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Guiding an Improved Dementia Experience Model

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
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What's Changed?

- 330 organizations are currently participating in the Guiding an Improved Dementia Experience (GUIDE) Model (page 3)
- We added:
  - Details to the GUIDE participant's required responsibilities (page 3)
  - The target patients for the model are community-dwelling Medicare patients living with dementia (page 4)
  - Services covered under the Dementia Care Management Payment (page 4)
- We replaced the previous adjustment factor with a population and income adjustment (page 4)
- We specified:
  - The service facility's ZIP code will determine the geographic adjustment factor we apply (page 4)
  - The conditions in which we assign patients to a model tier (page 5)
- The annual cap for GUIDE respite services in performance year 2025 is $2,563 per patient (page 6)
- We clarified that participants may bill for multiple calendar months on the same GUIDE claim (page 6)
- We clarified billing criteria (page 7)

Substantive content changes are in dark red.

The Guiding an Improved Dementia Experience (GUIDE) Model is an 8-year voluntary national model that began on July 1, 2024. The model offers:

- A standardized approach to comprehensive dementia care
- 24/7 access to an interdisciplinary care team member or help line
- Caregiver education and support services, including respite services

What Are the Model's Goals?

- Improve quality of life for people living with dementia
- Reduce burden and strain on their caregivers
- Reduce hospital, emergency department, and post-acute care use
- Reduce Medicare and Medicaid spending by preventing or delaying long-term nursing home stays

Which Providers Can Participate in the Model?

The application and selection period to participate in the model has ended. We announced the 330 organizations participating in the model and published the GUIDE Participant List. We selected participants for 2 program tracks—1 for established dementia care programs (DCPs) and 1 for new DCPs. Participants in the established program track began on July 1, 2024, while participants in the new program track had a 1-year pre-implementation period and then began their performance on July 1, 2025.

There are currently 330 GUIDE Model participants, including 89 in the established program track and 241 in the new program track.

Participants are:

- Medicare Part B-enrolled providers or suppliers (excluding DME and laboratory suppliers)
- Eligible to bill for Physician Fee Schedule (PFS) services under a single Part B-enrolled Taxpayer Identification Number (TIN)

In the model, we require participants to:

- Provide care through an interdisciplinary team. This includes a care navigator and a clinician with dementia proficiency who's eligible to bill Part B evaluation and management services.
- Meet the model's care delivery requirements. Participants may contract with CMS-approved partner organizations to deliver GUIDE services.
- Maintain a GUIDE practitioner roster that includes the NPIs of individual Medicare-enrolled physicians and other non-physician practitioners who have reassigned their billing rights to the participant's TIN to participate in the model.

Who Are the Target Patients for the Model?

The model serves community-dwelling Medicare Fee-for-Service (FFS) patients living with dementia. This includes people who are dually eligible for Medicare and Medicaid. We encourage each participant to voluntarily align a minimum of 200 Medicare FFS patients by the end of their second performance year (PY). Participants will inform patients about the model and get their consent to receive services under the model.

How Do We Pay the Model's Participants?

We'll pay participants a per-patient per-month amount known as a dementia care management payment (DCMP). The DCMP covers certain services, including:

- Comprehensive assessments and care planning
- Home visits
- 24/7 access for caregivers
- Ongoing monitoring and support
- Care coordination and transitional care management
- Referral to and coordination of community-based services
- Medication management and reconciliation
- Caregiver training, education, and support

We'll adjust the DCMP rates by a population and income adjustment (PIA) and a performance-based adjustment (PBA) to provide an incentive for high-quality care. The PIA and PBA adjustments won't start until each track's second PY.

We also pay for a defined amount of respite services for patients who meet certain eligibility criteria and have an unpaid primary caregiver.

We'll adjust the DCMP and respite service base rates by the Medicare PFS Geographic Adjustment Factor (GAF) for each DCMP and respite service claim you submit to account for geographic variation in costs. GAFs are a weighted composite of each PFS locality's geographic practice cost index, which includes physician work, practice expenses, and malpractice insurance. We apply GAFs to each DCMP and respite service claim based on the claim's service facility ZIP code.

