE Participants will also be required to report quality and care delivery data on an annual basis. This information will be used to assess GUIDE Participant performance and inform the model evaluation. GUIDE Participants will also receive data from CMS, primarily in the form of a Data Dashboard. The Data Dashboard will provide GUIDE Participants with an interactive, user-friendly interface for viewing claims-based utilization data for their aligned beneficiaries, updated monthly, available and aggregated across the GUIDE Participant’s entire aligned population.

Background

6.7 million Americans currently live with Alzheimer's disease or another form of dementia, a number that is projected to grow to nearly 14 million by 2060.⁴ Despite the high prevalence of dementia—roughly 11 percent of U.S. adults over the age of 65 and nearly 35 percent over the age of 85 have dementia⁵—many people with dementia are not consistently receiving high quality, high value care. People with dementia experience poor outcomes across an array of metrics, including high rates of hospitalization, ED visits, and post-acute care utilization,^{6,7} high rates of depression, behavioral and psychological symptoms of dementia (BPSD),⁸ and poor management of other co-occurring conditions.^{9,10} As the condition progresses, many people with dementia will need long-term services and supports, including care in a nursing facility or home and community-based services.

With support and collaboration, primary care can play an important role in improving care delivered to people with dementia, including providing person-centered care and coordinating across providers to manage a person's co-occurring conditions.¹¹ However, the primary care setting often lacks the resources to independently provide the intensive services that people with dementia need—services such as identifying and helping connect to services and supports, addressing behavioral symptoms, and re-stabilizing after an acute health event.

Dementia not only affects quality of life for people with the disease—it also significantly impacts quality of life for caregivers. Many caregivers for people with dementia, who are often Medicare beneficiaries themselves, report high levels of stress and depression,¹² which negatively affect their overall health and increase their risk for serious illness, hospitalization, and mortality.^{13,14} Dementia also imposes a large financial burden on beneficiaries and their families: out-of-pocket spending in the last five years of life, including for long term services and supports, is higher for people with dementia compared to those

⁴ Alzheimer's Association. 2023 Alzheimer's Disease Facts and Figures.

<https://www.alz.org/media/documents/alzheimers-facts-and-figures.pdf>

⁵ Ibid.

⁶ Lin P-J, Fillit HM, Cohen JT, Neumann PJ, et al. Potentially avoidable hospitalizations among Medicare beneficiaries with Alzheimer's and related disorders. *Alzheimer's & Dementia*. January 2013. 9(1): 30-38.

⁷ Feng Z, Coots LA, Kaganova Y and Wiener JM. Hospital and ED Use Among Medicare Beneficiaries with Dementia Varies by Setting and Proximity to Death. *Health Affairs*. April 2014. 33(4).

⁸ Lyketsos, CG, Lopez O, Jones B, et al. Prevalence of Neuropsychiatric Symptoms in Dementia and Mild Cognitive Impairment: Results from the Cardiovascular Health Study. *JAMA*. September 2002. 288(12): 1475-1483.

⁹ Zhao Y, Kuo T-C, Weir S, et al. Healthcare costs and utilization for Medicare beneficiaries with Alzheimer's. *BMC Health Services Research*. May 2008.

¹⁰ Thorpe CT, Thorpe JM, Kind AJH, et al. Receipt of Diabetes Monitoring in Older Adults with Co-Morbid Dementia. *Journal of the American Geriatric Society*. April 2012. 60(4): 644-651.

¹¹ Boustani M, Schubert C, and Sennour Y. The challenge of supporting care for dementia in primary care. *Clin Interv Aging*. December 2007. 2(4).

¹² Teri L, McKenzie G, Logsdon RG, McCurry SM, Bollin S, et al. Translation of two evidence-based programs for training families to improve care of persons with dementia. *Gerontologist*. 2012. 52: 452–459.

¹³ Schubert CC, Boustani M, Callahan CM, Perkins AJ, Hui S, et al. Acute care utilization by dementia caregivers within urban primary care practices. *Journal of General Internal Medicine*. 2008; 23: 1736–1740.

¹⁴ Schulz R, Martire LM. Family caregiving of persons with dementia: prevalence, health effects, and support strategies. *American Journal of Geriatric Psychiatry*. 2004. 12: 240–249.

without dementia (\$61,522 vs. \$34,068), and people with dementia end up spending a significantly higher share of their total family assets on care in the last five years of life (32% vs 11%).^{15,16}

All of these issues are exacerbated for certain racial and ethnic groups. Black and Hispanic populations have a higher prevalence of dementia,^{17,18} but they also are less likely to receive a timely diagnosis,¹⁹ have more unmet needs,²⁰ are more likely to experience high caregiving demands, and spend a higher share of their family assets on dementia care.^{21,22,23,24}

Though much of the financial burden of dementia falls on beneficiaries and their caregivers through out-of-pocket spending, dementia also drives higher costs for federal health care programs. Two recent studies have estimated that, on average, a person with dementia will have an additional \$12,000-\$15,700 in total Medicare costs and an additional \$8,800-\$31,000 in total Medicaid costs over the 5 years after diagnosis.^{25,26}

Driven by this evidence of the enormous burden that dementia imposes on individuals, families, caregivers, and society at large, numerous federal groups and agencies have sought to identify interventions that can improve care and outcomes for people with dementia and their caregivers. Many of these federal partners have identified care coordination and caregiver education and support programs like the GUIDE Model as promising interventions. For example, the GUIDE Model is consistent with recommendations in the National Plan to Address Alzheimer's Disease, which is the nation's roadmap for addressing dementia that includes input from ASPE, OASH, NIA, CMS, CDC, ACL, HRSA,

¹⁵ Hudomiet P, Hurd M, Rohwedder S. The relationship between lifetime out-of-pocket medical expenditures, dementia, and socioeconomic status in the US. *The Journal of the Economics of Aging*. 2019; 14.

¹⁶ Kelley AS, McGarry K, Gorges R, Skinner JS. The Burden of Health Care Costs for Patients with Dementia in the Last 5 Years of Life. *Annals of Internal Medicine*. November 2015.

¹⁷ Lennon, et al. Black and white individuals differ in dementia prevalence, risk factors, and symptomatic presentation. *Alzheimer's and Dementia*. 2021.

¹⁸ Lines, LM and Wiener JM. Racial and Ethnic Disparities in Alzheimer's Disease: A Literature Review. Office of the Assistant Secretary for Planning and Evaluation (ASPE). 31 January 2014.

¹⁹ Gianattasio KZ, Prather C, Glymour MM, et al. Racial disparities and temporal trends in dementia misdiagnosis risk in the United States. *Alzheimer's & Dementia*. December 9, 2019.

²⁰ Black BS, Johnston D, Leoutsakos J, et al. Unmet needs in community-living persons with dementia are common, often non-medical and related to patient and caregiver characteristics. *International Psychogeriatrics*. November 2019; 31(11).

²¹ Friedman EM, Shih RA, Langa KM, Hurd MD. US prevalence and predictors of informal caregiving for dementia. *Health Affairs Project Hope*. 2015; 34(10):1637–41.

²² Lines LM, Wiener JM. Racial and Ethnic Disparities in Alzheimer's Disease: A Literature Review. Report prepared for Office of Disability, Aging and Long-Term Care Policy in the Office of the Assistant Secretary for Planning and Evaluation. February 2014. Contract #HHSP23320100021WI.

²³ Hudomiet et al. (2019).

²⁴ Kelley et al. (2015).

²⁵ White L, Fishman P, Basu A, et al. Medicare expenditures attributable to dementia. *Health Services Research*. 2019; 54: 773-781.

²⁶ Coe NB, White L, Oney M, et al. Public spending on acute and long-term care for Alzheimer's disease and related dementias. *Alzheimer's & Dementia*. 20 January 2022.

AHRQ, SAMHSA, FDA, IHS, and ACF²⁷ and is informed by the Advisory Council on Alzheimer’s Research, Care, and Services. The National Plan recommends that CMS explore the effectiveness of new models of care for people with Alzheimer’s disease and related dementias, and that CMS implement and evaluate care coordination models for people with dementia.²⁸

It is also consistent with a 2021 National Academies for Science, Engineering, and Medicine (NASEM) consensus report recommending that collaborative dementia care models and multi-component caregiver support programs should be implemented and evaluated in multiple and varied real-world settings.²⁹

The GUIDE Model also builds on lessons learned from the Department of Veteran Affairs (VA) Program of General Caregiver Support Services (PGCSS), which has experience implementing numerous caregiver education and support interventions, including caregiver skills trainings, individual and group counseling, peer support mentoring, and respite services.³⁰

The GUIDE Model is consistent with Executive Order 14095 signed on April 18, 2023, “Increasing Access to High-Quality Care and Supporting Caregivers”, which directed the Secretary of Health and Human Services to “consider whether to select for testing by the Center for Medicare and Medicaid Innovation an innovative new health care payment and service delivery model focused on dementia care that would include family caregiver supports such as respite care.”

Finally, the GUIDE Model builds on a substantial body of evidence from both previous CMS models and demonstration projects and external, provider-based dementia care programs. Like the GUIDE Model, these dementia care programs aimed to provide comprehensive, interdisciplinary care to people with dementia and their caregivers, with the goal of improving the person and their caregiver’s quality of life while reducing avoidable health care utilization and delaying or avoiding long-term nursing home stays. Overall, there is evidence that dementia care programs improve beneficiary and caregiver experience of care, increase self-reported caregiver efficacy, and lower caregiver stress.^{31,32}

²⁷ Office of the Assistant Secretary for Planning and Evaluation (ASPE), Office of the Assistant Secretary for Health (OASH), National Institute on Aging (NIA), Centers for Medicare & Medicaid Services (CMS), Centers for Disease Control and Prevention (CDC), Administration for Community Living (ACL), Health Resources and Services Administration (HRSA), Agency for Healthcare Research and Quality (AHRQ), Substance Abuse and Mental Health Services Administration (SAMHSA), Food and Drug Administration (FDA), Indian Health Service (IHS), and Administration for Children and Families (ACF).

²⁸ National Plan to Address Alzheimer’s Disease: 2022 Update. U.S. Department of Health and Human Services. <https://aspe.hhs.gov/sites/default/files/documents/59cefdd628581b48b2e389891a675af0/napa-national-plan-2022-update.pdf>

²⁹ NASEM Committee on Care Interventions for Individuals with Dementia and Their Caregivers. 2021.

³⁰ Factsheet: Department of Veterans Affairs Program of General Caregiver Support Services. March 2022. https://www.caregiver.va.gov/pdfs/FactSheets/CSP_PGCSS_Fact_Sheet.pdf

³¹ NASEM Committee on Care Interventions for Individuals with Dementia and Their Caregivers. Meeting the Challenge of Caring for Persons Living with Dementia and Their Care Partners and Caregivers: A Way Forward. Washington, DC: The National Academies Press. 2021.

³² Agency for Healthcare Research and Quality. Care Interventions for People with Dementia and Their Caregivers. Comparative Effectiveness Review Number 231. August 2020.

CMS has previously tested five dementia care models or demonstrations: four dementia care projects funded through the Innovation Center's Health Care Innovation Awards (HCIA),³³ and a multi-site Medicare demonstration.³⁴ According to a synthesis of evaluation results conducted by the Innovation Center's Research and Rapid Cycle Evaluation Group (RREG),³⁵ key findings across the five projects were that: 1) access to dementia care resources improved beneficiaries' and caregivers' experience of care; 2) caregivers reported increased efficacy in their caregiving abilities and lower stress; 3) there was a significant reduction in long-term nursing home stays in one project; and 4) there were non-significant reductions in Medicare expenditures, ED visits, and hospitalizations in several projects. The evaluation followed beneficiaries during their period of enrollment in each project, which varied from 12 to 36 months on average.

The GUIDE Model is designed to investigate whether 1) defining a specific package of dementia care services, 2) tiering the intervention intensity based on a person's needs and targeting high-intensity care to those with the greatest need, 3) providing access to GUIDE Respite Services, and 4) using a longer, eight-year performance period (as compared to previous dementia care demonstrations) could improve outcomes or our ability to detect improved outcomes.

Scope and Duration

The GUIDE Model will be an 8-year voluntary national model that is offered in all states, U.S. territories, and the District of Columbia. The Model Performance Period will begin on July 1, 2024 and end on June 30, 2032. The GUIDE Model will have two participant tracks, one for established dementia care programs and one for new dementia care programs. CMS will assign selected applicants to either the established program track or the new program track. The purpose of the two tracks is to allow established programs to begin their performance in the GUIDE Model on July 1, 2024, while giving organizations that do not currently offer a comprehensive community-based dementia care program, including safety net organizations, time and support to develop a new program. New program development is intended to help to increase beneficiary access to specialty dementia care, particularly in underserved communities.

The first performance year for the established program track will begin on July 1, 2024. The new program track will have a one-year pre-implementation period that begins on July 1, 2024. The first performance year for the new program track will begin on July 1, 2025 and both tracks will continue through June 30, 2032. Table 1 illustrates the timeline for both tracks.

³³ Health Care Innovation Awards. Centers for Medicare & Medicaid Services. <https://innovation.cms.gov/innovation-models/health-care-innovation-awards>

³⁴ Newcomer R, Miller R, Clay T, Fox P. Effects of the Medicare Alzheimer's disease demonstration on Medicare expenditures. *Health Care Financ Rev*. 1999; 20:45–65.

³⁵ CMS Innovation Center. Dementia Care Projects: Synthesis of Evaluation Results, 1989-2020. December 2022. <https://innovation.cms.gov/data-and-reports/2022/dementia-care-synthesis-1989-2020>

Table 1. Model Timeline for Established Program and New Program tracks

	Nov. '23-Jan. '24	July 2024-June 2025	July '25-June '26	July '26-June '27	July '27-June '28	July '28-June '29	July '29-June '30	July '30-June '31	July '31-June '32
Established Program Track	Application Period	Performance Year (PY) 1	PY 2	PY 3	PY 4	PY 5	PY 6	PY 7	PY 8
New Program Track	Application Period	Pre-Implementation (PI) Period	PY 1	PY 2	PY 3	PY 4	PY 5	PY 6	PY 7

The application period will close on January 30, 2024. Applicants will be notified as to whether they have been selected for participation in the GUIDE Model in Spring 2024. Onboarding for all selected GUIDE Participants will take place in Spring 2024 and the GUIDE Model will begin on July 1, 2024.

GUIDE Participants

A GUIDE Participant will be a Medicare Part B-enrolled provider or supplier, excluding DME and laboratory suppliers, that establishes a DCP to provide ongoing, longitudinal care to people with dementia. The GUIDE Participant must participate under a single, Medicare Part B-enrolled Taxpayer Identification Number (TIN) that is eligible to bill under the PFS.

The GUIDE Participant will be identified by a single TIN that is used to bill for GUIDE Model services, plus the National Provider Identifiers (NPIs) of individual Medicare-enrolled physicians and other non-physician practitioners who have re-assigned their billing rights to the GUIDE Participant's billing TIN. The GUIDE Participant will be required to maintain this list of physicians and non-physician practitioners ("GUIDE Practitioner Roster") and keep it up to date throughout the course of the GUIDE Model, as it will be used to determine who is eligible to bill for GUIDE Model payments.

Contracting with Providers, Suppliers, and/or Organizations to Meet Care Delivery Requirements

A GUIDE Participant must meet the care delivery requirements described in the "Care Delivery" section of this RFA. If a GUIDE Participant cannot meet the GUIDE care delivery requirements alone, the GUIDE Participant may contract with one or more other providers, suppliers, or organizations, including both Medicare-enrolled and non-Medicare enrolled entities, to meet the care delivery requirements. These providers, suppliers, or organizations will be known as "Partner Organizations."

For example, a multispecialty practice may contract with a Medicare enrolled home health agency to have an occupational therapist, who is employed by the home health agency, provide some of the required care delivery services.

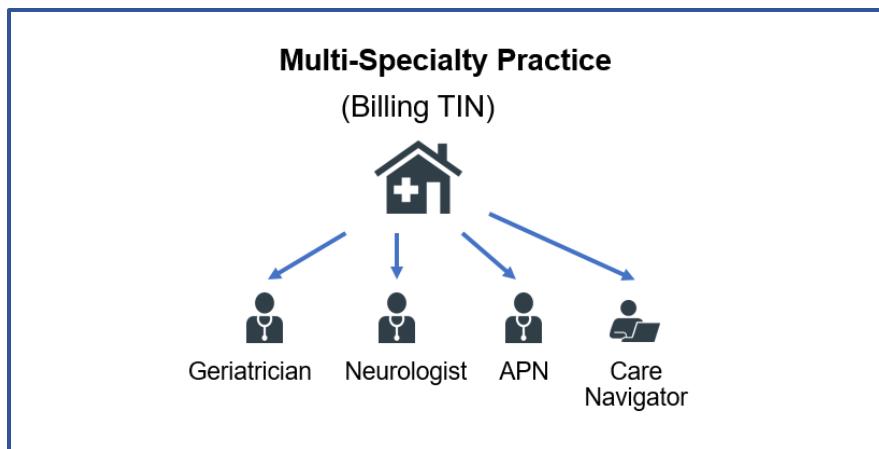
In another example, a primary care physician may contract with a community-based memory care clinic, that is not a Medicare enrolled provider, in order to provide some of the required care delivery services.

The GUIDE Participant will be expected to maintain a list of Partner Organizations ("Partner Organization Roster") and keep it up to date throughout the course of the GUIDE Model.

Both Medicare-enrolled and non-Medicare enrolled entities may contract with more than one GUIDE Participant.

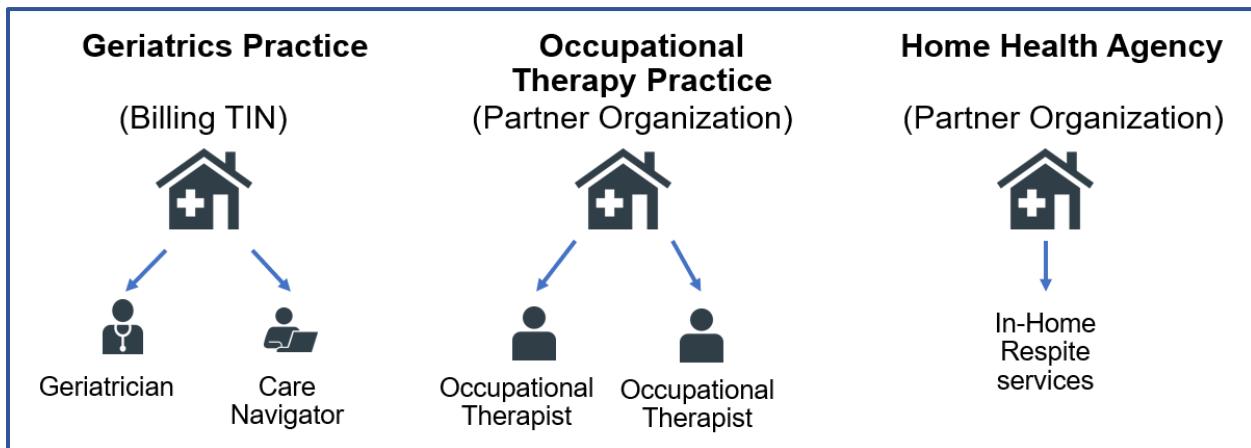
Examples of Dementia Care Programs

Example 1: A single Medicare provider forms a DCP



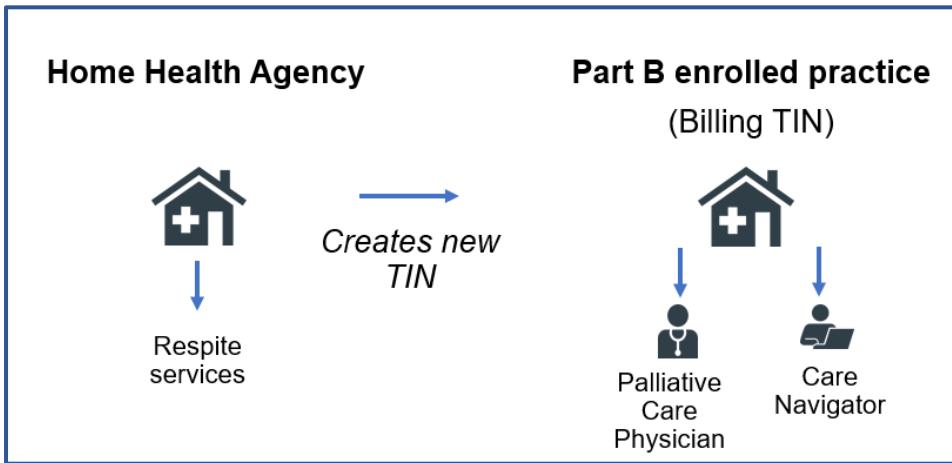
In this example, the DCP is established by a multi-specialty practice and model services are billed under the practice's TIN. The multi-specialty practice meets all care delivery requirements of the GUIDE Model, including in-home GUIDE Respite Services, without a Partner Organization.

