Guiding an Improved Dementia Experience (GUIDE) Model Overview Webinar

Center for Medicare and Medicaid Innovation
August 10, 2023

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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Agenda

This webinar provides an introduction to the GUIDE Model. The following topics will be discussed:

1. Welcome and Introductions
2. GUIDE Model Overview
3. Payment Methodology Overview
4. Data Reporting
5. Application Timeline, Process & Resources
6. Question and Answer Session
7. Closing and Resources

Welcome and Introductions

Today's Presenters

Tonya Saffer
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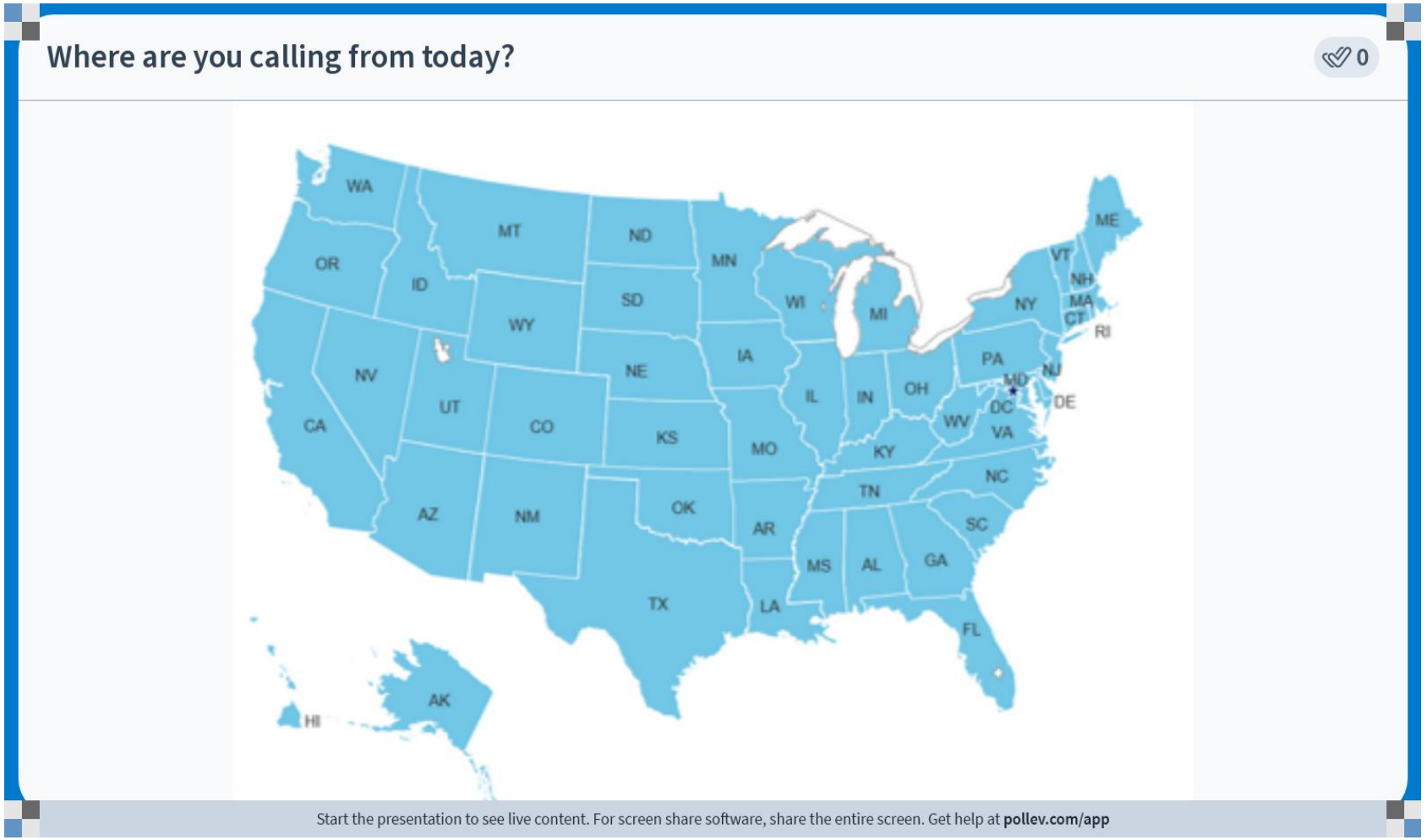
GUIDE Model Overview

