Centers for Medicare & Medicaid Services

GUIDE Payment Methodology Paper

Including Overview of Patient Alignment

Version 2.1

Effective June 11, 2025

Version History

Version Number	Update	Date
1.0	First release	May 8, 2024
2.0	Second release. Includes updates to model payment methodology based on the Amended and Restated Participation Agreement, including revised assessment and alignment requirements, tiering updates for patients who reside in residential care communities, Population and Income Adjustment (PIA) score calculations, performance measurement details, and updated billing guidance.	May 5, 2025
2.1	Update to second release. Includes updated payment rates and respite cap for PY 2025.	June 11, 2025

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1 Model Introduction and GUIDE Participants

1.1 Introduction

> The use of "participant(s)" refers to GUIDE Participant(s).
>
> The use of "aligned patient(s)" refers to GUIDE-aligned Patient(s).

The Guiding an Improved Dementia Experience (GUIDE) Model, a Center for Medicare and Medicaid Innovation (Innovation Center) alternative payment model, seeks to enhance quality of life for people living with dementia, reduce strain on their caregivers, and enable people living with dementia to remain in their homes and communities. The GUIDE Model will achieve these goals through Model participants who deliver a comprehensive package of care coordination and care management, caregiver education and support, and respite services. Model participants are organizations that signed the Participation Agreement and are responsible for meeting GUIDE Model requirements. GUIDE-aligned patients in the model will receive care from an interdisciplinary care team that will identify the patient's primary care provider and specialists and outline the care coordination services needed to manage the patient's dementia and co-occurring conditions.

This document describes the method CMS uses to align patients to a participant and pay for services delivered under the GUIDE Model.

1.2 GUIDE Performance Years

The GUIDE Model is an 8-year voluntary care model, offered nationwide, running from July 1, 2024, through June 30, 2032. **Exhibit 1** lists each GUIDE Model performance year (PY) by program track, and the respective time period.

Exhibit 1: GUIDE Performance Years

Performance Year Established Program Track	Performance Year New Program Track	Start Date	End Date
PY 1	**Pre-Implementation Year**	July 1, 2024	June 30, 2025
PY 2	**PY 1**	July 1, 2025	June 30, 2026
PY 3	**PY 2**	July 1, 2026	June 30, 2027
PY 4	**PY 3**	July 1, 2027	June 30, 2028
PY 5	**PY 4**	July 1, 2028	June 30, 2029
PY 6	**PY 5**	July 1, 2029	June 30, 2030
PY 7	**PY 6**	July 1, 2030	June 30, 2031
PY 8	**PY 7**	July 1, 2031	June 30, 2032

PY = performance year

1.3 Program Tracks

The GUIDE Model has two program tracks, one for established dementia care programs (DCP) and one for new DCPs. The purpose of the two tracks was to allow organizations in the Established Program Track to begin their performance in the GUIDE Model on July 1, 2024, while giving organizations that did not yet offer comprehensive dementia care services time and support for program development in accordance with GUIDE Model requirements. Participants will remain in their program track for the entirety of the model.

> For the GUIDE Model, 'dementia care program' refers to the participants and their partner organizations collectively.

1.3.1 New Program Track

As shown in **Exhibit 1**, New Program Track Participants had a 1-year pre-implementation period which began on July 1, 2024, for program development, including hiring and training staff, establishing program workflows and processes, developing referral networks, and building relationships with community-based organizations and respite providers.

During the pre-implementation period, New Program Track Participants may not bill the GUIDE-specific Healthcare Common Procedure Coding System (HCPCS) codes: Dementia Care Management Payment (DCMP) and GUIDE Respite Services G-codes. If appropriate, New Program Track Participants may continue to bill Medicare Physician Fee Schedule (PFS) services provided to patients during the pre-implementation year. New Program Track Participants who met the GUIDE safety net provider definition were eligible for the one-time GUIDE Infrastructure Payment during the pre-implementation period (see Section 6).

1.3.2 Established Program Track

Participants in the Established Program Track began billing for aligned patients receiving GUIDE services on July 1, 2024. As detailed further in Section 3, the DCMP replaces fee-for-service (FFS) payment for certain existing Medicare PFS services, including annual wellness visits, chronic and principal care management, transitional care management, advance care planning, and technology-based check-ins. Therefore, participants cannot bill separately for these Medicare PFS services for aligned patients.

1.4 GUIDE Participant Structures and Agreements

Participants are Medicare Part B–enrolled providers and suppliers, excluding durable medical equipment and laboratory suppliers, which are eligible to bill for Medicare PFS services and agree to provide comprehensive dementia care services in accordance with GUIDE Model requirements. CMS identifies a participant by a single Tax Identification Number (TIN) plus the National Provider Identifiers (NPI) of individual Medicare-enrolled physicians and other nonphysician practitioners who participate in the model. For detailed requirements, please refer to Section 3 of the Participation Agreement.

DCPs provide ongoing, longitudinal care and support to people living with dementia through an interdisciplinary care team. Participants must maintain an interdisciplinary care team, including,

at a minimum, a care navigator and a clinician with dementia proficiency[1] who is eligible to bill Medicare Part B evaluation and management services. Participants should retain copies and/or appropriate records of all descriptive materials and activities provided to eligible patients (See Section 15.02 of the Participation Agreement).

1.4.1 GUIDE Practitioners

A participant is composed of the NPIs of individual Medicare-enrolled physicians and other nonphysician practitioners who have reassigned their billing rights to the participant's billing TIN to participate in the model and who agree to meet the care delivery requirements of the model. Participants are required to maintain this list of physicians and nonphysician 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 provide dementia attestations related to patient alignment and bill for GUIDE Model payments.

Only practitioners listed on the GUIDE Practitioner Roster, and approved by CMS, can bill for GUIDE-specific G-codes for GUIDE Care Delivery Services. This also applies to services provided by organizations listed, and approved by CMS, on the Partner Organization Roster.

For GUIDE Model billing codes (GUIDE-specific G-codes), CMS has waived the reduction in the payment amounts for nonphysician practitioners, which is typically at 85% of the physician's fee schedule. For example, if the dementia-proficient clinician is a nurse practitioner or physician assistant and bills the GUIDE G-codes, these G-codes will not be subject to the reduction in payment rates under the PFS for services provided by nonphysician practitioners compared to those provided by physicians.

1.4.2 Partner Organizations

Participants may also contract with Partner Organizations. A participant may decide to contract with an organization(s) to meet the GUIDE care delivery requirements. A Partner Organization is an entity that has agreed to perform at least one of the GUIDE Care Delivery Services through a Partner Organization Arrangement. See **Exhibit 2** for examples of participant and Partner Organization collaboration to deliver GUIDE service.

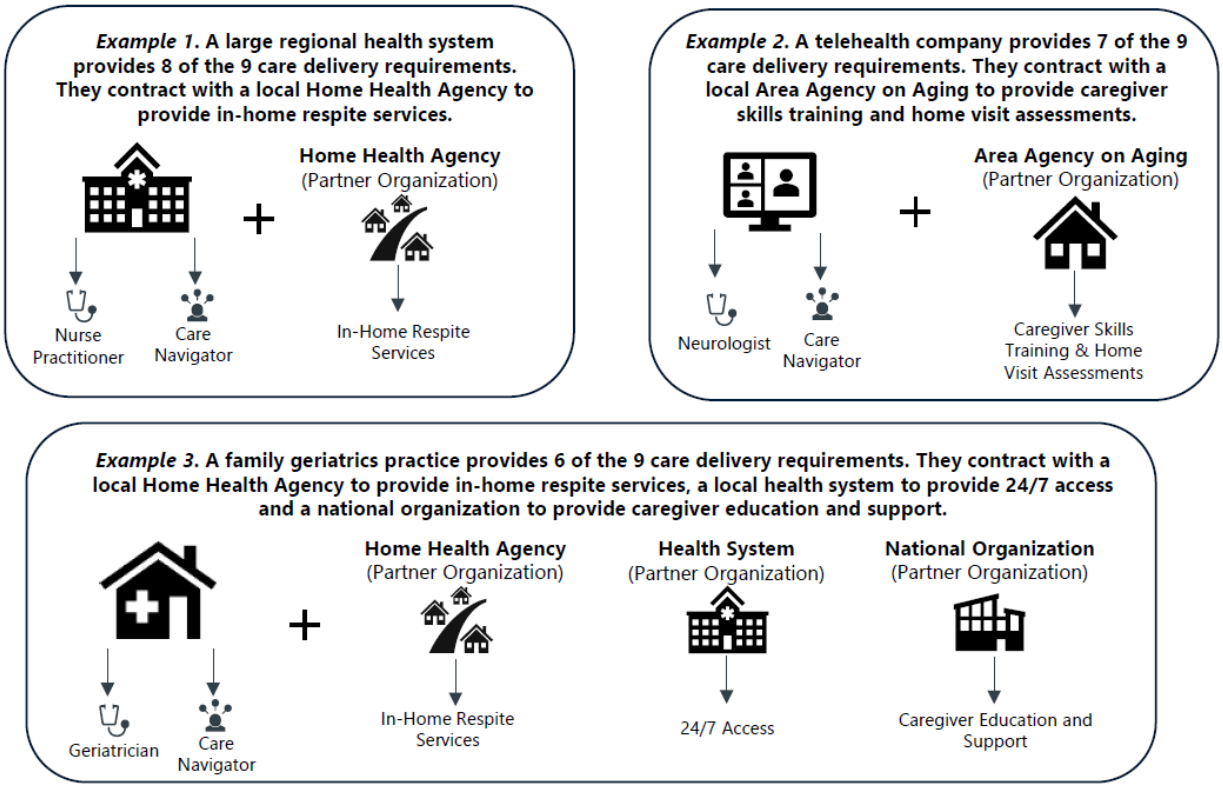
> CMS must review and approve Partner Organizations, which includes conducting program integrity screening. Partner Organizations may not provide services under the GUIDE Model until CMS has approved their participation.

Participants are responsible for having contracts and other arrangements in place with their Partner Organizations to pay for any GUIDE Care Delivery Services provided by those organizations. If a Partner Organization furnishes GUIDE Respite Services, the participant must bill for those services and pay the full amount of the respite payment from CMS to the Partner

[1] **Clinician with dementia proficiency:** A clinician will qualify as having dementia proficiency if they meet at least one of the following criteria:
- Attest to having at least 25% of their patient panel (regardless of payer) at some time in the past 5 years composed of adults with any cognitive impairment, including dementia
- Attest to having at least 25% of their patient panel (regardless of payer) at some time in the past 5 years composed of adults aged 65 years old or older
- Have a specialty designation of neurology, psychiatry, geriatrics, geriatric psychiatry, behavioral neurology, or geriatric neurology.

Organization (see Section 5 for information on GUIDE Respite Services). CMS will not directly reimburse Partner Organizations for services under the GUIDE Model because Partner Organizations are not participants.

Exhibit 2: Examples of GUIDE Participants and Partner Organizations Forming DCPs



1.4.3 Participant Service Area

Participants are required to submit to CMS and maintain a zip code–based service area encompassing the zip codes from which they will accept patients. In defining a service area, participants should keep in mind that the GUIDE Model requires they provide a home visit assessment and in-home GUIDE Respite Services to aligned patients in certain model tiers as well as make referrals to community-based services and supports. Participants may only align and bill for patients residing in their service area zip code.

> Only the first 250 zip codes are visible in the Participant Portal. This display limitation does not affect the participants' complete zip code-based service area. Updates submitted through Portal should be visible within 5-6 business days.

Participants are responsible for maintaining accurate service area zip codes. Updates should be submitted through the Participant Portal. Navigate to the Rosters Tile and select the Service Area Codes Tab to modify your list of zip codes. It is important to note that CMS will use zip code lists to generate Beneficiary Outreach Letters to support participants with identifying patients potentially eligible for the model. See Section 2.2 for more details.

CMS may also update a participant's zip-code based service area based on data reported to CMS (for example, via the Patient Assessment and Alignment Forms (PAAFs) described in Section 2).

2 Patient Alignment to the GUIDE Model

2.1 Overview

CMS designed the GUIDE Model to serve community-dwelling[2] Medicare FFS patients, including patients dually eligible for Medicare and Medicaid, who have dementia and to provide support and education to their caregivers, if applicable. For the purposes of the GUIDE Model, the definition of a caregiver is a relative, or unpaid nonrelative, who assists the aligned patient with activities of daily living[3] and/or instrumental activities of daily living.[4] Depending on the patient's needs, the assistance may be episodic, daily, or occasional.

> Starting PY 2025, "caregiver" includes staff at a residential care community regardless of whether a patient identifies a relative or unpaid nonrelative as their "primary caregiver".
>
> "Primary caregiver" means the relative, or an unpaid nonrelative, who assists the GUIDE patient with activities of daily living and/or instrumental activities of daily living. If applicable, participants document the patient's primary caregiver by name using the PAAF.

Participants develop provider networks and conduct outreach and engagement to identify and voluntarily align eligible patients for the GUIDE Model. During their first performance year, participants are required to offer the opportunity to voluntarily align to their DCP all patients with dementia to whom they already provide dementia care services. Patients will learn about the GUIDE Model through a participant's engagement activities or CMS' outreach strategies. CMS will employ several outreach strategies, such as Beneficiary Outreach Letters, to supplement participants' patient engagement activities (see Section 2.2 for more detail).

The GUIDE Model will use a voluntary process for aligning patients to participants. Participants must obtain consent from interested patients before submitting them for alignment to the model. Receiving GUIDE Model services does not restrict a patient's ability to receive health services from any other provider or supplier.

> A PAAF template is available on GUIDE Connect for reference only, to show the required data elements and general format. Participants must download the current PAAF template, also referred to as the Patient Assessment and Alignment (PAA) template, for data collection and submission from the HDR application.