Example 2: A Medicare provider partners with several other Medicare providers to form a DCP



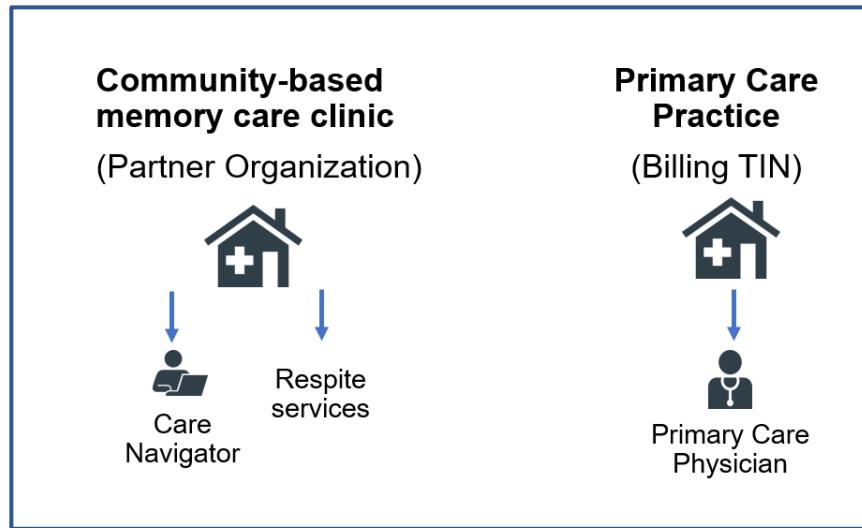
In example two, the DCP is established by a geriatrics practice, which is the GUIDE Participant. The geriatrics practice partners with an occupational therapy practice and a home health agency to meet the care delivery requirements of the GUIDE Model. The occupational therapy practice and the home health agency are considered Partner Organizations within the DCP. All model services are billed by the GUIDE Participant, in this case the geriatrics practice's TIN, and all practitioners must re-assign their billing rights to this TIN.

Example 3: Medicare-enrolled provider establishes a new Part B enrolled TIN to form a DCP



In example three, a home health agency establishes a new Medicare Part B-enrolled practice for the purposes of participating in GUIDE. The Part B-enrolled practice is the GUIDE Participant, and model services are billed under the practice's TIN.

Example 4: A community-based provider partners with a primary care practice to form a DCP



In example four, a community-based memory care clinic, without a Part B-enrolled provider on staff, partners with a Part B-enrolled primary care practice to meet the care delivery requirements of the GUIDE Model. The Part B-enrolled primary care practice is the GUIDE Participant, and model services are billed under the primary care practice's TIN.

Participation Requirements

An applicant that is accepted to participate in the GUIDE Model will become a GUIDE Participant upon execution of a Participation Agreement with CMS. The Participation Agreement will set forth the terms of the GUIDE Model and each party's obligations under the GUIDE Model.

GUIDE Participants must meet the following requirements, among others specified in the Participation Agreement, throughout the performance period of their assigned track (e.g., July 1, 2024 - June 30, 2032 for the established program track and July 1, 2025 - June 30, 2032 for the new program track):

- Meet the interdisciplinary care team, care delivery, and training requirements, as described in the Participation Agreement (see the “Care Delivery” section and appendix B of this RFA).
- Use an electronic health record platform that meets CMS and Office of the National Coordinator for Health Information Technology (ONC) standards for Certified Electronic Health Record Technology (CEHRT) as defined at [42 CFR 414.1305](#).³⁶
- The GUIDE Participant has the flexibility to provide most model services virtually or in-person (in office or in the beneficiary’s home) but must conduct an initial home visit in-person for aligned beneficiaries who have moderate to severe dementia.
- The GUIDE Participant is required to make available for eligible beneficiaries GUIDE Respite Services in the beneficiary’s home. The GUIDE Participant has the option, but is not required to, offer eligible beneficiaries GUIDE Respite Services at an adult day center or a facility that can provide 24-hour care. More details regarding GUIDE Respite Services can be found in the “Respite Payment” section of this RFA.
- Maintain an up-to-date GUIDE Practitioner Roster and Partner Organization Roster.
- Comply with all model reporting requirements, including care delivery, sociodemographic data, and quality reporting.

GUIDE Participants in the new program track will be required to use the one-year pre-implementation period, from July 1, 2024 to June 30, 2025, for program development, including hiring and training staff, establishing program work flows and processes, developing provider networks, and building relationships with community-based organizations and respite suppliers and providers, as applicable.

GUIDE Participants in the new program track will not be required to meet the GUIDE Model’s care delivery, care team, and Certified Electronic Health Record Technology (CEHRT) requirements until two months before the beginning of their first performance year (by May 1, 2025). GUIDE Participants in the new program track will be required to submit baseline care delivery reporting, a Proposed GUIDE Practitioner Roster and, if applicable, a Proposed Partner Organization Roster by May 1, 2025 to enable CMS to verify that they have met these requirements. CMS will conduct a program integrity screening based on the proposed rosters. CMS will terminate from the GUIDE Model any GUIDE Participants in the new program track who fail to meet these requirements by May 1, 2025. GUIDE Participants, who receive an infrastructure payment and are then terminated from the GUIDE Model under the provisions of this paragraph, are required to re-pay the infrastructure payment to CMS (see “Infrastructure Payment” section of this RFA).

Additional comprehensive participation requirements will be set forth in the Participation Agreement.

³⁶ ONC has proposed to require USCDI Version 3 in certified health IT products by January 1, 2025. Participants will be required to use certified health IT that has been updated to a required version of the United States Core Data for Interoperability (USCDI) Version 3, where applicable for certified functionality required under the CEHRT definition at 42 CFR 414.1305, by the deadline finalized by ONC.

Application

Application questions, including deadlines and contact information, can be found in Appendix A. Applicants must submit all application materials via an online portal available on the GUIDE Model website at <https://innovation.cms.gov/innovation-models/guide> by the deadline. It is the responsibility of the applicant to ensure that they include all required information in their application.

Applicants seeking to withdraw their application must submit an electronic withdrawal request to CMS via the following mailbox: GUIDEModelTeam@cms.hhs.gov. The request must be submitted as a PDF on the organization's letterhead and must be signed by a corporate official authorized to bind the applicant. It should include: the applicant organization's registered name; the organization's primary point of contact; the full and correct address of the organization; and a description of the nature of the withdrawal.

GUIDE Model Eligibility Criteria

To be selected for participation in the GUIDE Model, applicants must first meet the eligibility criteria, as described below. Then, if accepted, CMS will assign the selected applicants to either the established program track or the new program track based on the information provided in the application.

CMS will accept applicants that meet eligibility requirements for either the established program track or the new program track taking into consideration eligibility for the relevant track, the results of the program integrity screening, model size considerations, and other reasons.

Established Program Track

To be eligible for the established program track, an applicant must:

- Be a legal entity formed under applicable state, federal, or Tribal law, that is authorized to conduct business in each state in which it operates;
- Be a Medicare Part B enrolled provider or supplier (excluding DME and laboratory suppliers) that is eligible to bill under the Medicare Physician Fee Schedule at the time of application;
- Have a currently practicing interdisciplinary team at the time of model announcement that has provided at least 6 of the 9 care delivery domains described in the “Care Delivery” section, for at least the past 12 months prior to the deadline for application submissions, to people living with dementia;
- Submit the NPIs of the Medicare-enrolled physicians and non-physician practitioners who they are proposing to provide services under the GUIDE Model (“Proposed GUIDE Practitioner Roster”);
- If applicable, submit a proposed list of the Partner Organizations with whom they would like to partner in order to meet the care delivery requirements of the GUIDE Model (“Proposed Partner Organization Roster”); and

- Use an electronic health record platform that meets CMS and Office of the National Coordinator for Health Information Technology (ONC) standards for Certified Electronic Health Record Technology (CEHRT) as defined at [42 CFR 414.1305](#).³⁷

New program track

To be eligible for the new program track, an applicant must:

- Be a legal entity formed under applicable state, federal, or Tribal law, that is authorized to conduct business in each state in which it operates;
- Attest that prior to execution of the Participation Agreement (in Spring 2024), it will have established a single, Part B enrolled TIN that is eligible to bill under the Medicare Physician Fee Schedule for the purposes of GUIDE Model participation;
- Either not provide comprehensive dementia care to people living with dementia at time of application (defined as at least 6 of the 9 care delivery domains described in the “Care Delivery” section, delivered by an interdisciplinary team), or provide comprehensive dementia care, but have only done so for less than 12 months prior to the deadline for application submissions.
- Describe, in their application, plans to implement a dementia care program that include:
 - Strategies for staffing;
 - Development of program protocols and workflows;
 - Training;
 - Development of a provider network; and
 - Identifying a program director who will have primary accountability for implementing the dementia care program.

Applicants do not need to have a Medicare Part B enrolled TIN that is eligible to bill under the PFS at the time of application to the GUIDE Model, but if selected for participation, the applicant must have one prior to execution of the Participation Agreement. Signed Participation Agreements will be due back to CMS in Spring 2024.

Program Integrity Screening

CMS will conduct a Program Integrity (PI) screening of all applicants (including practitioners submitted on an applicant’s Proposed GUIDE Practitioner Roster) and their Proposed Partner Organizations Roster as part of the application review process. CMS may deny selection to an otherwise qualified applicant based on information found during PI screening of the applicant or any other relevant individuals or entities associated with the applicant. For Medicare enrolled providers, the PI review may include the following, without limitation, with respect to the applicant and Medicare enrolled Partner Organizations:

³⁷ ONC has proposed to require USCDI Version 3 in certified health IT products by January 1, 2025. Participants will be required to use certified health IT that has been updated to a required version of the United States Core Data for Interoperability (USCDI) Version 3, where applicable for certified functionality required under the CEHRT definition at 42 CFR 414.1305, by the deadline finalized by ONC.

- Confirmation of current Medicare enrollment status as relevant and history of adverse enrollment actions;
- Identification of Medicare and Medicaid debt;
- Review of performance in, and compliance with the terms of, other CMS models, demonstration programs, and initiatives;
- Review of compliance with Medicare and Medicaid program requirements;
- Review of billing history and any administrative audits, investigations, or other activities conducted regarding suspicious billing or other potential program fraud and abuse; and
- Review of any administrative, civil, or criminal actions related to program integrity or other factors relevant to participation in an initiative involving Federal funds.

The PI review may include the following, without limitation, with respect to the non-Medicare enrolled Partner Organizations:

- Confirmation of current licensure or certification with the state, in which they are providing services;
- Review of any criminal actions of the organization and its leadership, including related to program integrity or other factors relevant to participation in an initiative involving Federal funds.

In addition, CMS may also screen parent organizations to support an informed selection process and identify business practice, solvency, and program integrity concerns. Information evaluated may include, but is not limited to: ownership, executive leadership, and care delivery experience.

If an applicant is selected for the new program track, CMS will conduct an additional program integrity screening of the applicant's Proposed GUIDE Practitioner Roster and Proposed Partner Organization Roster when this information is submitted by the May 1, 2025 deadline as explained above under "Participation Requirements".

CMS will conduct program integrity screenings throughout the application period, after selecting participants, and during the performance period, and may deny or terminate participation in the GUIDE Model based on the results of a program integrity screening or other information obtained regarding an individual's or entity's history of program integrity issues at any point during or after the application and selection processes.

Participant Withdrawal Policy

The GUIDE Participant may terminate its participation in the GUIDE Model upon advance written notice to CMS, which must specify the effective date of termination. The GUIDE Participant must provide advance written notice at least 180 days prior to the effective date of termination. Until the effective date of termination, the GUIDE Participant must continue to provide model services to aligned beneficiaries and may not accept the voluntary alignment of new beneficiaries. The GUIDE Participant must also notify its aligned beneficiaries of its withdrawal from the GUIDE Model.

Beneficiary Eligibility and Beneficiary Alignment

Overview

The GUIDE Model is designed to serve community-dwelling³⁸ Medicare FFS beneficiaries, including beneficiaries dually eligible for Medicare and Medicaid, who have dementia. For the purposes of the GUIDE Model, a caregiver will be defined as a relative, or unpaid nonrelative, who assists the beneficiary with activities of daily living³⁹ and/or instrumental activities of daily living.⁴⁰ Depending on the beneficiary's need, the assistance may be episodic, daily, or occasional.

The GUIDE Participant will develop provider networks and conduct outreach and engagement to recruit beneficiaries for the GUIDE Model. GUIDE Participants in the established program track are required to offer the opportunity to voluntarily align to their DCP to all beneficiaries with dementia to whom they already provide dementia care services. CMS will also employ several outreach strategies to supplement GUIDE Participants' beneficiary recruitment activities (see "Beneficiary Outreach and Engagement" section below for more detail).

The GUIDE Model will use a voluntary alignment process for aligning beneficiaries to GUIDE Participants. The beneficiary will learn about the GUIDE Model through a GUIDE Participant's recruitment activities or CMS's outreach strategies and the beneficiary will have to consent to receive services from a specific GUIDE Participant to be aligned to that GUIDE Participant. Even after a beneficiary has opted in and been aligned to a GUIDE Participant, the GUIDE Model does not impact or restrict a beneficiary's ability to choose to receive health services from any provider or supplier.

Beneficiary Eligibility

A beneficiary must meet the following criteria to be eligible for voluntary alignment to a GUIDE Participant:

- Has dementia, as confirmed by attestation from a clinician on the GUIDE Participant's GUIDE Practitioner Roster (see "Dementia Diagnosis Attestation" for more information);
- Enrolled in Medicare Parts A and B;
- Not enrolled in Medicare Advantage, including Special Needs Plans (SNPs);
- Have Medicare as their primary payer;
- Not enrolled in the Program of All-Inclusive Care for the Elderly (PACE);
- Has not elected the Medicare hospice benefit; and
- Not a long-term nursing home resident (defined as residence in a nursing home that is not paid for under the Medicare skilled nursing facility benefit)

³⁸ "Community-dwelling" is defined as living in a personal home, assisted living facility, group home, or other community setting and excludes beneficiaries who become a long-term nursing home resident, defined as a nursing facility stay that is not covered under the Medicare skilled nursing facility benefit. Beneficiaries will still be considered community-dwelling for purposes of this model if they are admitted to an acute care hospital or receive post-acute care in skilled nursing facility.

³⁹ Basic personal everyday activities that include bathing, dressing, transferring, toileting, mobility and eating.

⁴⁰ Activities related to independent living, including preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework, and communication.

Beneficiaries who are enrolled in PACE or have elected hospice will not be eligible for alignment to a GUIDE Participant because PACE and hospice services could overlap significantly with the services that will be provided under the GUIDE Model.

Dementia Diagnosis Attestation

Beneficiaries must have dementia to be eligible for alignment to a GUIDE Participant but may be at any stage of dementia—mild, moderate, or severe (note that mild cognitive impairment is not a dementia diagnosis and is not sufficient to meet this eligibility criteria). To confirm that beneficiaries have dementia that makes them eligible for the GUIDE Model, CMS will rely on clinician attestation rather than prior claims-based ICD-10 dementia diagnosis codes.⁴¹ A clinician on the GUIDE Participant’s GUIDE Practitioner Roster must attest that based on their comprehensive assessment, beneficiaries meet the National Institute on Aging-Alzheimer’s Association diagnostic guidelines for dementia⁴² and/or the DSM-5 diagnostic guidelines for major neurocognitive disorder.⁴³ Alternatively, they may attest that they have received a written report of a documented dementia diagnosis from another Medicare-enrolled practitioner.

Beneficiary Outreach and Engagement

To maximize the number of beneficiaries who receive services through the GUIDE Model, the GUIDE Model will use a three-pronged approach to identifying and recruiting potentially eligible beneficiaries:

- 1) Provider Networks:** GUIDE Participants will develop provider networks with primary care providers, neurologists, hospitalists, hospital discharge planning staff, community-based organizations, and other relevant groups in the community. Organizations from those networks may recommend beneficiaries who already have a dementia diagnosis as well as beneficiaries with suspected dementia but no formal diagnosis to the GUIDE Participant. GUIDE Participants will work with network organizations to develop appropriate referral criteria and protocols. Any networks, criteria, and protocols must comply with all applicable fraud and abuse laws.
- 2) CMS data sharing based on claims:** Following a request by the GUIDE Participant, CMS will use claims data from a three-year historical look-back period that falls within the five years prior to the start date of the Model Performance Period, to identify beneficiaries who received Medicare services from a GUIDE Participant, have claims-based ICD-10 dementia diagnosis codes, and are eligible for the GUIDE Model. Using these criteria, CMS will offer GUIDE Participants a one-time opportunity to request, prior to the GUIDE Participant’s first performance year, a list of eligible Medicare FFS beneficiaries with dementia diagnosis codes. The list would include beneficiaries to whom the GUIDE Participant provided services during the three-year historical lookback

⁴¹ As discussed in more detail under the section titled Payment Design, after a beneficiary is voluntarily aligned to the GUIDE Participant, the GUIDE Participant must attach an eligible ICD-10 dementia diagnosis code to each DCMP claim for the claim to be paid.

⁴² McKhann GM, Knopman DS, Chertkow H, et al. The diagnosis of dementia due to Alzheimer's disease: Recommendations from the National Institute on Aging-Alzheimer's Association workgroups on diagnostic guidelines for Alzheimer's disease. *Alzheimers & Dementia*. May 2011; 7(3): 263–269.

⁴³ Sachdev PS, Blacker D, Blazer DG, et al. Classifying neurocognitive disorders: the DSM-5 Approach. *Nature Reviews Neurology*. 30 September 2014.

period, but who are not currently aligned to the GUIDE Participant. GUIDE Participants will be able to use this data to supplement their existing data to reach out to beneficiaries with dementia who they are serving or have already served. CMS will not automatically align these beneficiaries to the GUIDE Participant—these beneficiaries must still voluntarily align to the GUIDE Participant.

- 3) **Beneficiary Outreach Letter:** CMS will send targeted outreach letters to eligible beneficiaries with dementia diagnosis codes in their claims' history, informing them about the GUIDE Model and how to voluntarily align with a GUIDE Participant in their area, enabling them to self-identify for the GUIDE Model. Mailings will use sensitive, beneficiary-friendly language and will not include information about available in-kind beneficiary incentives. This beneficiary identification pathway is part of the GUIDE Model's health equity strategy.

To support this outreach, GUIDE Participants will be required to submit to CMS and maintain a zip-code based service area encompassing the zip codes from which the GUIDE Participants are willing to accept beneficiaries. In defining a service area, GUIDE Participants should keep in mind the GUIDE Model requirements to provide a home visit and GUIDE Respite Services to beneficiaries in certain model tiers and make referrals to community-based services and supports. CMS will list multiple GUIDE Participants in the targeted outreach letters if there is more than one GUIDE Participant in a service area. The beneficiary may decide, in their sole discretion, which GUIDE Participant to contact if the beneficiary is interested in the GUIDE Model.

Beneficiary Alignment

After a potentially eligible beneficiary is identified through one of the three pathways described above, the next step is for the GUIDE Participant to schedule the person with dementia, or suspected dementia, for an initial comprehensive assessment visit. The GUIDE Participant may choose to do an initial pre-screening call to rule out beneficiaries who are ineligible for the GUIDE Model, but this is not required. During the initial comprehensive assessment visit, which is similar to the Medicare service identified by CPT code 99483, Cognitive Assessment and Planning,⁴⁴ the GUIDE Participant's interdisciplinary care team will assess the beneficiary and their caregiver (if applicable) across a number of required domains, including cognitive function, functional status, clinical needs, behavioral and psychosocial needs, and caregiver burden, with the goal of confirming a dementia diagnosis and creating a comprehensive care plan.

During the assessment, if the interdisciplinary care team determines that the beneficiary has dementia and may be eligible to be aligned to the GUIDE Participant, then the care team must obtain the beneficiary's consent to voluntarily align to the GUIDE Participant. If the beneficiary, or their legal representative if applicable,⁴⁵ consents, the GUIDE Participant will electronically submit a Patient

⁴⁴ Cognitive Assessment and Care Plan Services. Centers for Medicare and Medicaid Services.
<https://www.cms.gov/cognitive>

⁴⁵ If the GUIDE Participant finds that the beneficiary lacks capacity to consent to voluntarily align to a participant, the GUIDE Participant will identify and recognize the beneficiary's legal representative, if any, who has the

Assessment and Alignment form to CMS (see Appendix C for a sample Patient Assessment and Alignment form).