Poll #1



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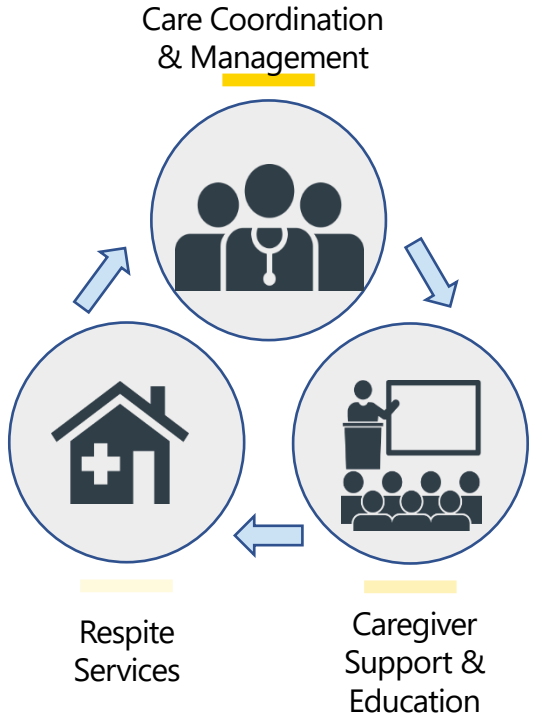
Model Purpose and Overview

The GUIDE Model will test whether a comprehensive package of care coordination and management, caregiver support and education, and respite services can **improve quality of life for people with dementia and their caregivers** while **delaying avoidable long-term nursing home care** and **enabling more people to remain at home** through end of life.



Care Coordination & Management

Beneficiaries will receive care from an **interdisciplinary team** that will develop and implement a comprehensive, person-centered care plan for **managing the beneficiary's dementia and co-occurring conditions** and provide **ongoing monitoring and support.**

Caregiver Support & Education

GUIDE participants will provide a **caregiver support program**, which must include caregiver skills training, dementia diagnosis education, support groups, and access to a personal care navigator who can help problem solve and connect the caregiver to services and supports.

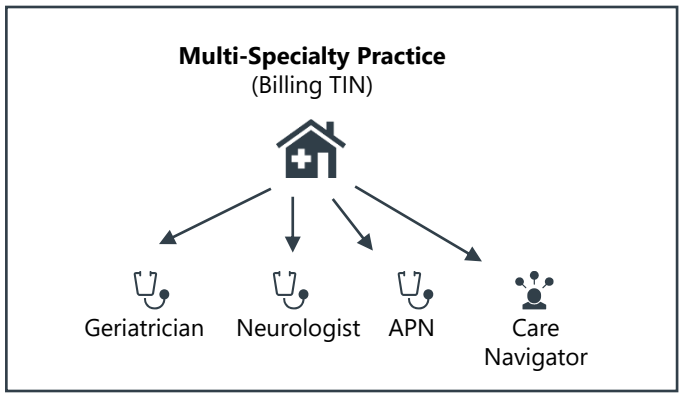
Respite Services

A subset of beneficiaries in the model will be eligible to receive payment for respite services with no cost sharing, up to a cap of **$2,500 per year**. These services may be provided to beneficiaries in a variety of settings, including **their personal home, an adult day center, and facilities that can provide 24-hour care** to give the caregiver a break from caring for the beneficiary.

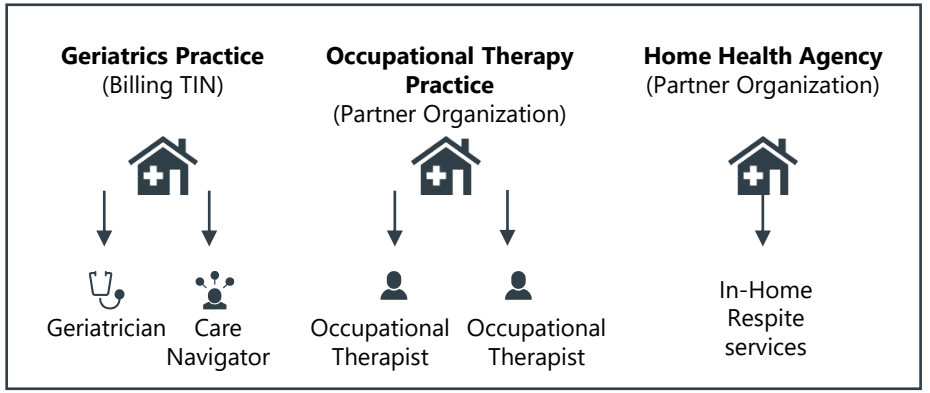
Who is Eligible to Participate in GUIDE?

