Centers for Medicare & Medicaid Services

GUIDE Payment Methodology Paper

Including Overview of Beneficiary Alignment

July 2024 – June 2025

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1 Model Introduction and GUIDE Participants

1.1 Introduction

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 a comprehensive package of care coordination and care management, caregiver education and support, and respite services. Beneficiaries in the GUIDE Model will receive care from an interdisciplinary care team that will identify the beneficiary's primary care provider and specialists and outline the care coordination services needed to manage the beneficiary's dementia and co-occurring conditions.

This document describes the method that CMS uses to align beneficiaries to a GUIDE Participant and pay for services delivered under the GUIDE Model.

1.2 GUIDE Performance Years

The GUIDE Model is an eight-year voluntary care model that is offered nationwide, launching on July 1, 2024, and running through June 30, 2032 (see **Exhibit 1**).

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 will have two participant tracks, one for established dementia care programs (DCP) and one for new DCPs. The purpose of the two tracks is to allow organizations in the Established Program Track to begin their performance in the GUIDE Model on July 1, 2024, while giving organizations that do not currently offer a comprehensive DCP consistent with the GUIDE Model's care delivery approach time and support to develop their program. New program development is intended to help increase beneficiary access to specialty dementia care, particularly in underserved communities. GUIDE Participants will remain in their assigned track for the entirety of the model.

1.3.1 New Program Track

As shown in **Exhibit 1**, New Program Track GUIDE Participants have a 1-year pre-implementation period beginning July 1, 2024. New Program Track GUIDE Participants are required to use the pre-implementation period 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 GUIDE 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 GUIDE Participants may continue to bill Medicare Physician Fee Schedule (PFS) services provided to patients during the pre-implementation year. New Program Track GUIDE Participants may also be eligible for the one-time Infrastructure Payment (see Section 6).

1.3.2 Established Program Track

GUIDE Participants assigned to the Established Program Track should be ready to begin billing for aligned beneficiaries for GUIDE services on July 1, 2024. As detailed further in Section 3, the DCMP will replace 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, the GUIDE Participant will not be able to bill separately for these Medicare PFS services for aligned beneficiaries once they start billing for GUIDE services.

1.4 GUIDE Participant Structures and Agreements

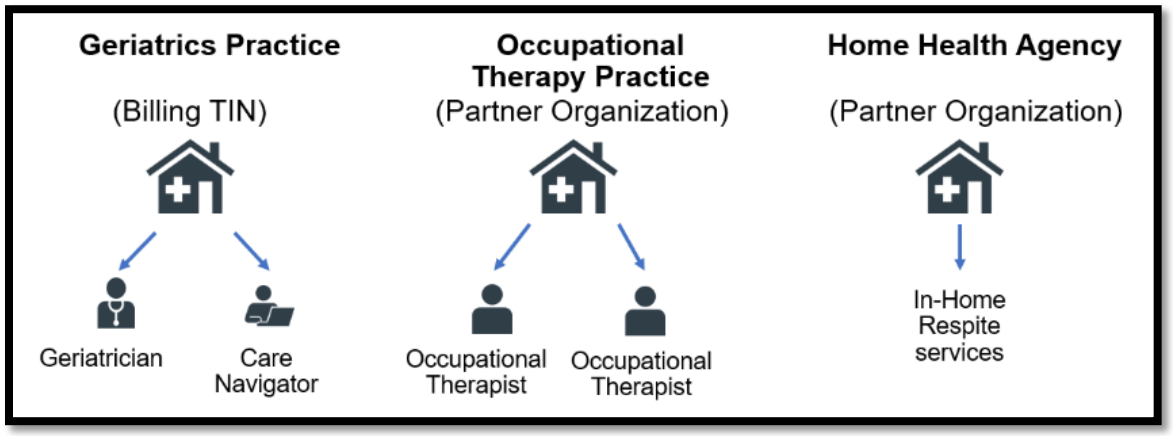
GUIDE Participants will operate DCPs that provide ongoing, longitudinal care and support to people living with dementia through an interdisciplinary care team. GUIDE Participants are Medicare Part B–enrolled providers and suppliers, excluding durable medical equipment and laboratory suppliers, which are eligible to bill for Medicare PFS services and agree to meet the care delivery requirements of the model. A GUIDE Participant is identified by a single Tax Identification Number (TIN) plus the National Provider Identifiers (NPI) of individual Medicare-enrolled physicians and other nonphysician practitioners who choose to participate in the model. For detailed GUIDE Participant requirements, please refer to the GUIDE Request For Applications (RFA) document.

A GUIDE Participant will 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. **Exhibit 2** illustrates a care team made up of a

[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.

Geriatrician and Care Navigator, who partners with an occupational therapy practice and a home health agency to meet the care delivery requirements of the GUIDE Model.

Exhibit 2: GUIDE Participants and Partner Organizations



TIN = Taxpayer Identification Number

1.4.1 GUIDE Practitioners

The GUIDE Participant is composed of the NPIs of individual Medicare-enrolled physicians and other nonphysician practitioners who have reassigned their billing rights to the GUIDE Participant's billing TIN. The GUIDE Participant will be 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 beneficiary alignment and bill for GUIDE Model payments.

For GUIDE Model billing codes (GUIDE-specific G-codes), CMS has waived the reduction in the payment amounts for nonphysician practitioners. 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 of the physician FFS rate.

1.4.2 Partner Organizations

GUIDE Participants may also contract with Partner Organizations. A GUIDE Participant may decide to contract with a Partner 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 an example of a GUIDE Participant and Partner Organization. The GUIDE Participant will be responsible for the arrangement and payment to its Partner Organizations. Partner Organizations may not bill Medicare for delivery of GUIDE care delivery services. If a Partner Organization is Medicare enrolled, it does not need to reassign billing rights to the GUIDE Participant as a result of serving as a Partner Organization in the GUIDE Model.

1.4.3 Participant Service Area

GUIDE Participants are required to submit to CMS and maintain a zip code–based service area encompassing the zip codes from which the GUIDE Participants are willing to accept beneficiaries. In defining a service area, GUIDE Participants should keep in mind the GUIDE

Model requirements to provide a home visit and GUIDE Respite Services to beneficiaries in certain model tiers and make referrals to community-based services and supports. GUIDE Participants may bill only for beneficiaries residing in their service area zip code.

2 Beneficiary Alignment to the GUIDE Model

2.1 Overview

The GUIDE Model is designed to serve community-dwelling[2] Medicare FFS beneficiaries, including beneficiaries dually eligible for Medicare and Medicaid, who have dementia. For the purposes of the GUIDE Model, a caregiver is defined as a relative, or unpaid nonrelative, who assists the beneficiary with activities of daily living[3] and/or instrumental activities of daily living.[4] Depending on the beneficiary's need, the assistance may be episodic, daily, or occasional.

The GUIDE Participant will develop provider networks and conduct outreach and engagement to recruit beneficiaries for the GUIDE Model. During their first performance year, GUIDE Participants are required to offer the opportunity to voluntarily align to their DCP all beneficiaries with dementia to whom they already provide dementia care services. CMS will employ several outreach strategies to supplement GUIDE Participants' beneficiary recruitment activities (see Section 2.2 for more detail).