Participants will use the Patient Assessment and Alignment form (PAAF), an Excel spreadsheet available on the Health Data Reporting (HDR) application accessed via the CMS.gov Enterprise Portal ePortal, to gather and submit data collected during the initial Comprehensive Assessment. The PAAF will include an attestation from a dementia proficient practitioner, who is listed on the participant's GUIDE Practitioner Roster, that the patient has dementia. Participants must complete all elements of the Comprehensive Assessment, including the Caregiver Assessment and the Home Visit Assessment, within two months (60 days) after the date the dementia

[2] "Community-dwelling" is defined as living in a personal home, assisted living facility, group home, or other community setting and excludes patients 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. Patients 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 a skilled nursing facility.

[3] Basic personal everyday activities include bathing, dressing, transferring, toileting, mobility, and eating.

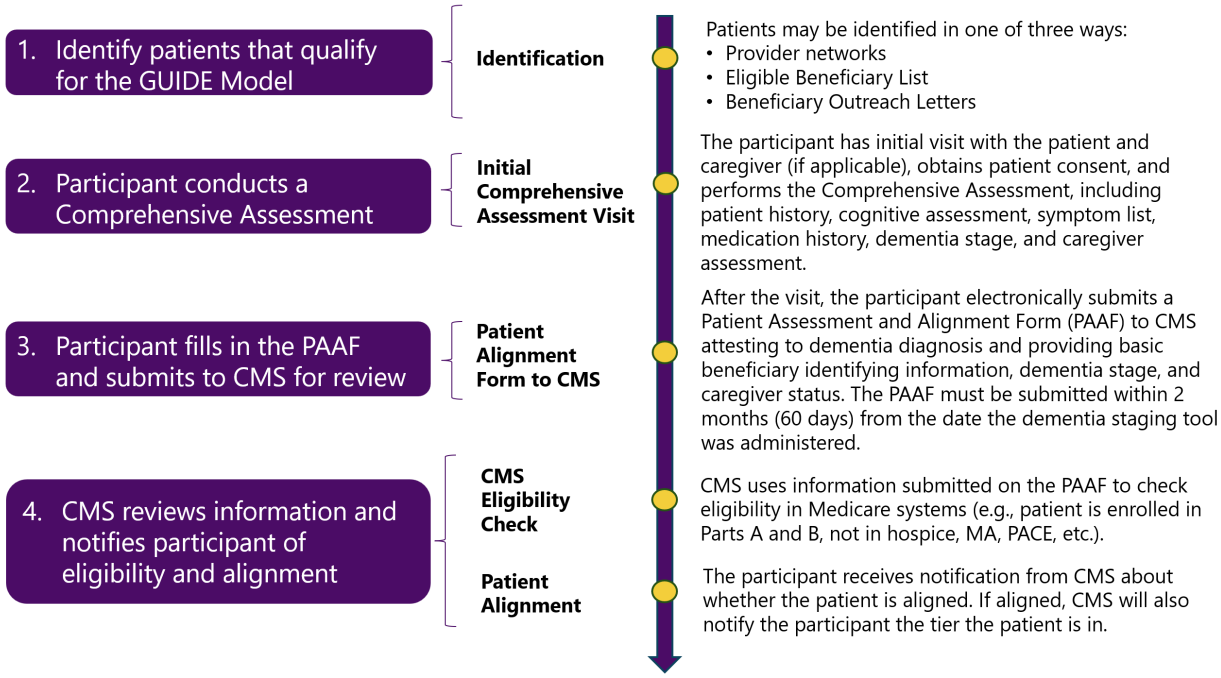
[4] Activities related to independent living include preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework, and communication.

staging tool was administered (see Section 2.8). In addition, participants will include the patient's primary caregiver, listed by name, if applicable. CMS will use the information submitted on the PAAF to confirm the patient's eligibility for alignment to the participant. If CMS finds that the patient is eligible, then CMS will align the patient to the participant and assign the patient to a model tier using data submitted on the PAAF (see Section 2.9 for more details). Participants can bill the GUIDE model G-codes only after receiving confirmation from CMS that the patient is eligible and aligned to the participant.

CMS may update the PAAF periodically to adjust to model needs and to improve the process for participants. Participants developing an automated data entry process for the PAAF should be aware that periodic changes to the PAAF Excel template will require updates to their automated solution. CMS will provide the details of each update so participants can easily identify changes.

Exhibit 3 outlines the steps involved for voluntary alignment.

Exhibit 3: New Patient Identification, Eligibility Check, and Voluntary Alignment Process



MA = Medicare Advantage; PACE = Program of All-Inclusive Care for the Elderly

2.2 Patient Outreach and Engagement

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

1) Provider Networks: 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 patients who already have a dementia diagnosis as well as patients with suspected dementia but no formal diagnosis to the participant (note that mild cognitive impairment does not meet dementia diagnosis criteria for voluntary alignment). 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) Eligible Beneficiary List: Participants can request to receive a list of potentially eligible Medicare FFS patients through a Data Request & Attestation (DRA) form. If requested, CMS will use claims data from a 3-year look-back period to identify patients who received Medicare services from the participant, have claims-based International Classification of Diseases, 10th edition (ICD-10) dementia diagnosis codes, and meet eligibility criteria for the GUIDE Model (see Section 2.3 for more information). Using these criteria, CMS will provide participants a list of potentially eligible patients with dementia diagnosis codes. The list will be made available on the Participant Portal and will include patients to whom the participant provided services during a 3-year look-back period, but who are not currently aligned to a participant at the time CMS generates the list. Participants will be able to use this data to supplement their existing data to reach out to potentially eligible patients with dementia who they are serving or have already served. CMS will not automatically align these patients to the participant—participants must determine whether these patients are eligible and conduct a required Comprehensive Assessment to voluntarily align the patient to the participant.
3) Beneficiary Outreach Letter: Starting PY 2025, CMS will send targeted outreach letters to potentially eligible patients with dementia diagnosis codes in their claims' history, informing them about the GUIDE Model and the process required to receive GUIDE Model services from a participant in their area, enabling them to self-identify their potential eligibility for the GUIDE Model. Mailings will use sensitive, patient-friendly language and will not include information about available in-kind patient incentives. If more than one participant serves a patient's zip code (see Section 1.4.3 for more information on Participant Service Area), CMS will list participants in a random, nonalphanumeric order in the targeted outreach letters. The patient may decide, at their sole discretion, which participants to contact if interested in the GUIDE Model.

2.3 Patient Eligibility

A patient must meet the following criteria to be eligible for voluntary alignment to a participant:

- Has dementia, as confirmed by attestation from a clinician on the participant's GUIDE Practitioner Roster (see Section 2.7 for more information);
- Is enrolled in Medicare Parts A and B;
- Is not enrolled in Medicare Advantage or another Medicare health plan, including Special Needs Plans (SNPs) and the Program of All-Inclusive Care for the Elderly (PACE);
- Has Medicare as their primary payer[5];
- Not enrolled in Medicare hospice benefit;
- Is not a long-term nursing home resident; and
- Is not aligned to another GUIDE Model Participant.

[5] Medicare is considered the primary payer when patients have worker's compensation and no-fault accident coverage.

A patient must also reside within the participant's zip code-based service area (see Section 1.4.3 for more information on Participant Service Area). For the purposes of the GUIDE Model, residence is determined based on the patient's most recent zip code as provided on the PAAF.

A patient must meet the qualifying threshold on the Clinical Dementia Rating (CDR) or Functional Assessment Staging Tool (FAST) to be eligible for alignment. If the patient has a primary caregiver, a Zarit Burden Interview (ZBI) must also be submitted (see Section 2.9 for additional information).

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

2.4 Patient Alignment

Participants must offer all potentially eligible patients the opportunity to voluntarily align and participate in the GUIDE Model. Participants will complete an initial Comprehensive Assessment visit for patients that may be eligible for the GUIDE Model (see Section 2.5 for more information). For those patients who consent, participants submit a PAAF to CMS via the HDR application within the CMS.gov Enterprise Portal (ePortal).

> Participants are encouraged to meet a minimum of 200 aligned patients by the end of their second performance year and meet or exceed this threshold throughout the rest of the Model Performance Period.

Patient alignment will occur on a rolling, ongoing basis for the first 7 years of the GUIDE Model (July 1, 2024–June 30, 2031). Participants in the Established Program Track began submitting patients for alignment starting July 1, 2024. Participants in the New Program Track can conduct Comprehensive Assessments and begin submitting patients for alignment starting July 1, 2025.

The aligned patient's start date in the GUIDE Model is the date that the patient was evaluated for severity of dementia using the Clinical Dementia Rating (CDR) or the Functional Assessment Staging Tool (FAST). Patients will remain aligned to a participant unless they become ineligible, the aligned patient or their legal representative request to no longer receive GUIDE services, or the participant does not file claims for the DCMP or the GUIDE Respite Services for the patient for a period of 8 months. For example, an aligned patient would be deemed ineligible if they no longer meet one of the GUIDE Model eligibility requirements in Section 2.3 or stop receiving model services from the participant (e.g., they move out of the participant's service area or request to no longer receive services from the participant).

Participants can bill the GUIDE model G-codes only for aligned patients. Once an aligned patient is found to be ineligible for GUIDE, participants should not bill the model G-codes for that patient (see Section 2.11 for additional information on changes to patient eligibility and alignment).

2.5 GUIDE Initial Comprehensive Assessment Visit

After a participant identifies a potentially eligible patient, the next step is to schedule an initial Comprehensive Assessment visit for the person with dementia, or suspected dementia. During the initial Comprehensive Assessment, the participant's interdisciplinary care team will assess the patient and their caregiver (if applicable) across required domains, including cognitive function, functional status, clinical needs, behavioral and psychosocial needs, severity of dementia, and caregiver burden, with the goal of confirming a dementia diagnosis and creating a comprehensive care plan.

> Participants must submit the PAAF to CMS no later than 2 months following the start of the initial Comprehensive Assessment.

Participants will use information gathered during the Comprehensive Assessment to complete the PAAF. For a checklist that details the required components of the Comprehensive Assessment, including required assessment and screening tools, please refer to the "GUIDE Model Comprehensive Assessment Checklist" available on GUIDE Connect.

During the initial Comprehensive Assessment, if the interdisciplinary care team determines that the patient may be eligible for alignment to the participant, then the care team obtains the patient's consent for voluntary alignment. **Appendix F** provides an example of a Consent to Check for Eligibility for GUIDE Model form that participants may, but are not required, to use for the purpose of recording the patient's consent. If the patient, or their legal representative if applicable,[6] consents, the participant will submit a PAAF to CMS using the HDR application.

2.6 Comprehensive Assessment Billing for Aligned Patients

Participants should bill the first month's Dementia Care Management Payment (DCMP) for the month of the initial Comprehensive Assessment. However, after a participant completes the initial Comprehensive Assessment and submits the PAAF to CMS, the participant must wait until they receive notice that the patient has been aligned to submit GUIDE G-codes. During this period, the participant is not permitted to perform or bill for any of the GUIDE Care Delivery Services under the model until CMS approval. However, if the billing practitioner is Medicare-enrolled, they may continue to bill under traditional FFS, subject to existing FFS rules.

If CMS confirms the patient is eligible for the GUIDE Model and confirms alignment to the participant, the participant may then submit a claim for the DCMP (see Section 3) and should not bill CMS separately for any Medicare PFS services included in the Comprehensive Assessment. For the first month of a patient's alignment, the date of service (DOS) on the DCMP claim should be the date of alignment (i.e., the initial Comprehensive Assessment date). The DCMP covers all assessments, including the initial, annual, and any necessary reassessments.

[6] If the GUIDE Participant finds that the patient lacks capacity to consent to voluntarily align to a participant, the GUIDE Participant will identify and recognize the patient's legal representative, if any, who has the authority to make health care decisions for the patient (e.g., health care power of attorney, court-appointed legal guardian), and obtain the legal representative's consent, acting on behalf of the patient, to voluntarily align the patient to the GUIDE Participant. The GUIDE Participant will record such legal representative's authority to make health care decisions for the patient 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 patient's file.

If CMS determines the patient does not meet eligibility criteria, CMS will notify the participant, and the participant may then submit a claim for any Medicare PFS services that corresponds to the services rendered. If the interdisciplinary care team assesses a patient or refers a patient for additional diagnostic testing and determines that the patient does not have dementia or otherwise qualify for the GUIDE Model, the participant can bill for an appropriate Medicare PFS code that corresponds to the services rendered (such as Current Procedural Terminology (CPT) code 99483 for Cognitive Assessment and Planning).

2.7 Dementia Diagnosis Attestation

At the time of billing, participants will need to record an ICD-10 diagnosis code for dementia on the claim (see Appendix B for a list of diagnosis codes for dementia).

Patients must have dementia to be eligible for alignment to a participant but may be at any stage of dementia—mild, moderate, or severe. Mild cognitive impairment **is not sufficient** to meet dementia staging criteria for voluntary alignment. To confirm a patient's dementia status, CMS relies on the attestation from a clinician rather than a claims-based ICD-10 diagnosis code for dementia. A dementia-proficient practitioner **on the participant's Practitioner Roster** may attest that, based on their Comprehensive Assessment, the patient meets the National Institute on Aging-Alzheimer's Association diagnostic guidelines for dementia[7] and/or the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-5) diagnostic guidelines for major neurocognitive disorder.[8] Alternatively, the dementia-proficient practitioner may attest that they have received a written report of a documented dementia diagnosis from another Medicare-enrolled practitioner. Participants document this attestation using the PAAF.

2.8 CMS Eligibility Check

Participants must submit completed PAAFs using the HDR application accessed via the CMS.gov ePortal to CMS within two months (60 days) after the date the dementia staging tool was administered. Each participant's data custodian(s) will download the PAAF from the HDR, enter the required information about patients and their primary caregiver (see Section 2.1), if applicable, save the file, and then upload the file to CMS through HDR. CMS will analyze the uploaded information, such as patient name, Medicare Beneficiary Identifier (MBI), dementia diagnosis attestation, and date of birth, and determine whether the patient can align to the participant. CMS will communicate the alignment decision to the participant's data custodian(s) within 15 business days via the Expanded Data Feedback Tool (eDFR) application.