GUIDE participants will be Medicare Part B enrolled providers/suppliers, excluding durable medical equipment (DME) and laboratory suppliers, who are eligible to bill for Medicare Physician Fee Schedule service and agree to meet the care delivery requirements of the model. If the GUIDE participant can't meet the GUIDE care delivery requirements alone, they have the ability to contract with "Partner Organizations," which are other Medicare providers/suppliers, to meet the care delivery requirements

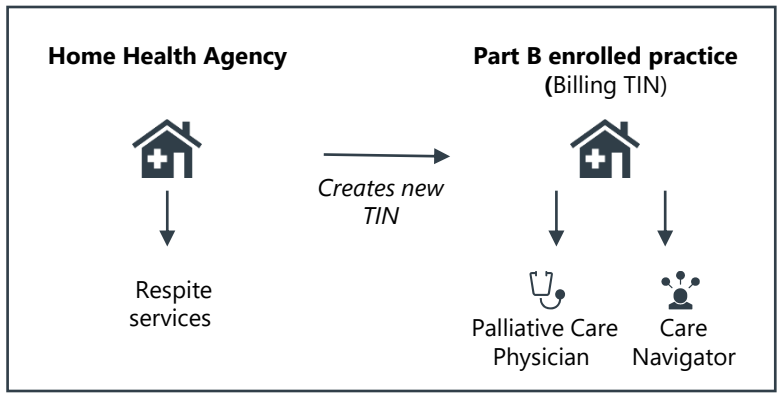
Example Dementia Care Program provider and supplier arrangements:



A single Medicare provider with multiple suppliers forms a GUIDE DCP



Several Medicare providers and multiple suppliers form a DCP



Medicare-enrolled provider establishes a new Part B enrolled TIN to form a GUIDE DCP

GUIDE is an 8-year voluntary model offered in all states, D.C., and the U.S. territories.

GUIDE Model Program Track Designation

In order to support the development of new dementia care programs, GUIDE has created two model tracks: a track for established programs that will launch on July 1, 2024, and a track for new programs that will launch on July 1, 2025 after a one-year pre-implementation period for participants to establish their new programs.

Model Participant Tracks	
ESTABLISHED PROGRAM	**NEW PROGRAM**
+ Designed for participants already providing comprehensive dementia care + Participants should be ready to immediately implement GUIDE's care delivery requirements	+ Designed for participants not operating a comprehensive outpatient dementia care program who are interested in scaling support + Participants must submit a detailed plan for implementing a dementia care program

Based on the information provided in their application, selected participants will be assigned to the established program track or the new program track. Track assignment will depend on whether a program is providing comprehensive dementia care at the time of model announcement.

Beneficiary Eligibility and Alignment

The GUIDE model is designed for community-dwelling Medicare FFS beneficiaries, including beneficiaries dually eligible for Medicare and Medicaid. Eligibility criteria for model beneficiaries are outlined below:

GUIDE Beneficiary Eligibility Criteria

Dementia Diagnosis
Beneficiary has dementia confirmed by attestation from clinician practicing within a participating GUIDE dementia care program

Enrolled in Medicare Parts A & B
Beneficiary must have Medicare as their primary payer and not enrolled in Medicare Advantage, including Special Needs Plans (SNPs)

Not Residing in Long-Term Nursing Home

Not Enrolled in Medicare Hospice Services overlap significantly with the services that will be provided under the GUIDE model

Not Enrolled in PACE
Services overlap significantly with the services that will be provided under the GUIDE model

Voluntary Alignment Process

The GUIDE model will use a voluntary alignment process for aligning beneficiaries to model participants. Participants must inform beneficiaries about the model and the services that they can receive through the model, and document that a beneficiary (or their legal representative if applicable) consents.

Model Tiers

Beneficiaries who align to model participants will be assigned to one of five "tiers," based on a combination of their disease stage and caregiver status. Beneficiary needs, and correspondingly, care intensity and payment, will increase by tier.

	TIER	CRITERIA
 **Beneficiaries with a caregiver**	Low complexity	Mild dementia
	Moderate complexity	Moderate or severe dementia and low to moderate caregiver strain
	High complexity	Moderate or severe dementia and high caregiver strain
 **Beneficiaries without a caregiver**	Low complexity	Mild dementia
	Moderate to high complexity	Moderate or severe dementia

Care Delivery Approach

The GUIDE Model will promote high-quality dementia care by defining and requiring a comprehensive, standardized care delivery approach.

1 Standardized Care Delivery

Standardized care delivery services that participants must provide to beneficiaries and their caregivers

2 Interdisciplinary Care Team

Interdisciplinary care team to deliver standardized care delivery services

3 Standardized Training

Standardized training requirement for care navigators who are part of the interdisciplinary care team

Establishing standard minimum requirements with adequate model payments to support these requirements will transform dementia related care for beneficiaries.