If after the initial assessment, the interdisciplinary care team determines that the beneficiary requires further testing to confirm a diagnosis, they may refer the beneficiary for such testing. If further testing confirms a dementia diagnosis, the GUIDE Participant could offer the beneficiary the opportunity to voluntarily align and submit a Patient Assessment and Alignment form to CMS at that time. If the interdisciplinary care team assesses a beneficiary, or refers a beneficiary for additional diagnostic testing, and determines that the beneficiary does not have dementia, the GUIDE Participant can bill for an appropriate Medicare-covered professional service that corresponds to the service rendered.

The Patient Assessment and Alignment form will include an attestation from a practitioner on the GUIDE Participant's GUIDE Practitioner Roster that the beneficiary has dementia. CMS will use the information submitted on the Patient Assessment and Alignment form to confirm the beneficiary's eligibility for alignment to the GUIDE Participant. If CMS finds that the beneficiary is eligible, then CMS will align the beneficiary to the GUIDE Participant. Figure 1 summarizes the entire beneficiary identification and voluntary alignment process.

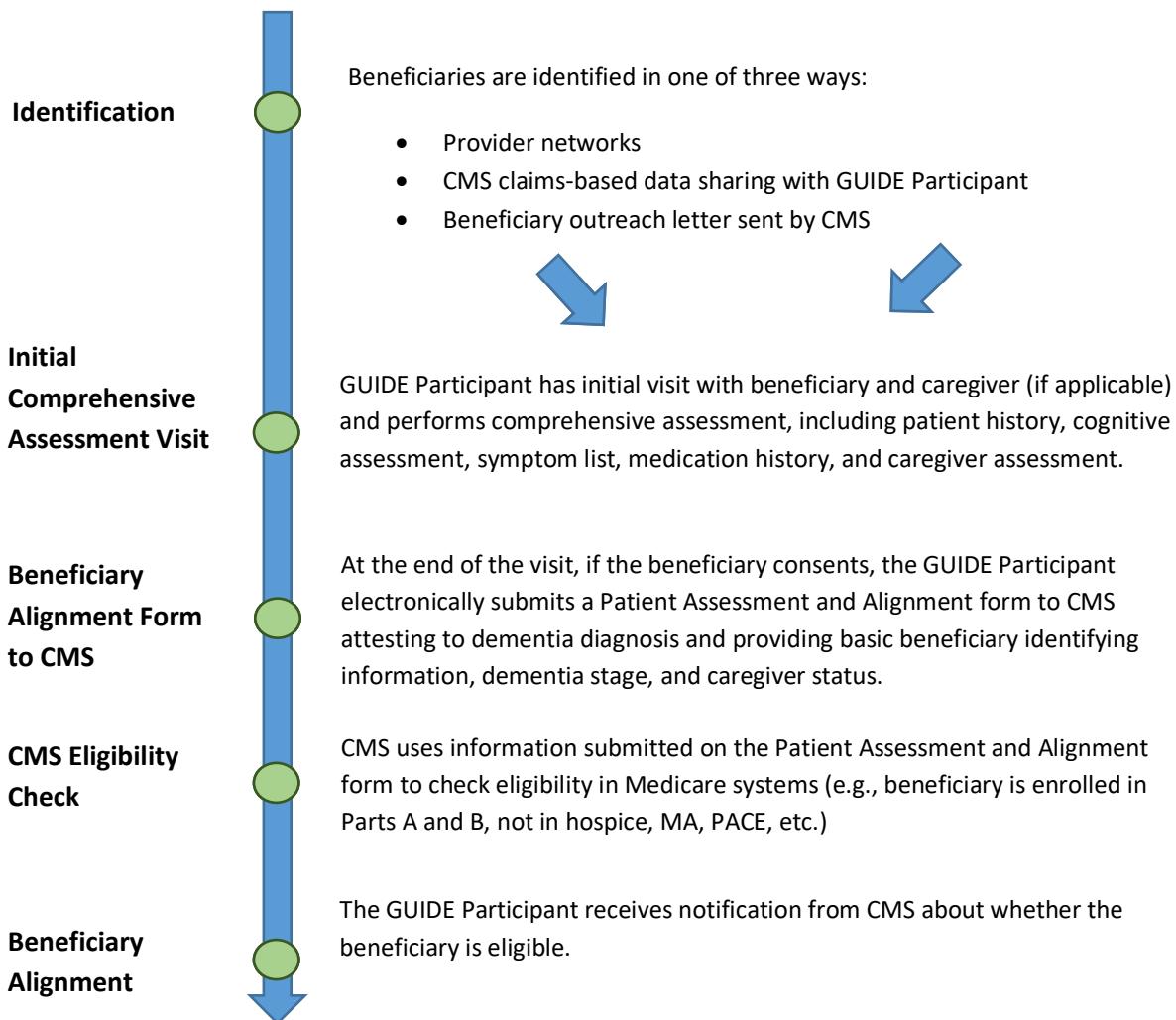
Beneficiary alignment will occur on a rolling, ongoing basis for the first seven years of the GUIDE Model (July 1, 2024-June 30, 2031). GUIDE Participants will be encouraged to meet a minimum threshold of 200 aligned beneficiaries by the end of their second performance year and maintain this alignment level throughout the rest of the Model Performance Period.

Beneficiaries will remain aligned to the GUIDE Participant until they become ineligible. For example, an aligned beneficiary would be deemed ineligible if they no longer meet one of the beneficiary eligibility requirements or stop receiving model services from the GUIDE Participant (e.g., because they move out of the program service area, no longer wish to be aligned to the GUIDE Participant, or cannot be contacted/are lost to follow-up).

To support an organized wind-down of model operations and ensure that all aligned beneficiaries receive meaningful support from the GUIDE Model, new beneficiaries may not be aligned during the eighth and final year of the GUIDE Model (July 1, 2031-June 30, 2032).

authority to make health care decisions for the beneficiary (i.e., health care power of attorney, court appointed legal guardian, etc.), and obtain the legal representative's consent, acting on behalf of the beneficiary, to voluntarily align the beneficiary to the GUIDE Participant. The GUIDE Participant will record such legal representative's authority to make health care decisions for the beneficiary by keeping a copy of the respective court order, medical power of attorney, or other relevant document granting the legal representative's authority in the beneficiary's file.

Figure 1: New Beneficiary Identification, Eligibility Check, and Voluntary Alignment Process



Model Tiers

CMS will assign aligned beneficiaries to one of five “model tiers,” based on a combination of their disease stage, whether they have a caregiver, and if applicable, the degree of burden their caregiver is experiencing. Beneficiary and caregiver complexity, and correspondingly, care intensity and payment, will increase by tier. See Table 2 for a description of the five tiers.

To ensure consistent beneficiary assignment to tiers across GUIDE Participants, the GUIDE Participant must use a tool from a set of approved screening tools to measure dementia stage and caregiver burden. Approved tools have established scoring thresholds that correspond to mild, moderate, and severe disease stage or caregiver burden. Alternatively, the GUIDE Participant will have the option to seek CMS approval to use an alternative tool by submitting the proposed tool, along with published evidence that it is valid and reliable and a crosswalk for how it corresponds to the GUIDE Model’s tiering thresholds.

The GUIDE Participant will administer the approved screening tools during the initial comprehensive assessment and submit the resulting scoring data as part of the Patient Assessment and Alignment form. The GUIDE Participant must additionally electronically submit the individual responses to the caregiver assessment to CMS.⁴⁶ CMS will use this data to assign beneficiaries to a model tier, per the tiering criteria outlined in Table 2. The GUIDE Participant will be informed of a beneficiary's model tier assignment at the same time the GUIDE Participant is informed that a beneficiary is eligible and has been aligned to them.

The approved measurement tool set will initially include two tools to report dementia stage – the Clinical Dementia Rating (CDR)⁴⁷ and the Functional Assessment Screening Tool (FAST)⁴⁸ – and one tool to report caregiver strain, the Zarit Burden Interview (ZBI).⁴⁹ Table 2 shows how these tools correspond to model tier criteria. For dementia staging tools (the CDR and the FAST), the selected tools include measures of both cognitive function and activities of daily living (ADL) and/or instrumental activities of daily living (IADL), as ADL/IADL function is an important determinant of level of need for people with dementia. Additional tools may be added to the approved measurement tool set throughout the course of the GUIDE Model. While these are the only specified assessment tools that CMS requires for model tiering and quality measure development, participants may use other assessment tools necessary to meet the care delivery requirements.

Table 2: Five Model Tiers and Assignment Criteria

	Tier	Criteria	Corresponding Assessment Tool Scores
Beneficiaries with a caregiver	Low complexity dyad tier	Mild dementia	CDR= 1, FAST= 4
	Moderate complexity dyad tier	Moderate or severe dementia AND Low to moderate caregiver strain	CDR= 2-3, FAST= 5-7 AND ZBI= 0-60
	High complexity dyad tier	Moderate or severe dementia AND High caregiver strain	CDR= 2-3, FAST= 5-7 AND ZBI= 61-88
Beneficiaries without a caregiver	Low complexity individual tier	Mild dementia	CDR= 1, FAST= 4
	Moderate to high complexity individual tier	Moderate or severe dementia	CDR= 2-3, FAST= 5-7

⁴⁶ CMS will use the caregiver assessment responses to inform the caregiver burden measure development and the Model's evaluation.

⁴⁷ Morris JC. Clinical Dementia Rating: A Reliable and Valid Diagnostic and Staging Measure for Dementia of the Alzheimer Type. International Psychogeriatrics. 10 January 2005.

⁴⁸ Sclan SG and Reisberg B. Functional Assessment Staging (FAST) in Alzheimer's Disease: Reliability, Validity, and Ordinality. International Psychogeriatrics. 07 January 2005.

⁴⁹ Bedard M, Molloy DW, Squire L, et al. The Zarit Burden Interview: A New Short Version and Screening Version. The Gerontologist. October 2021. 41(5): 652-657.

Care Delivery

The GUIDE Model will promote high-quality dementia care by defining and requiring GUIDE Participants to use a comprehensive, standardized care delivery approach for providing care to aligned beneficiaries and their caregivers. The GUIDE care delivery approach includes 1) a standardized package of services that the GUIDE Participant must provide to beneficiaries and their caregivers as relevant to the beneficiary's preferences and needs based on the person-centered plan ("GUIDE Care Delivery Services"), 2) an interdisciplinary care team to deliver these services, and 3) a standardized training requirement for care navigators who are part of the interdisciplinary care team.

Care Delivery Requirements

CMS will require the GUIDE Participant to provide GUIDE Care Delivery Services to its aligned beneficiaries, as applicable and appropriate to each individual beneficiary's needs. Table 3 summarizes the GUIDE Care Delivery Services under nine domains. See Appendix B for detailed requirements of each care delivery domain.

Table 3. Summary of Required Care Delivery Activities by Domain

Domain	Required Activities by Domain
Comprehensive Assessment	<ul style="list-style-type: none">Initial comprehensive assessment that includes clinical, behavioral and psychosocial, and advance care planning domains, as well as caregiver needs and capabilities and home visitReassessments for beneficiary and caregiver at least once per year
Care Plan	<ul style="list-style-type: none">Develop a comprehensive person-centered care plan that addresses all assessment domains and is led by the beneficiaryIf the GUIDE Participant is not a primary care practice, ensure the primary care provider has access to the beneficiary's person-centered care plan
24/7 Access	<ul style="list-style-type: none">Beneficiary has 24/7 access to an interdisciplinary care team member or help line (may be a 3rd party vendor during off-duty hours)Help line must be available to receive ad hoc one-on-one support calls from the caregiver
Ongoing Monitoring and Support	<ul style="list-style-type: none">Care navigator is primary point of contactGUIDE Participant maintains a minimum contact frequency with the beneficiary and/or their caregiver. Minimum contact requirements vary by model tier, as follows:<ul style="list-style-type: none">- Beneficiaries with a caregiver<ul style="list-style-type: none">Low complexity dyad tier: at least quarterlyModerate complexity dyad tier: at least once a monthHigh complexity dyad tier: at least once a month- Beneficiaries without a caregiver<ul style="list-style-type: none">Low complexity individual tier: at least once a monthModerate to high complexity individual tier: at least twice a month
Care Coordination and Transitional Care Management	<ul style="list-style-type: none">If the GUIDE Participant is not a primary care practice, the GUIDE Participant must coordinate with the beneficiary's primary care providerRefer beneficiary to specialists to address co-occurring conditions, as neededEnsure receipt of information back from specialist to add to care planSupport the beneficiary in transitions between personal home and care settings

Referral and Coordination of Services and Supports	<ul style="list-style-type: none"> Maintain or have access to inventory of local/community services Refer and connect beneficiaries to community-based services and supports⁵⁰ For dually eligible beneficiaries, coordinate the delivery of any community-based services and supports with beneficiary's Medicaid HCBS/LTSS case manager, if applicable
Medication Management and Reconciliation	<ul style="list-style-type: none"> Clinician with prescribing authority must review beneficiary's medications Any resulting medication changes must be shared and confirmed with the beneficiary's PCP and other relevant specialists
Caregiver Education and Support ⁵¹	<ul style="list-style-type: none"> Administer a caregiver support program, which must include: <ul style="list-style-type: none"> - caregiver skills training - dementia diagnosis information - support group services - ad hoc one-on-one support calls GUIDE Participant must provide dementia diagnosis information and ad hoc support calls directly, but may contract with a vendor or a community-based organization to provide caregiver skills training and/or refer caregivers to external support group services
Respite	<ul style="list-style-type: none"> Referral and coordination of in-home respite care Option to refer to adult day centers or facility-based respite providers

The GUIDE Care Delivery Services are the minimum services that the GUIDE Participant is required to offer beneficiaries. The GUIDE Participant must be able to provide the GUIDE Care Delivery Services at varying levels of intensity depending on model tier and the beneficiary's individual needs. The GUIDE Participant may offer certain additional services outside of the GUIDE Care Delivery Services, including the in-kind beneficiary engagement incentive permitting GUIDE Participants to use their own funds to provide environmental modifications to the beneficiary's home. See section titled, "Authority to Test the Model", for more information regarding this beneficiary engagement incentive.

As highlighted in Table 3, the delivery of services will be guided by the creation and maintenance of a person-centered care plan, which will detail 1) the beneficiary's goals, strengths, preferences and needs, 2) the results from the comprehensive assessment, 3) recommendations for service providers and community-based services and supports, including which individual or program is responsible for payment of each service provider, and 4) the caregiver's options and preferences for education and support services (if there is a caregiver). The care plan will also identify the beneficiary's primary care provider and any specialists and outline the care coordination services and specialists that are needed to manage the beneficiary's dementia and co-occurring conditions.

The requirements also recognize the critical role that caregivers play in caring for people with dementia by offering caregiver education and support services, as well as including the caregiver, with the

⁵⁰ For purposes of the GUIDE Model, the term "community-based services and supports" is defined as services and supports delivered to individuals living in their personal home, assisted living facility, group home, or other community setting that create or maintain the individual's ability to safely live in the community. For example, this term includes, but is not limited to, such services and supports as transportation, home-delivered meals or groceries, environmental modifications, in home care/assistance, and exercise and socialization activities.

⁵¹ Based on our conversations with stakeholders, we anticipate that most beneficiaries will identify a caregiver. Nevertheless, beneficiaries without caregivers may still receive services under the model. Under such circumstances, the domains of Caregiver Assessment and Caregiver Education and Support will not apply to that beneficiary, as a caregiver is not involved to receive those services. Instead, the GUIDE Participant must make additional efforts and put safeguards into its care delivery services to support beneficiaries without a caregiver.

beneficiary's consent, or the consent of the beneficiary's legal representative if applicable, in discussions about the beneficiary's diagnosis, care, and needs. The GUIDE Participant must administer a caregiver support program that is based on the caregiver's needs as identified through the comprehensive assessment and is responsive to ongoing changes in need. The minimum level of services available to the caregiver should include caregiver skills training, dementia diagnosis information, and support services. For support services, at a minimum, the GUIDE Participant must include ad hoc one-on-one support calls with a member of the care team and referral to support group services.

Care Team Requirements

The GUIDE Participant must maintain an interdisciplinary care team to meet the care delivery requirements of the GUIDE Model.

At a minimum, the interdisciplinary care team must include a "care navigator" and a clinician with "dementia proficiency" who is eligible to bill Medicare Part B evaluation and management services (E/M), such as a physician, nurse practitioner, physician assistant, or clinical nurse specialist. The interdisciplinary care team may also include additional members, such as a pharmacist or behavioral health specialist, at the GUIDE Participant's discretion.

Care Navigator: To serve as a care navigator under the GUIDE Model, an individual must satisfy the training requirements described under the section titled "Care Navigator Training." CMS is not requiring individuals to have specific professional backgrounds or certifications to work as a Care Navigator, though CMS believes that registered nurses, licensed clinical social workers, and community health workers would all be well-suited to this role. The care navigator must be an individual and not artificial intelligence.

Clinician with dementia proficiency: A clinician will qualify as having "dementia proficiency" if they can meet at least one of the following criteria:

- i. Attest to having at least 25 percent of their patient panel (regardless of payer) at some time in the past 5 years comprised of adults with any cognitive impairment, including dementia; or
- ii. Attest to having at least 25 percent of their patient panel (regardless of payer) at some time in the past 5 years comprised of adults aged 65 years old or older; or
- iii. Have a specialty designation of neurology, psychiatry, geriatrics, geriatric psychiatry, behavioral neurology, or geriatric neurology.

To be eligible for the established program track, an applicant must attest that their care team includes a clinician that meets "dementia proficiency" qualifications when they apply to participate in the GUIDE Model. Participants in the new program track must complete this attestation when they submit their Proposed GUIDE Practitioner Roster before the start of their first performance year. If the clinician with dementia proficiency is not a physician, the GUIDE Participant must have an additional part-time medical director who is a physician oversee the quality of care for its dementia care program.

Care Navigator Training

A comprehensive training program is necessary to support the individuals in the care navigator role, particularly since this role can be filled by a non-practitioner lay person such as a community health worker.⁵² The purpose of the training is to provide a foundation for care navigators prior to delivering services to beneficiaries. The GUIDE Participant must deliver this one-time training when a care navigator joins the care team, regardless of the care navigator's professional background.⁵³ This required training will also promote consistency of the model intervention by ensuring that care navigators are receiving training on a standardized set of topics across all GUIDE Participants.

The GUIDE Participant must develop and administer care navigator training that covers certain required topics, as outlined below and described in the Participation Agreement. To the extent possible, the GUIDE Participant may use a combination of training programs that are already available to meet this requirement.

An applicant with an established dementia care program may already provide staff trainings that are largely consistent with the proposed training topics, but they may need to modify, or add to, their training program to comply with model requirements. GUIDE Participants in the new program track must develop a training program to comply with model requirements by the start of their first performance year.

CMS will support GUIDE Participants in both the established program track and the new program track in obtaining training and support resources through webinars, affinity groups and written materials. The GUIDE Model will also provide an online platform for GUIDE Participants to engage with each other to discuss forums, conferences, and other additional learning opportunities.

The GUIDE Participant's care navigator training curriculum must address the following topics:

Table 4. Required Care Navigator Training Topics

Topic	Further detail of topic
Background on Dementia	Overview of dementia as a medical condition; Progression of disease and balancing dementia with other co-morbidities
Overview of Assessments	Assessments available related to dementia; Recommendations for a successful assessment
Care Plan	What is a care plan; Including beneficiary in the development of plan
Person-Centered Planning	What person-centered planning means; How to incorporate into planning
Challenging Behaviors	Behavioral symptom management; Common behavioral changes due to dementia and how to address

⁵² For an overview of the benefits that community health worker programs can bring to health care organizations and the people they serve, see On the Front Lines of Health Equity: Community Health Workers. U.S. Department of Health and Human Services. April 2021. <https://www.cms.gov/files/document/community-health-worker.pdf>.

⁵³ If an established dementia care program has staff that took training on a model's required topic in the past five years and has continued to work for the program during this time, the staff will not need to retake the training on that topic for the purposes of the model.