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

The Patient Assessment and Alignment form (shown in Appendix F) will be used to gather and submit data collected during the initial Comprehensive Visit Assessment. The Patient Assessment and Alignment form will include an attestation from a practitioner on the GUIDE Participant's GUIDE Practitioner Roster that the beneficiary has dementia. CMS will use the information submitted on the Patient Assessment and Alignment form to confirm the beneficiary's eligibility for alignment to the GUIDE Participant. If CMS finds that the beneficiary is eligible, then CMS will align the beneficiary to the GUIDE Participant. GUIDE Participants can bill the GUIDE model G-codes only after receiving confirmation from CMS that the beneficiary is eligible and has been aligned to the GUIDE Participant's DCP. **Exhibit 3** outlines the steps involved for voluntary alignment.

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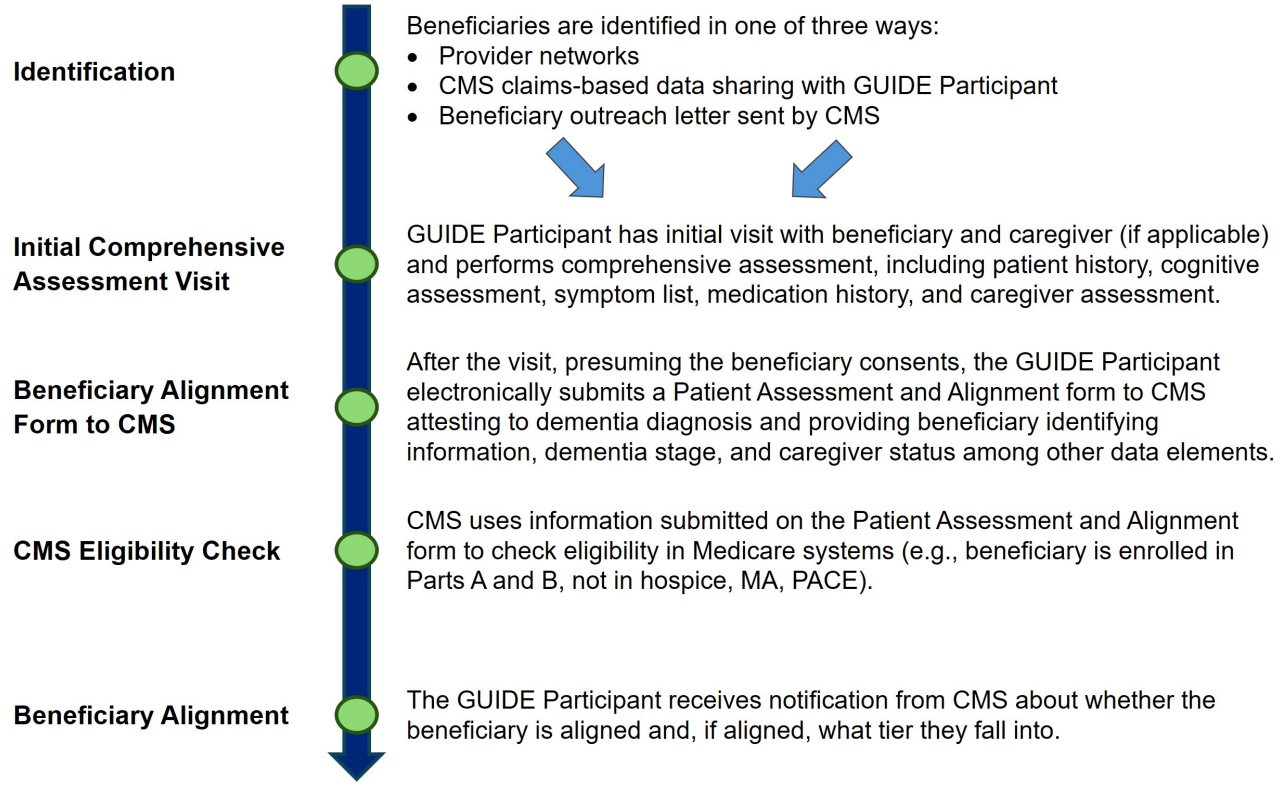
2 "Community-dwelling" is defined as living in a personal home, assisted living facility, group home, or other community setting and excludes beneficiaries who become a long-term nursing home resident, defined as a nursing facility stay that is not covered under the Medicare skilled nursing facility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

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



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

2.2 Beneficiary Outreach and Engagement

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

1) Provider Networks: GUIDE Participants will develop provider networks with primary care providers, neurologists, hospitalists, hospital discharge planning staff, community-based organizations, and other relevant groups in the community. Organizations from those networks may recommend beneficiaries who already have a dementia diagnosis as well as beneficiaries with suspected dementia but no formal diagnosis to the GUIDE Participant. GUIDE Participants will work with network organizations to develop appropriate referral criteria and protocols. Any networks, criteria, and protocols must comply with all applicable fraud and abuse laws.
2) CMS data sharing based on claims: GUIDE Participants can request to receive a list of potentially eligible beneficiaries through their Data Request & Attestation (DRA) form. If requested, CMS will use claims data from a three-year historical look-back period to identify beneficiaries who received Medicare services from a GUIDE Participant, have claims-based *International Classification of Diseases*, 10th edition (ICD-10) dementia diagnosis codes, and are eligible for the GUIDE Model. Using these criteria, CMS will offer GUIDE Participants a one-time opportunity to request, prior to the GUIDE Participant's first performance year, a list of eligible Medicare FFS beneficiaries with dementia diagnosis codes. The list would include beneficiaries to whom the GUIDE

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

3) Beneficiary Outreach Letter: Starting in the spring to summer of 2025, CMS will send targeted outreach letters to eligible beneficiaries with dementia diagnosis codes in their claims' history, informing them about the GUIDE Model and how to voluntarily align with a GUIDE Participant in their area, enabling them to self-identify for the GUIDE Model. Mailings will use sensitive, beneficiary-friendly language and will not include information about available in-kind beneficiary incentives. This beneficiary identification pathway is part of the GUIDE Model's health equity strategy. To support this outreach, GUIDE Participants will be required to submit to CMS and maintain a zip-code based service area encompassing the zip codes from which the GUIDE Participants are willing to accept beneficiaries. In defining a service area, GUIDE Participants should keep in mind the GUIDE Model requirements to provide a home visit and GUIDE Respite Services to beneficiaries in certain model tiers and make referrals to community-based services and supports. CMS will randomly list multiple GUIDE Participants in the targeted outreach letters if there is more than one GUIDE Participant in a service area. The beneficiary may decide, in their sole discretion, which GUIDE Participant to contact if the beneficiary is interested in the GUIDE Model.