Interdisciplinary Care Team Requirements

Participants must have an interdisciplinary care team that includes, 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).

The interdisciplinary care team will assess the beneficiary and their caregiver 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.

Interdisciplinary Care Teams may include additional members at the participant's discretion.

Dementia proficiency is defined as:

i. At least 25% of a clinician's patient panel comprised of adults with any cognitive impairment, including dementia; or
ii. At least 25% of a clinician's patient panel aged 65 years old or older; or
iii. Have a specialty designation of neurology, psychiatry, geriatrics, geriatric psychiatry, behavioral neurology, or geriatric neurology.

Care Delivery Requirements

Participants must provide specified services across the domains outlined below. Participants will tailor the exact mix of services based on each beneficiary's individual care plan.

COMPREHENSIVE ASSESSMENT

Beneficiaries and caregivers receive separate assessments to identify their needs and a home visit to assess the beneficiary's safety.

CARE PLAN

Beneficiaries receive care plans that address their goals, preferences, and needs, which helps them feel certain about next steps.

24/7 ACCESS

Beneficiaries and caregivers can call a member of their care team or a third-party representative using a 24/7 helpline.

ONGOING MONITORING & SUPPORT

Care navigators provide long-term help to beneficiaries and caregivers so they can revisit their goals and needs at any time and are not left alone in the process.

REFERRAL & SUPPORT COORDINATION

Beneficiaries' care navigator connects them and their caregivers to community-based services and supports, such as home-delivered meals and transportation.

CAREGIVER SUPPORT

Caregivers take educational classes and beneficiaries receive respite services, which helps relieve the burden of caregiving duties.

MEDICATION MANAGEMENT

Clinician reviews and reconciles medication as needed; care navigators provide tips for beneficiaries to maintain the correct medication schedule.

CARE COORDINATION & TRANSITION

Beneficiaries receive timely referrals to specialists to address other health issues, such as diabetes, and the care navigators coordinate care with the specialist.

Example Beneficiary Persona

Margaret Smith

Situation: Margaret, 82, was diagnosed with Alzheimer's disease by her primary care physician (PCP) two years ago. She now experiences moderate symptoms. Her daughter, Kathy, visits her daily at her home but is unable to provide the increased level of attention she now requires. Margaret is unsure how to access support, and her PCP is not equipped to provide the necessary guidance.

Key Information

Location: Atlanta, Georgia

Family: 2 children, 4 grandchildren

Medical Utilizations in Last Year: 1 Emergency Department visit followed by post-acute care at home

Income: $1,700 per month

Margaret's Needs

- Culturally competent, coordinated care.
- Financial support for out-of-pocket medical costs.
- Support for household and personal tasks, such as cooking, cleaning, bathing, and maintaining a medication schedule.
- Assistance with light activity, such as short walks or physical therapy.

Margaret's Challenges

- Lack of savings for in-home care services and medical costs.
- Suffers from sundowning every evening and often forgets to take medications on time.
- Lives alone in a home with steps, which have caused 2 falls in the last 6 months.
- Struggles with Type 2 Diabetes and impaired vision that limits her ability to drive a vehicle.

Margaret's Experience in the GUIDE Model

Comprehensive Assessment and Care Plan

Margaret receives a comprehensive assessment and develops a care plan with her care team, which addresses her safety walking down stairs.

Ongoing Monitoring and Support

Care navigator checks in with Margaret monthly. Kathy also calls care navigator for suggestions on how to cope with sundowning.

Medication Management

Margaret's care navigator provides tips for Margaret to maintain her correct medication schedule.