Functional Needs	What are activities of daily living (ADLs) and instrumental activities of daily living (IADLs); Evaluation of ADLs and IADLs; Common changes in ADLs and IADLs due to dementia and how to address; Medication monitoring and maintaining a medication schedule
Advanced Care Planning	What is an advance medical directive and POLST form; How to assist beneficiary in advance care planning
Decision-Making Capacity	What is capacity for medical decision-making; What it means when a beneficiary does not have capacity for medical decision-making; supported decision-making
Safety	Considerations for safety at home, in public, and driving; elder abuse, neglect, and financial exploitation; access to weapons and dangerous substances
Communication	Communication strategies for persons with dementia and their caregivers
Coordination of medical care and community services	Communication with clinical providers; Supporting beneficiary in transitions between settings; Accessing community-based services and supports, including respite services; Working with case managers and other coordinators to address gaps and duplication in a beneficiary's community-based services and supports
Supporting a Caregiver	Caregiver strain and support (e.g.: peer-to-peer support, support group, 1:1 support); In-home caregiver training and importance of caregiver education
Diversity in Dementia	Treating dementia and communicating with diverse populations in a culturally competent way

The training must be a minimum of 20 hours, including a minimum of 10 hours of didactic instruction plus a minimum of 10 hours of experiential training, e.g., job shadowing of experienced care navigators, supervised interactions with beneficiaries, case studies, or on-the-job training. The minimum of 10 hours of didactic instruction may be live or a web-based training. The minimum of 10 hours of experiential training must be live, not asynchronous. The GUIDE Participant must develop an assessment for care navigators to take after the training to ensure comprehension.

Care navigators must take an additional 2 hours of training each year. This training may be developed and offered by the GUIDE Participant or be a continuing education training offered by a third party.

Care Delivery Reporting

The GUIDE Participant will complete care delivery reporting at least once per year, which will consist of a series of questions about how they are implementing the care delivery requirements of the GUIDE Model, including how frequently they are interacting with aligned beneficiaries and their caregivers and what care modalities they are using. Care delivery reporting will also include a Health Equity Plan section, as discussed in the “Health Equity Strategy” section.

GUIDE Participants in the established program track will be required to complete their first care delivery reporting during a 60-day window that will begin one month before the start of the Model Performance Period (June 1, 2024—July 31, 2024). This “baseline” care delivery reporting will enable CMS to understand GUIDE Participants’ capabilities at the beginning of the GUIDE Model and assess how they evolve over time. Beginning in their second performance year, established program track participants will complete care delivery reporting, including health equity plan submission, annually at the start of each performance year.

GUIDE Participants in the new program track will be required to complete their first care delivery reporting by May 1, 2025, which is two months before the beginning of their first performance year. This reporting will be used to determine whether new program track participants are able to meet the care delivery requirements of the GUIDE Model before starting their first performance year. Beginning in their second performance year, new program track participants will be required to complete care delivery reporting, including health equity plan submission, on the same timeline as established participants (i.e., annually at the start of each performance year).

Figure 2: Care Delivery Reporting Timeline



Performance Measurement

CMS will adjust GUIDE Participants' monthly DCMP based on the GUIDE Participant's performance on a set of performance metrics that align with the GUIDE Model's goals, so that GUIDE Participants are financially rewarded when they achieve these goals for their aligned beneficiaries and held accountable when they do not.

Performance Metrics

To the extent possible, the CMS Innovation Center aims to minimize provider burden and create alignment across CMS by selecting performance measures for the GUIDE Model that are already being used in other CMS programs. In particular, the CMS Innovation Center aims to align to the extent feasible with the MIPS Value Pathway (MVP) called "Supportive Care for Neurodegenerative Conditions MVP" ("Neuro MVP"), which focuses on the clinical theme of promoting high quality care for patients with cognitive-based neurological disorders, including but not limited to dementia.

CMS will also develop two new metrics to assess GUIDE Participant performance: a measure of caregiver burden and a metric of long-term nursing home utilization.

CMS intends to eventually include five measures in the GUIDE performance measure set: one clinical quality process measure, two patient-reported outcome measures, one cost measure, and one utilization measure. Table 5 provides an overview of the five measures and is followed by a more detailed discussion of each measure. The five measures in the performance measure set will be used to adjust GUIDE Participants' monthly payments. CMS plans to phase in the use of these measures over

time. See the “Performance-Based Adjustment” section for details on how this adjustment will be calculated.

Table 5: GUIDE Performance Measure Set

Measure Name	Aligned Model Goals	MIPS, NQF Measure?	Neuro MVP?	Measure Type & Mode
Use of High-Risk Medications in Older Adults	Improve beneficiary quality of life; reduce hospital and ED utilization	MIPS: Yes, #238 NQF: Yes, #0022	Yes	Process CQM eCQM
Quality of Life Outcome for People with Neurological Conditions	Improve beneficiary quality of life	MIPS: Yes, #AAN22 NQF: No	Yes	PROM Survey (Registry)
Caregiver Burden Measure	Reduce caregiver burden	MIPS: No NQF: No	No	PROM Survey
Total Per Capita Cost (TPCC)	Reduce cost of care	MIPS: Yes NQF: Yes, #3575	No	Cost Claims-based
New: Rate of beneficiaries entering a long-term nursing home stay	Prevent or delay long-term nursing home stays; reduce cost of care (or maintain budget neutrality)	MIPS: No NQF: No	No	Utilization Claims-based

Use of high-risk medications in older adults (MIPS #238, NQF #0022)⁵⁴: Medication-related issues, including prescription of contraindicated medications and non-adherence to recommended medications, are common among people with dementia and can lead to avoidable hospitalizations and ED use.^{55,56} This process measure assesses the percentage of patients 65 years of age and older who were ordered two or more high-risk medications. This measure is part of the Neuro MVP.

Quality of life outcome for people with neurological conditions (MIPS #AAN22): Beneficiary quality of life will be the primary patient-reported outcome measure (PROM) for the GUIDE Model. This PROM measures the percentage of patients whose quality-of-life assessment results are maintained or improved during the measurement period, and is reported through a registry. This measure is part of the Neuro MVP.

Caregiver Burden Measure: Reducing caregiver burden is another primary model objective, for which there is not an existing outcomes measure. CMS will develop a measure of this purpose and use a

⁵⁴ Link to the Neuro MVP measure specifications: <https://qpp.cms.gov/mips/explore-mips-value-pathways/M0004>

⁵⁵ El-Saifi N, Moyle W, Jones C, and Tuffaha H. Medication Adherence in Older Patients with Dementia: A Systematic Literature Review. Journal of Pharmacy Practice. May 2017. 31(3).

⁵⁶ Wucherer D, Thyrian JR, Eichler T et al. Drug-related problems in community-dwelling primary care patients screened positive for dementia. International Psychogeriatrics. August 2017.

survey-based tool to capture the burden and strain caregivers encounter in their caregiving role. The measure development process could take several years.

Total per capita cost (TPCC) (NQF #3575): The TPCC measure will measure performance on costs and incentivize reductions in a variety of avoidable utilization categories, including hospital, ED, and post-acute care. TPCC is a MIPS measure.

Rate of beneficiaries entering a long-term nursing home: A metric of long-term nursing home stays is important because nursing home delay or avoidance is expected to be a key source of model savings. There is no existing performance measure that fully captures long-term nursing home stays in older adults (existing measures are specified for Medicaid managed care, and either include primarily short-term nursing home stays or are more appropriate for adults with intellectual and developmental disabilities).⁵⁷ Rather than fully develop a new, validated performance measure, CMS will calculate a performance rate and benchmarks using CMS administrative data, which will allow CMS to incorporate this metric into the performance-based payment adjustment more quickly (i.e., in the first or second model performance year). Specifically, CMS will use the CMS Minimum Data Set file to identify beneficiaries residing in a nursing home whose stay is not covered under the Medicare skilled nursing facility benefit.

Performance Benchmarks

CMS will compare GUIDE Participants' scores on the five model performance metrics to performance benchmarks in order to determine their performance-based adjustment (see "Payment Design" section for more information on the PBA). CMS will calculate performance benchmarks that are specific to the GUIDE Model (in other words, CMS will not use benchmarks from other programs, such as MIPS). Where possible, when measures are claims-based, CMS will calculate benchmarks from a blend of both GUIDE Participants and non-participants.

For non-claims-based measures, where non-participant data is unavailable, CMS will calculate benchmarks from GUIDE Participant data alone. For such measures, in later years of the GUIDE Model, CMS may consider modifying benchmarks as more data becomes available.

To ensure that CMS is setting accurate and meaningful benchmarks for GUIDE Participants, the GUIDE Model will have a "pay for reporting" approach for the first year of the Model Performance Period for the non-claims-based measures (beneficiary quality of life and high-risk medication utilization). Viewing the distribution of data from this year will allow CMS to set appropriate performance benchmarks for future years. Based on the data reported in the first year of the Model Performance Period, CMS will set benchmarks for each measure and keep them constant for the second and third years. For example, for the quality-of-life measure, GUIDE Participants in the established program track will receive credit for reporting quality data for July 1, 2024 – June 30, 2025. CMS will use this data to calculate performance benchmarks. These benchmarks will be used to assess performance for GUIDE Participants in both the new and established program tracks in the second and third years of the Model Performance Period. After the third year, based on the two additional years of quality data, CMS will decide whether to

⁵⁷ CMS SMD# 22-003 RE: Home and Community-Based Services Quality Measure Set:
<https://www.medicaid.gov/federal-policy-guidance/downloads/smd22003.pdf>

continue to hold the benchmarks constant or update the benchmark for future years. Participants in the new program track will not have pay for reporting, since their first performance year will be the second year of the Model Performance Period, when benchmarks have been established.

For the claims-based measures (TPCC and Long-Term Nursing Home Stay Rate), benchmarks for the first year of the Model Performance Period will be calculated based on claims data from prior to the Model (e.g., CY 2022). Benchmarks will then be updated for the second year based on data from the first year. Benchmarks will be kept constant for the third year, after which time CMS will decide whether to update the benchmarks.

On an annual basis, CMS will publish a methodology paper with the technical specifications and benchmarks for the performance measures. The methodology paper will be made available to GUIDE Participants 30 days before the applicable performance year.

Table 6: GUIDE Performance Metric Benchmarks

Measure	Benchmark group	Timing
Use of High-Risk Medications in Older Adults	GUIDE Participants	-Pay for reporting PY 1 -PY 2 and PY 3 benchmark based on PY 1 data -CMS to decide how to update benchmarks after PY 3 and publish information in the annual methodology paper
Quality of Life Outcome for People with Neurological Conditions	GUIDE Participants	-Pay for reporting Year 1 -PY 2 and PY 3 benchmark based on PY 1 data -CMS to decide how to update benchmarks after PY 3 and publish information in the annual methodology paper
Caregiver Burden Measure	GUIDE Participants	Pending measure development process
Total Per Capita Cost	GUIDE Participants and non-participants within a geographic region	-Based on CY 2023 data for PY 1 -PY 2 and PY 3 benchmark based on PY 1 data -CMS to decide how to update benchmarks after PY 3 and publish information in the annual methodology paper
Rate of beneficiaries with a long-term nursing home stay	GUIDE Participants and non-participants	-Based on CY 2023 data for PY 1 -PY 2 and PY 3 benchmark based on PY 1 data -CMS to decide how to update benchmarks after PY 3 and publish information in the annual methodology paper

Payment Design

The GUIDE Model will include a monthly per beneficiary care management payment: the Dementia Care Management Payment (DCMP). CMS will adjust the DCMP for health equity and performance on a set of performance measures. The GUIDE Model will also include two other payments: a payment for GUIDE Respite Services and a one-time infrastructure payment for safety net providers in the new program track (if eligible).

The five main components of the GUIDE Model's payment methodology are:

- 1) Monthly DCMP (tiered by patient complexity);
- 2) A health equity adjustment to the DCMP;
- 3) A performance-based payment adjustment to the DCMP;
- 4) A payment for GUIDE Respite Services; and
- 5) A one-time infrastructure payment for safety net providers in the new program track (if eligible)

Dementia Care Management Payment

The DCMP is designed to offer GUIDE Participants more flexibility to deliver personalized dementia care than is possible under traditional FFS. It will cover a more comprehensive set of services than existing care management codes, be less burdensome to bill, and allow for payment to members of the interdisciplinary care team who are otherwise not eligible to bill for Medicare services. The DCMP also will not be subject to beneficiary cost sharing. GUIDE Participants will continue to bill for all services not included in the DCMP under traditional FFS.

GUIDE Participants will use a set of new G-Codes created for the GUIDE Model to submit claims for the monthly DCMP. The DCMP is intended to cover the GUIDE Care Delivery Services (with the exception of GUIDE Respite Services, which is paid for under a separate respite payment).

Each model tier will have a different DCMP rate to reflect the fact that covered services and care intensity will vary across the tiers. For example, for tiers that include beneficiaries without a caregiver, the DCMP does not incorporate payment for caregiver education and support. However, the DCMP rates also reflect the fact that beneficiaries without a caregiver are expected to have more intensive care needs than beneficiaries at a similar disease stage who have a caregiver.

The DCMP rate will also be higher for the first six months that a beneficiary is aligned to a GUIDE Participant to reflect the high intensity of initial program activities, such as the comprehensive assessment, home visit, and establishment and implementation of a new care plan. Beginning in the seventh month after the beneficiary is aligned to a GUIDE Participant, the DCMP rate for that beneficiary will be lower. Each model tier will have two G-codes, for a total of 10 DCMP G-codes: a "new patient" code for the first six months that a beneficiary is aligned to the GUIDE Participant and an "established patient" code for after the first six months. Table 7 shows the DCMP G-code base rates, by model tier and length of alignment.

The GUIDE Participant will be responsible for billing the correct G-code for each aligned beneficiary each month, based on the beneficiary's model tier and length of alignment. The GUIDE Participant must attach an eligible ICD-10 dementia diagnosis code to each DCMP claim for it to be paid; DCMP claims without an eligible ICD-10 diagnosis code will be denied.⁵⁸ In order to support accurate billing, CMS will provide each GUIDE Participant with a monthly beneficiary alignment file that lists all the beneficiaries

⁵⁸ Initial list of eligible ICD-10 dementia diagnosis codes will include: F01.50, F01.511, F01.518, F02.80, F02.811, F02.818, F03.90, F03.911, F03.918, G30.0, G30.1, G30.8, G30.9, G31.1, G31.2, G31.01, G31.09, G31.83. Eligible code list may change over time to reflect updates to ICD-10 codes.

aligned to that GUIDE Participant, their model tier assignment, and the length of their alignment to the GUIDE Participant.

Table 7: Per Beneficiary Per Month (PBPM) Base Payment Rates

	Beneficiaries with Caregiver: Low Complexity Dyad Tier	Beneficiaries with Caregiver: Moderate Complexity Dyad Tier	Beneficiaries with Caregiver: High Complexity Dyad Tier	Beneficiaries without Caregiver: Low Complexity Individual Tier	Beneficiaries without Caregiver: Moderate to High Complexity Individual Tier
First 6 months (New Patient Payment Rate)	\$150	\$275	\$360	\$230	\$390
After first 6 months (Established Patient Payment Rate)	\$65	\$120	\$220	\$120	\$215

The DCMP rates above represent base payment rates and will be adjusted for geographic variation in costs as well as cost growth over time.

To account for geographic variation in costs, CMS will adjust the DCMP base rates by the Medicare Geographic Adjustment Factor (GAF) for each DCMP claim submitted by a GUIDE Participant. The GAF applied to the DCMP is a weighted geographic adjustment based on all services in the Medicare PFS. It summarizes the combined impact of the 3 Geographic Practice Cost Index (GPCI) expense categories (work, practice expense, malpractice) on a locality's (state or metropolitan region's) physician reimbursement level.⁵⁹

To account for cost growth over time, CMS will annually update the DCMP base rates by the Medicare Economic Index (MEI)⁶⁰, a measure of physician practice cost growth calculated by the CMS Office of the Actuary.

Movement between tiers

The GUIDE Participant will be required to re-assess aligned beneficiaries on at least an annual basis. The GUIDE Participant will have the discretion to re-assess beneficiaries more frequently; however, CMS will only accept aligned beneficiary re-assessments from a GUIDE Participant once every 180 days for purposes of the beneficiary moving between tiers. Based on the results of the re-assessment, CMS could assign aligned beneficiaries to either a higher or lower tier, leading to either an increase or decrease in payment rates. When an aligned beneficiary is re-assessed into a new tier, in the following month the GUIDE Participant will be eligible to bill the G-code for the established patient payment rate associated with that tier. The GUIDE Participant will submit re-assessment results to CMS using the Patient Assessment and Alignment Form (see Appendix C).

Cost-sharing for the DCMP

⁵⁹ Updated GAF amounts are published annually as part of the Medicare Physician Fee Schedule regulation addenda: <https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/pfs-federal-regulation-notices>

⁶⁰ For further information on MEI calculations visit <https://www.cms.gov/newsroom/fact-sheets/effect-medicare-economic-index-meи-physician-update>

The DCMP amount will cover both face-to-face and non-face-to-face services in one lump sum. Cost sharing for non-face-to-face services like chronic care management codes has historically been a significant barrier to utilization of these services. CMS will waive the standard 20% coinsurance for the DCMP and CMS will pay the GUIDE Participant 100% of the appropriate DCMP rate rather than 80% for purposes of the GUIDE Model.

Additional Guidance on billing duplicative FFS codes

The DCMP will replace fee-for-service payment for some existing Medicare Physician Fee Schedule (PFS) services, including chronic care management and principal care management, transitional care management, advance care planning, and technology-based check-ins. Therefore, the GUIDE Participant will not be able to bill separately for these services for aligned beneficiaries. CMS will provide GUIDE Participants, who are participating in multiple CMS Innovation Center models, with additional instruction related to billing these services (see section titled, “Program Overlaps and Synergies”). Table 8 provides the set of services that GUIDE Participants will not be able to bill for aligned beneficiaries. CMS may add or remove codes from this list over time to reflect changes in Physician Fee Schedule billing codes.

Table 8: Medicare Physician Fee Schedule Services Included Under DCMP

Service Type	HCPCS Codes
Advance care planning	99497, 99498
Welcome to Medicare and Annual Wellness Visits	G0402, G0438, G0439
Home Health Care Plan Oversight	G0181
Hospice Care Plan Oversight	G0182
Cognitive Assessment and Planning	99483
Technology-based check-in services	G2012, G2252
Transitional Care Management	99495-99496
Chronic Care Management	99487, 99489-99491, 99437, 99439, G0506
Principal Care Management	99424-99427
Administration of patient-focused health risk assessment (HRA)	96160
Administration of caregiver-focused HRA	96161
Depression screening	G0444
Group Caregiver Behavior Management/ Modification Training Services*	96202, 96203
Caregiver Training Services under a Therapy Plan of Care established by a PT, OT, SLP*	97550, 97551, and 97552
Community Health Integration Services*	G0019, G0022
Principal Illness Navigation Services*	G0023, G0024, G0140, and G0146
Administration of a Standardized, Evidence-based Social Determinants of Health Risk Assessment*	G0136

* Services listed on the 2024 Physician Fee Schedule proposed rule which will become effective on or after January 1, 2024.

Health Equity Adjustment

The GUIDE Health Equity Adjustment (HEA) is designed to provide additional resources to GUIDE Participants to deliver care to beneficiaries from underserved communities. CMS will calculate an HEA for each beneficiary that is aligned to a GUIDE Participant, based on the beneficiary's health equity score. The HEA will be calculated annually, and then applied to the DCMP for each beneficiary as a monthly adjustment. The HEA is intended to be budget neutral to minimize the financial impact on the overall model.

The HEA will be calculated using a composite methodology that includes both area-level and beneficiary-level measures of deprivation. Specifically, the HEA will be composed of four measures: state and national comparison Area Deprivation Index (ADI), which are measured at the census block group⁶¹ level, and Low-Income Subsidy (LIS) status and dual eligibility (DE), which are beneficiary-level measures. CMS will calculate an *Equity Score* for every beneficiary b and their corresponding geography g in the aligned population:

$$\text{Equity Score}_{b,g} = (0.1 \times \text{National } ADI_g) + (\text{State } ADI_g) + (20 \times LIS_b \text{ or } DE_b)$$

In the above formula, *National ADI_g* is the ADI national percentile of the census block group the beneficiary resided in on their first day of eligibility and can range from 1 to 100. *State ADI_s* is the ADI state decile of the census block group the beneficiary resided in on their first day of eligibility, and can range from 1 to 10, corresponding to the state decile. CMS is using LIS and DE as the beneficiary-level variables. CMS is including both measures even though CMS expects significant overlap between these two measures because the objective of this policy is to increase access regardless of a beneficiary's full or partial dual status. *LIS_b* represents LIS status and is equal to 1 if the beneficiary receives the LIS, and 0 otherwise. Similarly, *DE_b* represents dual eligibility and is equal to 1 if the beneficiary is dually eligible and 0 otherwise. The possible range of health equity scores is from 0 to 40. In the case of a maximum score, a beneficiary's National ADI would contribute 25%, State ADI would contribute 25%, and LIS or DE status would contribute 50% to the overall score. The equity score formula weights are designed to help CMS most accurately identify underserved populations. The contribution of each factor to the final score balances geographic deprivation in low-income states, geographic deprivation in high-income states, and individual-level income status. LIS/DE is weighted more generously than the area-level measures to ensure that beneficiary-level measures are meaningfully contributing to the beneficiary's overall equity score. CMS may revisit this weighting based on the geographic makeup of participants.