2.3 Beneficiary Eligibility

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

- Has dementia, as confirmed by attestation from a clinician on the GUIDE Participant's GUIDE Practitioner Roster (see 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;
- Not enrolled in Medicare hospice benefit;
- Is not a long-term nursing home resident (defined as a beneficiary whose nursing home stay is 4 months or longer and not covered under the Medicare skilled nursing facility benefit); and
- Resides inside the participant's zip code–based service area.

Beneficiaries who are enrolled in PACE or have elected hospice will not be eligible for alignment to a GUIDE Participant because PACE and hospice services overlap significantly with the services that will be provided under the GUIDE Model. Once a beneficiary is found to be ineligible for GUIDE, GUIDE Participants should not bill the model G-codes for that beneficiary.

2.4 Existing Beneficiary Alignment

At the beginning of the first model performance year, GUIDE Participants will be required to offer their eligible patients, who reside in the GUIDE Participant's zip code–based service area, the opportunity to voluntarily align to the GUIDE Participant and join the model. GUIDE Participants must complete an initial comprehensive assessment visit for beneficiaries that may be eligible for the GUIDE model. For those beneficiaries who consent, GUIDE Participants will submit a Patient Assessment and Alignment Form to CMS via the CMS.gov ePortal. If a beneficiary who was receiving dementia care services from a GUIDE Participant before the start of the model chooses not to voluntarily align initially, they could still choose to voluntarily align at a later time.

Beneficiary alignment will occur on a rolling, ongoing basis for the first 7 years of the GUIDE Model (July 1, 2024–June 30, 2031). GUIDE Participants will be encouraged to meet a minimum threshold of 200 aligned beneficiaries by the end of their second performance year and maintain this alignment level throughout the rest of the Model Performance Period. Beneficiaries will remain aligned to the GUIDE Participant until they become ineligible. For example, an aligned beneficiary would be deemed ineligible if they no longer meet one of the beneficiary eligibility requirements or stop receiving model services from the GUIDE Participant (e.g., they move out of the program service area, they no longer wish to be aligned to the GUIDE Participant, they cannot be contacted); see Section 2.11 for more detail.

2.5 GUIDE Initial Comprehensive Assessment Visit

After a potential eligible beneficiary is identified, the next step is for the GUIDE Participant to schedule the person with dementia, or suspected dementia, for an initial comprehensive assessment. The GUIDE Participant may choose to do an initial prescreening call to rule out beneficiaries who are ineligible for the GUIDE Model, but this is not required. During the initial comprehensive assessment, the GUIDE Participant's interdisciplinary care team will assess the beneficiary and their caregiver (if applicable) across required domains, including cognitive function, functional status, clinical needs, behavioral and psychosocial needs, and caregiver burden, with the goal of confirming a dementia diagnosis and creating a comprehensive care plan.

2.6 Comprehensive Assessment Billing for GUIDE Beneficiaries

If CMS finds the beneficiary eligible for alignment to the GUIDE Participant, the GUIDE Participant should submit a claim for the DCMP (see Section 3) and not bill CMS separately for services provided in the comprehensive assessment. The comprehensive assessment (and any reassessments) is covered by the DCMP.

If the interdisciplinary care team assesses a beneficiary or refers a beneficiary for additional diagnostic testing and determines that the beneficiary does not have dementia or otherwise qualify for the GUIDE Model, the GUIDE Participant can bill for an appropriate Medicare-covered professional service that corresponds to the services rendered (such as Current Procedural Terminology code 99483).

2.7 Dementia Diagnosis Attestation

Beneficiaries must have dementia to be eligible for alignment to a GUIDE Participant but may be at any stage of dementia—mild, moderate, or severe (note that mild cognitive impairment is not a dementia diagnosis and is not sufficient to meet this eligibility criterion). To confirm that beneficiaries have dementia that makes them eligible for the GUIDE Model, CMS will rely on clinician attestation rather than prior claims-based ICD-10 dementia diagnosis. A practitioner on the GUIDE Participant's GUIDE Practitioner Roster must attest that, based on their comprehensive assessment, beneficiaries meet the National Institute on Aging-Alzheimer's Association diagnostic guidelines for dementia[5] and/or the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-5) diagnostic guidelines for major neurocognitive disorder.[6] Alternatively, they may attest that they have received a written report of a documented dementia diagnosis from another Medicare-enrolled practitioner. This attestation occurs at the time the Patient Assessment and Alignment Form is submitted to the CMS.gov Enterprise Portal (ePortal). The text of the Patient Assessment and Alignment Form can be found in Appendix F. At the time of billing, an ICD-10 diagnosis code for dementia will need to be recorded on the claim (see Appendix B for a list of acceptable diagnosis codes).

During the initial comprehensive assessment, if the interdisciplinary care team determines that the beneficiary may be eligible to be aligned and wishes to be aligned to the GUIDE Participant, then the care team obtains the beneficiary's consent to voluntarily align to the GUIDE Participant. Appendix E provides an example of a Consent to Check for Eligibility for GUIDE Model form that GUIDE Participants may, but are not required to, use for the purpose of recording the beneficiary's consent. If the beneficiary, or their legal representative if applicable,[7] consents, the GUIDE Participant will electronically submit a Patient Assessment and Alignment form to CMS.

2.8 CMS Eligibility Check

The GUIDE Participant should submit a completed Patient Assessment and Alignment form to CMS using the Health Data Reporting (HDR) application accessed via the CMS.gov Enterprise Portal (ePortal). CMS will provide access to the ePortal—a secure, browser-based, centralized point of entry—to Participants prior to model launch along with detailed instructions on how to use applications housed within the portal. To allow Participants to submit multiple beneficiaries for eligibility and alignment checks at one time, CMS will provide GUIDE Participants with an Excel spreadsheet template to populate beneficiary-level data contained in the Patient Assessment and Alignment form for transmission to CMS. Participants will upload the Excel

[5] 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.

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

[7] If the GUIDE Participant finds that the beneficiary lacks capacity to consent to voluntarily align to a participant, the GUIDE Participant will identify and recognize the beneficiary's legal representative, if any, who has the authority to make health care decisions for the beneficiary (e.g., health care power of attorney, court-appointed legal guardian), and obtain the legal representative's consent, acting on behalf of the beneficiary, to voluntarily align the beneficiary to the GUIDE Participant. The GUIDE Participant will record such legal representative's authority to make health care decisions for the beneficiary by keeping a copy of the respective court order, medical power of attorney, or other relevant document granting the legal representative's authority in the beneficiary's file.

template to the HDR system. CMS will analyze uploaded information, such as beneficiary name, Medicare Beneficiary Identifier (MBI), and date of birth, to decide whether the beneficiary can be aligned to the GUIDE Participant. CMS will communicate the alignment decision to Participants via applications located in the CMS.gov ePortal.

Within 45 days of CMS notifying the GUIDE Participant that a beneficiary is eligible and has been aligned to the GUIDE Participant, the Participant must provide the GUIDE Beneficiary with written notice that the GUIDE Beneficiary has been voluntarily aligned to the GUIDE Participant. Such written notice may be provided to the GUIDE Beneficiary in person, via postal mail, via email, or via patient portal or other similar technology application. An example template letter can be found in Appendix D.