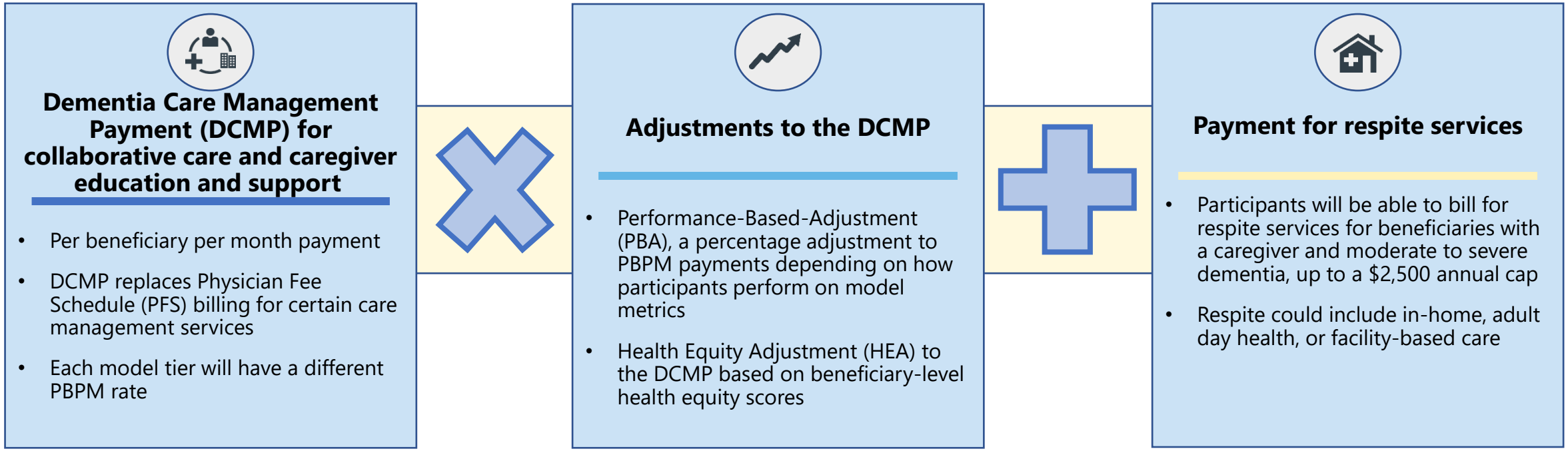
Referral and Coordination

Care navigator refers Margaret to a community-based organization that helps her identify service providers.

Payment Methodology Overview

Payment Methodology

The Model's core payment methodology is a per beneficiary per month care management payment, called the Dementia Care Management Payment (DCMP), that is adjusted for health equity and performance on a set of quality metrics, plus a separate payment for respite services.



Participants in the new program track that are classified as safety net providers will also be eligible to receive an infrastructure payment to cover some of the upfront costs of establishing a new dementia care program. Safety net provider status will be defined based on the share of a provider's patient population that receives the Medicare Part D Low Income Subsidy or is dually eligible for Medicare and Medicaid

Payment Amounts

Model participants will use a set of new G-Codes created for the GUIDE model in order submit claims for the monthly Dementia Care Monthly Payment (DCMP). The DCMP is intended to cover the model's required care delivery activities.

Per Beneficiary Per Month Payment Rates

	Monthly payment rates for beneficiaries with caregiver			Monthly payment rates for beneficiaries without caregiver	
	Low complexity dyad tier	**Moderate complexity dyad tier**	**High complexity dyad tier**	**Low complexity individual tier**	**Moderate to high complexity individual tier**
First 6 months (New Beneficiary Payment Rate)	$150	$275	$360	$230	$390
After first 6 months (Established Beneficiary Payment Rate)	$65	$120	$220	$120	$215

In order to support accurate billing, CMS will provide each participant with a monthly beneficiary alignment file that lists all beneficiaries aligned to that participant, their model tier assignment, and the length of their alignment to the participant.

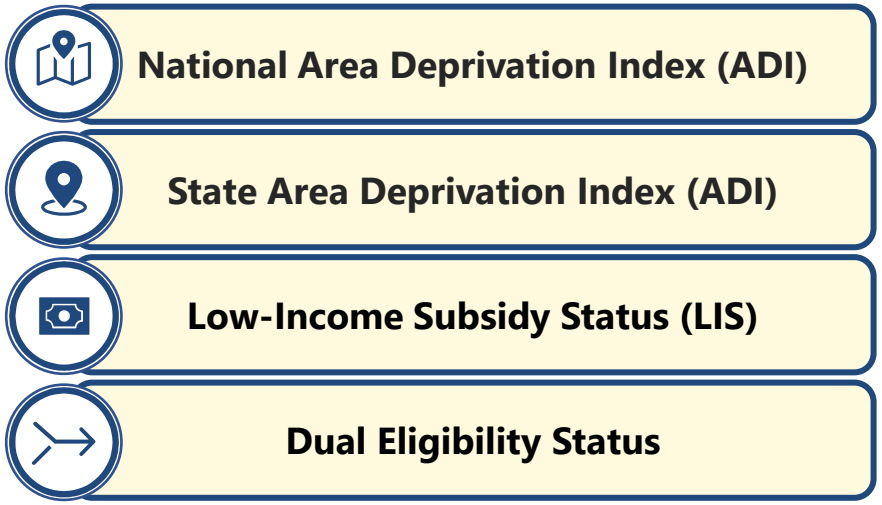
Payment Adjustments

When participants bill the per beneficiary per month Dementia Care Management Payment (DCMP), the DCMP will be adjusted by a Performance-Based Adjustment (PBA), as well as a Health Equity Adjustment (HEA).