CMS will calculate beneficiary health equity scores and percentiles annually, before the start of the performance year in which they are applied. Because beneficiaries will not be aligned to GUIDE Participants at the time of model launch, the first health equity adjustments will not be applied to the DCMP until the start of the second year of the Model Performance Period, and will be determined based

⁶¹ Census block groups are the next level above census blocks in the geographic hierarchy that is used by the U.S. Census Bureau to report aggregated census data. A census block group is a combination of census blocks.

on data from the first year of the Model Performance Period. Beneficiary health equity scores and percentiles will be reassessed each subsequent year. Table 9 shows how health equity scores are translated into an adjustment to the monthly DCMP.

Table 9. Equity Score Percentiles and Associated Health Equity Adjustment Amounts

Equity Score Percentile	Health Equity Adjustment to DCMP
≥80 th percentile of equity scores	+\$15
51 st -79 th percentile of equity scores	\$0
0-50 th percentile of equity scores	-\$6

This adjustment methodology is designed to provide a material incentive for GUIDE Participants to care for underserved beneficiaries and to be budget neutral while limiting the magnitude of any downward adjustments. CMS may elect to add other measures to the GUIDE Model’s HEA in future performance years.

Performance-Based Adjustment

The performance-based adjustment (PBA) will increase or decrease GUIDE Participants’ monthly DCMPs, depending on how they performed on the GUIDE Model’s five performance metrics during the previous performance year (see the “Performance Measurement” section for more information on the performance metrics and benchmarks). The PBA will be applied as an ongoing percentage adjustment to each GUIDE Participant’s monthly DCMP. Once all the performance metrics are fully phased in, GUIDE Participants can increase their DCMP amount by up to 10% through high performance or decrease their DCMP by as much as -3.5% for poor performance.

Timing of PBA

The GUIDE Participant’s performance during a given performance year will affect their payment in future years. Specifically, the GUIDE Participant’s performance will be calculated beginning three months after the end of the performance year to allow time for reporting and claims run-out, and the resulting PBA will be applied to the GUIDE Participant’s DCMP beginning six months after the end of the performance year, and continuing for 12 months. In other words, there is a six-month lag between the end of the performance year and when results begin to affect payment. For example, for the established program track, the first performance year will be July 2024 through June 2025 and the resulting PBA will be applied from January 2026 through December 2026. Figure 3 demonstrates this timeline. The new program track will follow the same timeline but beginning one year later and with one less performance year.

Figure 3: Timing of Performance Year and Corresponding Performance-Based Adjustment

Calendar Year		2025	2026	2027	2028	2029	2030	2031	2032
Established Program Track	PY 1	PY 2	PY 3	PY 4	PY 5	PY 6	PY 7	PY 8	
	7/2024 – 6/2025	7/2025 – 6/2026	7/2026 – 6/2027	7/2027 – 6/2028	7/2028 – 6/2029	7/2029 – 6/2030	7/2030 – 6/2031	7/2031 – 6/2032	
New Program Track			PBA 1 1/2026-12/2026	PBA 2 1/2027-12/2027	PBA 3 1/2028-12/2028	PBA 4 1/2029-12/2029	PBA 5 1/2030-12/2030	PBA 6 1/2031-12/2031	PBA 7 1/2032-06/2032
	Pre-Implementation Year	PY 1 7/2025 – 6/2026	PY 2 7/2026 – 6/2027	PY 3 7/2027 – 6/2028	PY 4 7/2028 – 6/2029	PY 5 7/2029 – 6/2030	PY 6 7/2030 – 6/2031	PY 7 7/2031 – 6/2032	

PBA Domains, Measures, and Weights

Each of the GUIDE Model's five performance measures will be assigned to one of four domains: care coordination and management, beneficiary quality of life, caregiver support, and utilization.

Each domain, and each measure within a domain, is associated with a minimum and maximum potential PBA amount that GUIDE Participants can earn. How much of the potential PBA amount GUIDE Participants earn for a given measure is determined by their performance. The amount that GUIDE Participants earn for each measure will then be added together to determine their total PBA.

As discussed in more detail below, scoring works differently for domains with a single measure versus domains with multiple measures. There will also be a distinct scoring approach for the two pay-for-reporting measures in the first year of the Model Performance Period.

Scoring for domains with a single measure

For the three domains with a single measure (care coordination and management, beneficiary quality of life, and caregiver support), there will be four performance categories – fail, no adjustment, pass, and exceed. The performance thresholds and associated percentage payment adjustments are as follows:

Table 10: Measure Performance Categories and Associated Payment Adjustments for Domains with a Single Measure

Performance Category		Percentage Adjustment Earned
Fail		-1%
No adjustment		0%
Pass		1.5%
Exceed		3%

Note: Please see the “Performance Measurement” section for more information on how CMS will set the performance benchmarks that determine the cut-off points between each category.

Scoring for the utilization domain

CMS will establish pass/fail benchmarks for the measures in the utilization domain. As shown in Table 11, for each measure in the utilization domain, the GUIDE Participant will receive 1.5% positive adjustment for a pass or a 0.5% negative adjustment for a fail, for a maximum of possible score in the overall domain of a three percent positive adjustment (+3%) or a one percent negative adjustment (-1%).

Table 11: Measure Performance Categories and Associated Payment Adjustments for Utilization Domain

Performance Category	Percentage Adjustment Earned
Fail	-0.5%
Pass	1.5%

Scoring for Pay-for-Reporting in First Year of the GUIDE Model

As discussed in the “Performance Measurement” Section, in the first year of the Model Performance Period, CMS will use a pay-for-reporting methodology for the two non-claims-based measures—high-risk medication utilization and beneficiary quality of life. This means that GUIDE Participants in the established program track will receive full credit for reporting measure data, regardless of their performance. For the high-risk medication measure, the maximum PBA potential for reporting will be +1%. For the quality-of-life measure, the maximum PBA potential for reporting will be +2%. GUIDE Participants will receive a 0% adjustment for any measure they fail to report.

Table 12: Pay-for-Reporting Payment Adjustments

Performance Measure	Percentage Adjustment Earned for Reporting	Percentage Adjustment Earned for Non-Reporting
High-risk medication utilization	+1%	0%
Beneficiary quality of life	+2%	0%

Summary of PBA Domains, Measures, and Associated PBA Potential

Table 13 summarizes how the measures will be assigned to domains and an associated PBA potential once all of the quality metrics are fully phased in.

Table 13: PBA Domains, Measures, and Weights in later Model Performance Years, Once All Performance Measures are Phased In

Domain	Domain Weight	Measure Name	Percent of total domain	Percent of total PBA	Associated PBA Potential
Care coordination and management	10%	Use of High-Risk Medications in Older Adults	100%	10%	-.5% – +1%
Beneficiary quality of life	30%	Quality of Life Outcome for People with Neurological Conditions	100%	30%	-1% – +3%
Caregiver support	30%	New: Caregiver Burden Measure	100%	30%	-1% – +3%
Utilization	30%	Total Per Capita Cost	50%	15%	-.5% – +1.5%
		Rate of beneficiaries entering a long-term nursing home	50%	15%	-.5% – +1.5%
Total PBA Potential					-3.5% to +10%

As a result of measure phase-ins and the development time for certain measures, we anticipate that the maximum PBA adjustment will be no more than 6% and no lower than -1% in the first year of the Model Performance Period, and no more than 7% and no lower than -2.5% in the second year of the Model Performance Period. Tables 14 and 15 show how domain weights will differ in the first two years of the GUIDE Model.

Table 14: PBA Domains, Measures, and Weights for First Year of the GUIDE Model

Domain	Domain Weight	Measure Name	Percent of total domain	Percent of total PBA	Associated PBA Potential
Care coordination and management	16%	Use of High-Risk Medications in Older Adults	100%	16%	0% - +1%
Beneficiary quality of life	34%	Quality of Life Outcome for People with Neurological Conditions	100%	34%	0% - +2%
Utilization	50%	Total Per Capita Cost	50%	25%	-.5% – +1.5%
		Rate of beneficiaries with a long-term nursing home stay	50%	25%	-.5% – +1.5%
Total PBA Potential					-1% to +6%

Table 15: PBA Domains, Measures, and Weights for Second Year of the GUIDE Model (e.g., PY 2 for the established program track and PY 1 for the new program track)

Domain	Domain Weight	Measure Name	Percent of total domain	Percent of total PBA	Associated PBA Potential
Care coordination and management	14%	Use of High-Risk Medications in Older Adults	100%	20%	-.5% – +1%
Beneficiary quality of life	43%	Quality of Life Outcome for People with Neurological Conditions	100%	40%	-1% – +3%
Utilization	43%	Total Per Capita Cost	50%	21.5%	-.5% – +1.5%
		Rate of beneficiaries with a long-term nursing home stay	50%	21.5%	-.5% – +1.5%
Total PBA Potential					-2.5% to +7%

Example PBA Calculations

Example #1:

In the first year of the GUIDE Model, one measure will be under development, and two measures will be pay-for-reporting. Table 16 shows an example PBA calculation for the first year of the GUIDE Model.

Table 16: Example PBA calculation for established program in first year of the GUIDE Model

Domain	Measure	Performance Achieved	PBA
Care Coordination and Management	High-risk medications	Data reported (<i>Pass</i>)	+1%
Beneficiary quality of life	Quality of life outcome	Data reported (<i>Pass</i>)	+2%
Caregiver Support	Caregiver Burden Measure (<i>in development</i>)	n/a	n/a
Utilization	TPCC measure	Fail	-0.5%
	Long-term nursing home stay rate	Pass	+1.5%
Total PBA Earned			+4%

Example #2:

Table 17 shows an example PBA calculation for a GUIDE Participant once all performance measures are fully phased in.

Table 17: Example PBA calculation once all performance measures are fully phased in

Domain	Measure	Performance Achieved	PBA
Care Coordination and Management	High-risk medications	Pass	+1%
Beneficiary quality of life	Quality of life outcome	Exceed	+3%
Caregiver Support	Caregiver Burden Measure	Exceed	+3%
Utilization	TPCC measure	Pass	+1.5%
	Long-term nursing home stay rate	Pass	+1.5%
Total PBA Earned			+10%

Respite Payment

GUIDE Participants must provide, or contract with another organization to provide, in-home GUIDE Respite Services to aligned beneficiaries who are eligible to receive GUIDE Respite Services⁶² (see below, *Eligibility Requirements for Aligned Beneficiaries to Receive GUIDE Respite Services*). GUIDE Participants may also choose to provide, or contract with another organization to provide, GUIDE Respite Services provided in an adult day center⁶³ or a facility that can provide 24-hour care. The GUIDE Participant has the flexibility to use a combination of any or all of these respite options for each beneficiary eligible to receive GUIDE Respite Services.

The GUIDE Participant will bill for GUIDE Respite Services by submitting claims using three new respite G-codes created for the GUIDE Model, one for each setting of care (in-home, adult day, and facility-based). Respite payments will not be made on a claim-by-claim basis; instead, CMS will aggregate the respite payments and make one monthly respite payment for all GUIDE Respite Services billed in the preceding month.

The in-home respite G-code will cover a 4-hour unit of service and be paid at \$104; the adult day respite G-code will cover an 8-hour unit paid at \$78; the facility-based respite G-code will cover a 24-hour unit paid at \$260. The GUIDE Participant can bill as many or as few of the codes as needed for an eligible beneficiary, up to a per beneficiary annual cap of \$2,500.⁶⁴ In order to help the GUIDE Participant track

⁶² GUIDE Respite Services are temporary services provided to a beneficiary in their home, at an adult day center, or at a facility that can provide 24-hour care, for the purpose of giving the caregiver a break from caring for the beneficiary.

⁶³ Adult day center, as used herein, refers to adult day care, adult medical day care, adult day services, adult day health centers, and other commonly used terms that describe centers that provide care for older adults similar to the entities listed here.

⁶⁴ The GUIDE respite allotment of \$2,500 per year equates to roughly 96 hours of in-home GUIDE Respite Services per year, paid at a rate of \$26 per hour. If the GUIDE respite allotment were used solely at an adult day center, it

how close beneficiaries are to the annual cap, CMS will provide the GUIDE Participant with a monthly payment file showing the amount of GUIDE Respite Services that each aligned beneficiary has used in the year to-date.

The respite G-codes and the annual respite cap will be geographically adjusted using the same methodology as the DCMP; they will be updated annually by the amount of the Home Health Agency market basket less the productivity adjustment (a metric that is calculated by the CMS Office of the Actuary for the Home Health Prospective Payment System to measure cost growth for home health agencies).⁶⁵ The respite payment will not have beneficiary cost sharing and will be paid at 100% of the determined amounts.

The GUIDE Participant must bill for all GUIDE Respite Services rendered to aligned beneficiaries. If the GUIDE Participant provides GUIDE Respite Services by contracting with another organization, the GUIDE Participant is responsible for entering into a contract with the organization, billing for the GUIDE Respite Services, and then reimbursing the organization.

As detailed in paragraph 6.2 of the GUIDE Care Delivery Services, for dually eligible beneficiaries who receive respite care through a state Medicaid program, the GUIDE Participant shall contact and attempt to coordinate the delivery of GUIDE Respite Services with the beneficiary's Medicaid state agency and/or Medicaid managed care plan's case manager. GUIDE Respite Services are intended to be additive to, and not duplicative of, any available Medicaid respite care benefit offered to dually eligible beneficiaries. The GUIDE Participant is prohibited from billing under both the GUIDE Model and Medicaid for the same unit of respite (e.g., billing under both the GUIDE Model and Medicaid for the same 24-hour nursing home stay).

Eligibility Requirements for Aligned Beneficiaries to Receive GUIDE Respite Services

An aligned beneficiary must meet the following requirements in order to be eligible to receive GUIDE Respite Services:

- i. have a caregiver; and
- ii. be assigned to either the moderate complexity dyad tier or the high complexity dyad tier.

Requirements for Respite Providers to Provide GUIDE Respite Services

As discussed under the section titled "Program Integrity Screening", CMS will conduct a program integrity screening of all applicants and their proposed Partner Organizations, which includes any Medicare-enrolled and non-Medicare enrolled respite providers, as part of the application review process. CMS will confirm that the GUIDE Participant, or the contracted organization furnishing GUIDE Respite Services, complies with the qualifications to provide GUIDE Respite Services under the GUIDE Model.

would cover 32 days of adult day per year; if it were used solely for facility-based care, it would cover roughly 10 days of facility-based care per year.

⁶⁵ Additional information regarding the Home Health Agency market basket and productivity adjustment can be found at: <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/marketbasketdata>.

The GUIDE Participant must also ensure that they, or the contracted organization furnishing GUIDE Respite Services, complies with the qualifications to provide GUIDE Respite Services under the GUIDE Model, and that any direct care workers that provide in-home GUIDE Respite Services meet the requirements listed below, at all times that the GUIDE Participant, or organization, is providing GUIDE Respite Services.

In order to qualify to provide GUIDE Respite Services under the GUIDE Model, in-home respite providers, adult day centers, and facilities that can provide 24-hour care must be one of the following:

- i. a Medicare-certified facility that can provide 24-hour care or a Medicare-certified provider that provides in-home respite services;
- ii. a Medicaid-certified adult day center, Medicaid-certified facility that can provide 24-hour care, or a Medicaid-certified provider that provides in-home respite services; or
- iii. a company or organization licensed or certified with the state, in which they are providing services, to provide one of the following services:
 - a. respite,
 - b. home care,
 - c. residential services,
 - d. adult day services, or
 - e. residential facility or group home (not a private residence).

In addition, any direct care workers that provide in-home GUIDE Respite Services must:

- i. be at least 18 years old,
- ii. have passed a background check,
- iii. be licensed or certified as a direct care worker in the state in which they are providing services if such licensure or certification is a requirement to work as direct care worker in the state, and
- iv. meet the training requirements to be a direct care worker, if any, of the state in which they are providing services.

If the GUIDE Participant, or the contracted organization furnishing GUIDE Respite Services, loses their Medicare certification, Medicaid certification, state license or state certification, they will no longer be permitted to provide GUIDE Respite Services. The GUIDE Model will not pay, and GUIDE Participants may not bill, for GUIDE Respite Services provided by a GUIDE Participant, or a contracted organization furnishing GUIDE Respite Services, that loses their Medicare certification, Medicaid certification, state license or state certification.

Example GUIDE Respite Services Claim:

The following is an example claim for GUIDE Respite Services calculated over one month. This example is illustrative in nature and intended to give applicants a baseline understanding of how the respite payments will be calculated.

Beneficiary B has a caregiver and is in the severe model tier. This claim is for one month's worth of GUIDE Respite Services.

In Home Care: 4-Hour unit	16 hours (4 units)	\$104	\$416
Adult Day Center: 8-Hour Unit	8 hours (1 unit)	\$ 78	\$ 78
Facility: 24-Hour Unit	48 hours (2 units)	\$ 260	\$ 520
Total GUIDE Respite Services			\$ 1,014

*The GAF is also calculated for the respite payments but do not count towards the total annual cap.

To calculate the amount of the GUIDE respite payment available for the GUIDE Participant to furnish the GUIDE Respite Services under the GUIDE Model for rest of the year: \$2500 - \$1014 = \$1486

Payment Examples

The first two payment examples below show how total GUIDE Model payments will be calculated for an individual aligned beneficiary over the course of a full performance year. The third example shows how total GUIDE Model payments will be calculated for a GUIDE Participant's total aligned beneficiary population. The examples assume that all beneficiaries are newly aligned in the first month of the performance year, and therefore are eligible for the new patient DCMP rate for the first six months of the year and the established patient DCMP rate for the next six months. All examples are assumed to occur after the PBA and HEA are fully phased in but reflect the current base rate and do not account for future MEI updates. In the first example, the beneficiary is in a tier that is eligible for GUIDE Respite Services, and the example assumes that she reaches the respite cap for the year. In the second example, the beneficiary is in a tier that is not eligible for GUIDE Respite Services. The third example assumes that all beneficiaries eligible for GUIDE Respite Services reach their respite cap for the year. Examples are rounded to the nearest dollar.

Payment Example #1: Beneficiary in the Moderate Complexity Tier with Caregiver

 Jane Smith Lives in Miami, FL	Moderate Complexity, Caregiver Tier: New Patient DCMP rate: \$275 Established Patient DCMP Rate: \$120	GAF for Miami, FL: 1.067 GUIDE Participant's PBA: 4% Mrs. Smith's HEA: +\$15	
Step 1: Geographically Adjust DCMP	Step 2: Apply PBA	Step 3: Apply HEA	Step 4: Calculate total for 6 months
First 6 months: $\$275 \times 1.067 = \293	$\$293 \times 1.04 = \305	$\$304 + \$15 = \$320$	$\$320 \times 6 = \$1,920$
Next 6 months: $\$120 \times 1.067 = \128	$\$128 \times 1.04 = \133	$\$133 + \$15 = \$148$	$\$148 \times 6 = \888
Total Annual DCMP.....		\$2,808	
Step 5: Geographically Adjust Respite Cap		$\$2,500 \times 1.067 = \$2,668$	
Total Annual DCMP and Respite.....		\$5,476	

Payment Example #2: Beneficiary in the Moderate/Severe Complexity Tier without Caregiver

 Jack Johnson Lives in Phoenix, Arizona	Moderate/Severe Complexity, No Caregiver Tier: New Patient DCMP rate: \$390 Established Patient DCMP Rate: \$229	GAF for Phoenix, AZ: 0.973 GUIDE Participant's PBA: 7% Mr. Johnson's HEA: -\$6	
Step 1: Geographically Adjust DCMP	Step 2: Apply PBA	Step 3: Apply HEA	Step 4: Calculate total for 6 months
First 6 months: $\$390 \times 0.973 = \379	$\$379 \times 1.07 = \406	$\$406 - \$6 = \$400$	$\$400 \times 6 = \$2,400$
Next 6 months: $\$229 \times 0.973 = \209	$\$209 \times 1.07 = \224	$\$224 - \$6 = \$218$	$\$218 \times 6 = \$1,308$
Total Annual DCMP.....		\$3,708	

Note: Example 3 is a stylized example and does not include the HEA, which is a beneficiary level adjustment. The HEA could increase or decrease participants' total payment. It also assumes that all patients are aligned at the beginning of the year as new patients.