2.9 Model Tiers

CMS will assign GUIDE Beneficiaries to one of five "model tiers," based on a combination of their disease stage, whether they have a caregiver, and if applicable, the degree of burden their caregiver is experiencing. Beneficiary and caregiver complexity, and correspondingly, care intensity and payment, will increase by tier. See **Exhibit 4** for a description of the five tiers.

To ensure consistent beneficiary assignment to tiers across GUIDE Participants, the GUIDE Participant must use a tool from a set of approved screening tools to measure dementia stage and caregiver burden. The approved measurement tool set will include two tools to report dementia stage—the Clinical Dementia Rating (CDR)[8] and the Functional Assessment Screening Tool (FAST)[9]—and one tool to report caregiver strain, the Zarit Burden Interview (ZBI).[10] **Exhibit 4** shows how these tools correspond to model tiers. CMS may add to the approved measurement tool set throughout the course of the GUIDE Model. While these are the specified screening tools that CMS requires for model tiering, GUIDE Participants may also use other assessment tools necessary to meet the care delivery requirements.

The GUIDE Participant will administer the approved screening tools during the comprehensive assessment and submit the resulting scoring data as part of the Patient Assessment and Alignment form. In addition, the GUIDE Participant must electronically submit the individual responses to the ZBI to CMS.[11] CMS will use these data to assign beneficiaries to a model tier, per the tiering criteria outlined in **Exhibit 4**. The GUIDE Participant will be informed of a beneficiary's model tier assignment at the same time the GUIDE Participant is informed that a beneficiary is eligible and has been aligned to them.

GUIDE Participants have the option to seek CMS approval to use an alternative screening tool in place of the CDR or FAST by submitting to CMS the proposed alternative screening tool, published evidence that it is valid and reliable, and a crosswalk for how it corresponds to the GUIDE Model's tiering thresholds. CMS will approve or reject the use of the proposed

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

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

[10] 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.

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

alternative screening tool(s) within 90 days of CMS receiving the GUIDE Participant's submission. CMS reserves the right to reject a proposed screening tool for any reason. The GUIDE Participant may not submit scoring data on the Patient Assessment and Alignment form for a proposed alternative screening tool until the Participant receives written notice from CMS that CMS approves the use of the alternative scoring tool.

Exhibit 4: Model Tiers

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

Note: *CMS will use the model tiers to determine the base DCMP rate and whether the beneficiary is eligible to receive respite care. Section 3 provides further detail on tiering.

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

2.10 Reassessments

The GUIDE Participant is required to perform a Comprehensive Assessment for aligned beneficiaries at least once every 365 days. Completing and submitting annual or semi-annual Comprehensive Assessments serve two purposes: (1) they are the mechanism by which CMS gathers data on GUIDE Beneficiaries for use in evaluating GUIDE Participants' performance (see Section 7) and the model as a whole, and (2) they are the avenue by which GUIDE Participant's share updated information that may impact the GUIDE Beneficiary's tier and thus the amount the Participant is paid. GUIDE Participants will have the discretion to complete assessments for beneficiaries more frequently than annually; however, Comprehensive Assessments to determine model tiering and payment will only be accepted at most once every 180 days. The GUIDE Participant will submit Comprehensive Assessment results to CMS using the Patient Assessment and Alignment Form functionality in the HDR application within the CMS.gov ePortal. CMS will provide further details on the reassessment process in the coming months.

2.11 Beneficiary Removal from Alignment File

A GUIDE beneficiary will be “unaligned” from a GUIDE Participant if any of the following occur:

- The GUIDE Beneficiary dies.
- The GUIDE Beneficiary becomes a Long-Term Nursing Home Resident (defined as having a nursing home stay 4 months or longer that is not covered under the Medicare skilled nursing facility benefit).
- The GUIDE Beneficiary enrolls in the Medicare Hospice Benefit.
- The GUIDE Beneficiary enrolls in PACE.
- The GUIDE Beneficiary enrolls in a Medicare Advantage Plan.
- A GUIDE Practitioner attests in writing to CMS that the GUIDE Beneficiary no longer has mild, moderate, or severe dementia.
- The GUIDE Beneficiary, or their legal representative, makes a request to the GUIDE Participant to no longer receive services under the model.
- The GUIDE Beneficiary moves out of the GUIDE Participant’s zip code–based service area.
- The GUIDE Participant does not file claims for the DCMP or the GUIDE Respite Payment for the GUIDE Beneficiary for a period of 8 months.
- The GUIDE Beneficiary voluntarily aligns with another GUIDE Participant.

GUIDE Participants are required to report if the GUIDE Beneficiary no longer has dementia or makes a request to no longer receive services under the model. CMS will provide further details on the method for reporting these and similar situations in the coming months.

Once a beneficiary is no longer aligned to the model, the practitioner may not bill the DCMP or respite beginning with the calendar month following the beneficiary’s alignment end date. If the participant had an encounter with the beneficiary during the month that the beneficiary leaves the program, the participant may still bill for this beneficiary. The DCMP will not be prorated based on the length of time that the GUIDE beneficiary participates during a month.

3 Dementia Care Management Payment

The primary GUIDE Model payment is the DCMP, which is a per-beneficiary, 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 5** provides the full list of these services.

Exhibit 5: Medicare Physician Fee Schedule Services Included Under the DCMP

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	G2012, G2252
Transitional Care Management	99495-99496
Chronic Care Management	99487, 99489-99491, 99437, 99439, G0506
Principal Care Management	99424–99427
Administration of patient-focused health risk assessment (HRA)	96160
Administration of caregiver-focused HRA	96161
Depression screening	G0444
Group Caregiver Behavior Management/ Modification Training Services	96202, 96203
Caregiver Training Services under a Therapy Plan of Care established by a PT, OT, SLP	97550, 97551, and 97552
Community Health Integration Services	G0019, G0022
Principal Illness Navigation Services	G0023, G0024, G0140, and G0146
Administration of a Standardized, Evidence-based Social Determinants of Health Risk Assessment	G0136

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

The DCMP is designed to offer GUIDE Participants more flexibility to deliver personalized dementia care than is possible under traditional FFS. It will cover a more comprehensive set of services than existing care management codes, be less burdensome to bill, and enable payment to members of the interdisciplinary care team who are otherwise not eligible to bill for Medicare services. GUIDE Participants will 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 5**) may continue to be billed under traditional FFS.

CMS will use the model tier assignment described in Section 2.9 to determine: (1) the DCMP rate and (2) whether the beneficiary is eligible to receive GUIDE Respite Services. A GUIDE Participant will bill for the codes in **Exhibit 6** based on the tier.