The Health Equity Adjustment (HEA) is designed to decrease the resource gaps in serving historically disadvantaged communities.

The Performance Based Adjustment (PBA) will increase or decrease participants' monthly DCMPs, depending on how they perform during the previous performance year.

HEA will be based on certain social risk factors, which may include:



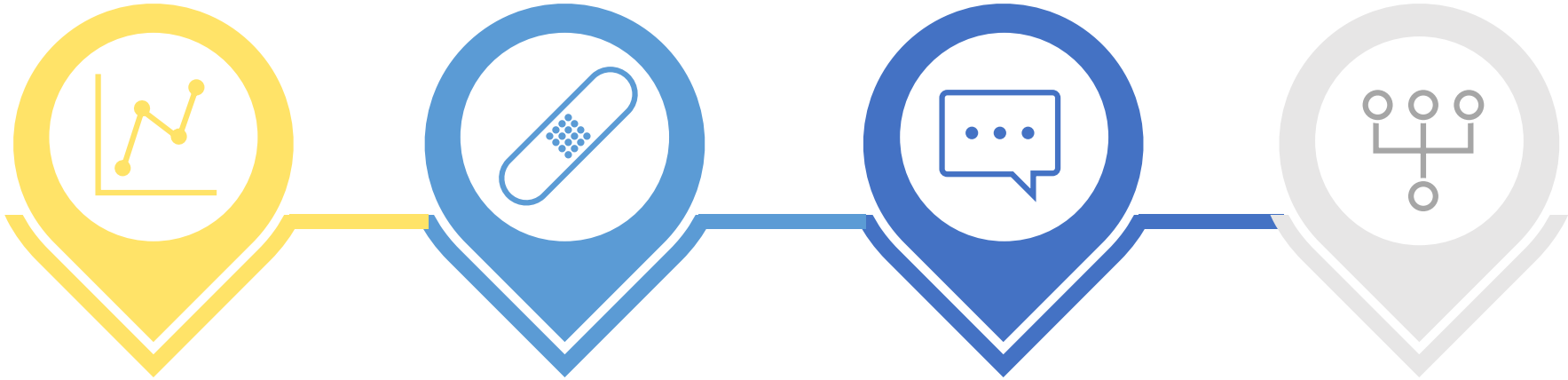
PBA will calculate five model performance metrics across four domains that include:

DOMAIN	METRICS
Care Coordination and Management	High-risk medications (eCQM/CQM)
Beneficiary quality of life	Quality of life outcome (Survey-based)
Caregiver Support	Zarit Burden Interview (Survey-based)
Utilization	Total Per Capita Cost (Claims-based)
	Long-term nursing home stay rate (Claims-based)

GUIDE Data Reporting

Data Reporting

All Innovation Center model participants are required to collect and report data deemed necessary to monitor and evaluate the model, including "protected health information". GUIDE will require participants to report the following:



Quality Data*

Care Delivery Data

Beneficiary and Caregiver Assessment Data

Sociodemographic and Health Related Social Needs (HRSN) Data

*Participants will annually report quality data for the three non-claims-based performance metrics (high-risk medication use, beneficiary quality of life, and caregiver burden).

Expanded Data Collection Efforts

Under the GUIDE model, participants will be required to collect and report data on aligned beneficiaries' sociodemographic characteristics and health-related social needs, though beneficiaries will always have the option to opt out of data sharing.

Socio-demographic Data

Participants will be required to report a core set of sociodemographic measures for their aligned beneficiaries annually.

Example measures are:

- Race
- Ethnicity
- Sex assigned at birth
- Disability status
- Preferred language.

Health-Related Social Needs (HRSN) Data

HRSN collection and referrals will be part of the model's broader care delivery requirements for comprehensive assessment and referral for services and supports.

Model participants will be encouraged to use one of two preferred HRSN screening tools:

- The Accountable Health Communities (AHC) HRSN Screening tool
- The Protocol for Responding to and Assessing Patient Risk (PRAPARE) tool.

This data will help participants identify and address disparities within their beneficiary population and track their progress towards health equity goals over time.

Health Equity Plan

The Health Equity Plan will allow each GUIDE participant to identify disparities in outcomes in their patent populations and implement initiatives to measure and reduce these disparities over the course of the model.

FOCUS

Beneficiary Outreach and Engagement

GOAL

Encourage Participants to develop and implement health equity recruitment strategies from model start

Health Equity Plan Requirements

- Regularly update and report progress on their Health Equity Plan, as an element of the model's annual care delivery reporting
- Set goals and monitor progress over time
- Identify and select evidence-based interventions for addressing health disparities and achieving equitable outcomes

Example Health Equity Plan Questions

- What specific outreach strategies for model recruitment will you use that are tailored to the underserved populations you are seeking to engage?
- What metrics and targets will you use to measure the success of your engagement and outreach strategies?
- Please list the data source you used to identify disparities and the primary intervention strategies you are planning in order to address the disparities you have identified.

