DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Centers for Medicare & Medicaid Services

DATE: August 2, 2023

TO: All Medicare Advantage Organizations

FROM: Sarah Fogler, Ph.D., Acting Director, Patient Care Models Group, Center for Medicare & Medicaid Innovation

SUBJECT: Information regarding the Center for Medicare & Medicaid Innovation's GUIDE model

The Center for Medicare & Medicaid Innovation (Innovation Center) developed the Guiding an Improved Dementia Experience (GUIDE) model through its authority under section 1115A of the Social Security Act.[1] The Innovation Center designed GUIDE with support of federal partners and consistent with the directive found in the Executive Order of Increasing Access to High-Quality Care and Supporting Caregivers dated April 18, 2023.[2]

GUIDE is not available to individuals enrolled in Medicare Advantage plans, including Special Needs Plans; however, Medicare Advantage plans have the flexibility to directly contract with GUIDE participants to provide payment for services similar to the approach of the GUIDE model. The purpose of this memorandum is to make Medicare Advantage plans aware of the GUIDE model through a brief overview of the model.

Overview of the GUIDE model

The GUIDE model provides an opportunity to improve the quality of life for people living with dementia and their caregivers and to realize possible cost savings. GUIDE tests whether a comprehensive package of care management and coordination, caregiver education and support, and respite services can improve quality of life and outcomes for beneficiaries living with dementia and their caregivers, while reducing Medicare and Medicaid expenditures on long-term nursing home care and on hospital, emergency department, and post-acute care utilization.

[1] The Innovation Center was established for the purpose of testing innovative payment and service delivery models to reduce Medicare and Medicaid expenditures while preserving or enhancing the quality of care furnished to beneficiaries of such programs.
[2] Sec. 2(d)(i) of the Executive Order of Increasing Access to High-Quality Care and Supporting Caregivers. 88 Fed. Reg. 24669, 24671. April 21, 2023. https://www.whitehouse.gov/briefing-room/presidential-actions/2023/04/18/executive-order-on-increasing-access-to-high-quality-care-and-supporting-caregivers/

GUIDE is a new approach to the delivery of care to individuals with dementia in that the model:

i. defines a comprehensive care management and coordination approach with standardized care delivery requirements,
ii. provides monthly, per-beneficiary dementia care management payments (DCMP) to support care management and coordination requirements,
iii. incentivizes participants to achieve better outcomes and health equity for beneficiaries and caregivers through performance-based and health equity adjustments to the DCMP, and
iv. provides additional support for caregivers through payment of respite services for beneficiaries who qualify under the model.

GUIDE is an 8-year voluntary national model. The model performance period begins on July 1, 2024 and ends on June 30, 2032. Eligible Medicare-enrolled providers and suppliers will apply for participation in GUIDE.

Appendix A to this memorandum is a GUIDE Model Overview Factsheet.

More Information

For full details on the screening tools, quality measures, and payment policies included in the GUIDE model design visit https://innovation.cms.gov/innovation-models/guide. A list of GUIDE participants will be posted on this website prior to model launch.

Guiding an Improved Dementia Experience (GUIDE) Model Overview Factsheet

MODEL PURPOSE

Dementia takes a toll on not just the people living with the disease but also on their loved ones and caregivers in a way that almost no other illness does. About 6.7 million Americans currently live with Alzheimer's disease or another form of dementia, a number that is projected to grow by nearly 14 million by 2060. To help address the unique needs of this population, the GUIDE Model aims to:

Improve quality of life for people living with dementia by addressing their behavioral health and functional needs, coordinating their care for dementia and co-occurring conditions, and improving transitions between community, hospital, and post-acute settings.

Reduce burden and strain on unpaid caregivers of people living with dementia by providing caregiver skills training, referrals to community-based social services and supports, 24/7 access to a support line, and respite services.

Prevent or delay long-term nursing home care for as long as appropriate by supporting caregivers and enabling people living with dementia to remain safely in their homes for as long as possible.

CARE DELIVERY APPROACH

The model will promote improved dementia care by defining and requiring a comprehensive, standardized care delivery approach that will include the following:

Standardized set of services for beneficiaries and their unpaid caregivers.

An interdisciplinary care team to deliver these services.

A training requirement for care navigators who are part of the care team.

The interdisciplinary care team will deliver services by creating and maintaining a **person-centered care plan**, which will include details on the beneficiary's goals, strengths, and needs; comprehensive assessment results; and recommendations for service providers and community-based social services and supports.

CARE COORDINATION

The care plan will identify the beneficiary's primary care provider and specialists and outline the care coordination services needed to help manage the beneficiary's dementia and co-occurring conditions.

CAREGIVER SERVICES

Participants will assess and address caregiver needs and include the caregiver as part of the care team as appropriate. Caregiver services will include ongoing monitoring and support via 24/7 access to a support line.

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BENEFICIARY TIERS

People with Medicare who receive care from model participants will be placed in one of five "tiers," based on a combination of their disease stage and caregiver status. Beneficiary needs, and correspondingly, care intensity and payment, increase by tier.

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

PAYMENT OVERVIEW

INFRASTRUCTURE PAYMENT

Certain safety net providers in the new program track will be eligible for a one-time, lump sum infrastructure payment to support program development activities.