Payment Example #3: Dementia Care Program



Dementia Care Program
Located in Philadelphia, PA

GAF for Philadelphia, PA: 1.05
GUIDE Participant's PBA: 6%

Model Tier	Patient Count		Step 1: Geographically Adjust DCMP (DCMP x 1.05)	Step 2: Apply PBA (Step 1 x 1.06)	Step 3: Calculate total for 6 months (Step 2 x 6)	Step 4: Geo. adjust respite (Cap x 1.05)	Step 5: Calculate Total (DCMP + respite) x patient count
Mild Caregiver	30	New Est.	\$158 \$68	\$167 \$72	\$1,001 \$434	N/A	\$43,073
Moderate Caregiver	80	New Est.	\$289 \$126	\$306 \$134	\$1,836 \$801	\$2,625	\$421,025
Severe Caregiver	70	New Est.	\$378 \$231	\$401 \$245	\$2,404 \$1,469	\$2,625	\$454,877
Mild No Caregiver	10	New Est.	\$242 \$126	\$256 \$134	\$1,536 \$801.36	N/A	\$23,373
Moderate/ Severe No Caregiver	10	New Est.	\$410 \$226	\$434 \$239	\$2,604 \$1,436	N/A	\$40,402
Total Annual GUIDE Payments.....							\$982,750

Infrastructure Payment

In addition to technical assistance and support, GUIDE Participants in the new program track that are classified as safety net providers will be eligible to receive an infrastructure payment to cover some of the upfront costs of establishing a new dementia care program. This payment is intended for GUIDE Participants who want to develop new dementia care programs to serve underserved beneficiaries but need upfront resources to get started. The infrastructure payment will be a one-time payment of \$75,000 made at the beginning of the pre-implementation period. The payment will be geographically adjusted using the same PFS GAF that will be used to adjust the DCMP.

The infrastructure payment is intended to assist GUIDE Participants in the new program track that qualify as safety net providers with: 1) hiring, 2) training, 3) developing program workflows, protocols, community partnerships, and materials, 4) community outreach and engagement, and 5) electronic health record technology adaptations. Infrastructure payment funds may only be used for costs in these five categories. GUIDE Participants will be required to report on how they used infrastructure funds as part of their care delivery reporting.

GUIDE Participants will be required to pay the infrastructure payment back to CMS if they withdraw or are terminated from the GUIDE Model. GUIDE Participants that withdraw or are terminated before the start of the second performance year will be required to repay the whole infrastructure payment to

CMS. GUIDE Participants that withdraw from the GUIDE Model or are terminated during the second performance year will be required to repay half of the infrastructure payment.

Safety net provider eligibility determination

To qualify as a GUIDE safety net provider, a new program applicant must have a Medicare FFS beneficiary population comprised of at least 36% beneficiaries receiving the Part D low-income subsidy (LIS) or 33.7% of beneficiaries who are dually eligible for Medicare and Medicaid. These thresholds are based on the safety net definition that the Innovation Center has developed to assess and track safety net provider participation in its models.⁶⁶ CMS will use Medicare claims to assess the composition of an applicant's Medicare FFS beneficiary population and determine whether they meet the safety net criteria. CMS will notify the selected applicant of whether they meet the GUIDE safety net criteria before the deadline to sign their Participation Agreement.

If an applicant plans to create a new TIN for the purposes of participating in the GUIDE Model, then in order to be assessed for the GUIDE safety net provider criteria, at time of application, the applicant must provide to CMS a Proposed GUIDE Practitioner Roster that is as similar as possible to the Proposed GUIDE Practitioner Roster that the applicant will submit two months prior to their first Performance Year (see section titled, "Participation Requirements" for more information on application requirements for GUIDE Participants in the new program track) if accepted to participate in the Model. The Proposed GUIDE Practitioner Roster must include at least one clinician with dementia proficiency and list the historical TIN(s) under which each practitioner(s) on their Proposed GUIDE Practitioner Roster has previously billed for Part B services.

At the time of the GUIDE safety net provider eligibility determination, CMS will deem a beneficiary to be part of an applicant's beneficiary population in the following order of precedence:

- 1) If the beneficiary selected, on Medicare.gov, one of the Medicare-enrolled physicians or non-physician practitioners listed on the applicant's Proposed GUIDE Practitioner Roster;
- 2) If the applicant or one or more practitioners from the applicant's Proposed GUIDE Practitioner Roster furnished the plurality of the beneficiary's qualifying CPT/HCPCS code services (see Table 18 for a list of CPT or HCPCS Codes Used to Identify Applicant's Beneficiary Population) over the past two years; or
- 3) If the applicant or one or more practitioners from the applicant's Proposed GUIDE Practitioner Roster billed the beneficiary's most recent claim (if that claim was for an Annual Wellness Visit or a Welcome to Medicare Visit) during the most recently available 24-month period.

At the time of determination, CMS will also confirm whether each applicable beneficiary:

- 1) Received a qualifying service from the GUIDE Participant (defined at the TIN level – please see paragraph above on the GUIDE Model's policy for applicants who create a new TIN for purposes of participating in the GUIDE Model) during the lookback period (see Table 18 below);

⁶⁶ Person-Centered Innovation—An Update on the Implementation of the CMS Innovation Center's Strategy—Supplemental Document. November 7, 2022. <https://innovation.cms.gov/media/document/cmmi-strategy-imp-update-tech>

- 2) Has both Medicare Parts A and B;
- 3) Has Medicare as their primary payer; and
- 4) Was not enrolled in a Medicare Advantage plan.

The following list of patient encounter codes will be used to identify an applicant's beneficiary population according to the process outlined above for purposes of the GUIDE safety net provider determination:

Table 18. HCPCS Codes Used to Identify Applicant's Beneficiary Population

Service	Code
Office/Outpatient Visit E/M	99201-99205, 99211-99215, G2212
Nursing Facility, FQHC, and RHC Services	99304-99310; 99315, 99316- 99318
Complex Chronic Care Coordination Services	99487
Chronic Care Management (CCM) Services	99489-99491, 99437, 99439, G2058
Principal Care Management (PCM)	99424-99427, G2064, G2065
Transitional Care Management Services	99495-99496
Home Care/Domiciliary Care E/M	99324-99328, 99334-99337, 99339-99345, 99347-99350
Online Digital E/M	99421-99423
Audio-Only Telephone E/M	99441-99443, G2252
Technology-based check-in services	G2010, G2012, G2252
Advance Care Planning	99497, 99498
Depression, substance use disorder, and alcohol misuse screening and counseling services	G0396-G0397, G0442-G0444
Welcome to Medicare and Annual Wellness Visits	G0402, G0438, G0439
Assessment/care planning for patients requiring CCM services	G0506
Care management services for behavioral health conditions	99484
Cognition and functional assessment for patient with cognitive impairment	99483
Administration of patient-focused health risk assessment (HRA)	96160
Administration of caregiver-focused HRA	96161
Psychiatric Collaborative Care Model	99492-99494, G0511, G0512, G2214
Outpatient clinic visit for assessment and management (for critical access hospital-based outpatient primary care practices)	G0463

Health Equity Strategy

The Innovation Center believes that equitable care is a key component of achieving high-quality care for beneficiaries and is therefore critical to the GUIDE Model's success. CMS defines health equity as: "the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes."⁶⁷ The term "underserved communities" refers to populations sharing a particular characteristic, as well as geographic communities, that have been systematically denied a full opportunity to participate in aspects of economic, social, and civic life.⁶⁸

Along with the health equity adjustment to model payments, the new program track and infrastructure payment for safety net providers, the Referral and Coordination of Services and Supports domain in care delivery, and the requirement for care navigator training to include a cultural competency domain, the GUIDE Model has two additional model requirements which are designed to promote health equity:

- 1) Health Equity Plan Requirement
- 2) Health Equity Data Collection Requirement

Health Equity Plan Requirement

GUIDE Participants will be required to develop and implement a Health Equity Plan. The purpose of a Health Equity Plan is for each GUIDE Participant to identify disparities in outcomes in their patient populations and implement initiatives to measure and reduce these disparities over the course of the GUIDE Model.

On an annual basis, GUIDE Participants will be required to report on the progress of their Health Equity Plan as a section of the GUIDE Model's care delivery reporting. The focus of health equity planning will be on improving quality of care for underserved beneficiaries and addressing health disparities. GUIDE Participants will be required to set goals and monitor progress over time, identifying and selecting evidence-based interventions for addressing health disparities and achieving equitable outcomes. The Innovation Center will provide a framework for Health Equity Plans, and will review, but not assess, plans submitted by GUIDE Participants.

The first Health Equity Plan will be due as part of the baseline care delivery reporting (see "Care Delivery" section for more information about reporting timeline). The first Health Equity Plan must focus specifically on beneficiary outreach and engagement as a precursor to more comprehensive annual Health Equity Plans. The goal of the first Health Equity Plan will be to encourage GUIDE Participants to

⁶⁷ CMS Framework for Health Equity 2022-2023. Centers for Medicare and Medicaid Services. April 2022. <https://www.cms.gov/files/document/cms-framework-health-equity-2022.pdf>

⁶⁸ Executive Order on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government. January 20, 2021. <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/>

develop and implement strategies to reach potentially eligible beneficiaries from historically underserved communities from the outset of the GUIDE Model.

GUIDE Participants will be required to prepare and submit comprehensive Health Equity Plans beginning in the second care delivery reporting period, at the start of GUIDE Participants' second performance year, and update the plans annually thereafter.

Health Equity Plans may not propose or use actions that selectively target beneficiaries based on race, ethnicity, national origin, disability, religion, or sex. In addition, Health Equity Plans must comply with all applicable non-discrimination laws, including section 1557 of the Affordable Care Act, Title IX of the Education Amendments of 1972, Title VI of the Civil Rights Act of 1964, and Section 504 of the Rehabilitation Act. GUIDE Participants will be permitted to identify beneficiaries for health equity plan interventions based on other factors, including but not limited to medical history, health status, health needs, disability status, or income, provided the GUIDE Participant and other individuals or entities performing functions or services related to the Health Equity Plan comply with all applicable non-discrimination laws and regulations.

Health Equity Data Collection Requirement

CMS will require all GUIDE Participants to collect and report certain beneficiary-reported sociodemographic data and health-related social needs (HRSN) data from their aligned beneficiaries willing to share this information. To avoid discouraging beneficiaries from accessing care from GUIDE Participants, beneficiaries are not required to share this data with their providers. GUIDE Participants are not required to report this data to CMS for any beneficiary who chooses not to disclose them.

HRSNs are used to describe individual-level social needs and are individual-level, adverse social conditions that negatively impact a person's health or health care. Some GUIDE Participants may already be collecting HRSNs from their beneficiaries, but it is important that all GUIDE Participants collect this information to provide adequate services, plan for future interventions, and increase quality of care. HRSN collection and referrals will be part of the GUIDE Model's broader care delivery requirements for comprehensive assessment and referral for social services and supports.

GUIDE Participants will be encouraged to use one of two preferred HRSN screening tools: the Accountable Health Communities (AHC) HRSN Screening tool⁷⁰ or the Protocol for Responding to and Assessing Patient's Assets, Risks, and Experiences (PRAPARE) tool.^{TM-71} GUIDE Participants will be required to annually report HRSN data that is aggregated across aligned beneficiaries and includes domains such as: food insecurity, housing instability, transportation needs, utility difficulty, and interpersonal safety. This data collection will allow CMS and GUIDE Participants to evaluate health inequities and disparities in GUIDE communities.

⁷⁰ The Accountable Health Communities Health-Related Social Needs Screening Tool. Center for Medicare and Medicaid Innovation. <https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf>

⁷¹ PRAPARE Screening Tool. <https://prapare.org/the-prapare-screening-tool/>

GUIDE Participants will also be required to collect and report a core set of sociodemographic measures on an annual basis from their aligned beneficiaries willing to share this information. The data elements in this core set will use standardized United States Core Date for Interoperability (USCDI) definitions. Example measures are race, ethnicity, sex assigned at birth, disability status, and preferred language.

Learning Systems Strategy

The GUIDE learning system will include: 1) a learning community for all GUIDE Participants, and 2) virtual coaching and facilitation provided by CMS for GUIDE Participants in the new program track.

The GUIDE Participant Learning Community will:

- Facilitate the provision of technical assistance, reaching GUIDE Participants with written materials and communication about the GUIDE Model payment, requirements, deadlines, and conditions for participation.
- Capture, document, and disseminate tactics and strategies in the provision of comprehensive dementia care.
- Foster peer-to-peer sharing of tools, experience, and tactics.
- Provide opportunities for GUIDE Participants to convene and share experiences and resources regionally or nationally, through existing in-person meetings or new virtual meetings.
- Provide opportunities for learning and peer-to-peer sharing of strategies for improving health equity.

Coaching and facilitation for GUIDE Participants in the new program track will use a virtual group coaching approach. CMS will offer coaching sessions in group settings to allow GUIDE Participants to learn from each other's experiences and include brief didactics (how-tos) and case-based learning with cases presented by GUIDE Participants to expert faculty on challenges, questions, etc. that arise as they establish their dementia care programs. Topics for the coaching sessions could include developing a caregiver support program or a care navigator training program. Coaching sessions will occur during the pre-implementation period and the first performance year for the new program track.

Data

Data Reporting Requirements

In accordance with 42 CFR 403.1110(b), any entity participating in the testing of an Innovation Center model is required to collect and report such information, including “protected health information” as defined in 45 CFR 160.103, as the Secretary determines is necessary to monitor and evaluate the GUIDE Model. Below is a list of all data elements that the GUIDE Participant will be required to report to CMS.

- Beneficiary and Caregiver Assessment Data (See Beneficiary Eligibility and Beneficiary Alignment section)
- Quality Data (See Performance Measurement section)
- Care Delivery Reporting (See Care Delivery section)
- Sociodemographic Data (See Health Equity Data Collection Requirement section)

- Health-related social needs (See Health Equity Data Collection Requirement section)

Data Sharing

Data sharing is an important tool for helping GUIDE Participants understand how they are doing relative to other GUIDE Participants, track their performance over time, identify trends, and target areas for improvement. GUIDE Participants will be strongly encouraged to use data sharing provided under the GUIDE Model to i) assess their model implementation; ii) measure effects on quality of care; and iii) develop data-based strategies to improve both model implementation and quality of care. The model learning system will support GUIDE Participants in understanding how to use their data for quality improvement efforts. Under the GUIDE Model, there will be two primary sources of data sharing:

- 1) **Data Dashboard:** The primary platform that CMS will use to share data with GUIDE Participants is through the GUIDE Data Dashboard. The Data Dashboard will provide GUIDE Participants with an interactive, user-friendly interface for viewing claims-based utilization data for their aligned beneficiaries, updated monthly. Data will be available and aggregated across the GUIDE Participant's entire aligned population, for domains including hospitalizations, physician services, and post-acute care. The Data Dashboard will also incorporate quality and sociodemographic data reported by GUIDE Participants, so that they can view key data points within a single tool. The Data Dashboard will also show GUIDE Participants how they compare to peer organizations on important quality and utilization outcomes.
- 2) **Monthly payment and beneficiary alignment files:** On a monthly basis, CMS will provide GUIDE Participants with a beneficiary alignment and payment file. The beneficiary alignment file will show which beneficiaries are aligned to the GUIDE Participant, their model tier assignment, and other beneficiary-level data. The payment file will provide data on GUIDE payment amounts for each aligned beneficiary and aggregated across the GUIDE Participant's total aligned beneficiary population.

The data sharing and data analytics in the GUIDE Model will comply with all applicable laws, including the privacy and security requirements promulgated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). GUIDE Participants will be required to submit a HIPAA-Covered Data Disclosure Request and Attestation (DRA) form to request the specific types of data that the GUIDE Participants will need to perform certain health care operations activities related to the GUIDE Model and will attest that the data requested is the minimum necessary to perform those activities, consistent with HIPAA rules and regulations. CMS will provide the DRA to be completed by the Participant.

All GUIDE Participants will be required to provide beneficiaries and their caregivers with information about how to modify their data sharing preferences and opt out of claims data sharing of beneficiary-identifiable information for care coordination and quality improvement purposes.

In the event the Innovation Center develops new, center-wide data sharing strategies, including data aggregation, during the Model Performance Period, CMS will also strive to align GUIDE data sharing with

these strategies as appropriate. CMS will also consider publicly reporting performance data as part of our Innovation Center model data sharing initiative.⁷²

Participant Monitoring, Auditing, and Termination Strategy

CMS will monitor GUIDE Participants on a regular, ongoing basis. CMS will use GUIDE Participant care delivery reporting, beneficiary and caregiver assessment data, GUIDE Practitioner Rosters, Partner Organization Rosters, claims, cost, utilization, and quality data in its monitoring strategy.

Regular program monitoring may result in audits of select GUIDE Participants. Data that GUIDE Participants submit to CMS, performance on utilization and quality measures, referral and billing patterns, and other practice information may trigger an audit of GUIDE Participants with anomalous findings. CMS may also randomly select GUIDE Participants for audit.

GUIDE Participants will be informed of the possibility of being selected for an audit and will be required to maintain copies of all documentation related to their use of model payments and their implementation of the GUIDE Model in case of an audit. More information related to the GUIDE Model's record retention policy will be provided in the Participation Agreement.

CMS reserves the right to terminate a GUIDE Participant's Participation Agreement at any time during the term of the Participation Agreement for reasons associated with poor performance, program integrity issues, non-compliance with the terms and conditions of the Participation Agreement, or as otherwise specified in the Participation Agreement or required by section 1115A(b)(3)(B) of the Social Security Act.

Evaluation

All GUIDE Participants will be required to cooperate with CMS efforts to conduct an independent, federally-funded evaluation of the GUIDE Model, which may include completion of surveys and participation in interviews, site visits, and other activities that CMS determines necessary to conduct a comprehensive evaluation. The evaluation will use a mixed-methods approach to assess both model impact and implementation experience.

Authority to Test the Model

Authority to Test the Model

The GUIDE Model will be operated under Section 1115A of the Social Security Act (the Act) (added by Section 3021 of the Affordable Care Act) (42 U.S.C. 1315a). Section 1115A of the Act establishes the Innovation Center for the purpose of testing innovative payment and service delivery models to reduce Medicare and Medicaid expenditures while preserving or enhancing the quality of care furnished to beneficiaries of such programs.

Section 1115A(b)(2) of the Act requires the Secretary "to select models to be tested from models where the Secretary determines that there is evidence that the model addresses a defined population for

⁷² CMMI Model Data Sharing Model Participation Data Initiative. Center for Medicare and Medicaid Innovation. <https://resdac.org/cms-data/files/cmmi-model-data-sharing-cmds-model-participation-data-initiative>

which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures.” The GUIDE Model addresses a defined population (community-dwelling, Medicare FFS beneficiaries, including beneficiaries dually eligible for Medicare and Medicaid, who have dementia) for which there are deficits in care resulting in both poor outcomes and potentially avoidable expenditures in unnecessary hospital, emergency department (ED), and post-acute care utilization.

Waiver and OIG Safe Harbor Authority

Under section 1115A(d)(1) of the Act, the Secretary of Health and Human Services may waive such requirements of Titles XI and XVIII and of sections 1902(a)(1), 1902(a)(13), 1903(m)(2)(A)(iii), and certain provisions of section 1934 of the Act as may be necessary solely for purposes of carrying out section 1115A with respect to testing models described in section 1115A(b).

For this model and consistent with the authority under section 1115A(d)(1), the Secretary may consider issuing waivers of certain fraud and abuse provisions in sections 1128A, 1128B, and 1877 of the Act. No fraud or abuse waivers are being issued in this document; fraud and abuse waivers, if any, would be set forth in separately issued documentation. Any such waiver would apply solely to the GUIDE Model and could differ in scope or design from waivers granted for other programs or models. Thus, notwithstanding any provision of this RFA, GUIDE Participants must comply with all applicable laws and regulations, except as explicitly provided in any such separately documented waiver issued pursuant to section 1115A(d)(1) specifically for the GUIDE Model.

In addition to or in lieu of a waiver of certain fraud and abuse provisions in sections 1128A and 1128B of the Act, CMS may determine that the anti-kickback statute safe harbor for CMS-sponsored model arrangements and CMS-sponsored model patient incentives (42 C.F.R. § 1001.952(ii)) is available to protect remuneration exchanged pursuant to certain financial arrangements or patient incentives permitted under the GUIDE participation documentation. No such determination is being issued in this document. Such determination, if any, would be set forth in documentation separately issued by CMS.