The first Health Equity Plans will be due after participants have signed Participation Agreements, but before model launch.

Application Timeline, Process, and Resources

GUIDE Model Timeline

The model application period will start in Fall 2023 and the performance period for the established program track and pre-implementation period for the new program track will begin on July 1, 2024

	Fall '23-Winter '24	July '24-June '25	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	Application Period	Performance Year (PY) 1	PY 2	PY 3	PY 4	PY 5	PY 6	PY 7	PY 8
NEW PROGRAM	Application Period	Pre-Implement-ation (PI) Period	PY 1	PY 2	PY 3	PY 4	PY 5	PY 6	PY 7

Prospective applicants are strongly encouraged to submit a non-binding Letter of Intent (LOI) by September 15, 2023.

Model Resources

The GUIDE Model team has a host of resources to support interested organizations. To see the latest resources, visit the model's website at https://innovation.cms.gov/innovation-models/guide.

Letter of Intent (LOI)

The GUIDE model's non-binding LOI will help us better assess your interest in the model. Information from the LOI helps the Model team better understand your organization's goals and challenges in applying to the GUIDE Model so that we can facilitate a smooth application process.

Model Factsheets

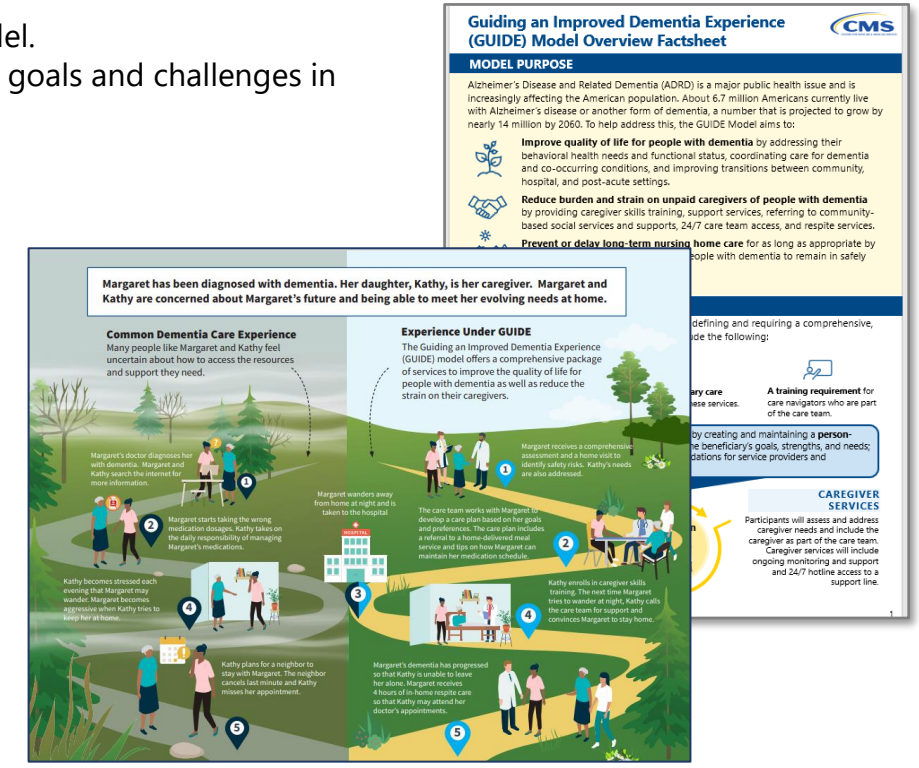
Model Overview and GUIDE Model Dementia Pathways Infographic may be found on the Model's website.

Request for Applications (RFA)