Within 45 days of CMS notifying the participant that a patient is eligible and aligned to the participant, the participant must provide the aligned patient with written notice of voluntarily alignment to the participant. Participants can provide written notice in person, via postal mail, via email, or via patient portal or other similar technology application. An example template letter is available in **Appendix D**. Participants also have the option to submit written notice to a patient

[7] 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. *Alzheimer's & Dementia*. May 2011; 7(3): 263–269.

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

in cases where CMS determined the patient does not align to the participant. An example template letter is available in **Appendix E**.[9]

2.9 Assigning Model Tiers

CMS will assign aligned patients 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. Aligned patient and caregiver complexity, and correspondingly, care intensity and payment, increases by tier. See **Exhibit 4** for a description of the five tiers. For information specific to aligned patients residing in a residential care community (RCC), see Section 2.9.1.

To ensure consistent aligned patient assignment to tiers across participants, the participant must measure and report dementia stage of the patient and level of caregiver burden using approved screening tools. The approved tools include two tools to report dementia stage and one tool to report caregiver burden. Participants will select one of the two dementia staging tools—the Clinical Dementia Rating (CDR)[10] and the Functional Assessment Staging Tool (FAST)[11]—and will use the Zarit Burden Interview (ZBI)[12] to report the level of caregiver strain. **Exhibit 4** shows how the scores of each tool correspond to model tiers. CMS may, in its sole discretion, modify the approved screening tools and/or the criteria for the corresponding scores upon 30-days written notice to participants.

Participants will administer the approved screening tools during the Comprehensive Assessment and submit the resulting scoring data as part of the PAAF. In addition, participants must electronically submit the individual responses to the ZBI from caregivers to CMS.[13] CMS will use these data to assign aligned patients to a model tier, per the tiering criteria outlined in **Exhibit 4**. CMS will inform participants of an aligned patient's model tier assignment at the same time CMS informs the participant that the patient is eligible and has been aligned to them.

Participants have the option to seek CMS approval to use an alternative dementia staging tool by submitting to the GUIDE Help Desk (GUIDEModelTeam@cms.hhs.gov) the proposed tool, along with published evidence that the tool is valid and reliable, and a crosswalk for how the tool(s) corresponds to the Model's tiering thresholds outlined in **Appendix F**, Table 1. Consistency of staging tools across all participants is critical to the evaluation of the model, therefore, participants should carefully consider seeking an alternative tool. CMS will approve or reject the use of the proposed alternative staging tool(s) within 90 days of CMS receiving all

[9] The CMMI Innovation Support Platform now accepts GUIDE, PAAF, PROMIS-10, and ZBI submissions via FHIR API. These data can be shared via an HL7 FHIR Questionnaire Response Resource. Participants using FHIR-enabled systems who are interested in learning more about this option should submit a Help Desk ticket to GUIDEModelTeam@cms.hhs.gov with the subject, "FHIR Submission" that includes the following information: Model ID (This must be "GUIDE"), Entity ID (e.g., GUIDE-####), Data Custodian first name, Data Custodian last name, and Data Custodian email.

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

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

[12] 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.

[13] CMS will use the caregiver assessment responses to inform the caregiver burden measure development and the model's evaluation.

required documentation. CMS reserves the right to reject a proposed staging tool for any reason. *A participant may not submit scoring data on the PAAF using a proposed alternative staging tool until the participant receives written notice from CMS approving use of the alternative staging tool.*

Exhibit 4: Model Tiers

Patient Type	Tier	Criteria	Corresponding Assessment Tool Scores
Patient with a caregiver (includes all patients residing in RCCs)	Low complexity dyad tier	Mild Dementia	CDR = 1, FAST = 4 *and* ZBI = 0-88
	Moderate complexity dyad tier	Moderate or severe dementia *and* Low to moderate primary caregiver strain (for patients with primary caregiver only)	CDR = 2–3, FAST = 5–7 *and* ZBI = 0-60
	High complexity dyad tier	Moderate or severe dementia *and* High primary caregiver strain (for patients with primary caregiver only)	CDR = 2–3, FAST = 5–7 *and* ZBI = 61–88
Patient 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

Note: CMS will use the model tiers to determine the base DCMP rate and whether the patient is eligible to receive GUIDE Respite Services. Section 3 provides further detail on tiering.

CDR = Clinical Dementia Rating; FAST = Functional Assessment Staging Tool; ZBI = Zarit Burden Interview

2.9.1 Residential Care Communities

Starting PY 2025, CMS will use a type of residence for purposes of assigning model tiers called a residential care community (RCC) which is a residential facility staffed to provide comprehensive care services and supports, including assistance with activities of daily living, medication management, and supervision, to adults who cannot live independently but do not require intensive nursing care. Examples may include an assisted living facility or memory care program (excludes nursing home level of care) that create or maintain the individual's ability to safely live in the community.

CMS will no longer assign aligned patients residing in RCCs who have not identified a Primary Caregiver to individual model tiers for aligned patients without a caregiver (such as the low complexity individual tier). CMS will assign all aligned patients residing in RCCs to either the low complexity dyad tier or the moderate complexity dyad tier for aligned patients **with a caregiver** per the tiering criteria outlined in **Exhibit 4** and updated definitions for "caregiver" and "primary caregiver" in Section 2.1 (see Section 5.02(E)(iv) of the Participation Agreement for additional details). For aligned patients residing in RCCs **who have not** identified a primary caregiver, their model tier will change from an individual tier to a dyad tier beginning PY 2025.

Since the distinction between the moderate complexity dyad tier and the high complexity dyad tier is the ZBI score for caregiver strain, and participants should only report ZBI scores for primary caregivers, CMS will not assign aligned patients residing in RCCs who have not identified a primary caregiver to the high complexity dyad tier. Instead, CMS will assign aligned patients residing in RCCs who have not identified a primary caregiver to a dyad tier based on only dementia stage.

2.10 Annual Assessments & Reassessments

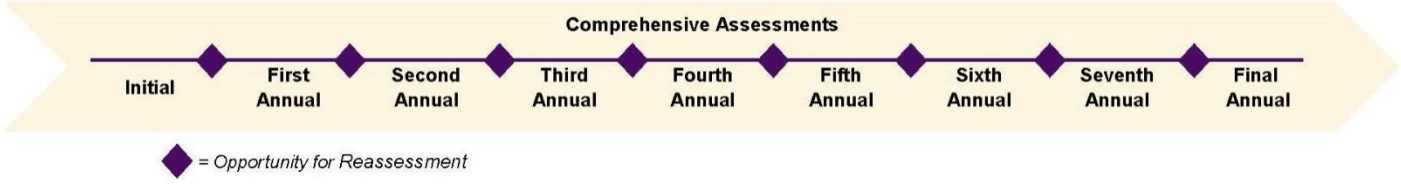
Participants are required to perform and submit a Comprehensive Assessment for aligned patients once every twelve months from the date of the previous Comprehensive Assessment date for the purposes of appropriate severity tiering.

Participants will submit annual assessments and reassessments to CMS using the PAAF in the HDR application within the CMS.gov ePortal.

Annual Assessment: Completing and submitting initial and annual Comprehensive Assessments serves three purposes: (1) they are the mechanism by which CMS gathers data on aligned patients for use in evaluating the performance of participants (see Section 4) and the model as a whole, (2) they are the avenue by which participants share updated information that may impact the aligned patient's tier and thus the amount the participant is paid, and (3) they are used to create and update the patient-centered care plan to reflect the patient's changing circumstances, goals, preferences, and needs. Data submissions from annual assessments will be accepted between 306 and 425 days from the last initial or annual assessment.

Reassessment: A reassessment submission to CMS is necessary only when an aligned patient's dementia stage, caregiver status and/or burden, or place of residence which impacts tiering (e.g., a move to or from an RCC) has changed outside of the annual timing for the annual Comprehensive Assessment. Data from reassessments to determine model tiering and payment will only be accepted, and tier changes enacted, every 180 days, as illustrated in **Exhibit 5**. A reassessment ***does not*** satisfy the requirement to conduct an annual Comprehensive Assessment.

Exhibit 5: Reassessment Opportunities Every 180 Days



2.11 Patient Removal from Alignment File

CMS will remove, or "unalign", an aligned patient from the participant's Beneficiary Alignment Report if any of the following occur:

- The patient no longer meets one or more of the criteria to be eligible for voluntary alignment to a participant as outlined in Section 2.3.
- The patient dies.

- The patient moves out of the participant's zip code–based service area (defined by the patient's most recent zip code as provided on the most recently accepted PAAF).
- The patient, or their legal representative, makes a request to the participant to no longer receive services under the model and from the participant.
- The participant does not file claims for the DCMP or the GUIDE Respite Payment for the patient for a period of 8 months.
- The patient was aligned in error by the participant (e.g., patient was aligned using the wrong MBI, etc.).

Once a patient is no longer receiving services from a participant, the participant should not bill the model G-codes for that patient.

Under certain circumstances, the status of an aligned patient's voluntary alignment to a participant may change. Participants must ensure that their Beneficiary Alignment Report (see **Appendix G** for details on its contents) remains up-to-date and continues to represent the most current information about each aligned patient. Participants must report known cases of unalignment for patients who request to no longer receive services under the model. Participants must also report cases of unalignment for patients who were aligned in error to the participant. Participants will notify CMS of unalignments using the PAAF available through the HDR application within the CMS.gov ePortal. Participants may submit unalignment requests if they are aware of an aligned patient's death, enrollment in hospice, or scheduled permanent move to a LTNH. Otherwise, CMS does not require participants to submit unalignment requests. CMS will conduct ongoing monthly eligibility checks to identify if aligned patients no longer meet eligibility criteria.

In general, once a patient is no longer aligned to a participant, the patient's alignment end date is set to the last day of the calendar month in which unalignment occurred. The participant may not bill the DCMP or for GUIDE Respite Services beginning with the calendar month following the patient's alignment end date. If the participant had an encounter with the patient during the month that the patient leaves the program, the participant may still bill for this patient. The DCMP will not be prorated based on the length of time that the patient participates during a month. Unalignment dates for patients enrolled in Medicare Advantage, PACE, and who are deceased may differ from the standard date, because Medicare will deny GUIDE claims made after these events. For patients who unalign because of enrollment in a Medicare Advantage Plan or PACE, the patient's alignment end date will be the day before MA or PACE coverage begins. For deceased patients, the alignment end date will be the date of death. In cases of unalignment due to Medicare Advantage enrollment, PACE enrollment, or death, participants must use a billing date prior to the unalignment date, as claims with dates of service on or after the unalignment date are subject to denial.

Any DCMPs paid in error to unaligned patients are subject to reconciliation and settlement per Section 9.08 of the Participation Agreement.

3 Dementia Care Management Payment

The primary GUIDE Model payment is the DCMP, which is a per-patient, per-month care management payment that replaces the traditional FFS payment for certain existing Medicare PFS services. These services include annual wellness visits, chronic and principal care management, transitional care management, advance care planning, and technology-based check-ins. **Exhibit 6** provides the full list of these services.

Exhibit 6: Medicare Physician Fee Schedule (PFS) Services Included Under the DCMP[14,15]

Service Type	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	G2252, 98016
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
Advanced Primary Care Management (APCM) (effective January 1, 2025)	G0556, G0557, and G0558
Caregiver Training Services in Behavior Management/ Modification (effective January 1, 2025)	G0539, G0540

Note: These HCPCS codes are current as of the CY 2025 Medicare PFS final rule[16] but are subject to change based on updates to the PFS.

HCPCS = Healthcare Common Procedure Coding System; OT = occupational therapist; PT = physical therapist; SLP = speech and language pathologist

[14] Services included under the DCMP effective as of July 1, 2025.

[15] CPT® codes, descriptions and other data are copyright 2004–2025 American Medical Association. All rights reserved. CPT is a trademark of the American Medical Association. No fee schedules, basic units, relative values or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.

[16] CMS Federal Regulation CMS-1807-F.

The DCMP offers participants more flexibility to deliver personalized dementia care than under traditional FFS. It covers a more comprehensive set of services than existing care management codes, is less burdensome to bill, and enables payment to members of the interdisciplinary care team who are otherwise not eligible to bill for Medicare services. Participants use a set of new HCPCS G-codes created for the GUIDE Model to submit claims for the monthly DCMP. All services not included in the required care delivery elements of the model (i.e., those services not in **Exhibit 6**) may continue to be billed under original FFS, subject to existing FFS rules.

Important update

CMS has updated GUIDE DCMP base rates for PY 2025 (see **Exhibit 7**).

For each aligned patient, CMS uses the model tier assignment described in Section 2.9 to determine: (1) the DCMP rate and (2) whether the aligned patient is eligible to receive GUIDE Respite Services. Participants bill the codes in **Exhibit 7** based on the tier.

Exhibit 7: GUIDE Monthly DCMP Base Rates for PY 2025[17]

Patient Status	Monthly Payment Rates for Patients With Caregiver			Monthly Payment Rates for Patients 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 Patient Payment Rate)	G0519: $154	G0520: $282*	G0521: $369*	G0522: $236	G0523: $400
After First 6 Months (Established Patient Payment Rate)	G0524: $67	G0525: $123*	G0526: $226*	G0527: $123	G0528: $220

PY = performance year

* Indicate tiers that are eligible for GUIDE Respite Services (starting in PY 2025, patients residing in RCCs without a primary caregiver will not qualify for GUIDE Respite Services)

For example, a GUIDE Practitioner may see an aligned patient in the low complexity tier with a primary caregiver during the third month that the patient is aligned to the participant. In this case, the GUIDE Practitioner should bill G0519 for that visit because the aligned patient is considered a new patient for the first 6-months they are aligned to the participant. Then, if the GUIDE Practitioner provides a qualifying GUIDE Care Delivery Service for that same aligned patient in the seventh month that the patient is aligned to the participant (and there have been no changes to the patient's tier or caregiver status), the GUIDE Practitioner should bill G0524 as the aligned patient is now considered an established patient.