Benefit Enhancement and Beneficiary Engagement Incentive

The GUIDE Model will use the authority under section 1115A(d)(1) of the Act to make available the telehealth benefit enhancement and the environmental modification beneficiary engagement incentive.

Telehealth benefit enhancement

If necessary during the Model Performance Period, CMS intends to make available to GUIDE Participants a conditional waiver of (1) the “originating site” requirements at section 1834(m)(4)(C) of the Social Security Act and 42 CFR § 410.78(b)(3)–(4) with respect to telehealth services furnished to eligible beneficiaries; (2) the “originating site” requirement in the eligible telehealth individual provision at section 1834(m)(4)(B) of the Social Security Act with respect to telehealth services being “furnished at an originating site”; and (3) the “originating site” facility fee provision in section 1834(m)(2)(B) of the Social Security Act and 42 CFR § 414.65(b) with respect to telehealth services furnished to an aligned beneficiary at their home.

Environmental modification beneficiary engagement incentive

CMS also intends to permit GUIDE Participants to use their own funding to provide in-kind environmental modifications to the beneficiary's home of a total value of up to \$1,000 per beneficiary per year. Environmental modifications will contribute to a safer home environment for the beneficiary and provide the beneficiary with tools to continue to live at home.

The environmental modification shall be either (i) an item purchased by the Participant and delivered to the Beneficiary or (ii) the Participant will arrange and pay for installation of the environmental modification by a handy worker or home improvement contractor. The environmental modification must have a reasonable connection to the beneficiary's health care and not promoted or marketed to potential beneficiaries. Depending on the beneficiary's needs, environmental modifications could include expenses for modifications such as grab bars, flexible shower head, safer flooring, signs, or improved lighting.

This beneficiary engagement incentive will be optional for GUIDE Participants to make available to aligned beneficiaries. If the GUIDE Participant offers this beneficiary engagement incentive, it must be offered in addition to the care delivery requirements detailed in Appendix B and in accordance with the requirements described in the Participation Agreement. The GUIDE Participant will be required to retain certain documentation in conjunction with the provision of this in-kind incentive.

Merit-Based Incentive Payment System (MIPS) Alternative Payment Model (APM) and Advanced APM Status

MIPS APM: An Innovation Center model may be considered a MIPS APM if it meets two criteria: 1) participants in the Model ("APM Entities") participate under an agreement with CMS or through a law or regulation; and 2) the APM bases payment on quality measures and cost/utilization. CMS requires GUIDE Participants to sign a participation agreement with CMS and bases payment on utilization and quality measures through the performance-based adjustment. Therefore, the GUIDE Model will satisfy both MIPS APM criteria and is expected to qualify as a MIPS APM.

Advanced APM: A model (or track within a model) must meet three specific criteria to be considered an Advanced APM: 1) require use of Certified Electronic Health Record Technology (CEHRT), 2) provide for payment based on performance on MIPS-comparable quality measures, and 3) require participants to bear a more than nominal amount of financial risk. We do not expect GUIDE to qualify as an Advanced APM because it does not meet the financial risk standard.

Because we expect the GUIDE Model to be a MIPS APM, we also expect that any MIPS-eligible clinician who is included on a GUIDE Participant's GUIDE Practitioner roster will be eligible for voluntary scoring under the APM Performance Pathway as described at 42 CFR § 414.1367.

Program Overlaps and Synergies

CMS will allow organizations (identified at the TIN level) to participate in both the GUIDE Model and all other current Innovation Center models for which they meet the eligibility criteria, as well as the Medicare Shared Savings Program (Shared Savings Program). Individual practitioners (identified at the

NPI level) and Partner Organizations will also generally be permitted to be part of a GUIDE Practitioner Roster or Partner Organization Roster and furnish services under other current Innovation Center models and the Shared Savings Program. Current and future Innovation Center models may establish their own model overlaps policies with the GUIDE Model as well. The following sections discuss overlap policies for three types of models and programs: Shared Savings Program and Innovation Center ACO models; BPCI Advanced and Comprehensive Care for Joint Replacement (CJR) Models; and Innovation Center models that have care management payments.

Overlaps with Shared Savings Program and Innovation Center ACO Models

Participant overlap

CMS will allow participant overlap at the TIN and NPI level with the ACO Realizing Equity, Access, and Community Health (REACH) model, the Shared Savings Program, and the three Comprehensive Kidney Care Contracting (CKCC) Options in the Kidney Care Choices (KCC) Model.

Beneficiary overlap

Eligible beneficiaries may simultaneously be aligned to the GUIDE Model and attributed to participants in ACO REACH, the Shared Savings Program, or the CKCC options in KCC. For beneficiaries who are aligned to both a GUIDE Participant and a participant in ACO REACH, the Shared Savings Program, or the CKCC Options of the KCC model, the GUIDE Model will share beneficiary-level data on GUIDE Model payments with each of these programs, allowing them the flexibility to account for these payments in their benchmarking or spending calculations.

In 2024, the Innovation Center’s Total Cost of Care Models will not include the DCMP and respite payments in the shared savings calculations. Beginning in July 2025 or July 2026, the DCMP (including the performance-based adjustment, health equity adjustment, and the respite payments) made to a GUIDE Participant for an aligned beneficiary may be included in an ACO’s expenditures and benchmarks.

Beginning July 1, 2024, the DCMP and respite payments made to a GUIDE Participant for an aligned beneficiary will count towards the shared savings/losses in the Medicare Shared Savings Program. In future years, GUIDE payments may be included in ACO benchmark and expenditure calculations.

Overlaps with the BPCI Advanced and Comprehensive Care for Joint Replacement (CJR) Models

Participant overlap

The GUIDE Model will allow participant overlap with the BPCI Advanced model at the TIN level. However, given the differing clinical focuses of these models and the GUIDE Model, we would expect this type of overlap to be rare.

Beneficiary overlap

Eligible beneficiaries may simultaneously be aligned to a GUIDE Participant and a participant in the BPCI Advanced and CJR models. GUIDE Model payments will not be incorporated into BPCI Advanced or CJR episode reconciliation calculations. CJR overlap will only be relevant for 6 months, as CJR is scheduled to end in December 2024.

Overlaps with Innovation Center models that have care management payments

Participant overlap

The DCMP includes care coordination services similar to other Innovation Center models such as Primary Care First (PCF), Making Care Primary (MCP), the Maryland Primary Care Program (MDPCP), the Enhancing Oncology Care Model (EOM), and Kidney Care First (KCF). GUIDE will permit participant overlap at the TIN and NPI level with PCF, MCP, MDPCP, EOM, and KCF.

Beneficiary overlap

Eligible beneficiaries may simultaneously be aligned to a GUIDE Participant in the GUIDE Model and attributed or aligned to participants in active CMMI models, including ACO Reach, Kidney Care Choices, Making Care Primary, Maryland Total Cost of Care Model, Primary Care First, and Vermont All Payer Model. The same provider or supplier cannot receive payment for care coordination under the GUIDE Model and another model for treating the same beneficiary who may be aligned or attributed to both models. If such an overlap occurs, the GUIDE Model will reconcile the overlap amount for that provider retrospectively. If only the beneficiary, and not the provider, or only the provider and not the beneficiary, overlaps with two models that have care management payments, then no payment will be recouped.

Appendices

Appendix A: Participant Application Guidance and Questions

This document is not the application to be filled out by the applicant; this is a list of the questions that may be found in the online application portal and is provided for reference only. The online application portal can be accessed via a link on the GUIDE Model website: <https://innovation.cms.gov/innovation-models/guide>. All GUIDE applications must be submitted through the online application portal by 11:59 pm Eastern Daylight Time on January 30, 2024.

CMS may seek additional information from applicants to the GUIDE Model after the application period closes. Not all applicants are guaranteed participation in the GUIDE Model. In selecting participants, CMS will consider factors critical to ensuring a robust evaluation of the GUIDE Model. CMS may also deny individual clinicians or any other individual or entity participation in the GUIDE Model based on the results of a program integrity review.

CMS will safeguard the information provided in accordance with the Privacy Act of 1974, as amended (5 U.S.C. § 552a). For more information, please see the CMS Privacy Policy at <https://www.cms.gov/privacy>.

For questions regarding the GUIDE Model or the GUIDE application process, email GUIDEmodelteam@cms.hhs.gov.

Complete Profile (Section 1)

Organization Information (Tab 1)

1. GUIDE Model Applicant Information

Legal Business Name:

Doing Business As (DBA):

Organization TIN/EIN:

Street Address:

City:

State:

ZIP Code:

Website, if applicable:

2. How would you define your organization (Check all that apply or check N/A if your organization is not on this list):

- Physician Group Practice/Clinic
- Health System
- Accountable Care Organization (ACO)
- Hospice Agency
- Home Health Agency (HHA)
- Other Group Practice/Clinic
- N/A

3. Did the applicant submit a Letter of Interest (LOI) for the GUIDE Model? (Optional) (A Letter of Interest is not a requirement to apply for the Model, this information will only be used for tracking purposes)

- Yes
- No

If yes, please note the number on your LOI submission _____

4. Provide an executive summary describing the applicant including the history/context of applicant's interest in the Model, the applicant's strategies and goals for forming a dementia care program, and the applicant's fit with the Model's goals. [5000 character limit]
5. Explain how participation in the GUIDE Model will allow your organization to deliver comprehensive dementia care to the populations you serve. Include how your participation in the GUIDE Model will expand your care model to additional populations, if relevant. [5000 character limit]
6. Is your organization currently or formerly part of, operated, managed, or led by an entity that is participating in or plans to participate in a CMS initiative listed below? Check all that apply and enter dates:

Example:

- *Kidney Care Choices Model: 1/2022 to 1/2023*
- *ACO REACH: 1/2022 to present*
- *Enhancing Oncology Model: 1/2024 to 1/2026*

- Enhancing Oncology Model: _____ to _____
- ACO Realizing Equity, Access, and Community Health (ACO REACH) Model: _____ to _____
- Bundled Payments for Care Improvement (BPCI) Advanced Model: _____ to _____
- Comprehensive Care for Joint Replacement Model: _____ to _____
- ESRD Treatment Choices (ETC) Model: _____ to _____
- Making Care Primary (MCP): _____ to _____
- Comprehensive Kidney Care Choices Model: _____ to _____
- Maryland Total Cost of Care Model: _____ to _____
- Medicare Shared Savings Program (MSSP): _____ to _____
- Primary Care First (PCF): _____ to _____
- Vermont All Payer Model: _____ to _____
- Other (Please specify) [[Text box]]: _____ to _____
- None

7. I certify that I am applying with a TIN that is enrolled in Medicare Part B and eligible to bill under the Medicare Physician Fee Schedule (PFS), or that prior to the execution of the Participation Agreement I will establish a TIN that is enrolled in Medicare Part B and eligible to bill under the PFS.

Please select one:

- Yes, I certify that I am applying with a TIN that is enrolled in Medicare Part B and eligible to bill under the PFS.
- Yes, I certify that prior to execution of the Participation Agreement, I will establish a TIN that is enrolled in Medicare Part B and eligible to bill under the PFS. **Help Text to option:** I understand that if I do not establish a Medicare Part B TIN that is eligible to bill under the PFS prior to execution of the Participation Agreement, my organization will not be able to participate in the Model.
- I cannot certify that I am applying with a TIN, or that I will establish a TIN prior to execution of the Participation Agreement, that is enrolled in Medicare Part B and eligible to bill under the PFS.

8. I certify that my organization is a recognized legal entity formed under applicable state, federal, or tribal law and authorized to conduct business in each state in which it operates.

- Yes.

8a. Attach a copy of a certificate of incorporation or other documentation that demonstrates that the applicant is recognized as a legal entity by the state in which it is located. [Allow attachments]

9. To the best of your knowledge, has your organization, your organization's parent company, or anyone employed by your organization or parent company had a final adverse legal action (as defined on page 11 of the [Medicare Enrollment Application for Physicians and Non-Physician Practitioners, CMS-855i](#)) or been the subject of an investigation by, prosecution by, or settlement with the Health and Human Services Office of the Inspector General, U.S. Department of Justice, or any other Federal or State enforcement agency in the last five years relating to allegations of failure to comply with applicable Medicare or Medicaid billing rules, the Anti-Kickback Statute, the physician self-referral prohibition, or any other applicable fraud and abuse laws? Failure to disclose could be grounds for application denial or immediate termination from the initiative.

- Yes
- No

9a. If yes, please explain the legal actions, investigations, prosecutions, and/or settlements; the agency involved; and the resolution, if any. [3000 character limit]

10. Please check here to opt out of consideration for the GUIDE safety net provider designation for infrastructure payment consideration per the definition provided in the RFA. (Optional)

- Yes, I wish to opt out of consideration for the GUIDE safety net provider designation.

Ownership Interest

11. Please complete the “Ownership” attachment to provide CMS with a full and complete understanding of the ownership interests in the applicant, as well as the ownership interests in the entities with an ownership interest in the applicant. Each party with at least 5% ownership interest in the applicant should be listed.

*If the privately held company with an ownership or control interest in the applicant is a subsidiary of another privately held company, please list the parent company(ies) and ownership interests in that privately held company.

Organization Contacts (Tab 2)

This section asks for organization contact information. Please use the explanations provided to identify the most appropriate person for each contact field and enter their most current contact information.

If the applicant has a program director who will have primary accountability for implementing the dementia care program, please include it here.

1. For Primary Application Contact/Secondary Application Contact (Optional)/Program Director (Optional)

First Name:

Last Name:

Title/Position:

Contact Type: (Primary/Secondary/Program Director)

Phone Number:

Email Address:

Street Address:

City:

State:

ZIP Code:

Complete Application (Section 2)

Staffing and Interdisciplinary Care Team (Tab 1)

1. Describe the interdisciplinary team(s) that the applicant organization will use to deliver services under the GUIDE Model, including the number and types of staff members and whether members of the team will be co-located or spread across multiple locations. Please specify whether the interdisciplinary team currently includes a care navigator and where staff will need to be hired, and include a hiring plan for these identified staff. Responses should enable application reviewers to determine whether and how the applicant will meet the interdisciplinary care team requirements described in the Care Delivery section of the RFA. [5000 character limit]

2. Describe the training that your organization currently provides for staff that deliver care to people with dementia and their caregivers. If the organization does not currently provide training, please describe how the organization will meet the care navigator training requirements. Describe whether and how the applicant will modify this training to meet the care navigator training requirements of the GUIDE Model, as described in the Care Navigator Requirements listed in the RFA. [5000 character limit]
3. Does your organization plan to partner with a Medicare Part A or Part B enrolled health care organization, identified by a different Taxpayer Identification Number or CMS Certification Number (CCN), such as a physician practice, federally qualified health center, home health provider, or occupational or physical therapy practice, to meet the Model's care delivery requirements?
 Yes
 No
4. Complete the attachment to submit the applicant organization's Proposed GUIDE Practitioner Roster, including all historic TINs that any practitioner has used to bill for Medicare services in the two years prior to November 17, 2023. [Allow attachments]

Note: This is optional, but to be eligible for the Established Program track or designated a safety net provider under the New Program Track, at time of application the applicant must provide a Proposed GUIDE Practitioner Roster with the historical TIN(s) under which the practitioner(s) on their Proposed GUIDE Practitioner Roster have previously billed for Part B services (see section the Infrastructure Payment section of the RFA).

5. Complete the attachment to submit the applicant organization's Proposed GUIDE Partner Organization Roster, including the organization's TIN. [Allow attachments]

Care Delivery (Tab 2)

The following questions are about your organization's care delivery methods. Answer each question as carefully and accurately as possible, based on the current and planned activities if you are accepted to participate in the GUIDE Model. Your responses will help to determine whether your organization is assigned to the established program track or the new program track.

1. Has your organization, through an interdisciplinary team that includes at a minimum a care navigator and a clinician with dementia proficiency, provided any of the following services to people with dementia for the past 12 months or longer? (check all that apply):
 Comprehensive assessment
 Care planning
 24/7 access
 Ongoing monitoring and support
 Care coordination and transitional care management

- Referral and coordination of services and supports
 - Medication management and reconciliation
 - Caregiver education and support
 - Respite services (including in-home respite, adult day centers, and respite in a 24-hour facility)
 - None of the above
2. For each of the nine GUIDE Care Delivery Service domains, describe in detail:
- Whether and how the applicant organization currently provides these services,
 - If the applicant organization currently provides some form of these services, whether and how their service provision will need to evolve to meet Model requirements,
 - If the applicant organization does not currently provide these services, how it plans to meet these requirements by the start of the Model performance period.
- Responses should enable application reviewers to understand which services will be provided by the GUIDE Participant versus a Partner Organization. Responses should also describe the care setting and modality (e.g., in-office, in-home, virtual) that will be used to deliver the activities under each care delivery domain. Review and address the detailed care delivery requirements in Appendix B of the Request for Applications in your responses.
- Comprehensive assessment [Text Box, 3000 character limit]
 - Care planning [Text Box, 3000 character limit]
 - 24/7 access [Text Box, 3000 character limit]
 - Ongoing monitoring and support [Text Box, 3000 character limit]
 - Care coordination and transitional care management [Text Box, 3000 character limit]
 - Referral and coordination of services and supports [Text Box, 3000 character limit]
 - Medication management and reconciliation [Text Box, 3000 character limit]
 - Caregiver education and support [Text Box, 3000 character limit]Respite services (including in-home respite, adult day centers, and respite in a 24-hour facility) [Text Box, 3000 character limit]
3. Describe how you will affect outcomes for your target beneficiary population through participation in the GUIDE Model. How will you ensure ongoing quality improvement throughout the GUIDE Model's performance period and address the Model's goals? [Text Box, 3000 character limit]

Alignment (Tab 3)

1. Describe the population of people with dementia that the applicant organization currently serves. This should include geographic service area, sociodemographic characteristics, type and/or stage of dementia, number of people currently served, and

- referral source, i.e., how the applicant organization identifies people to receive services. [Text box, 3000 character limit]
2. Estimate the number of Medicare Fee-for-Service beneficiaries with dementia that the applicant organization intends to serve per year under the GUIDE Model. [Text Box, numeric values only]
 3. Describe how the applicant plans to identify and recruit beneficiaries and caregivers through voluntary alignment over the course of the Model. [[Note: Please include experience of the applicant in engaging caregivers and people living with dementia in their care as well as an overview of marketing and communication plans that the applicant has for recruitment. Also, include the safeguards the applicant has implemented or will implement to ensure that, in conducting voluntary alignment activities, the applicant does not coerce a beneficiary into voluntary alignment or involuntary exclusion, and to otherwise ensure that beneficiary freedom of choice is honored.]] [Text Box, 5000 character limit]

Health Equity (Tab 4)

1. Describe your organization's role in improving health equity among your beneficiary population. [Text Box, 3000 character limit]
2. Describe your organization's historical or planned processes in engaging underserved populations. Note: Applicant should include engagement processes through community outreach, program materials such as translated materials, partnerships with community-based organizations, or other materials, and results on engagement where relevant. [Text Box 3000 character limit]

Health Information Technology (Tab 5)

Please select one of the following:

- I certify that my organization will be able to adopt and maintain the health IT needed to meet the CEHRT definition at 42 CFR 414.1305 by the first performance year as referenced under the Participation Requirements section of the RFA.
- I am unsure if my organization will be able to adopt and maintain the health IT needed to meet the CEHRT definition at 42 CFR 414.1305 by the first performance year as referenced under the Participation Requirements section of the RFA.
- My organization will not be able to adopt and maintain the health IT needed to meet the CEHRT definition at 42 CFR 414.1305 by the first performance year as referenced under the Participation Requirements section of the RFA.