Coming in Fall 2023

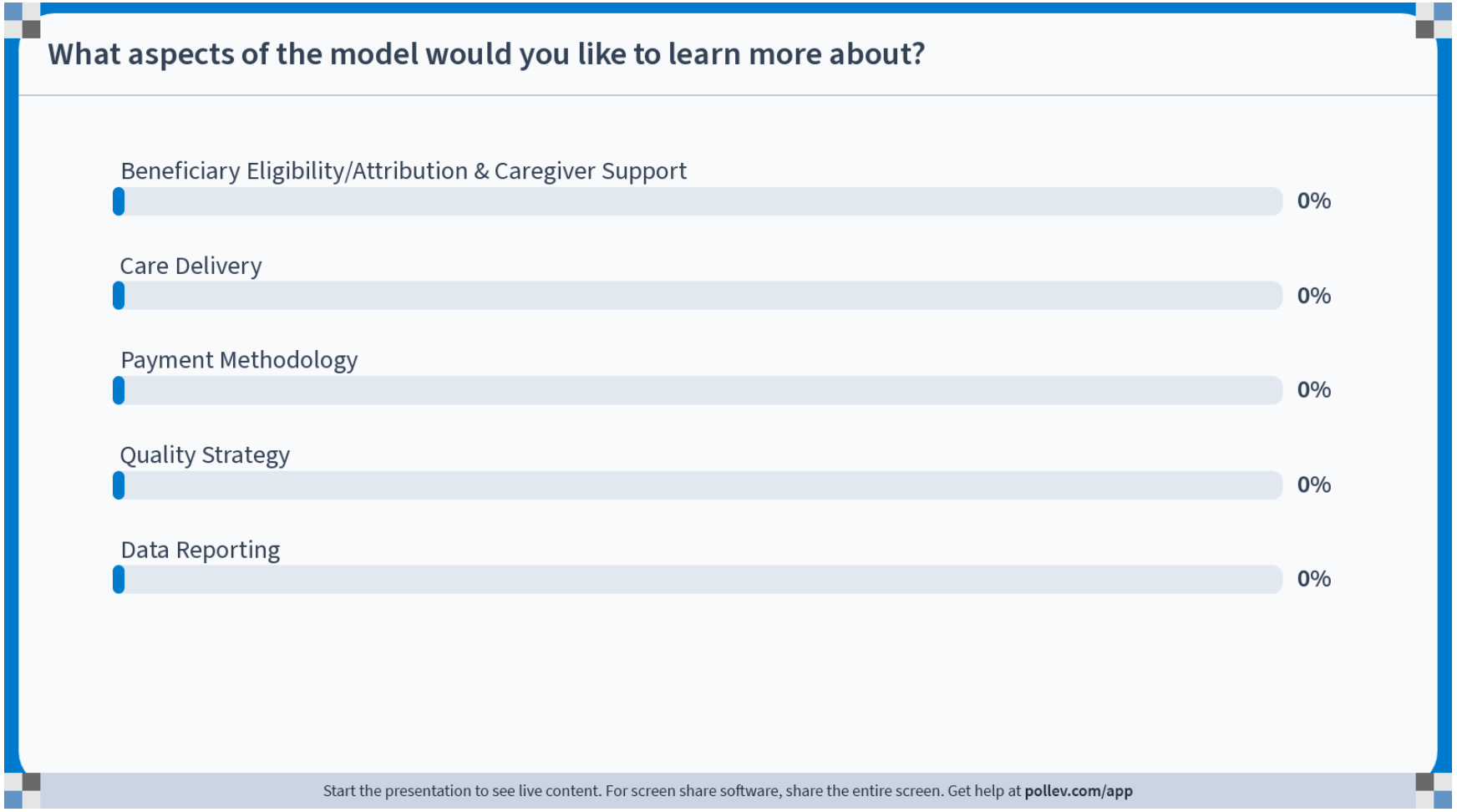
Helpdesk

If you have questions for the model team, please reach out to us via email at GUIDEModelTeam@cms.hhs.gov.



Question and Answer Session

Poll #2



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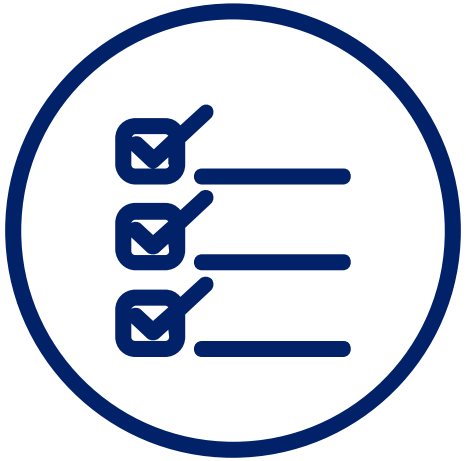

We appreciate your input!

Please click the link posted in the chat to take our survey.

We would love to learn how to make our events better.

Question & Answer Session

Open Q&A

Please **submit questions via the Q&A pod** to the right of your screen.
Specific questions about your organization can be submitted to GUIDEModelTeam@cms.hhs.gov.

Closing & Resources

Thank You for Attending this Webinar

We appreciate your time and interest!

Please take the survey following this webinar so we can learn how to make our events better.

Do you have questions? Email your comments and feedback to GUIDEModelTeam@cms.hhs.gov with subject line ***GUIDE Model Overview Webinar***

THANK YOU!