Exhibit 6: GUIDE Monthly DCMP Base Rates for PY 2024

Patient Status	Monthly Payment Rates for Beneficiaries With Caregiver			Monthly Payment Rates for Beneficiaries Without Caregiver	
	Low Complexity Dyad Tier	Moderate Complexity Dyad Tier	High Complexity Dyad Tier	Low Complexity Individual Tier	Moderate to High Complexity Individual Tier
First 6 Months (New Patient Payment Rate)	G0519: $150	G0520: $275*	G0521: $360*	G0522: $230	G0523: $390
After First 6 Months (Established Patient Payment Rate)	G0524: $65	G0525: $120*	G0526: $220*	G0527: $120	G0528: $215

PY = performance year

* Indicate tiers that are eligible for respite care services

For example, a GUIDE Practitioner may see a beneficiary in the low complexity tier with a caregiver in the third month that the beneficiary is aligned to the GUIDE Participant. In this case, the GUIDE Practitioner should bill G0519 for that visit because as the patient is considered a new patient for the first 6six months they are aligned to the GUIDE Participant. CMS will help track beneficiary tiers for GUIDE Participants by sharing a monthly report via the CMS.gov ePortal; more details will be provided on accessing this report in June 2024.

The dollar amounts in **Exhibit 6** indicate the base rate for the respective G-codes listed. These rates will be adjusted for each beneficiary in accordance with the adjustments detailed in Section 4.

3.1 Billing for the DCMP

A GUIDE Participant may bill the correct HCPCS G-code for each GUIDE Beneficiary each month that the participant provides a GUIDE Care Delivery Service, other than the GUIDE Respite Services, to the GUIDE Beneficiary.

The GUIDE Participant is not permitted to bill an HCPCS G-code for any month that the GUIDE Participant does not provide a GUIDE Care Delivery Service to the GUIDE Beneficiary. These services need not include a clinical encounter, and are, for example, inclusive of transitional care management and medication management.

GUIDE Participants will be required to bill GUIDE-specific G-codes, including both the DCMP (see **Exhibit 6**) and Respite Services G-codes (see **Exhibit 12**), on a standalone claim with no other Healthcare Common Procedure Coding System (HCPCS) codes. Multiple GUIDE-specific G-codes may be billed on the same standalone claim, as needed. However, at most one DCMP can be billed per calendar month – that is, two or more calendar months may be billed on the same claim with service dates in separate months. All DCMP claims must include a diagnosis code listed in Appendix B.

The Date of Service (DOS) for the DCMP should be listed as the first day of the calendar month in which the GUIDE Participant or GUIDE Partner Organization provided GUIDE Care Delivery Services to the GUIDE Beneficiary or the caregiver. If a Partner Organization administers the care delivery service, the Partner Organization should record the service date and provide that information to the GUIDE Participant to bill the DCMP for that service.

If a GUIDE Participant bills the incorrect G-code for a beneficiary reflecting the incorrect tier, the claim will not be processed and will be sent back to the Participant for resubmission. GUIDE Participants should use the beneficiary alignment report, which will be available via the HDR application within the CMS.gov ePortal (more details will be provided on accessing this report in June 2024) to confirm each beneficiary's tier and corresponding G-code.

When a GUIDE Participant bills for a DCMP, the claim must include the following:

- One or more of the GUIDE-specific G-codes reflecting the beneficiary tier
- Date of Service (DOS)
  - DOS is the first day of the calendar month in which GUIDE Care Delivery Services were provided.
  - DOS must be within the effective Start and End dates for both the GUIDE Practitioner and GUIDE Beneficiary alignment records.
- GUIDE TIN and rendering NPI
  - The rendering NPI must be part of the GUIDE Participant's Practitioner Roster
- GUIDE-aligned beneficiary's Health Insurance Claim Number/MBI
- Dementia Diagnosis Code (see Appendix B) in any position
- The Servicing Facility Location
  - This should reflect the location of the GUIDE Participant or Partner staff member at the time of the contact/service. If the staff member was present at the beneficiary's home, use the beneficiary's home address.

If a claim fails to meet these requirements, or is submitted with incomplete or invalid information, it may be denied returned to the submitter as unprocessable, which may cause a delay in payment.

3.2 Beneficiary Cost Sharing

Medicare FFS beneficiaries are typically required to pay a 20% coinsurance for Medicare Part B physician services. GUIDE will waive this required 20% cost sharing for the DCMP, and Medicare will pay 100% of the DCMP amount. Participants shall not subject beneficiaries to any additional cost sharing for the DCMP or 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. Therefore, GUIDE Participants are not permitted to bill separately for these services for aligned

beneficiaries. CMS will provide GUIDE Participants who are participating in multiple CMS Innovation Center models with additional instruction related to billing these services.

For PY 2, CMS may change the codes in **Exhibit 5** at its discretion based on analysis performed in PY 1.

4 DCMP Adjustment Methodology

4.1 Performance-Based Adjustments

To incentivize high-quality care, the DCMP will be adjusted for participant performance using a performance-based adjustment (PBA). Participant performance will be assessed on five measures, focusing on patient and caregiver experience, utilization, and cost. The PBA amount, when all five quality measures are fully implemented, can range from –3.5% to +10.0% and will be applied at the participant level. This means that the same percentage amount will be applied for all beneficiaries aligned to a participant.

The PBA percentages will be calculated and provided to GUIDE Participants annually and will be applied to the DCMP for the next 12 months after their issue date.

For the period July 2024 to December 2025, and applying to Established Program Track GUIDE Participants only, the two participant-reported measures (Use of High-Risk Medications in Older Adults and Quality of Life Outcome for People with Neurological Conditions) will be scored using a pay-for-reporting methodology (see **Exhibit 7**). The survey-based measure (Caregiver Burden Measure) will not be scored because it is under development. The two claims-based measures (Total per Capita Cost and Rate of Beneficiaries with a Long-term Nursing Home Stay) will also be scored using a pay-for-performance methodology (see **Exhibit 8**). The total potential PBA based on PY 1 and applied mid-way through PY 2 will range from –1% to +6%. The total potential PBA for performance during PY 2 will range from –2.5% to +7.0% (see **Exhibit 9**). Information regarding the PBA calculation PY 3 following PY2 will be provided as it becomes available.

Exhibit 7: Pay-for-Reporting Payment Adjustments for First Year of the GUIDE Model

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

Exhibit 8: Measure Performance Categories and Associated Payment Adjustments for Utilization Domain

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

Note: CMS will release the benchmark thresholds to determine whether a Participant passes or fails a utilization domain measure before the end of PY 1.

Exhibit 9: PBA Domains, Measures, and Weights for First Year of the GUIDE Model

Domain	Domain Weight	Measure Name	Percent of total domain	Percent of total PBA	Associated PBA Potential
Care coordination and management	16%	Use of High-Risk Medications in Older Adults	100%	16%	0% – +1%
Beneficiary quality of life	34%	Quality of Life Outcome for People with Neurological Conditions	100%	34%	0% – +2%
Utilization	50%	Total Per Capita Cost	50%	25%	-0.5% – +1.5%
		Rate of beneficiaries with a long-term nursing home stay	50%	25%	-0.5% – +1.5%
				Total PBA Potential	**-1% to +6%**

4.2 Timeline for Performance-Based Adjustment Application

The GUIDE Participant's performance during a given performance year will affect their payment in future years. Specifically, the GUIDE Participant's performance will be calculated beginning 3 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 GUIDE Participant's DCMP beginning 6 months after the end of the performance year and continuing for 12 months. In other words, there is a 6-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 performance year 2 and first half of performance year 3). **Exhibit 10** demonstrates this timeline. The New Program Track will follow the same timeline but begin 1 year later.