Each month, CMS shares information to confirm each aligned patient's tier and corresponding DCMP G-code with participants through a monthly Beneficiary Alignment Report via the HDR application within the CMS.gov ePortal (see **Appendix G** for details on its contents). CMS updates the Beneficiary Alignment File twice monthly; it will contain the most recent information regarding each aligned patient's tier, including any changes that occur (for example, because of a reassessment; see Section 2.9 and Section 2.11 for additional information).

[17] Starting PY 2025, the dyad tiers for patients with caregiver includes all patients residing in RCCs. See Section 2.8 for additional information on the model tiering criteria and Section 2.1 for updated definitions for caregiver and primary caregiver. GUIDE DCMP rates for PY 2025 were increased 2.5% from PY 2024. See Section 4.5 for additional details.

Note that an aligned patient's 6-month "clock" starts in the first month of alignment, even if this is a partial month, and ends six months later, on the last day of the month. For example, if an aligned patient in the low complexity tier with a caregiver aligns to a participant on July 15, the participant should bill G0519 from July through December and then should bill G0524 beginning January 1.

The dollar amounts in **Exhibit 7** indicate the base rate for the respective GUIDE-specific G-codes listed. Actual payment rates will vary for each aligned patient in accordance with the adjustments detailed in Section 4. GUIDE G-codes cover all reimbursement under the model and GUIDE does not distinguish between facility and non-facility rates, such that these G-codes will not be subject to the reduction in reimbursement rates for services provided in certain settings. As noted in Section 1.4.1, GUIDE G-codes do not include reductions in the payment amounts for nonphysician practitioners, which is typically at 85% of the physician's fee schedule. For example, if the dementia-proficient clinician is a nurse practitioner or physician assistant and bills the GUIDE G-codes, these G-codes will not be subject to the reduction in reimbursement rates for services provided by nonphysician practitioners compared to those provided by physicians.

3.1 Billing for the DCMP

Participants may bill the correct DCMP HCPCS G-code for each aligned patient each month that the participant provides a GUIDE Care Delivery Service, other than the GUIDE Respite Services. These services need not include a clinical encounter, and are, for example, inclusive of transitional care management and medication management. Participants may only bill a DCMP G-code for months that the participant provides a non-respite GUIDE Care Delivery Service to the aligned patient.

Important billing considerations

Participants are not permitted to bill an DCMP G-code for any month that a GUIDE Care Delivery Service was not provided to an aligned patient.

Participants may not bill the DCMP for an aligned patient if they only maintained the infrastructure to deliver a GUIDE Care Delivery Service, such as providing access to a 24/7 helpline, developing caregiver trainings, or offering a caregiver support group.

For all aligned patients who do not fall into the low complexity dyad tier, the minimum contact frequency requirements dictate that they will be contacted either at least twice a month or at least once a month. As long as the participant performs the required touchpoints, they can bill the DCMP each month. However, aligned patients who fall into the low complexity dyad are only required to have contact quarterly. This means that there may be some months that the participant might not need to have contact with the patient. The participant may bill the DCMP for non-contact-based Care Delivery Services as long as the participant has complied with the quarterly contact frequency required under Section 4.3.1 of Appendix C of the Participation Agreement. Non-contact-based Care Delivery Services include, but are not limited to, actively managing an aligned patient's care coordination and transitional care management, referrals and coordination of service and supports, and medication management and reconciliation.

Exhibit 8 shows a sample of GUIDE DCMPs billed by a participant for a single patient for the first six months of alignment. This example assumes that the initial Comprehensive Assessment was provided on July 15, 2025, and the patient was aligned to the participant. This illustrates how GUIDE DCMP Payments are calculated by CMS.

Exhibit 8: Sample Billing for GUIDE DCMP

Month	GUIDE Care Delivery Service Provided?	Date of Service	G-Code Billed	DCMP Base Rate
July 2025	Yes	07/15/2025	G0519	$154
August 2025	Yes	08/03/2025	G0519	$154
September 2025	Yes	09/01/2025	G0519	$154
October 2025	No			
November 2025	Yes	11/06/2025	G0519	$154
December 2025	Yes	12/01/2025	G0519	$154
			Totals for 2025:	**$770**

Note: DCMP base rates are used for illustration purposes; actual payments are subject to GUIDE DCMP adjustments (see Section 4) and all other adjustments and policies applicable to other fee for service claims. Patient has a caregiver and is in the low complexity tier. In the example above, the participant did not provide a GUIDE Care Delivery Service to the patient in October and was unable to bill for the DCMP.

Participants are required to bill GUIDE-specific G-codes, including both the DCMP (see **Exhibit 7**) and GUIDE Respite Services G-codes (see **Exhibit 17**), on a standalone claim with no other Healthcare Common Procedure Coding System (HCPCS) codes. Participants may bill multiple GUIDE-specific G-codes on the same standalone claim, as needed. However, at most, participants can bill one DCMP per calendar month – that is, participants can bill two or more calendar months on the same claim with service dates in separate months.

Participants will submit GUIDE claims using the CMS-1500 claim form. When a participant bills for a DCMP, the claim must include the following, as shown in **Exhibit 9**.

Exhibit 9: GUIDE DCMP Billing Requirements

Required Information	Description
GUIDE-specific HCPCS G-Code	Using the Beneficiary Alignment Report, which is available via the HDR application within the CMS.gov ePortal, confirm each patient's tier and corresponding G-code to include on the claim. See **Appendix G** for details on its contents.
Date of Service (DOS)	DOS is the earliest day of the calendar month in which the participant or GUIDE Partner Organization provided GUIDE Care Delivery Services. For the first month of a patient's alignment, the DOS should be the date of alignment (i.e., the initial Comprehensive Assessment date). DOS must be within the effective Start and End dates for both the GUIDE Practitioner and patient alignment records. If a Partner Organization administers the care delivery service, the Partner Organization should record the service date and provide that information to the participant to bill the DCMP for that service.
GUIDE TIN and rendering NPI	The entered TIN must match the TIN on file with the GUIDE Model. The rendering NPI must be part of a participant's Practitioner Roster
Patient's Health Insurance Claim Number/MBI	From the Beneficiary Alignment Report, input the aligned patient's Medicare Beneficiary Identifier (MBI).

Required Information	Description
Patient's Dementia Diagnosis Code (see Appendix B) in any position	Enter the aligned patient's diagnosis or condition to the highest level of specificity for the Date of Service. For the claim to be accepted, one or more of the diagnoses listed in this field must appear in the list of GUIDE ICD-10 Diagnosis Codes (see **Appendix B**).
Servicing Facility Location	This should reflect the location of the participant or Partner staff member at the time of the contact/service. If the staff member was present at the aligned patient's home, use the patient's home address.

If a claim fails to meet these requirements, or is submitted with incomplete or invalid information, it may be denied or returned to the submitter as unprocessable, which may cause a delay in payment. For example, if a participant bills the incorrect G-code for an aligned patient reflecting the incorrect tier, the claim will not be processed and will be sent back to the participant for resubmission. Please refer to the Billing Fact Sheet for additional details regarding claim requirements and troubleshooting guidance.

In setting charge amounts for DCMP claims, participants should follow their own process to establish a fee schedule. CMS does not provide specific advice on what amount to charge. However, participants may want to consider that CMS will pay the lesser of the participant's charge amount and the allowed amount. Each participant's allowed amount will be the DCMP base rate adjusted based on the participants' geographic region, Performance-Based Adjustment (PBA), and Population and Income Adjustment (PIA) which are described in Section 4). At most, a DCMP base rate could receive a +75% adjustment after considering all adjustments, or 1.75 times the base rate. As such, participants should consider incorporating potential adjustments into DCMP charge amounts.

Participants will be able to track their GUIDE billing and payment data through the Payment Report, which is updated monthly and available via the HDR application within the CMS.gov ePortal. It includes information on DCMP claims, GUIDE Respite Services claims and payments, and remaining GUIDE Respite Services cap for aligned patients. Participants can use this report to reconcile actual and expected payments and to facilitate the payment of Partner Organizations who provide GUIDE Respite Services. See **Appendix H** for more details.

3.2 Waiver of Patient Cost Sharing for the DCMP

Medicare FFS patients are typically required to pay a 20% coinsurance for Medicare Part B physician services. GUIDE waives this required 20% cost sharing for the DCMP, and Medicare will pay 100% of the DCMP amount. *Participants shall not subject aligned patients to any additional cost sharing for the DCMP or GUIDE Respite Services*.

3.3 Medicare Physician Fee Schedule Services Included Under the DCMP

The DCMP will replace FFS payment for certain existing Medicare PFS services (i.e., those services listed in **Exhibit 6**). Therefore, participants are not permitted to bill separately for these services for aligned patients. For example, a participant may not bill a Chronic Care Management code (e.g., 99487) for an aligned patient as it is considered duplicative with the DCMP. If a participant does bill for and receives payment for any of the services in **Exhibit 6** for an aligned

patient, CMS will recoup the amount of the payment for that claim from a future Medicare payment. Please refer to Section 9.02(D) of the Participation Agreement for more information.

CMS may change the codes in **Exhibit 6** at its discretion based on updates to the PFS.

3.4 Interaction with Other Innovation Center Models and Payments

Participants and aligned patients may overlap with other CMS Innovation Center models, where it is possible to account for the financial impact of the overlap. GUIDE Practitioners who participate in another CMS Innovation Center Model may continue to bill for services in **Exhibit 6** when required by another model for the purposes of patient attribution. Please refer to the Section 9.09 of the Participation Agreement for more information.

As an example, participants and aligned patients are permitted to participate in both GUIDE and the ACO Realizing Equity, Access, and Community Health (ACO REACH) Model. As of January 1, 2025, DCMP expenditures contribute to the REACH ACOs' total cost of care expenditures and ACO REACH will include the DCMP for purposes of alignment and in the calculation of shared savings/shared losses. Overlapping providers participating in both models (i.e., GUIDE practitioners in ACO REACH) should follow GUIDE billing requirements, including to discontinue billing the Medicare Physician Fee Schedule Services included under the DCMP (See **Exhibit 6**). ACO REACH claim reductions will not apply to the DCMP.

GUIDE Participants may also simultaneously participate as an ACO Participant in an ACO participating under any track in the Medicare Shared Savings Program. The 2024 Shared Savings Program expenditures will include the DCMP. When 2024 becomes a benchmark year, Shared Savings Program benchmark calculations will include the DCMPs. As an example, if an ACO participated in both the GUIDE Model and the Shared Savings Program during PY 2024 and then renewed and started a new agreement period as of January 1, 2025, that ACO would have their Shared Savings Program benchmark based on 2022, 2023 and 2024, and would have DCMPs counted in Benchmark Year 3.

4 DCMP Adjustment Methodology

4.1 Performance-Based Adjustment

To incentivize high-quality care, the DCMP will be adjusted for participant performance using a performance-based adjustment (PBA). CMS will calculate the PBA based on participant performance on measures, which focus on the patient experience, utilization, and cost. When all five performance measures are fully implemented, the PBA amount shall range from -3.5% to +10.0%. The PBA will be applied annually at the participant level. This means that the same percentage amount will be applied for all patients aligned to a participant.

CMS will calculate and assign PBA percentages to participants each Performance Year. These adjustments will be applied to the DCMP in January; they will be in place for the 12 months following their issue date. As a reminder, the PBA does not apply to the DCMP in PY 1; it is first applied beginning January 2026 (midway through PY 2). See Section 4.2 for more information.

For PY 1 (July 2024 through June 2025), CMS will use four of the five measures to determine the PBA for Established Program Track Participants. The Caregiver Burden (CB) measure will not be scored for PY 1 because the measure is under development. The list of all measures, including how they are reported to CMS, appears in **Exhibit 10**.

Exhibit 10. GUIDE Performance Measures

Measure Title	Domain	Data Source	Type of Reporting by Participant
Use of High-Risk Medications in Older Adults (HRRx)[18]	Care coordination and management	GUIDE Participant reported (chart abstraction)	Participant will complete Excel workbook for GUIDE-aligned patients, downloaded via the eDFR and provided to CMS via the HDR application. Workbook is due once annually (by end of August).[19]
Quality of Life Outcome for Patients with Neurological Conditions (QoL)[20]	Patient quality of life	GUIDE Participant reported (PROMIS-10)	Participant will enter results for each GUIDE-aligned patient or caregiver via the HDR application upon submission of PAAF. PAAF submitted on an ongoing basis, with final data due by end of August to be included in measure calculation.
Caregiver Burden (CB)[21]	Caregiver support	GUIDE Participant reported (ZBI-22)	

[18] The HRRx measure steward is the National Committee for Quality Assurance (NCQA).
[19] For Established Program Track Participant PY 1, the HRRx workbook is due to CMS by Friday, August 29, 2025.
[20] The QoL measure steward is the American Academy of Neurology (AAN). Technical specifications for this measure have been reproduced with permission.
[21] The CB measure is still under development. It will be implemented in a future PY; its technical specifications shall be added to the PMM once available publicly.

Measure Title	Domain	Data Source	Type of Reporting by Participant
Total Per-Capita Cost (TPCC)	Utilization	Claims	No participant reporting required, as CMS will calculate using administrative data.
Admissions to Long-Term Nursing Home Stay (LTNH)	Utilization	Claims; Minimum Data Set (MDS) 3.0[22]	

Information about the scoring strategies used to evaluate a participant's performance on the measures incorporated into the PBA is shown in **Exhibit 11**. More information appears in the GUIDE Performance Measurement Manual (PMM) available in the Connect Library under the Model Participation Folder.

4.1.1 PY1 PBA for Established Program Track Participants

For PY 1, for Established Program Track Participants, the PBA methodology is summarized in **Exhibit 11** and detailed below. The total PBA potential for PY 1 (and applied mid-way through PY 2) will range from -0.5% to +4.5%. Information regarding the PBA methodology for PBA potential available in PY 2 (that is, July 2026 through June 2027) will be provided in a future release of this document.

The Use of High-Risk Medications in Older Adults (HRRx) and Quality of Life Outcome for Patients with Neurological Conditions (QoL) measures will be scored using a pay-for-reporting methodology where participants are rewarded for providing data to CMS, regardless of their overall performance on the measure.