DCMP G-Codes

You'll submit claims for the monthly DCMP using a set of 10 G-codes based on the patient's model tier. We assign model tiers based on information you provide from the GUIDE comprehensive assessment. Each model tier has a different DCMP base rate to reflect that covered services and care intensity vary across tiers. We'll base a patient's model tier assignment on:

- Whether the patient is part of a patient-caregiver pair
- The severity or complexity of the patient's dementia
- The complexity of the caregiver's burden (if applicable)
- The patient's residence type
- Whether the patient is within their first 6 months of participating in the model or has been in the model for more than a 6-month period

Table 1. DCMP Codes for Patients with a Caregiver

Patient Status	Low Complexity Dyad Tier	Moderate Complexity Dyad Tier	High Complexity Dyad Tier
First 6 months (new patient)	G0519	G0520	G0521
After first 6 months (established patient)	G0524	G0525	G0526

Table 2. DCMP Codes for Patients without a Caregiver

Patient Status	Low Complexity Dyad Tier	Moderate to High Complexity Dyad Tier
First 6 months (new patient)	G0522	G0523
After first 6 months (established patient)	G0527	G0528

GUIDE Respite Service G-Codes

There are 3 G-codes, G0529–G0531, for billing GUIDE respite services, one for each setting of respite care you use.

Table 3. GUIDE Respite Service Codes

HCPCS Code	Description
G0529	In-home respite care, 4-hour unit
G0530	Adult day center, 8-hour unit
G0531	Facility-based respite, 24-hour unit

You'll bill GUIDE respite services on an ad hoc basis to your MAC for certain eligible patients. The annual cap for PY 2025 is $2,563 per patient. We'll aggregate and pay monthly for all qualifying GUIDE respite services through the Innovation Payment Contractor, a CMS-contracted entity.

How Do the Model's Participants Submit Claims?

You must bill GUIDE-specific G-codes, including both the DCMP and GUIDE respite service G-codes, on a standalone claim with no other HCPCS codes. You may bill multiple GUIDE-specific G-codes on the same standalone claim, as needed. In other words, you can include multiple calendar months on the same claim if the service dates were in separate months. All DCMP claims must include a diagnosis code in the ICD-10 list in Appendix D of change request (CR) 13412. You'll submit GUIDE claims using the CMS-1500 claim form or the electronic equivalent.

If you submit a GUIDE claim with other HCPCS codes, or with incomplete or invalid information, your MAC won't process it and will return the claim to you for resubmission. You should continue to bill HCPCS codes for all other non-GUIDE services delivered to GUIDE patients on other claims as you normally do under Original Medicare (also called FFS Medicare). Don't include the A6 demonstration code on claims that aren't for GUIDE services.

> Normal FFS detail lines, any other demonstration codes, and demonstration detail lines should never be on a GUIDE model claim. GUIDE model claims are standalone claims. Only detail lines with GUIDE Model HCPCS codes should be on GUIDE model claims.

GUIDE payments won't include a non-physician practitioner's payment reduction. We're also waiving patient coinsurance and deductible payments on DCMP and GUIDE respite services under the model; we'll pay 100% of the allowed amount. Unless noted, GUIDE claims are subject to all other adjustments, like sequestration, and policies applicable to other FFS claims. Your MAC will verify patient and provider eligibility for claims you submit with GUIDE HCPCS codes.

Billing Criteria for DCMP Claims

Criteria for patient eligibility and alignment include claims that:

- Are for a patient in the GUIDE patient alignment file, identified by their MBI
- Are for an appropriate date of service (DOS) within effective patient alignment
- Contain a dementia diagnosis code from Appendix D of CR 13412
- Contain the correct DCMP G-code for the patient's model tier

Criteria for provider eligibility and alignment include:

- The rendering NPI must be on the GUIDE practitioner roster on the DOS on the claim
- The participant's GUIDE TIN is the Federal Tax Identification (ID) Number on the claim

You may only bill for the DCMP once per calendar month per patient.

Billing Criteria for GUIDE Respite Service Claims

Criteria for patient eligibility and alignment include claims that:

- Are for a patient in the GUIDE patient alignment file, identified by their MBI
- Are for an appropriate DOS within effective patient alignment
- Are for a patient eligible for GUIDE respite services based on their model tier
- Contain a dementia diagnosis code from Appendix D of CR 13412

> Only patients with an unpaid primary caregiver in moderate to high complexity dyad tiers are eligible for GUIDE respite services.

Criteria for provider eligibility and alignment include:

- The rendering NPI must be on the GUIDE practitioner roster on the DOS on the claim
- The participant's GUIDE TIN is the Federal Tax ID Number on the claim

We may retroactively add or remove GUIDE participating providers and patients. Your MAC may reprocess related claims with a retroactive effective date, debiting or crediting payments, as necessary.

Resources

- CR 13412
- GUIDE Model FAQs
- GUIDE Model Overview Fact Sheet
- GUIDE Payment Methodology Paper