Exhibit 10: 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 Health Equity Adjustment

To support and incentivize GUIDE Participants in providing care to historically underserved communities, a Health Equity Adjustment (HEA) will be applied to the base DCMP beginning the second year of the Model Performance Period.

The HEA is a fixed dollar amount that will be applied at the beneficiary level and will be based on the beneficiary's equity score percentile. The HEA will be calculated using a composite methodology that includes both area-level and beneficiary-level measures of deprivation. Specifically, the HEA will be composed of four measures: state and national comparison Area

Deprivation Index (ADI), which are measured at the census block group level, and Low-Income Subsidy (LIS) status and dual eligibility (DE), which are beneficiary-level measures. CMS will calculate an *Equity Score* for every beneficiary *b* and their corresponding geography *g* in the aligned population:

$$Equity\ Score_{b,g} = (0.1\ x\ National\ ADI_g) + (State\ ADI_g) + (20\ x\ LIS_b\ or\ DE_b)$$

In the formula, *National* ADI_g is the ADI national percentile of the census block group the beneficiary resided in on their first day of eligibility and can range from 1 to 100. *State*ADI_g is the ADI state decile of the census block group the beneficiary resided in on their first day of eligibility and can range from 1 to 10, corresponding to the state decile. LIS_b represents LIS status and is equal to 1 if the beneficiary receives the LIS and 0 otherwise. Similarly, DE_b represents dual eligibility and is equal to 1 if the beneficiary is dually eligible and 0 otherwise.

The possible range of health equity scores is from 0 to 40. In the case of a maximum score, a beneficiary's National ADI would contribute 25%, State ADI would contribute 25%, and LIS or DE status would contribute 50% to the overall score. CMS may revisit this weighting at its discretion.

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

This adjustment methodology is designed to provide a material incentive for GUIDE Participants to care for underserved beneficiaries and to be budget neutral while limiting the magnitude of any downward adjustments. CMS may elect to add other measures to the GUIDE Model's HEA in future performance years. **Exhibit 11** shows how health equity scores are translated into an adjustment to the monthly DCMP.

Exhibit 11: Equity Score Percentiles and Associated Health Equity Adjustment

Equity Score Percentile	Health Equity Adjustment to DCMP
≥ 80 percentile of beneficiaries	+$15
51–79 percentile of beneficiaries	$0
0–50 percentile of beneficiaries	−$6

4.4 Medicare Economic Index Measures

To account for cost growth over time, the GUIDE DCMP base rates will be adjusted by the Medicare Economic Index (MEI). The MEI is a measure of inflation faced by physicians with respect to their practice costs and general wage levels. The MEI includes a bundle of inputs used in furnishing physicians' services such as physician's own time, nonphysician employees' compensation, rents, and medical equipment. The MEI measures year-to-year changes in prices for these various inputs based on appropriate price proxies. The MEI has already been accounted for in the PY 2024 DCMP amounts. Additional information regarding the MEI can be

found on the CMS webpage for Market Basket Data. To see MEI for current and past years, download the ZIP file and open the excel file.

4.5 Geographic Adjustment

To account for geographic variation in costs, CMS will adjust the DCMP base rates by the Medicare PFS Geographic Adjustment Factor[12] (GAF) for each DCMP claim submitted by a GUIDE Participant. The GAF applied to the DCMP is a weighted geographic adjustment based on all services in the Medicare PFS. It summarizes the combined impact of the 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 GAF is intended to ensure that the Medicare program does not overpay GUIDE 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. GUIDE Participants should be aware that geographic adjustment to each DCMP claim will be based on the Service Facility Zip Code submitted on the claim form. In the case of services provided at a beneficiary's home, the Service Facility Location should be the beneficiary's home. As a result, a given Participant may be subject to different geographic adjustments if they serve beneficiaries across multiple localities. While the other adjustments listed in this section will not be applied in PY 1, the GAF will begin to apply to the DCMP and respite base rates immediately. For examples of how to calculate the GAF, see Section 4.6 and Appendix C.

4.6 Payment Examples with Adjustments

The first two payment examples in **Exhibit 12** show how total GUIDE Model payments will be calculated for an individual-aligned beneficiary over the course of a full performance year. The third example shows how total GUIDE Model payments will be calculated for a GUIDE Participant's total aligned beneficiary population. The examples assume that all beneficiaries are newly aligned in the first month of the performance year and therefore are eligible for the new patient DCMP rate for the first 6 months of the year and the established patient DCMP rate for the next 6 months. All examples are assumed to occur after the PBA and HEA are fully phased in but reflect the current base rate and do not account for future MEI updates.

In the first example, the beneficiary is in a tier that is eligible for GUIDE Respite Services, and the example assumes that the beneficiary reaches the respite cap for the year. In the second example, the beneficiary is in a tier that is not eligible for GUIDE Respite Services. The third example assumes that all beneficiaries eligible for GUIDE Respite Services reach their respite cap for the year. Examples are rounded to the nearest dollar.

[12] Updated GAF amounts are published annually as part of the Medicare Physician Fee Schedule Final Rule Addenda: https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/pfs-federal-regulation-notices

Exhibit 12: Payment Examples

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

Jane Smith
Lives in Miami, FL

Moderate Complexity, Caregiver Tier:
New Patient DCMP rate: **$275**
Established Patient DCMP Rate: **$120**

GAF for Miami, FL: **1.067**
GUIDE Participant's PBA: **4%**
Mrs. Smith's HEA: **+$15**

	Step 1: Geographically Adjust DCMP	**Step 2:** Apply PBA	**Step 3:** Apply HEA	**Step 4:** Calculate total for 6 months
First 6 months:	$275 X 1.067 = **$293**	$293 X 1.04 = **$305**	$305 + $15 = **$320**	$320 X 6 = **$1,920**
Next 6 months:	$120 X 1.067 = **$128**	$128 X 1.04 = **$133**	$133 + $15 = **$148**	$148 X 6 = **$888**

Total Annual DCMP.....$2,808

Step 5: Geographically Adjust Respite Cap — $2,500 x 1.067 = **$2,668**

Total Annual DCMP and Respite.....$5,476

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

Jack Johnson
Lives in Phoenix, Arizona

Moderate/Severe Complexity, No Caregiver Tier:
New Patient DCMP rate: **$390**
Established Patient DCMP Rate: **$229**

GAF for Phoenix, AZ: **0.973**
GUIDE Participant's PBA: **7%**
Mr. Johnson's HEA: **-$6**

	Step 1: Geographically Adjust DCMP	**Step 2:** Apply PBA	**Step 3:** Apply HEA	**Step 4:** Calculate total for 6 months
First 6 months:	$390 X 0.973 = **$379**	$379 X 1.07 = **$406**	$406 - $6 = **$400**	$ 400 X 6 = **$2,400**
Next 6 months:	$215 X 0.973 = **$209**	$209 X 1.07 = **$224**	$224 - $6 = **$218**	$218 X 6 = **$1,308**

Total Annual DCMP.....$3,708

Payment Example #3: Dementia Care Program

Dementia Care Program
Located in Philadelphia, PA

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

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

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

5 GUIDE Respite Payments

To alleviate caregiver burden, beneficiaries in the moderate and high complexity tiers and who have a caregiver will be eligible for three types of respite services covered by the GUIDE Model:

1. Respite services provided in the beneficiary'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

Beneficiaries in either the moderate or high complexity dyad tiers will be eligible for Respite Services under the GUIDE Model (See **Exhibit 4**). GUIDE Participants will have some flexibility in the type of services that they make available to beneficiaries. The model requires providing, or contracting with a Partner Organization to provide, in-home respite services. However, GUIDE Participants have the option, and are not required, to make available respite through an adult center or a 24-hour facility. **Exhibit 13** shows the base rate per service unit for the three settings in which respite services can be provided.