The Caregiver Burden (CB) measure will not be scored for PY 1 or PY 2 because it is under development. Although the CB measure is not yet developed and will not be included in the calculation of the PBA, participants are required to submit ZBI-22 survey data for their patient caregivers as part of the PAAF starting at the beginning of PY 1 (July 1, 2024, for Established Program Track Participants, and July 1, 2025, for New Program Track Participants).

The Total Per-Capita Cost (TPCC) measure will be scored using a pay-for-performance methodology. CMS determined the PY 1 benchmark for the TPCC measure is 0.91. Participants' TPCC scores will be compared to this benchmark to determine the measure-specific contribution to their PBA. Therefore, participants who meet this benchmark will receive a 1.5% positive adjustment; those who do not meet this benchmark will receive a 0.5% negative adjustment.

Admissions to Long-Term Nursing Home Stay (LTNH) will be scored using a pay-for-performance methodology beginning in PY 2. For PY 1, CMS determined the PY 1 benchmark for the LTNH measure is 0.57, but a "null adjustment" or 0% measure-specific adjustment, shall be applied. Therefore, for PY 1, there will be no impact on the PBA based on participant performance compared to this benchmark. The LTNH measure requires a look-forward period to determine if admissions to a nursing home meet the minimum length of stay to be considered long term (that is, a stay of 101 days, or more, is considered a long-term nursing home stay and contributes to the measure's numerator). Because sufficient data following the benchmarking period were not

[22] MDS data is Minimum Data Set (MDS) 3.0 data, or results from a health status screening and assessment tool used for all residents of long-term care nursing facilities and noncritical access hospital swing beds.

available, the PY 1 PBA potential for LTNH will be a null adjustment (of 0%, regardless of participant performance). Therefore, complete data necessary to calculate the LTNH benchmark accurately are not available at this time.

Exhibit 11: PBA Domains, Measures, and Weights for First Year of the GUIDE Model

Domain	Measure Name	EPT PY1 Associated PBA Potential
Care Coordination and Management	Use of High-Risk Medications in Older Adults (HRRx)	0% (non-reporting) +1% (reporting)
Patient Quality of Life	Quality of Life Outcome for Patients with Neurological Conditions (QoL)	0% (non-reporting) +2% (reporting)
Utilization	Total Per-Capita Cost (TPCC)	-0.5% (benchmark not met) +1.5% (benchmark met)
	Admissions to Long-Term Nursing Home Stay (LTNH)	0%
	Total PBA Potential	-0.5%–+4.5%

4.1.2 PY1 PBA for New Program Track Participants

Information about the PBA for New Program Track Participants will be provided in a future update of the PMP. The PBA for New Program Track Participants shall be applied to the DCMP beginning in January 2027. Additional details for New Program Track Participants can be found within the PMM.

4.2 Timeline for Performance-Based Adjustment Application

A participant's performance during a given performance year will affect their payment in future years. Specifically, the 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. The resulting PBA will be applied to the 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 period between the end of the Performance Year and when the PBA begins 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 (second half of PY 2 and first half of PY 3).

The New Program Track will follow the same timeline but begin one year later. For example, for the New Program Track, the first performance year will be July 2025 through June 2026, and the resulting PBA will be applied from January 2027 through December 2027 (second half of PY 2 and first half of PY 3).

Exhibit 12 demonstrates this timeline for both program tracks throughout the entire model.

Exhibit 12: Performance-Based Adjustment Timing

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

PBA = performance-based adjustment; PY = performance year

4.3 Population and Income Adjustment

To support and incentivize participants in providing care to particular communities, each aligned patient's DCMP will also be adjusted using a Population and Income Adjustment (PIA). CMS will apply the PIA to aligned patients' base DCMPs for Established Program Track Participants beginning on July 1, 2025.

The PIA is a fixed dollar amount that will be applied at the patient level and will be based on the aligned patient's PIA score percentile. The PIA will be calculated using a composite methodology that includes both community-level and patient-level measures of deprivation. Specifically, the PIA will be composed of three measures: Community Deprivation Index (CDI),[23] which is measured at the census block group level based on the aligned patient's residence, and Low-Income Subsidy (LIS) status and dual eligibility (DE) for Medicare and Medicaid, which are patient-level measures. CMS will calculate a *PIA Score* for every aligned patient *b* and their corresponding geography *g* in the aligned population:

$$PIA\ Score_{b.g} = (0.1 \times CDI_g) + (10 \times LIS_b \text{ or } De_b)$$

In the formula, CDI_g is the CDI percentile for the census block group in which the aligned patient resided on their first day of eligibility and can range from 1 to 100. CDI exhibits strong correlations with several health outcome and utilization measures. CDI also uses statistical shrinkage to account for imprecise measurement of factors, standardizes deprivation factors to be unit-neutral, and reweights factors using the most recently available data.[24]

LIS_b represents LIS status and is equal to 1 if the aligned patient is enrolled in the Medicare Part D LIS program and 0 otherwise. Similarly, DE_b represents dual eligibility and is equal to 1 if the aligned patient is dually eligible and 0 otherwise.

The possible range of PIA scores is from 0 to 20. In the case of a maximum score, an aligned patient's CDI would contribute 50% to the overall PIA score and LIS or DE status would contribute the other 50% to the overall score. CMS may revisit this weighting at its discretion.

[23] The previously published adjustment methodology used the Area Deprivation Index instead of CDI; CMS may continue to update measures in future PYs.

[24] Robst J, Cogburn R, Forlines G, et al. The development of the Community Deprivation Index and its application to accountable care organizations. *Health Affairs Scholar*. 27 November 2024.

4.4 Timeline for Population and Income Adjustment Application

CMS will calculate aligned patient PIA scores and percentiles annually before the start of the performance year in which they are applied. Because patients were not aligned to participants at the time of model launch, CMS will not apply the PIA to the DCMP until July 1, 2025. CMS will calculate the adjustment based on aligned patients' data from the first year of the Model Performance Period. CMS will apply each aligned patient's PIA to their base DCMP for the duration of the performance year, including applying PIA scores upon alignment for patients who align to an Established Program Track participant during the performance year. The Established Program Track will receive the PIA from July 2025 through June 2026 based on all aligned patients in the prior year (e.g., July 2024 through June 2025). Beginning in July 2026, both Established Program Track and New Program Track participants will receive the PIA based on all aligned patients in both tracks in the prior year (e.g., July 2025 through June 2026). The reassessment of the PIA will occur each subsequent year. Information regarding the PIA scores and PIA percentiles will be provided as they become available.

The PIA methodology design provides a material incentive for participants to care for particular patients 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 PIA in future performance years.

Exhibit 13 shows how PIA scores translate into an adjustment to the monthly DCMP. The PIA amount can range from -$6 to +$15 and will apply at the patient level. This means that PIA amounts and adjusted DCMP payments will vary by patient aligned to a participant. **Exhibit 14** demonstrates the timing PIA percentile calculations and the annual application of the adjustment.

Exhibit 13: PIA Score Percentiles and Associated Population and Income Adjustment

PIA Score Percentile	Population and Income Adjustment to DCMP
≥ 80 percentile of patients	+$15
51–79 percentile of patients	$0
0–50 percentile of patients	−$6

Exhibit 14: PIA Calculation and Application Timeline

Calendar Year	2024	2025	2026	2027	2026	2029	2030	2031	2032
PIA	N/A	PIA 1 7/2025-6/2026	PIA 2 7/2026-6/2027	PIA 3 7/2027-6/2028	PIA 4 7/2028-6/2029	PIA 5 7/2029-6/2030	PIA 6 7/2030-6/2031	PIA 7 7/2031-6/2032	
Program Track(s)	N/A	EPT Only	EPT & NPT	EPT & NPT	EPT & NPT	EPT & NPT	EPT & NPT	EPT & NPT	
Basis for Percentiles	N/A	All aligned EPT patients during 7/2024-6/2025	All aligned EPT & NPT patients during 7/2025-6/2026	All aligned EPT & NPT patients during 7/2026-6/2027	All aligned EPT & NPT patients during 7/2027-6/2028	All aligned EPT & NPT patients during 7/2028-6/2029	All aligned EPT & NPT patients during 7/2029-6/2030	All aligned EPT & NPT patients during 7/2030-6/2031	

4.5 Medicare Economic Index Adjustment

To account for cost growth over time, CMS adjusts the GUIDE DCMP base rates using the Medicare Economic Index (MEI). The MEI measures price changes in the inputs (goods and services) required to operate a physician practice in the United States. These inputs are aggregated into two broad categories – the physicians own time and his or her practice

expenses. The MEI measures year-to-year changes in prices for these various inputs based on appropriate price proxies.

CMS applied the MEI adjustment to the PY 2024 DCMP base amounts to create the PY 2025 DCMP base amounts. PY 2024 DCMP payment rates were increased by 2.5% for PY 2025. Updates to the MEI will apply to the DCMP base rates at the beginning of each PY and will be reflected in **Exhibit 7** (see Section 3). MEI updates are applied at the beginning of each PY and will apply for the entirety of the PY. For example, GUIDE monthly DCMP base rates were updated for PY 2025 using the forecasted growth in the MEI from July 1, 2025, through June 30, 2026. Additional information regarding the MEI is available on the CMS webpage for Market Basket Data.

4.6 Geographic Adjustment

To account for geographic variation in costs, CMS adjusts the DCMP base rates by the Medicare PFS Geographic Adjustment Factor[25] (GAF) for each DCMP claim submitted by a 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 three Geographic Practice Cost Index (GPCI) expense categories (work, practice expense, malpractice) on a locality's (state or metropolitan region's) physician reimbursement level. The intent of the GAF is to ensure that the Medicare program does not overpay participants in certain areas and underpay in others because of geographic differences in prices for resources such as clinical and administrative staff salaries and benefits, office or hospital space (rent), medical supplies, and malpractice insurance.

CMS updates GAFs annually as part of the update to Payment Policies under the Physician Fee Schedule (PFS).[26] GAF updates will be applied at the beginning of each PY and will be consistently applied to the DCMP for the entirety of the PY. For example, 2024 GAFs were applied to GUIDE payments effective July 1, 2024, and will be in effect until June 30, 2025. 2025 GAFs will go into effect on July 1, 2025.

The GAF applied to each DCMP claim is based on the Service Facility Zip Code submitted on the claim form. In the case of services provided at an aligned patient's home, the Service Facility Location should be the patient's home. As a result, a given participant may be subject to different geographic adjustments if they serve aligned patients across multiple localities or if they provide services to the same aligned patient in different localities each month (e.g., if they provide DCMP services in their office location and one month and in the patient's home the next month).

For examples of how to calculate the GAF, see **Appendix C**.

4.7 Payment Examples with Adjustments

The first two payment examples in **Exhibit 15** shows the calculation of total GUIDE Model payments for an individual-aligned patient over the course of a full performance year. The third

[25] Updated GAF amounts are published annually as part of the Medicare Physician Fee Schedule Final Rule Addenda.

[26] The annual Geographic Adjustment Factors can be found in Addendum D.

example shows the calculation of total GUIDE Model payments for a participant's total aligned patient population.

Note that these examples are for illustration only and include several assumptions, including that all patients are initially aligned in the first month of the performance year and therefore are eligible for the new patient DCMP rate for the first 6 months of the PY and the established patient DCMP rate for the next 6 months of the PY. All examples reflect the PY 2024 DCMP base rates but are assumed to occur after the PBA and PIA are fully phased in and may not account for the most recent updates to MEI and GAF. Examples are rounded to the nearest dollar.

Exhibit 15: Payment Examples

In the first example, the aligned patient is in a tier that is eligible for GUIDE Respite Services, and the example assumes that the patient reaches the GUIDE Respite Services cap for the year.

Jane Smith
Lives in Miami, FL

Moderate Complexity, Caregiver Tier:
New Patient DCMP rate: **$282**
Established Patient DCMP Rate: **$123**

GAF for Miami, FL: **1.075**
GUIDE Participant's PBA: **4.5%**
Mrs. Smith's PIA: **+$15**

	Step 1: Geographically Adjust DCMP	**Step 2:** Apply PBA	**Step 3:** Apply PIA	**Step 4:** Calculate total for 6 months
First 6 months:	$282 X 1.075 = **$303.15**	$303.15 X 1.045 = **$316.79**	$316.79 + $15 = **$331.79**	$331.79 X 6 = **$1,990.75**
Next 6 months:	$123 X 1.075 = **$132.23**	$132.23 X 1.045 = **$138.18**	$138.18 + $15 = **$153.18**	$153.18 X 6 = **$919.05**

Total Annual DCMP……$2,909.80

Step 5: Geographically Adjust Respite Cap — $2,563 x 1.075 = **$2,755.23**

Total Annual DCMP and Respite……$5,665.03

In the second example, the aligned patient is in a tier that is not eligible for GUIDE Respite Services.

Jack Johnson
Lives in Phoenix, Arizona

Moderate/Severe Complexity, No Caregiver Tier:
New Patient DCMP rate: **$400**
Established Patient DCMP Rate: **$220**

GAF for Phoenix, AZ: **0.983**
GUIDE Participant's PBA: **4.5%**
Mr. Johnson's PIA: **-$6**

	Step 1: Geographically Adjust DCMP	**Step 2:** Apply PBA	**Step 3:** Apply PIA	**Step 4:** Calculate total for 6 months
First 6 months:	$400 X 0.983 = **$393.20**	$393.20 X 1.045 = **$410.89**	$406 - $6 = **$404.89**	$404.89 X 6 = **$2,429.36**
Next 6 months:	$220 X 0.983 = **$216.26**	$216.26 X 1.045 = **$225.99**	$224 - $6 = **$219.99**	$219.99 X 6 = **$1,319.95**

Total Annual DCMP……$3,749.31

The third example assumes that all patients eligible for GUIDE Respite Services reach their respite cap for the year.