Applicant Service Area (Tab 6)

Please complete and submit the Excel template to identify, by 5-digit zip-code, the service area from which your organization will accept patients. If you are selected to participate in the GUIDE Model, CMS will use this service area data to identify beneficiaries who will receive outreach letters that list your organization as an available dementia care provider in their area (see the Beneficiary Outreach and Engagement section of the RFA for more information). [Require attachment]

Appendix B: Care Delivery Requirements

<p style="text-align: center;">1</p> <p style="text-align: center;">Comprehensive Assessment</p>	<p>1.1 Comprehensive Assessment:</p> <p>1.1.1 GUIDE Participant shall deliver a comprehensive assessment of, and care planning for, the beneficiary with dementia in accordance with the requirements below.</p> <p>1.1.2 Frequency:</p> <p>1.1.2.1 GUIDE Participant shall perform a comprehensive assessment of the beneficiary. The comprehensive assessment will initiate the model intervention and serve as the initial model visit.</p> <p>1.1.2.2 GUIDE Participant shall complete a new comprehensive assessment under the terms of Section 1.1 for any beneficiaries that the GUIDE Participant may have previously assessed as a patient prior to the beneficiary voluntarily aligning with the GUIDE Participant for purposes of this Model.</p> <p>1.1.2.3 After the initial comprehensive assessment, GUIDE Participant shall perform a comprehensive assessment of the beneficiary at least once every twelve months.</p> <p>1.1.2.4 The GUIDE Participant has the discretion to re-assess the beneficiary more frequently; however, the GUIDE Model will only accept data from reassessments once every one hundred and eighty days.</p> <p>1.1.3 Modality:</p> <p>1.1.3.1 An assessment may be performed via telehealth or in-person in the care team's office or other outpatient home or domiciliary based on the preference of the beneficiary and/or caregiver.</p> <p>1.1.3.2 The assessment shall be administered by appropriate members of the interdisciplinary care team according to their license and scope of practice.</p> <p>1.1.4 Required Domains:</p> <p>1.1.4.1 Clinical:</p> <p>1.1.4.1.1 Cognition-focused evaluation including a pertinent history and examination;</p> <p>1.1.4.1.2 Evaluation of medical decision-making of moderate or high complexity;</p> <p>1.1.4.1.3 Functional assessment (e.g., Basic and Instrumental Activities of Daily Living);</p> <p>1.1.4.1.4 Screening, or referral to screening, for hearing loss;</p>
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1.1.4.1.5 Use of standardized instruments for staging of dementia;

1.1.4.1.6 Medication reconciliation and review.

1.1.4.2 Behavioral Health and Psychosocial Needs:

1.1.4.2.1 Evaluation of beneficiary with dementia for behavioral health needs, including screening for depression, anxiety, substance use, and suicidal ideation;

1.1.4.2.2 Evaluation of safety, including, but not limited to, environmental, driving, wandering, fall risk, and abuse, neglect and exploitation.

1.1.4.3 Health-Related Social Needs:

1.1.4.3.1 Screening of beneficiary's health-related social needs in accordance with the requirements detailed in the "Health Equity Strategy" section of this RFA.

1.1.4.4 Advance Care Planning:

1.1.4.4.1 Development, revision, and/or review of an Advance Care Plan and a Physician Order for Life-Sustaining Treatment (POLST) if available and beneficiary wishes to complete.

1.1.4.5 Coordination:

1.1.4.5.1 Identification of beneficiary's primary care provider, behavioral health provider, and specialty provider(s), if any, and coordination services to manage the beneficiary's dementia and any co-occurring conditions.

1.1.4.5.2 Identification of any community-based services and supports, and home and community-based services that the beneficiary is receiving.

1.2 Caregiver Assessment: GUIDE Participant shall deliver an assessment of the beneficiary's caregiver in accordance with the requirements hereinbelow.

1.2.1 GUIDE Participant shall identify the beneficiary's caregiver(s) and their ability and willingness to assume, or to continue to furnish, assistance.

1.2.2 GUIDE Participant shall assess the caregiver's knowledge, needs, and social supports, and assess the caregiver's well-being, stress level, and other challenges.

1.2.3 If the beneficiary does not have a caregiver, the GUIDE Participant shall make a reasonable effort to help identify a caregiver for the beneficiary.

1.2.3.1 If the GUIDE Participant and the beneficiary are not able to locate a caregiver for the beneficiary, then Section 1.2: Caregiver Assessment and Section 8: Caregiver Education and Support do not apply to that beneficiary, and instead the GUIDE Participant shall make additional efforts and put safeguards into its care delivery to support the beneficiary continuing to reside in the community.

	<p>1.3 Home Visit Assessment:</p> <p>1.3.1 For beneficiaries in the low complexity dyad tier or low complexity individual tier: GUIDE Participant may, but is not required to, visit the beneficiary and, if applicable, his or her caregiver in person at the current residence of the beneficiary. If the GUIDE Participant does not visit the beneficiary in person, the visit may be performed remotely through electronic means. For beneficiaries in moderate or high complexity dyad tiers, or moderate to high complexity individual tier: GUIDE Participant shall visit the beneficiary and, if available, his or her caregiver at the current residence of the beneficiary. If the caregiver or other members of the care team are not present, the GUIDE Participant may facilitate participation of the caregiver and other members of the care team by enabling such individuals to participate in the visit remotely through electronic means.</p> <p>1.3.2 The home visit with the beneficiary should occur within two months after the initial assessment and can be performed by any member of the interdisciplinary care team.</p> <p>1.3.3 During the home visit, the GUIDE Participant shall assess the following: i) safety of the home environment and the beneficiary's ability to navigate and manage the home environment, ii) beneficiary's function in activities of daily living, and iii) other environmental, social, and behavioral factors that might impact the function and needs of the beneficiary and their caregiver.</p>
2 Care Plan	<p>2.1 Based on findings from the comprehensive initial assessment, including the HRSN screening, home visit, and guidance from the beneficiary and the caregiver, the GUIDE Participant shall develop elements of the person-centered care plan with recommendations for i) addressing the beneficiary's goals, strengths, preferences and needs, ii) the required domains of the comprehensive assessment, iii) the coordination of community-based services and supports, including respite services if applicable, and a listing of recommended service providers and which individual or program is responsible for payment of each service provider, and iv) the caregiver's education and support services.</p> <p>2.2 The initial care plan and future revisions shall be led by the beneficiary. At the discretion of the beneficiary and as appropriate to the individual, the GUIDE Participant may also incorporate input from the beneficiary's caregiver. The GUIDE Participant shall share the initial care plan and future revisions with the beneficiary and their caregiver along with any relevant education, supports, and other resources, to carry out the goals of the plan.</p> <p>2.3 The GUIDE Participant shall modify the written care plan as needed, or requested, to reflect the beneficiary's changing circumstances, goals, preferences, and needs.</p> <p>2.4 The person-centered care plan shall be incorporated into the beneficiary's electronic health record and shared with the beneficiary's primary care provider (if the beneficiary's primary care provider is not a member of the GUIDE Participant's care</p>

	team) and any specialist or other provider in accordance with Section 5, Care Coordination and Transitional Care Management.
3 24/7 Access	<p>3.1 GUIDE Participant shall provide either (i) 24/7 access to an interdisciplinary care team member or (ii) maintain a 24/7 helpline that the beneficiary and/or their caregiver may call to speak with either a member of the care team or a third party engaged by the GUIDE Participant to provide communication with human support (e.g., not artificial intelligence) during off-duty hours. A third party engaged by the GUIDE Participant to provide communication during off-duty hours shall share with the interdisciplinary care team information of any communication with a beneficiary and/or their caregiver.</p> <p>3.2 If the GUIDE Participant uses a 24/7 helpline, the 24/7 helpline shall be available to receive ad hoc one-on-one support calls from the caregiver (see Section 8.2.4).</p>
4 Ongoing Monitoring and Support	<p>4.1 The care navigator shall be the primary point of contact for the beneficiary and their caregiver.</p> <p>4.2 The care navigator shall provide ongoing contact with the beneficiary and/or caregiver in order to revise and maintain the person-centered care plan as needed (see Section 2), identify unmet needs and coordinate clinical and community-based services and supports (see Section 6), monitor medication management and adherence (see Section 7), and provide caregiver education and support (see Section 8) as may be needed to support the beneficiary and their caregiver.</p> <p>4.2.1 If the care navigator is a non-clinical professional, the care navigator should consult with the care team's clinical team members for any medical or other issues that present with complexity.</p> <p>4.3 Frequency: GUIDE Participant shall maintain a minimum contact frequency with the beneficiary and/or their caregiver. Minimum contact requirements vary by model tier, as follows:</p> <ul style="list-style-type: none"> 4.3.1 Beneficiaries with a caregiver <ul style="list-style-type: none"> ○ Low complexity dyad tier: at least quarterly ○ Moderate complexity dyad tier: at least once a month ○ High complexity dyad tier: at least once a month 4.3.2 Beneficiaries without a caregiver <ul style="list-style-type: none"> ○ Low complexity individual tier: at least once a month ○ Moderate to high complexity individual tier: at least twice a month <p>4.4 Modality: GUIDE Participant may provide ongoing contact in-person (in-clinic or in-home), by phone, and/or by audio-visual modalities in accordance with the beneficiary's and/or caregiver's preferences, as applicable. Short Messaging Service (SMS) may not be used to contact the beneficiary or caregiver to meet the minimum contact frequency, but can be used, with the beneficiary's and caregiver's consent, in other communications.</p>

<p style="text-align: center;">5 Care Coordination and Transitional Care Management</p>	<p>5.1 If the beneficiary's primary care provider is not a member of the GUIDE Participant's care team, GUIDE Participant shall coordinate with the beneficiary's primary care provider and notify the beneficiary's primary care provider that the beneficiary is participating in a dementia care management program and ensure that the primary care provider has access to the beneficiary's care plan and any updated/revised care plans.</p> <p>5.2 GUIDE Participant may refer the beneficiary to a specialist or other provider to address any physical or behavioral health (such as, mental health or substance use) co-occurring conditions of the beneficiary. GUIDE Participant may notify the specialist or other provider that the beneficiary is participating in a dementia care management program and send the specialist or other provider the beneficiary's person-centered care plan, and any updated/revised care plans, by electronic health record, fax, or mail. The GUIDE Participant shall also notify the beneficiary's primary care provider of the referral to a specialist and/or other provider. If the primary care provider is actively co-managing the beneficiary, the GUIDE Participant should make this referral in consultation with the primary care provider. The dementia care team must close the referral loop with the specialist by ensuring they receive documentation from the beneficiary's visit and any changes to their care plan.</p> <p>5.3 If the GUIDE Participant refers the beneficiary to a specialist or other provider, a member of the care team shall introduce the beneficiary to the new provider if requested by the beneficiary and/or their caregiver so that the new provider is aware of the patient history and can share recommendations with the care team for incorporation into the care plan.</p> <p>5.4 GUIDE Participant shall provide care coordination services, medication management/reconciliation, and support to the beneficiary in transitions between their personal residence and care settings, such as a hospital, emergency department, nursing facility, and/or hospice.</p> <p>5.5 GUIDE Participant shall provide additional care coordination services needed to help manage the beneficiary's dementia and co-occurring conditions, if any, across the care-continuum.</p>
<p style="text-align: center;">6 Referral and Coordination of Services and Supports</p>	<p>6.1 GUIDE Participant shall i) refer and connect beneficiaries and their caregivers to community-based services and supports that address the common needs of persons with dementia and their caregivers (e.g., home-delivered meals, adult day centers, personal care, environmental modifications, contractors, food banks), and/or ii) enter into a written agreement with a local Area Agency on Aging or a Tribal Aging Program (funded through Title VI of the Older Americans Act) requiring that the local Area Agency on Aging or Tribal Aging Program assists beneficiaries and their caregivers with coordinating community-based services and supports.</p> <p>6.2 If the beneficiary is eligible for and receiving home- and community-based services (HCBS) through a state Medicaid program, the GUIDE Participant shall contact and attempt to coordinate the delivery of community-based services and supports and HCBS with the beneficiary's waiver/HCBS program case manager. Coordination</p>

	<p>between the GUIDE Participant and the beneficiary's waiver/HCBS program case manager shall include sharing information about the GUIDE Model and reviewing the services that the beneficiary receives through both the GUIDE Model and Medicaid for the purpose of understanding gaps or duplication in the beneficiary's care.</p> <p>6.3 GUIDE Participant shall join or maintain a community referral inventory system that includes resources for the health-related social needs screened as part of the comprehensive assessment (see Section 1.1.4.3), and the care navigator shall refer and connect the beneficiary and their caregiver to resources relevant to their needs.</p> <p>6.4 GUIDE Participant shall maintain, or have access to, an inventory of community-based resources for services and supports that address the common needs of persons with dementia and their caregivers (e.g., home-delivered meals, adult day centers, personal care, environmental modification, contractors, food banks) and as appropriate, share these resources with the beneficiary and their caregiver.</p>
7 Medication Management and Reconciliation	<p>7.1 A clinician with prescribing authority shall review and reconcile the medications that beneficiary is taking at the time of the comprehensive initial assessment, at any additional future assessments, and then periodically as requested by other members of the care team, the beneficiary or the caregiver, as appropriate. Medication review would customarily include, as part of this element, a review of prescription drugs, over-the-counter medications, supplements, natural treatments, and/or any other substances the beneficiary might be using for any purpose.</p> <p>7.2 If clinically advisable for the beneficiary, GUIDE Participant's advanced practice nurse, physician assistant, or physician shall consider prescribing medications that are beneficial for the beneficiary.</p> <p>7.3 If clinically advisable for the beneficiary, GUIDE Participant's advanced practice nurse, physician assistant, or physician shall de-prescribe any medications that are inappropriate for the beneficiary to continue taking.</p> <p>7.4 GUIDE Participant shall share recommended changes to the beneficiary's medications with the beneficiary's primary care provider and other medical specialists, as applicable, and confirm that the relevant medical provider, either the primary care provider or the medical specialist, agrees to the proposed change to the beneficiary's medications prior to the beneficiary changing their medications.</p> <p>7.5 GUIDE Participant's care navigator shall provide information on supports to help the beneficiary maintain the correct medication schedule, such as pill reminders, pill boxes, and/or software applications.</p>
	<p>8.1 In order to provide education and support to the caregiver of a beneficiary, GUIDE Participant shall administer a caregiver support program, which is based on the caregiver assessment referred to in Section 1.2 and is responsive to ongoing caregiver needs.</p> <p>8.2 The caregiver support program shall offer the following services:</p>

<p>8</p> <p>Caregiver Education and Support</p>	<p>8.2.1 Caregiver skills training: GUIDE Participant shall provide the caregiver with the option to receive training to help the beneficiary continue to live as safely and comfortably as possible in the community. The training shall include the following topics: emergency services, safety in the home, assistance with activities of daily living (ADL) and instrumental ADLs, responding to and managing the beneficiary's behavioral and psychosocial symptoms, identifying and obtaining help across the care continuum, working with health care and other community-based providers, recreation, social and leisure activities, making plans for the future, and caregiver self-care and stress management.</p> <p>8.2.2 Dementia diagnosis information: If beneficiary and/or caregiver wish to receive further information regarding the beneficiary's dementia diagnosis, GUIDE Participant shall speak with and provide written educational materials to the caregiver regarding the beneficiary's dementia diagnosis. These materials may include, but are not limited to, information on dementia, common behavioral changes, functional status, and resources available publicly and through the GUIDE Participant. These materials should be comprehensible to a lay person and in the primary language spoken by the beneficiary and the caregiver.</p> <p>8.2.3 Support group services: GUIDE Participant shall provide the caregiver with the option to participate in a group setting where a facilitator trained in dementia and caregiving shall work with caregivers on self-care, home safety, caregiver skills, personal care, and managing challenging behaviors.</p> <p>8.2.4 Ad hoc one-on-one support calls: GUIDE Participant shall be available for one-on-one support calls with the caregiver to address issues in furnishing care and support to the beneficiary as the issues arise. For example, these calls may focus on the caregiver's needs and goals by coaching caregivers on stress management, self-care and well-being behaviors, and how to identify and address behavioral challenges and functional status of the beneficiary with dementia, and support safety of the caregiver, and the beneficiary. The calls may be initiated by the beneficiary, the caregiver, or the GUIDE Participant. The GUIDE Participant's requirement to maintain minimum contact with the beneficiary in accordance with Section 4.3 may be used to satisfy this requirement for one-on-one support calls.</p> <p>8.3 Modality: All services may be provided virtually or in-person. In addition, GUIDE Participant shall deliver the services listed under Section 8.2 as follows:</p> <p>8.3.1 Caregiver skills training: Must be provided by either a member of the care team or through a contracted vendor or community organization that is reimbursed by the GUIDE Participant; may be provided in a one-on-one setting or group format.</p> <p>8.3.2 Dementia diagnosis information at program entry: Must be provided directly by a member of the care team in a one-on-one setting.</p> <p>8.3.3 Support group services: May be provided directly by a member of the care team, through a contracted vendor or community organization that is reimbursed by the GUIDE Participant, or through referral to a community organization that offers</p>
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	<p>support group services to the community free of charge. Beneficiaries with dementia and caregivers may decline to participate in support groups or change their mind about participation at any time.</p> <p>8.3.4 Ad hoc one-on-one support calls: Must be provided directly by a member of the care team.</p> <p>8.4 In addition to the required services listed above, the GUIDE Participant should consider whether to provide the following optional services:</p> <p>8.4.1 Peer-to-peer support: Experienced caregivers, whose caregiving experience has come to an end, would provide practical information, and support and mentoring to the caregiver participating in the Model.</p> <p>8.4.2 Resources or referrals for self-care and well-being instruction (e.g., group walks, meditation classes): Specialized services centered around caregiver stress and health management. Services could include, but are not limited to, mindfulness and relaxation techniques, cognitive behavioral therapy, musical and arts classes, and exercise classes.</p> <p>8.4.3 Assist with education on the role of the caregiver: Information on the traditional responsibilities of a caregiver for a person living with dementia and the resources available to them through the GUIDE Participant.</p> <p>8.4.4 Accessing community-based resources: Coaching the caregiver on how to access community-based resources relevant to their caregiving role, such as transportation, nutrition support, homemaker/yard services. This service is in addition to the referral support provided under Section 6 Referral and Coordination of Services and Supports.</p> <p>8.5 Psychological counseling referral: The caregiver may work with a specialist on developing new behaviors or strategies to help address caregiving demands, identifying areas for improvement for the beneficiary-caregiver dyad, or assistance in addressing depression, anxiety, and suicidal ideation in the caregiver and/or the beneficiary.</p>
9 Respite	<p>9.1 GUIDE Participant shall provide GUIDE Respite Services to beneficiaries who qualify for respite under the Model and choose to receive respite. GUIDE Respite Services are furnished based on the beneficiary's qualifying status. GUIDE Participants and eligible beneficiaries shall decide how much GUIDE Respite Services the beneficiary will receive taking into consideration the beneficiary's need for GUIDE Respite Services and the capped amount of GUIDE Respite Services covered under the Model.</p> <p>9.2 GUIDE Participant shall provide in-home GUIDE Respite Services directly or contract with at least one provider of in-home respite services. The contract must specify how the GUIDE Participant will reimburse the respite provider for Respite Services rendered to eligible beneficiaries.</p>

	<p>9.3 GUIDE Participant may also contract with adult day centers or facilities that can provide 24-hour care to deliver GUIDE Respite Services in these settings to eligible beneficiaries.</p>
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Appendix C: Example Patient Assessment and Alignment Form

Example GUIDE Patient Assessment and Alignment Form

Results from (check one):

Initial Assessment Re-assessment Re-assessment due to new primary caregiver

Date of assessment: _____

Patient first name: _____ Patient middle name:(if applicable) _____ Patient last name: _____

Patient Address: _____ Email: _____ Phone Number: _____

Patient resides in: home assisted living facility memory care program (excludes nursing home level of care)

Patient Date of Birth: ____/____/____

Patient Medicare Beneficiary Identifier: _____

Patient Medicaid ID number: _____ (*as applicable*)

Patient dementia stage: (Drop-down menu: CDR, FAST): ____ (enter numerical score)

Does patient have a caregiver, defined as a relative, or an unpaid nonrelative, who assists the beneficiary with activities of daily living and/or instrumental activities of daily living? (Drop-down menu: yes-multiple, yes-one, no, undetermined)

If yes:

Caregiver first name: _____ Caregiver last name: _____

Caregiver Address: _____ Email: _____ Phone Number: _____

What is primary caregiver's relationship to patient? (Drop-down menu: spouse, child, non-immediate family member, friend, other)

Does primary caregiver live with patient? (Drop-down menu: yes, no)

Is primary caregiver a Medicare beneficiary? (Drop-down menu: yes, no)

If yes, what is the primary caregiver's Medicare Beneficiary Identifier: _____

Primary caregiver Zarit Burden Interview score: ____ (enter numerical score as a whole number)

In my clinical judgment, the assessed beneficiary meets the National Institute on Aging-Alzheimer's Association diagnostic guidelines for dementia and/or the DSM-5 diagnostic guidelines for major neurocognitive disorder, or I have received a written report (electronic or hard-copy) of a documented dementia diagnosis from another Medicare qualified health professional.

Yes

No

Attesting clinician:

First name: _____ Middle Name: _____ Last name: _____

National Provider Identification (NPI): _____

Patient referral source:

- Referred by a healthcare provider Referred by a community-based organization Self-referral