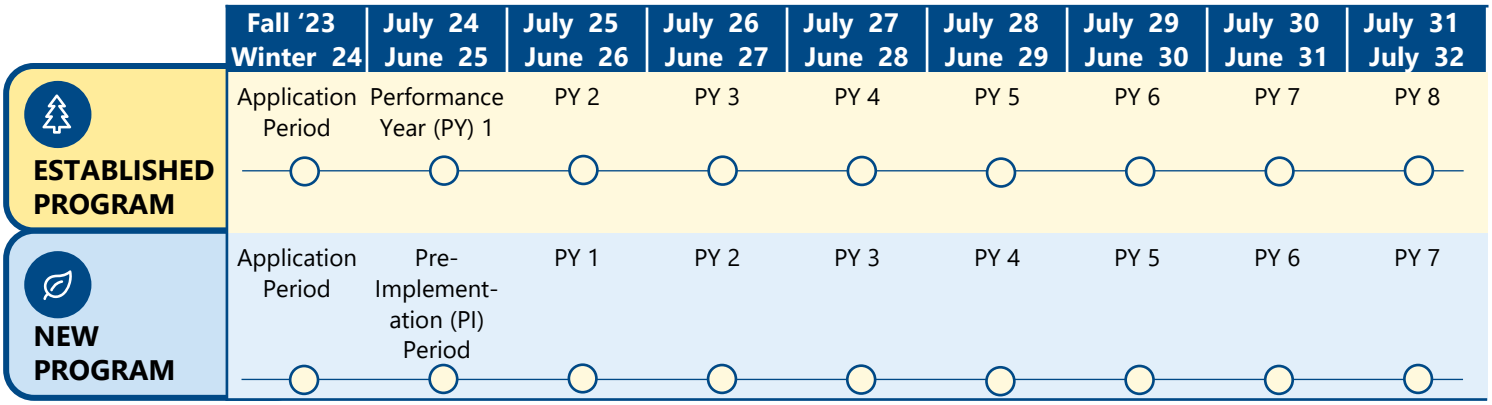
PER-BENEFICIARY-PER-MONTH PAYMENT

Participants will receive a monthly, per-beneficiary amount for providing care management and coordination and caregiver education and support services to beneficiaries and caregivers.

RESPITE CARE PAYMENT

Participants will be able to bill for respite services for beneficiaries with a caregiver and moderate to severe dementia, up to an annual respite cap amount.

MODEL TIMELINE



GUIDE MODEL AND HEALTH EQUITY

The GUIDE Model aims to advance health equity in alignment with the CMS Innovation Center's Strategy Refresh. For instance, the new program track intends to diversify participation, including among providers caring for underserved populations. Care delivery reporting will include a section where participants report on equity objectives based on their beneficiary population and describe equity strategies they are implementing.

Model Contact Information and Resources

Webpage: https://innovation.cms.gov/innovation-models/guide

Email: GUIDEModelTeam@cms.hhs.gov

Guiding an Improved Dementia Experience (GUIDE) Model Overview Factsheet

MODEL PARTICIPANT ELIGIBILITY

GUIDE is an 8-year voluntary model offered in all states, U.S. territories, and D.C. The GUIDE Model is designed to attract a range of Medicare Part-B enrolled providers and suppliers (excluding durable medical equipment and laboratory suppliers) with the expertise and capabilities to provide ongoing, longitudinal care and support to people living with dementia.

Participants must maintain an **interdisciplinary care team** to meet GUIDE's care delivery requirements. At a minimum, care teams must include the following:

1. Care navigator who has received required training in dementia, assessment, and care planning.
2. Clinician with dementia proficiency as recognized by experience caring for adults with cognitive impairment; experience caring for patients 65 years or older; or specialty designation in neurology, psychiatry, geriatrics, geriatric psychiatry, behavioral neurology, or geriatric neurology.

Note: Additional members may be included at the participant's discretion, such as pharmacists or behavioral health specialists.

Model Participant Tracks

ESTABLISHED PROGRAM

+ Designed for participants already providing comprehensive dementia care
+ Applicants should be ready to immediately implement GUIDE's care delivery requirements

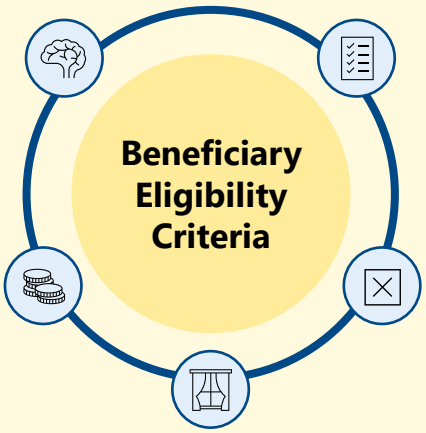
NEW PROGRAM

+ Designed for participants not operating a comprehensive outpatient dementia care program who are interested in scaling support
+ Applicants must submit a detailed plan for implementing a dementia care program

MODEL BENEFICIARY ELIGIBILITY

The GUIDE Model's intended beneficiary population is community-dwelling Medicare fee-for-service beneficiaries, including beneficiaries dually eligible for Medicare and Medicaid, living with dementia. Eligible beneficiaries must meet the following criteria:

- ✓ Beneficiary has a diagnosis of dementia, as confirmed by clinician attestation.
- ✓ Have Medicare as their primary payer.



- ✓ Enrolled in Medicare Parts A and B (not enrolled in Medicare Advantage, including Special Needs Plans and PACE).
- ✓ Not enrolled in Medicare hospice benefit.
- ✓ Not residing in a long-term nursing home.