Dementia Care Program
Located in Philadelphia, PA

GAF for Philadelphia, PA: **1.043**
GUIDE Participant's PBA: **4.5%**

Model Tier	Patient Count		**Step 1:** Geographically Adjust DCMP (DCMP x 1.043)	**Step 2:** Apply PBA (Step 1 x 1.045)	**Step 3:** Calculate total for 6 months (Step 2 x 6)	**Step 4:** Geo. adjust respite (Cap x 1.043)	**Step 5:** Calculate Total (DCMP + respite) x patient count
Mild Caregiver	**10**	New Est.	$160.62 $69.88	$167.85 $73.03	$1,007.10 $438.15	N/A	**$14,452.54**
Moderate Caregiver	**30**	New Est.	$294.13 $128.29	$307.36 $134.06	$1,844.17 $804.37	$2,673.21	**$239,848.80**
Severe Caregiver	**20**	New Est.	$384.87 $235.72	$402.19 $246.33	$2,413.12 $1,477.95	$2,673.21	**$184,749.72**
Mild No Caregiver	**10**	New Est.	$246.15 $128.29	$257.22 $134.06	$1,543.35 $804.37	N/A	**$23,477.20**
Moderate/ Severe No Caregiver	**15**	New Est.	$417.20 $229.46	$435.97 $239.79	$2,615.84 $1,438.71	N/A	**$60,818.37**

Total Annual GUIDE Payments…..……..……$523,346.63

Notes: GAFs presented in the Payment Examples are for demonstration purposes only. Please refer to CMS Final Rule CMS 1807-F Addendum D for specific GAF information.

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

5 GUIDE Respite Payments

To alleviate caregiver burden, aligned patients in the moderate and high complexity dyad tiers who have a primary caregiver are eligible for GUIDE Model Respite Services (See **Exhibit 4**). GUIDE Respite Services made available by participants may include:

1. Respite services provided in the patient's home
2. Respite services provided in an adult center, including both medical and social programs
3. Respite services provided in a 24-hour facility

Participants have some flexibility in the type of GUIDE Respite Services that they make available to patients. The model requires providing, or contracting with a Partner Organization to provide, in-home respite services. However, participants have the option, and are not required, to make respite available through an adult center or a 24-hour facility.

GUIDE Respite Services are temporary services provided to a GUIDE patient in their home, at an adult day center, or at a facility that can provide 24-hour care, for the purpose of giving the primary caregiver a break from caring for the aligned patient. Aligned patients who have not identified a relative or unpaid nonrelative as a primary caregiver – even if they are assigned to the moderate or high complexity dyad tier – will not qualify for GUIDE Respite Services.

Important update

CMS has updated GUIDE Respite Services base rates and the per-patient annual cap for PY 2025 (see **Exhibit 16**).

Partner Organizations are not permitted to perform any GUIDE Care Delivery Services – including GUIDE Respite Services – until the respective participant has received written notice from CMS that CMS has approved and added the Partner Organization to the participant's Partner Organization Roster under Section 3.07(C)(6) of the Participation Agreement.

Exhibit 16 shows the updated PY 2025 base rates and service units for the three settings in which GUIDE Respite Services participants can provide.

Exhibit 16: GUIDE Respite Services G-codes and Rates for PY 2025[27]

Respite Services Setting	G-Code	Service-Unit	Base Rate
In Home	G0529	4-hour unit	$135
Adult Day Center	G0530	8-hour unit	$102
Facility Based	G0531	24-hour unit	$313

Participants shall bill CMS in accordance with the GUIDE Respite Services respite payment base rates based on the unit of service associated with each GUIDE Respite Services G-Code. The services rendered should represent the full hourly service units listed for the three service options and participants should bill the appropriate G-code that represents the services provided. The in-home respite G-code G0529 will cover a 4-hour unit of service and be paid at

[27] GUIDE in-home respite rates were increased 12.5%, adult day center respite rates were increased 30.8%, and facility-based respite rates were increased 17.2% for PY 2025 from PY 2024.

$135; the adult day respite G-code G0530 will cover an 8-hour unit paid at $102; and the facility-based respite G-code G0531 will cover a 24-hour unit paid at $313.

If participants contract with a Partner Organization, CMS requires them to contract and make GUIDE Respite Services available in these increments. However, extenuating circumstances may make it difficult to meet the full hourly service unit requirements (e.g., an aligned patient leaves an adult day center after 7.5 hours). In these circumstances, as long as the Partner Organization is contracted to meet the requirements for the service, and both intended to and provided a substantive portion of the time requirements for the unit (e.g., 3 hours for a 4-hour unit of service), participants are allowed to bill the appropriate G-code.

Participants can bill as many or as few of the codes as needed for a respite-eligible, aligned patient, up to a per-patient annual cap of $2,563.[28] Participants are responsible for managing the available funds for GUIDE Respite Services and alerting aligned patients when they reach the $2,563 cap. The GUIDE Model does not require participants to continue offering GUIDE Respite services to an aligned patient after the patient reaches the $2,563 cap. Providers may continue to recommend respite outside of the GUIDE Model when GUIDE Respite Services funds are expended, but GUIDE Respite Services beyond the $2,563 cap will not be covered by GUIDE Model payments. Aligned patients are free to personally pay for respite services beyond the $2,563 cap; however, participants cannot require an aligned patient to pay for additional respite or balance bill for amounts not covered by CMS. If a patient aligns to the GUIDE Model starting during the calendar year, they will receive the full $2,563 for the rest of the performance year. The GUIDE Model does not prorate the annual cap.

CMS annually updates the GUIDE Respite Services base rates to account for geographic variation in costs and inflation over time in prices. Using the same PFS GAF that is used to adjust the DCMP (see Section 4.6), CMS geographically adjusts the respite base rates. To account for cost growth over time, CMS adjusts the GUIDE Respite Services base rates using the home health market basket percentage increase reduced by the productivity adjustment calculated by the CMS Office of the Actuary. This metric is used in the Home Health Prospective Payment System to measure input price growth for home health agencies.

As shown in **Exhibit 16**, CMS applied the adjustments to the PY 2024 GUIDE Respite Service base rates to create the PY 2025 GUIDE Respite Services base amount. Updates to the PFS GAF and the inflation adjustment are applied to the GUIDE Respite Services base rates at the beginning of each PY and apply for the entirety of the PY. For example, GUIDE Respite Services base rates have been updated for PY 2025 using the forecasted growth in the home health market basket reduced by a productivity adjustment from July 1, 2025, through June 30, 2026. Additional information regarding the Home Health Agency market basket and productivity adjustment is available on the CMS webpage for Market Basket Data.

[28] The GUIDE respite allotment of $2,563 was increased 2.5% for PY 2025 from PY 2024. The $2,563 per year equates to roughly 76 hours of in-home GUIDE Respite Services per year, paid at a rate of $33.75 per hour. If the GUIDE respite allotment were used solely at an adult day center, it would cover 25 days of adult day per year; if it were used solely for facility-based care, it would cover roughly 8 days of facility-based care per year.

5.1 Billing and Payment for GUIDE Respite Services

Three GUIDE Respite Service G-codes are available for participants to bill, one for each setting and unit of care (in home, adult day, and facility based), as described in **Exhibit 16**. Participants bill for GUIDE Respite Services by submitting claims using these GUIDE Respite Service G-codes. Billing GUIDE Model Services is the same as billing Medicare Part B services. Participants will use the CMS-1500 claim form and submit their GUIDE Respite Services claims to the Medicare Administrative Contractor (MAC) servicing the jurisdiction in which the services are provided.

While GUIDE Respite Services claims are submitted via Medicare Part B, GUIDE Respite Services are paid by the Innovation Payment Contractor (IPC), a CMS-contracted entity. Participants will input banking information in the IPC Portal (https://portal.cms.gov/) to receive payment for GUIDE Respite Services. Respite claims are not reimbursed on a claim-by-claim basis; instead, CMS aggregates all qualifying GUIDE Respite Services billed in the preceding month and makes one lump sum respite payment.

Based on the respite-eligible patient's preferences and needs, participants may bill for GUIDE Respite Services until the patient reaches the $2,563 annual cap. To help participants track progress toward the annual cap, CMS will provide a monthly payment report via CMS.gov ePortal showing the amount of GUIDE Respite Services that each aligned patient has used in the year to date.

Participants must bill for all GUIDE Respite Services rendered to aligned patients. If a participant provides GUIDE Respite Services by contracting with a Partner Organization, the participant must pay the Partner Organization the full amount of the GUIDE Respite Payment received from CMS.

Participants are required to bill GUIDE-specific G-codes, including both the DCMP (see **Exhibit 7**) and GUIDE Respite Services (see **Exhibit 16**), on a standalone claim with no other HCPCS codes. As described in Section 3.1, multiple GUIDE-specific G-codes may be billed on the same standalone claim, as needed.

When a participant bills for a GUIDE Respite Service, the claim must include the following, as shown in **Exhibit 17**.

Exhibit 17: GUIDE Respite Services Billing Requirements

Required Information	Description
GUIDE-specific HCPCS G-Code	This should be one of the three GUIDE Respite Service G-codes for either in home, adult day, or facility-based respite services.
Date of Service (DOS)	This should be the date on which a GUIDE Practitioner or Partner provides GUIDE Respite Services to the aligned patient. The DOS must be within the effective Start and End dates for both the GUIDE Practitioner or Partner and patient alignment records. If a Partner Organization provides the service, the Partner Organization should record the service date and provide that information to the participant to bill for that service.
GUIDE TIN and rendering NPI	The entered TIN must match the TIN on file with the GUIDE Model. The rendering NPI must be part of a participant's Practitioner Roster

Required Information	Description
Patient's Health Insurance Claim Number/MBI	From the Beneficiary Alignment Report, input the aligned patient's Medicare Beneficiary Identifier (MBI).
Patient's Dementia Diagnosis Code (see Appendix B) in any position	Enter the aligned patient's diagnosis or condition to the highest level of specificity for the Date of Service. For the claim to be accepted, one or more of the diagnoses listed in this field must appear in the list of GUIDE ICD-10 Diagnosis Codes (see **Appendix B**).
Servicing Facility Location	Enter your main office or headquarters. The location you provide will not affect the geographic adjustment to GUIDE Respite Services; the patient's home address is used to automatically GAF-adjust the GUIDE Respite Service payment.

If a claim fails to meet these requirements, or is submitted with incomplete or invalid information, it may be denied or returned to the submitter as unprocessable, which may cause a delay in payment. For example, if a participant submits a claim for GUIDE Respite Services claims but the aligned patient is not assigned to the moderate or high complexity dyad tiers with a caregiver, the claim will not be processed and will be sent back to the participant for resubmission. Participants may use the Beneficiary Alignment Report, which is available via the eDFR application within the CMS.gov ePortal, to confirm each aligned patient's tier and eligibility for GUIDE Respite Services. See Appendix G for details on its contents. Please refer to the Billing Fact Sheet for additional details regarding claim requirements and troubleshooting guidance.

Exhibit 18 shows a sample of GUIDE Respite Services provided by a participant to a single patient over one month. This illustrates how GUIDE Respite Payments are calculated by CMS.

Exhibit 18: Sample Billing for GUIDE Respite Services

Date of Service	Type of Care	Units	Price
08/01/2025	In-home care	4 hours (1 unit)	$135
08/24/2025	In-home care	4 hours (1 unit)	$135
08/28/2025–08/29/2025	Facility based	48 hours (2 units)	$626
	Totals for August 2025:	**56 hours**	**$896**

Note: Patient has a caregiver and is in the moderate or high complexity tier. This claim is for all GUIDE Respite Services provided to the patient during the month of August 2025.

Using the example in **Exhibit 18**, to determine the amount of the GUIDE respite payment available for providing GUIDE Respite Services for the rest of the performance year (in this example, until June 30, 2026), the participant would use the following calculation: $2,563 − $896 = $1,667. Note that while respite payments will be made in GAF-adjusted dollars, the annual cap will be expressed and tracked in base dollars. The GAF for GUIDE Respite Services claims will be assigned based on the aligned patient's home address. In the example in **Exhibit 18**, if the GAF adjustment is 1.1, the participant would receive a GAF-adjusted payment of $858 ($780 multiplied by 1.1). However, only the base rate would be subtracted from the cap, leaving the aligned patient with $1,667 remining on the cap ($2,563 minus $896).

Participants will be able to track their GUIDE billing and payment data through the Payment Report, which is updated monthly and available via the HDR application within the CMS.gov ePortal. It includes information on DCMP claims, GUIDE Respite Services claims and payments, and remaining GUIDE Respite Services cap for each aligned patient. Participants

can use this report to reconcile actual and expected payments and to facilitate the payment of Partner Organizations who provide GUIDE Respite Services. See **Appendix H** for more details.

For dually eligible, aligned patients who receive respite care through a state Medicaid program, participants shall contact and attempt to coordinate the delivery of GUIDE Respite Services with the patient's Medicaid state agency and/or Medicaid managed care plan's case manager. The intent of GUIDE Respite Services is to be additive to, and not duplicative of, any available Medicaid respite care benefit offered to dually eligible, aligned patients. Participants are 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 facility respite stay).

5.2 Waiver of Patient Cost-Sharing for GUIDE Respite Services

Medicare FFS patients are typically required to pay a 20% coinsurance for Medicare Part B physician services. The GUIDE Model waives this required 20% cost sharing for the DCMP, and Medicare will pay 100% of the GUIDE Respite Payment. As defined in Section 9.05(B)(5) of the Participation Agreement, the GUIDE Respite Payment is not subject to patient cost sharing. Therefore, participants shall not subject aligned patients to any additional cost sharing for GUIDE Respite Services.

As described above, participants cannot require an aligned to pay for additional GUIDE Respite Services or balance bill for amounts not covered by CMS beyond the $2,563 annual cap.

5.3 Interaction with Other Innovation Center Models and Payments

As described in Section 3.4, participants and aligned patients may overlap with other CMS Innovation Center models, where it is possible to account for the financial impact of the overlap. As an example, participants and aligned patients are permitted to participate in both GUIDE and the ACO REACH Model and the Shared Savings Program. Unlike DCMP expenditures (see Section 3.4), GUIDE Respite Service expenditures will not contribute to ACO total cost of care expenditures, shared savings/shared losses, or benchmark calculations throughout the entire GUIDE Model Performance Period (July 1, 2024 – June 30, 2032). GUIDE Respite Services will continue to be paid to GUIDE Participants and will continue to be excluded from the calculation of shared savings/shared losses in ACO REACH.