Exhibit 13: Respite Service G-codes

Respite Services Setting	G-Code	Service-Unit	Base Rate
In Home	G0529	4-hour unit	$120
Adult Day Center	G0530	8-hour unit	$78
Facility Based	G0531	24-hour unit	$260

The in-home respite G-code G052952 will cover a 4-hour unit of service and be paid at $120; the adult day respite G-code G0530 will cover an 8-hour unit paid at $78; the facility-based respite G-code G0531 will cover a 24-hour unit paid at $260. The GUIDE Participant can bill as many or as few of the codes as needed for an eligible beneficiary, up to a per-beneficiary annual cap of $2,500.[13]

GUIDE Participants are responsible for managing the available funds for respite services and alerting beneficiaries when they are at their cap. Providers may continue to recommend respite outside of the GUIDE Model when respite funds are expended, but respite services beyond the $2,500 cap will not be covered by GUIDE Model payments.

The respite services base rates will be calculated annually and will be adjusted to account for geographic variation in costs and inflation over time in prices. The payment will be geographically adjusted using the same PFS GAF that will be used to adjust the DCMP (See Section 4.5). The inflation adjustment will be determined using the Home Health Agency market basket update less the productivity adjustment. This is a metric utilized in the Home Health Prospective Payment System to measure cost growth for home health agencies. Additional information regarding the Home Health Agency market basket and productivity adjustment can be found on the CMS webpage for Market Basket Data. To see the market basket update and

[13] The GUIDE respite allotment of $2,500 per year equates to roughly 83 hours of in-home GUIDE Respite Services per year, paid at a rate of $30 per hour. If the GUIDE respite allotment were used solely at an adult day center, it would cover 32 days of adult day per year; if it were used solely for facility-based care, it would cover roughly 10 days of facility-based care per year.

productivity adjustment, download the Actual Regulation Market Basket Update ZIP file and open the Excel file.

5.1 Beneficiary Cost-Sharing for Respite Services

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

If a beneficiary aligns to the GUIDE Model starting during the calendar year, they will receive the full $2,500 for the rest of the performance year. The GUIDE Model does not prorate the annual cap.

5.2 Billing and Payment for GUIDE Respite Services

Three new respite G-codes were created for the GUIDE Model, one for each setting of care (in home, adult day, and facility based), as described in **Exhibit 13** the GUIDE Participant will bill for GUIDE Respite Services by submitting claims using these new respite G-codes. Respite payments will not be made on a claim-by-claim basis; instead, CMS will aggregate the respite payments and make one monthly respite payment for all GUIDE Respite Services billed in the preceding month.

GUIDE Participants can bill as many or as few of the codes as needed for an eligible beneficiary, up to a per-beneficiary annual cap of $2,500. To help the GUIDE Participant track progress toward the annual cap, CMS will provide the GUIDE Participant with a monthly payment report via CMS.gov ePortal showing the amount of GUIDE Respite Services that each aligned beneficiary has used in the year to date.

The GUIDE Participant must bill for all GUIDE Respite Services rendered to aligned beneficiaries. If the GUIDE Participant provides GUIDE Respite Services by contracting with a Partner Organization, the GUIDE Participant must pay the Partner Organization the full amount of the payment from CMS to the GUIDE Participant for GUIDE Respite Services.

As with the DCMP, the GUIDE Participant will be required to bill GUIDE Model claims on a stand-alone claim with no other HCPCS codes (aside from other GUIDE Model claims) and to include at least one dementia diagnosis code from Appendix B. Respite Services claims for beneficiaries not falling in the moderate or high complexity dyad tiers will be denied.

The DOS for respite services should be the date on which a GUIDE Practitioner or Partner provides GUIDE Respite Services to the beneficiary. GUIDE Participants may bill the respite codes for eligible beneficiaries on an ad hoc basis until the beneficiary reaches the $2,500 cap. **Exhibit 14** shows a sample claim for GUIDE Respite Services calculated over one month. This illustrative exhibit is intended to give applicants a baseline understanding of how the respite payments will be calculated.

Exhibit 14: Billing for GUIDE Respite Services

Date of Service	Type of Care	Units	Price
07/01/2024	In-home care: 4-hour unit	4 hours (1 unit)	$120
07/24/2024	In-home care: 4-hour unit	4 hours (1 unit)	$120
07/28/2024–07/29/2024	Facility: 24-hour unit	48 hours (2 units)	$520
Totals for July 2024:		**56 hours**	**$760**

Note: Beneficiary has a caregiver and is in the moderate or high complexity tier. This claim is for one month's worth of GUIDE Respite Services.

To determine the amount of the GUIDE respite payment available for the GUIDE Participant to furnish the GUIDE Respite Services under the GUIDE Model for the rest of the performance year, use the following calculation: $2,500 − $760 = $1,740.

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

6 Infrastructure Payment

6.1 Safety Net Providers

In addition to technical assistance and support, GUIDE Participants in the New Program Track that CMS determined qualify as GUIDE safety net providers are eligible to receive an Infrastructure Payment to cover some of the upfront costs of establishing a DCP. CMS notified applicants whether they were eligible for the infrastructure payment in April 2024.

The Infrastructure Payment is a one-time payment of $75,000 made in quarter 4 of calendar year 2024. The payment will be geographically adjusted using the same PFS GAF that will be used to adjust the DCMP. The GAF adjustment will correspond to the state and county GAF associated with the main address for the GUIDE Participant provided in the application package.

6.2 Allowed Uses

The Infrastructure Payment is intended to assist GUIDE Participants in the New Program Track that qualify as safety net providers with efforts falling 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.

Infrastructure Payment funds may be used for costs in only these four categories. GUIDE Participants will be required to submit a Spend Plan to CMS in June 2024 describing how they intend to use infrastructure funds. Additionally, GUIDE Participants will be required to submit a Spend Report annually as part of care delivery reporting, beginning with the New Program Track's first performance year, until there are no unspent infrastructure funds.