Overlapping providers participating in both models (i.e., GUIDE practitioners in ACO REACH) should follow GUIDE billing requirements. ACO REACH claim reductions will not apply to GUIDE Respite Payments.

For GUIDE Participants who simultaneously participate as an ACO Participant in an ACO participating under any track in the Shared Savings Program, GUIDE Respite Services expenditures will not count toward ACO expenditures, shared savings, nor benchmarking. GUIDE Respite Services will continue to be paid to GUIDE Participants but will not count as aligned patient identifiable final payments in the Shared Savings Program.

6 Infrastructure Payment

6.1 Safety Net Providers

In addition to technical assistance and support, participants in the New Program Track that CMS qualified as GUIDE safety net providers were eligible to receive an Infrastructure Payment to cover some of the upfront costs of establishing a DCP. CMS notified applicants of their eligibility for this payment in April 2024.

Throughout this section, 'participants" refers only to those who were eligible for the infrastructure payment.

The Infrastructure Payment was a one-time payment of $75,000 made during the pre-implementation period. The payment was geographically adjusted using the same PFS GAF that is used to adjust the DCMP. The GAF adjustment corresponded to the state and county GAF associated with the participant's main address.

6.2 Allowed Uses

The Infrastructure Payment was intended to assist participants with their efforts in the following four categories:

- Hiring or training of members of its interdisciplinary care team or administrative staff;
- Developing DCP workflows, protocols, community partnerships, and educational or outreach materials;
- Community outreach and engagement related to its DCP; and
- Electronic health record technology adaptations.

Participants were only allowed to use Infrastructure Payment funds for costs in these four categories. Participants were required to submit a Spend Plan to CMS in June 2024 describing how they intended to use infrastructure funds. Additionally, participants will be required to submit a Spend Report during Performance Year 2.

Participants are required to repay any portion of the Infrastructure Payment that remains unspent at the end of Performance Year 2025.

6.3 Reconciliation of Infrastructure Payment

Participants that withdraw or are terminated before the start of the New Program Track's second performance year (i.e., prior to July 2026) will be required to repay 100% of the Infrastructure Payment to CMS. Participants that withdraw from the GUIDE Model or are terminated during the New Program Track's second performance year (between July 2026 and June 2027) will be required to repay half (50%) of the Infrastructure Payment. Participants withdrawing after June 2027 will not be required to repay the Infrastructure Payment.

Participants that use the Infrastructure Payment for purposes other than those in Section 6.2 will be required to repay some or all of the payment. Please refer to Section 9.06(E) of the Participation Agreement for more information.

Appendix A: Glossary of Terms

Acronym	Definition
CDI	Community Deprivation Index
CB	Caregiver Burden Measure
CBE	Consensus-Based Entity
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
CQM	Clinical Quality Measure
DCMP	Dementia Care Management Payment
DCP	Dementia Care Program (GUIDE Participant and partner organizations)
DE	Dual Eligibility
DRA	Data Request & Attestation Form
eCQM	Electronic Clinical Quality Measure
ePortal	CMS.gov Enterprise Portal
FFS	Fee-for-Service
GAF	Geographic Adjustment Factor
GPCI	Geographic Practice Cost Index
GUIDE	Guiding an Improved Dementia Experience Model
HCPCS	Healthcare Common Procedure Coding System
HDR	Health Data Reporting
HICN	Health Insurance Claim Number
HRRx	Use of High-Risk Medications in Older Adults Measure
ICD-10	International Classification of Diseases, 10th edition
LIS	Low Income Subsidy
LTNH	Rate of Patients Entering a Long-Term Nursing Home
MEI	Medicare Economic Index
MIPS	Merit-Based Incentive Payment Program
MVP	MIPS Value Pathway
Neuro MVP	Supportive Care for Neurodegenerative Conditions MVP
NPI	National Provider Identifier
PBA	Performance-Based Adjustment
PCF	Primary Care First
PFS	Physician Fee Schedule
PROM	Patient Reported Outcome Measure
PIA	Population and Income Adjustment
PY	Performance Year
QoL	Quality of Life Outcome for Patients with Neurological Conditions Measure

Acronym	Definition
SSP	Shared Savings Program
TIN	Taxpayer Identification Number
TPCC	Total Per Capita Cost

Appendix B: GUIDE ICD-10 Dementia Diagnosis[29] Codes

Note that at the time of billing, participants must record the aligned patient's dementia diagnosis on each DCMP and GUIDE Respite Services claim for it to be paid; claims without one or more of these ICD-10 diagnosis codes will be denied. Please refer to Sections 2, 3, and 5 for additional information.

ICD-10 Dementia Codes	ICD-10 Dementia Code Definition
F01.50	Vascular dementia
F01.511	Vascular dementia, unspecified severity, with agitation
F01.518	Vascular dementia, unspecified severity, with other behavioral disturbance
F01.A0	Vascular dementia, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F01.A11	Vascular dementia, mild, with agitation
F01.A18	Vascular dementia, mild, with other behavioral disturbance
F01.A2	Vascular dementia, mild, with psychotic disturbance
F01.A3	Vascular dementia, mild, with mood disturbance
F01.A4	Vascular dementia, mild, with anxiety
F01.B0	Vascular dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F01.B11	Vascular dementia, moderate, with agitation
F01.B18	Vascular dementia, moderate, with other behavioral disturbance
F01.B2	Vascular dementia, moderate, with psychotic disturbance
F01.B3	Vascular dementia, moderate, with mood disturbance
F01.B4	Vascular dementia, moderate, with anxiety
F01.C0	Vascular dementia, severe, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F01.C11	Vascular dementia, severe, with agitation
F01.C18	Vascular dementia, severe, with other behavioral disturbance
F01.C2	Vascular dementia, severe, with psychotic disturbance
F01.C3	Vascular dementia, severe, with mood disturbance
F01.C4	Vascular dementia, severe, with anxiety
F02.80	Dementia in other diseases classified elsewhere
F02.811	Dementia in other diseases classified elsewhere, unspecified severity, with agitation
F02.818	Dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance
F02.A0	Dementia in other diseases classified elsewhere, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F02.A11	Dementia in other diseases classified elsewhere, mild, with agitation

[29] ICD-10 is copyright 2025 World Health Organization. All Rights Reserved.

ICD-10 Dementia Codes	ICD-10 Dementia Code Definition
F02.A18	Dementia in other diseases classified elsewhere, mild, with other behavioral disturbance
F02.A2	Dementia in other diseases classified elsewhere, mild, with psychotic disturbance
F02.A3	Dementia in other diseases classified elsewhere, mild, with mood disturbance
F02.A4	Dementia in other diseases classified elsewhere, mild, with anxiety
F02.B0	Dementia in other diseases classified elsewhere, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F02.B11	Dementia in other diseases classified elsewhere, moderate, with agitation
F02.B18	Dementia in other diseases classified elsewhere, moderate, with other behavioral disturbance
F02.B2	Dementia in other diseases classified elsewhere, moderate, with psychotic disturbance
F02.B3	Dementia in other diseases classified elsewhere, moderate, with mood disturbance
F02.B4	Dementia in other diseases classified elsewhere, moderate, with anxiety
F02.C0	Dementia in other diseases classified elsewhere, severe, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F02.C11	Dementia in other diseases classified elsewhere, severe, with agitation
F02.C18	Dementia in other diseases classified elsewhere, severe, with other behavioral disturbance
F02.C2	Dementia in other diseases classified elsewhere, severe, with psychotic disturbance
F02.C3	Dementia in other diseases classified elsewhere, severe, with mood disturbance
F02.C4	Dementia in other diseases classified elsewhere, severe, with anxiety
F03.90	Dementia (degenerative (primary)) (old age) (persisting)
F03.911	Unspecified dementia, unspecified severity, with agitation
F03.918	Unspecified dementia, unspecified severity, with other behavioral disturbance
F03.A0	Unspecified dementia, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F03.A11	Unspecified dementia, mild, with agitation
F03.A18	Unspecified dementia, mild, with other behavioral disturbance
F03.A2	Unspecified dementia, mild, with psychotic disturbance
F03.A3	Unspecified dementia, mild, with mood disturbance
F03.A4	Unspecified dementia, mild, with anxiety
F03.B0	Unspecified dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F03.B11	Unspecified dementia, moderate, with agitation
F03.B18	Unspecified dementia, moderate, with other behavioral disturbance
F03.B2	Unspecified dementia, moderate, with psychotic disturbance
F03.B3	Unspecified dementia, moderate, with mood disturbance
F03.B4	Unspecified dementia, moderate, with anxiety
F03.C0	Unspecified dementia, severe, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety

ICD-10 Dementia Codes	ICD-10 Dementia Code Definition
F03.C11	Unspecified dementia, severe, with agitation
F03.C18	Unspecified dementia, severe, with other behavioral disturbance
F03.C2	Unspecified dementia, severe, with psychotic disturbance
F03.C3	Unspecified dementia, severe, with mood disturbance
F03.C4	Unspecified dementia, severe, with anxiety
F10.27	Alcohol dependence with alcohol-induced persisting dementia
F10.97	Alcohol use, unspecified with alcohol-induced persisting dementia
F13.27	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting dementia
F13.97	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced persisting dementia
F18.97	Inhalant use, unspecified with inhalant-induced persisting dementia
F19.17	Other psychoactive substance abuse with psychoactive substance-induced persisting dementia
F19.27	Other psychoactive substance dependence with psychoactive substance-induced persisting dementia
F19.97	Other psychoactive substance use, unspecified with psychoactive substance-induced persisting dementia
G30.0	Alzheimer's disease
G30.1	Alzheimer's disease with late onset
G30.8	Other Alzheimer's disease
G30.9	Alzheimer's disease, unspecified
G31.01	Pick's disease
G31.09	Other front temporal dementia
G31.1	Senile degeneration of brain, not elsewhere classified
G31.2	Degeneration of nervous system due to alcohol
G31.83	Neurocognitive disorder with Lewy bodies

Notes: Codes presented in the table are from 2024 and are effective as of the date of publication. CMS may change the codes at its discretion based on updates to diagnosis codes. While these diagnosis codes are used for claims processing, patient eligibility for alignment to the GUIDE Model relies on the attestation from a clinician rather than a claims-based ICD-10 diagnosis code for dementia.

As described in Section 2, the participant's dementia-proficient practitioner may attest that, based on their Comprehensive Assessment, a patient 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 the practitioner may attest that they have received a written report of a documented dementia diagnosis from another Medicare-enrolled practitioner. Participants document this attestation using the PAAF.

Appendix C: Examples of GAF Adjustment to DCMP Base Rates by Locality

CMS adjusts the DCMP base rates by the Medicare PFS Geographic Adjustment Factor (GAF) for each DCMP claim submitted by a participant. This table demonstrates how actual payments will incorporate GAFs.

State	Locality Number	Locality Name	GAF	GAF + Low Complexity Dyad Tier (G0519)	GAF + Moderate Complexity Dyad Tier (G0520)	GAF + High Complexity Dyad Tier (G0521)	GAF + Low Complexity Individual Tier (G0522)
AL	0	Alabama	0.923	$138.45	$253.83	$332.28	$212.29
AK	1	Alaska	1.271	$190.65	$349.53	$457.56	$292.33
AZ	0	Arizona	0.983	$147.45	$270.33	$353.88	$226.09
AR	13	Arkansas	0.916	$137.40	$251.90	$329.76	$210.68
CA	54	Bakerfield	1.037	$155.55	$285.18	$373.32	$238.51
CA	55	Chico	1.031	$154.65	$283.53	$371.16	$237.13
CA	71	El Centro	1.032	$154.80	$283.80	$371.52	$237.36

Note: GAFs presented in the table are from 2024 and are presented for demonstration purposes only. Updated GAF amounts are published annually as part of the Medicare Physician Fee Schedule Final Rule Addenda.

Appendix D: Example Alignment Template Letter

[Insert GUIDE provider logo here]

[$BENENAME]
[$ADDRESS]
[$CITY, STATE, ZIP]

Dear [$BENENAME]:

We are pleased to inform you that Medicare has determined that you are eligible for a new Medicare pilot program called the Guiding an Improved Dementia Experience (GUIDE) Model.

The GUIDE Model is designed to improve the quality of life for people living with dementia and those in their lives who give them support with routine tasks. The GUIDE Model pays for the coordination of services, education about dementia, and the support people living with dementia often need to remain in their homes safely.

[GUIDE Participant may insert some information about the next step the patient should expect with the GUIDE Participant's program.]

Your Medicare benefits will NOT change. You remain eligible to receive the same Medicare benefits, and you still have the right to use any doctor, other health care professional, or hospital that accepts Medicare, at any time. If you have questions about GUIDE, feel free to ask your doctor or other health care professional, or call [GUIDE provider] at [GUIDE provider number], or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Sincerely,

[PROVIDER NAME]

Appendix E: Example Non-Alignment Template Letter

[Insert GUIDE provider logo here]

[$BENENAME]
[$ADDRESS]
[$CITY, STATE, ZIP]

Dear [$BENENAME]:

We regret to inform you that Medicare determined that you are **not eligible** to participate in the new Medicare pilot program called the Guiding an Improved Dementia Experience (GUIDE) Model. Medicare made this determination because {the results of your cognitive and functional assessment do not qualify you for the GUIDE Model/*you are not enrolled in Medicare Part A and B/ you are enrolled in Medicare Advantage/ you are enrolled in Program of All Inclusive Care for the Elderly (PACE)/ Medicare is not your primary payer/ you are enrolled in Medicare hospice benefit/ you are a long term nursing home resident/ you live outside of the GUIDE service area for [GUIDE provider]}*.

Your Medicare benefits will NOT change. You remain eligible to receive the same Medicare benefits, and you still have the right to use any doctor, other health care professional, or hospital that accepts Medicare, at any time.