6.3 Reconciliation of Infrastructure Payment

GUIDE 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. GUIDE 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. GUIDE Participants withdrawing after June 2027 will not be required to repay the Infrastructure Payment. GUIDE 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.

7 Performance Measurement

CMS will adjust GUIDE Participants' monthly DCMP based on the GUIDE Participant's performance on a set of performance metrics that aligns with the GUIDE Model's goals. Thus, GUIDE Participants will be financially rewarded for achieving or exceeding the established benchmarks and held accountable for poor performance.

In addition to existing quality measures, CMS will also develop a new quality measure to assess GUIDE Participant performance on improvements in caregiver burden. This measure is currently in development and is targeted for implementation in GUIDE Model performance evaluation starting in 2026 or later and, as a result, will not factor into performance measurement for the first years of the GUIDE Model.

Each of the GUIDE Model's five performance measures will be used to adjust GUIDE Participants' monthly DCMP payments. **Exhibit 15** provides an overview of the five measures and their corresponding domains. For further details on the measures, see the Quality Measure Manual, which will be available in June 2024.

Exhibit 15: GUIDE Performance Measures

Measure Name	Domain	MIPS, CBE Measure?	Measure Type and Reporting/ Calculation Method
Use of High-Risk Medications in Older Adults (HRRx)	Care coordination and management	MIPS: Yes, #238 CBE: Yes, #0022	Process Measure, reported through CMS.gov ePortal annually
Quality of Life Outcome for People with Neurological Conditions (QoL)	Beneficiary quality of life	MIPS: Yes, #AAN22 CBE: No	Patient Reported Outcoming Measure (PROM), reported through CMS.gov ePortal on a rolling basis
Caregiver Burden (CB)	Caregiver support	MIPS: No CBE: No	PROM based on caregiver responses, reported through CMS.gov ePortal on a rolling basis
Total Per Capita Cost (TPCC)	Utilization	MIPS: Yes CBE: Yes, #3575	Utilization Measure Claims-based, calculated by CMS
Rate of Beneficiaries Entering a Long-Term Nursing Home (LTNH)		MIPS: No CBE: No	Utilization Measure Claims and Assessment-based, calculated by CMS

MIPS = Merit-Based Incentive Payment System; CBE = Consensus-Based Entity

Each measure is associated with a minimum and maximum potential PBA percentage amount that GUIDE Participants can earn (see Section 4.1).

Appendix A: Glossary of Terms

Acronym	Definition
ADI	Area Deprivation Index
CB	Caregiver Burden Measure
CBE	Consensus-Based Entity
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
CQM	Clinical Quality Measure
DCMP	Dementia Care Management Payment
DCP	Dementia Care Program
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
HEA	Health Equity Adjustment
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 Beneficiaries 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

Acronym	Definition
PY	Performance Year
QoL	Quality of Life Outcome for People with Neurological Conditions Measure
SSP	Shared Savings Program
TIN	Taxpayer Identification Number
TPCC	Total Per Capita Cost

Appendix B: Diagnostic Codes for the DCMP

The GUIDE Participant must attach an eligible ICD-10 dementia diagnosis code to each DCMP claim for it to be paid; DCMP claims without an eligible ICD-10 diagnosis code will be denied. To support accurate billing, CMS will provide each GUIDE Participant with a monthly beneficiary alignment file that lists all the beneficiaries aligned to that GUIDE Participant, their model tier assignment, and the length of their alignment to the GUIDE Participant.

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
F02.A18	Dementia in other diseases classified elsewhere, mild, with other behavioral disturbance

ICD-10 Dementia Codes	ICD-10 Dementia Code Definition
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
F03.C11	Unspecified dementia, severe, with agitation

ICD-10 Dementia Codes	ICD-10 Dementia Code Definition
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

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

State	Locality Number	Locality Name	2024 GAF	GAF + Low Complexity Dyad Tier	GAF + Moderate Complexity Dyad Tier	GAF + High Complexity Dyad Tier	GAF + Low Complexity Individual Tier
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
CA	56	Fresno	1.031	$154.65	$283.53	$371.16	$237.13
CA	57	Hanford-Corcoran	1.031	$154.65	$283.53	$371.16	$237.13
CA	58	Madera	1.031	$154.65	$283.53	$371.16	$237.13
CA	59	Merced	1.031	$154.65	$283.53	$371.16	$237.13

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

Appendix D: Example 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 beneficiary 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: 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 F: GUIDE Patient Assessment and Alignment Form

Results from (check one):

□ Initial Assessment

If Initial Assessment, is this patient an existing patient of the practice or a new patient?

- □ Existing patient
- □ New patient

If Initial Assessment, provide patient referral source:

- □ Referred by a health care provider
- □ Referred by a community-based organization
- □ Self-referral

□ Re-assessment

If re-assessment, provide reason:

- □ Annual re-assessment
- □ Re-assessment due to change in severity of patient's dementia
- □ Re-assessment due to change in caregiver status

If re-assessment due to change in caregiver status, please specify reason for change:

- □ New primary caregiver
- □ Loss of caregiver so patient is without a caregiver
- □ Patient change in residence
- □ Other _____

Date of current assessment: _____

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

Patient address: _____
(Participant confirms the beneficiary resided within your zip code service area)

Patient email:_____ Patient phone number:_____ □ Check if mobile/cellular phone

Patient resides in: ____private residence ____assisted living facility ____memory care program (excludes nursing home level of care) □ check box to confirm patient is not a long-term nursing home resident

Patient date of birth: ___/___/_____

Patient Medicare Beneficiary Identifier: _____

Patient Medicaid ID number: _____ (if applicable)

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

PROMIS-10: ____ (enter numerical score)

Does the patient have a primary care provider: __Yes __No
If Yes, Name of primary care provider:_____
Phone number of primary care provider:_____

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

If yes:

Primary caregiver first name: _____ Primary caregiver last name: _____

Primary caregiver address:_____ Primary caregiver email:_____

Primary caregiver phone number: _____ □ Check if mobile/cellular phone

Primary caregiver date of birth:__/__/____

Primary caregiver gender: (Drop-down menu: Male, Female, Declined to identify)

Primary caregiver race/ethnicity: (Drop-down menu: White, Black or African American, Hispanic or Latino, American Indian or Alaska Native, Asian, Native Hawaiian or Other Pacific Islander, Declined to report)

What is primary caregiver's relationship to patient? (Drop-down menu: spouse, domestic partner, daughter, son, sibling, other family member, friend, other non-family member)

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

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

If yes, please list the primary caregiver's Medicare Beneficiary Identifier: _____

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

How long has the primary caregiver been in their caregiver role?
(enter length of time in months and years) ____months ____years OR □ Unsure/cannot recall

In my clinical judgment, the assessed 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 I have received a written report (electronic or hard-copy) of a documented dementia diagnosis from another Medicare qualified health professional.

- □ Yes, the 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
- □ Yes, I received a written report of a documented dementia diagnosis
- □ No, I cannot attest to either statement

Attesting clinician:

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

National Provider Identification (NPI) number of attesting clinician: _____

GUIDE Model Participant Taxpayer Identification Number (TIN) _____