If you have questions, feel free to ask your doctor or other health care professional, call [GUIDE provider] at [GUIDE provider number], or call Medicare at 1800MEDICARE (18006334227). Teletypewriter (TTY) users should call 18774862048.

Sincerely,

[PROVIDER NAME]

Appendix F: Consent to Check for Eligibility for GUIDE Model

1. CONFIRM

By signing below, I agree to allow [provider name] to submit my information to check for eligibility for the GUIDE model.

[$BENENAME]

_____ _____

Signature **Print Name**

___/_/_____

Date

[Caregiver or authorized representative]

_____ _____

Signature **Print Name**

___/_/_____

Date

[THE PROVIDER MAY REMOVE THIS SECTION IF SIGNED IN PERSON]

2. RETURN

Return this form in the envelope that we provided.

Note: Completing and returning this form is voluntary. It will not affect your Medicare benefits.

Appendix G: GUIDE Beneficiary Alignment Report

CMS GUIDE Beneficiary Alignment File

CMS Sensitive Information – Special Handling Required

GUIDE Participant ID	GUIDE-XXXX
GUIDE Participant Name	Name
Report Date	2025-04-09

You can use this table to inform what DCMP HCPCS billing code to use for each beneficiary at a given time. Select the DCMP HCPCS Code that applies as of the date of service.
Filter Current = "Y" to limit to beneficiaries aligned as of the Report Date.

ISO	Current	Beneficiary					Alignment							Annual Assessment	
		First Name	Last Name	Date of Birth	Sex	MBI	Attesting NPI	Tier	DCMP HCPCS Code	Respite Eligible ?	Start Date	End Date	End Reason (if Applicable)	Last Assessment Date	Date Range to Conduct and Submit Next Annual Assessment
1	N	Sandra	Smith	1945-06-06	Female	3FP0TE5NU80	123123123	Low Complexity Dyad Tier	G0519	N	2024-08-27	2025-01-31	Moved to Established Patient Code		
2	Y	Sandra	Smith	1945-06-06	Female	3FP0TE5NU80	123123123	Low Complexity Dyad Tier	G0524	N	2025-02-01			2024-08-27	2025-06-29 – 2025-10-26
3	N	Sandra	Smith	1945-06-06	Female	3FP0TE5NU80	123123123	Moderate Complexity Dyad Tier	G0525	Y	2025-05-01				
4	N	Justin	Jones	1957-07-07	Male	4FP0TE5NU70	123123123	Moderate Complexity Dyad Tier	G0520	Y	2024-10-09	2025-03-31	Moved to Established Patient Code		
5	Y	Justin	Jones	1957-07-07	Male	4FP0TE5NU70	123123123	Moderate Complexity Dyad Tier	G0525	Y	2025-04-01			2024-10-09	2025-08-11 – 2025-12-08
6	Y	Leo	Brown	1960-01-02	Male	5RK3TE6MR20	123123123	Low Complexity Dyad Tier	G0519	N	2025-03-28			2025-03-28	2026-01-28 – 2026-05-27

Note: The Beneficiary Alignment File of the GUIDE Beneficiary Alignment Report, found in the Expanded Data Feedback Reporting (eDFR) application, provides a list of all patients aligned to your organization from model start to current date. The table has one row per patient and tier. Patients may move between tiers over time, and as a result appear multiple times. You can use this table to inform what DCMP HCPCS billing code to use for each patient at a given time.

CMS GUIDE Patient Assessment and Alignment Form Results

CMS Sensitive Information – Special Handling Required

GUIDE Participant ID	GUIDE-XXXX
GUIDE Participant Name	Name
Report Date	2025-04-09

ISO	Submission Date/Time	Beneficiary					Alignment					
		First Name	Last Name	Date of Birth	Sex	MBI	Attesting NPI	Assessment Type	Decision	Rationale	Tier	Effective Date
1	2024-07-30-13:53_EST	Susan	Smith	1948-02-25	Female	5FP0TE5NU60	1234567890	Initial assessment	Aligned		High Complexity Dyad Tier	2024-07-05
2	2024-07-30-15:24_EST	John	Doe	1944-06-06	Male	3FP0TE5NU80	1234567890	Initial assessment	Aligned		Low Complexity Dyad Tier	2024-07-27
3	2025-03-27-12:55_EST	John	Doe	1944-06-06	Male	3FP0TE5NU80	1234567890	Re-assessment	Accepted		High Complexity Dyad Tier	2025-05-01
4	2025-03-28-15:45_EST	Jane	Doe	1947-07-10	Female	4FP0TE5NU20		Unalignment	Accepted			2025-03-18
5	2024-09-06-14:24_EST	Jane	Doe	1947-07-10	Female	4FP0TE5NU20	1234567890	Initial assessment	Aligned		High Complexity Dyad Tier	2024-08-28
6	2025-02-07-17:08_EST	Michael	Johnson	1938-02-07	Male	6FP0TE5NU80	1234567890	Initial assessment	Rejected	Beneficiary Ineligible Due to: Medicare Advantage		

Note: The PAAF Results Tracker of the GUIDE Beneficiary Alignment Report, found in the Expanded Data Feedback Reporting (eDFR) application, provides a list of all patients recently submitted on Patient Assessment and Alignment Forms (PAAFs) which have been processed by CMS, referenced by the date/time they were submitted. The data provided on this sheet gives the alignment decision as well as the tier the patient was aligned to, if applicable. Aligned patients will also appear on the Beneficiary Alignment File sheet. Refer to that sheet for complete information on currently aligned patients.

Appendix H: GUIDE Payment Report

CMS GUIDE DCMP Claim and Payment File

CMS Sensitive Information – Special Handling Required

GUIDE Participant ID	GUIDE-0521
GUIDE Participant Nam	Memory Care Practice
Report Date	2024-10-21

This sheet shows your paid DCMP claims as of the above report date. Claims paid within 4 weeks of the report date may not display until the next report due to data lags.
All DCMP claim questions and discrepancies should be first directed toward your Medicare Administrative Contractor.
You may use the Medicare Administrative Contractor ID and the Claim Control Number below to tie claims back to your original claim submissions.
You can look up your Medicare Administrative Contractor ID using this map: https://www.cms.gov/files/document/ab-jurisdiction-map03282023pdf.pdf

	Beneficiary					Claim & Payment													
Sort Order	Year/Month	MBI	First Name	Last Name	Date of Birth	Service Date	Claim Paid Date	Rendering Provider NPI	Medicare Administrative Contractor ID	Claim Control Number	Claim Line Number	DCMP HCPCS Code	Charge Amount	DCMP Base Rate	Sequestration Adjustment Amount	Population and Income Adjustment (PIA) Amount	Performance Based Adjustment (PBA) Amount	Geographic Adjustment Factor (GAF) Amount	Paid Amount
1	2024-08	1TE0ST1ZZ22	John	Smith	1/5/1949	8/1/2024	8/22/2024	1231234561	JF	1472788	1	G0523	$500.00	$390.00	($8.45)	$0.00	$18.19	$14.23	$413.97
2	2024-08	1TE0ST1ZZ25	Jane	Doe	2/10/1950	8/5/2024	8/23/2024	1231231231	JH	202657775	1	G0520	$1,000.00	$275.00	($5.87)	$15.00	$11.98	($8.70)	$287.41
3	2024-08	1TE0ST1ZZ30	Frank	Malone	6/8/1944	8/2/2024	8/18/2024	2342345641	JL	1527447	1	G0519	$250.00	$150.00	($2.80)	($6.00)	$6.29	($10.12)	$137.37
4	2024-08	2TE0ST1ZZ22	Betty	Jones	3/24/1952	8/1/2024	8/30/2024	1212121212	JK	1534559	1	G0521	$550.00	$360.00	($7.56)	$0.00	$16.28	$1.68	$370.40
5	2024-08	5TE0ST1ZZ25	Drake	Brady	11/7/1953	8/3/2024	8/25/2024	4444466666	J15	1558033	1	G0522	$1,000.00	$230.00	($5.19)	$15.00	$10.53	$3.96	$254.30

Note: The GUIDE DCMP Claim and Payment File of the GUIDE Payment Report, located in the Expanded Data Feedback Reporting (eDFR) application, displays your paid DCMP claims as of the report date.

CMS GUIDE Respite Claim File

CMS Sensitive Information – Special Handling Required

GUIDE Participant ID	GUIDE-0521
GUIDE Participant Name	Memory Care Practice
Report Date	2024-10-21

This sheet shows respite claims you have submitted and that CMS has processed.
The amounts shown here aggregate to the monthly payments made by the Innovation Payment Contractor (IPC) as displayed in the Respite Payment File sheet.
You can use the "IPC Paid Date" field, which is represented on both sheets, to understand which claims were aggregated into a given monthly payment.
You may use the Medicare Administrative Contractor ID and the Claim Control Number below to tie claims back to your original claim submissions.
You can look up your Medicare Administrative Contractor ID using this map: https://www.cms.gov/files/document/ab-jurisdiction-map03282023pdf.pdf

	Beneficiary					Claim and Payment												
Sort Order	MBI	First Name	Last Name	Date of Birth	Performance Year	Date of Service	Respite HCPCS	Units	Rendering NPI	Medicare Administrative Contractor ID	Claim Control Number	Claim Line Number	Payment status	IPC Paid Date	Base Rate	Exceeds Cap Adjustment	GAF adjustment	Paid Amount
1	1TE0ST1ZZ22	Justin	Smalls	1/5/1949	7/1/2024-6/30/2025	8/1/2024	G0529	1	1231234561	JF	1472788	1	Processed	2024-09-25	$120.00	$0.00	$14.23	$134.23
2	1TE0ST1ZZ25	Dave	Champ	2/10/1950	7/1/2024-6/30/2025	8/5/2024	G0529	1	1231231231	JH	202657775	1	Processed	2024-09-25	$120.00	$0.00	($8.70)	$111.30
3	1TE0ST1ZZ30	Mary	Wallace	6/8/1944	7/1/2024-6/30/2025	8/2/2024	G0530	1	2342345641	JL	1527447	2	Processed	2024-09-25	$78.00	$0.00	($20.12)	$57.88
4	2TE0ST1ZZ22	Patty	Ward	3/24/1952	7/1/2024-6/30/2025	8/1/2024	G0531	1	1212121212	JK	1534559	1	Processed	2024-09-25	$260.00	$0.00	$1.68	$261.68
5	5TE0ST1ZZ25	Stewart	Morgan	11/7/1953	7/1/2024-6/30/2025	8/3/2024	G0530	1	4444466666	J15	1558033	1	Processed	2024-09-25	$78.00	$0.00	$3.96	$81.96
6	5TE0ST1ZZ27	James	Douglas	12/30/1940	7/1/2024-6/30/2025	8/3/2024	G0530	1	4444466666	J15	1558037	1	Processed; Partially Exceeds Ca	2024-09-25	$78.00	($18.00)	$3.96	$63.96
7	5TE0ST1ZZ27	James	Douglas	12/30/1940	7/1/2024-6/30/2025	8/3/2024	G0530	1	4444466666	J15	1558038	1	Rejected: Exceeds Cap					

Note: The GUIDE Respite Services Claim File of the GUIDE Payment Report, located in the Expanded Data Feedback Reporting (eDFR) application, details each accepted GUIDE Respite Services claim billed by the participant. It details the type of respite code billed and tracks GAF and non-GAF adjusted payment amounts.

CMS GUIDE Respite Payment File

CMS Sensitive Information – Special Handling Required

GUIDE Participant ID	GUIDE-0521
GUIDE Participant Name	Memory Care Practice
Report Date	2024-10-21

This report shows the total amount received into GUIDE participants' bank accounts for respite services on a monthly basis.
These amounts aggregate the individual services processed in the Respite Claim File sheet.
You can use the "IPC Paid Date" field, which is represented on both sheets, to understand which claims were aggregated into a given monthly payment.
The amounts shown here are final payable amounts to participants, and should match to transactions in your bank accounts.
In months where you have no respite claims processed, you will have no payment in the table below.

Sort Order	IPC Paid Date	Amount Paid
1	2024-09-25	$675.00

Note: The GUIDE Respite Services Payment File of the GUIDE Payment Report, located in the Expanded Data Feedback Reporting (eDFR) application, details the total amount received into the participants' bank accounts for GUIDE Respite Services on a monthly basis.

CMS GUIDE Respite Cap Remaining

CMS Sensitive Information – Special Handling Required

GUIDE Participant ID	GUIDE-0521
GUIDE Participant Name	Memory Care Practice
Report Date	2024-10-21

This report shows total respite services processed and the remaining spend available before reaching the respite cap by performance year.
Respite spending and remaining respite spending until reaching the cap is reported in non-GAF adjusted dollars. For actual GAF-adjusted payment amounts, refer to the "Respite Claim File" tab.
All values are as of the above report date. Only currently aligned beneficiaries as of the above report date are displayed.

Sort Order	Performance Year	MBI	First Name	Last Name	Date of Birth	Respite Cap	Respite Spend	Remaining Spend Until Reaching Cap
1	7/1/2024-6/30/2025	1TE0ST1ZZ22	Justin	Smalls	1/5/1949	$2,500	$120	$2,380
2	7/1/2024-6/30/2025	1TE0ST1ZZ25	Dave	Champ	2/10/1950	$2,500	$120	$2,380
3	7/1/2024-6/30/2025	1TE0ST1ZZ30	Mary	Wallace	6/8/1944	$2,500	$78	$2,422
4	7/1/2024-6/30/2025	2TE0ST1ZZ22	Patty	Ward	3/24/1952	$2,500	$260	$2,240
5	7/1/2024-6/30/2025	5TE0ST1ZZ25	Stewart	Morgan	11/7/1953	$2,500	$78	$2,422
6	7/1/2024-6/30/2025	5TE0ST1ZZ27	James	Douglas	12/30/1940	$2,500	$63	$2,437

Note: The GUIDE Respite Services Cap Remaining of the GUIDE Payment Report, located in the Expanded Data Feedback Reporting (eDFR) application, details the total GUIDE Respite Services spending, by patient and performance year-to-date, as well as remaining spend available before reaching the cap.