



GUIDE Performance Measurement Manual

Version 3.0

May 18, 2026

Version History

Version Number	Release	Date	Primary Updates
1.0	First release	June 7, 2024	—
2.0	Second release	May 5, 2025	<ul style="list-style-type: none"> Updated resource name from <i>Quality Measure Manual (QMM)</i> to <i>Performance Measurement Manual (PMM)</i>. Reorganized content to improve readability and align with other Center for Medicare and Medicaid Innovation (CMMI) quality manuals. Presented additional information on the <i>Quality of Life Outcome for Patients with Neurological Conditions (QoL)</i> and <i>Caregiver-Reported Impact in Dementia (CID)</i> measure survey responses. Provided detailed specifications and example scenarios for the <i>Admissions to Long-Term Nursing Home Stay (LTNH)</i> measure. Incorporated benchmarking details for the <i>Admissions to Long-Term Nursing Home Stay</i> and <i>Total Per-Capita Cost (TPCC)</i> measures.
3.0	Third release	May 18, 2026	<ul style="list-style-type: none"> Updated information to reflect Performance Year (PY) 2025 benchmarking, performance-based adjustment (PBA), and specifications and provided forward-looking guidance for PY 2026. Revised <i>Use of High-Risk Medications in Older Adults</i> from the chart-abstracted measure (HRRx), using participant-reported data, to the claims-based measure (DAE). Revised <i>Quality of Life Outcome for Patients with Neurologic Conditions (QoL)</i> to include risk-adjustment methodology and retitled <i>Quality of Life for Patients Living with Dementia (QoL-PLWD)</i> for clarity. Added new <i>Caregiver-Reported Impact in Dementia (CID)</i> measure specifications (for the measure formerly entitled <i>Caregiver Burden</i>). Updated naming convention for performance years to align with nomenclature in Amended and Restated Participation Agreement (AR/PA), using calendar year as referent. Provided additional detail about derivation of benchmarking cohort for claims-based measures.

Table of Contents

Table of Contents	ii
1 Introduction	1
1.1 Overview of the GUIDE Model	2
1.2 Participant Tracks in the GUIDE Model	2
1.3 Overview of Payment in the GUIDE Model.....	3
1.4 Patient Alignment within the GUIDE Model and for Performance Measurement.....	3
1.5 GUIDE and QPP MIPS Eligibility	4
2 GUIDE Performance Measures.....	5
2.1 Overview of Measures.....	5
2.2 Data Submission.....	8
<i>Participant-Reported Measures and the PAAF.....</i>	<i>8</i>
<i>Submission Window for Participant-Reported Measures by GUIDE PYs.....</i>	<i>10</i>
2.3 Key Measure Updates.....	10
<i>Key Updates to the HRRx Measure</i>	<i>10</i>
<i>Key Updates to the Quality of Life Measure</i>	<i>11</i>
2.4 Performance Measures and the PBA.....	12
2.5 Performance Measures and Ongoing Monitoring in the DFT	15
3 GUIDE Performance Measure Benchmarks.....	16
3.1 Participant-Reported Measures.....	16
<i>Caregiver-Reported Impact in Dementia</i>	<i>17</i>
<i>Quality of Life for Patients Living with Dementia.....</i>	<i>17</i>
3.2 Claims Measures	19
<i>Claims Measures Benchmarking Cohort</i>	<i>19</i>
<i>Use of High-Risk Medications in Older Adults</i>	<i>20</i>
<i>Total Per-Capita Cost.....</i>	<i>20</i>
<i>Admissions to Long-Term Nursing Home Stay.....</i>	<i>22</i>
4 GUIDE Performance Measure Resources.....	24
Appendix A. Acronyms and Initialisms.....	25
Appendix B: Connecting Care Delivery to Performance Measurement	27

Table of Exhibits

<i>Exhibit 1. Performance Year Timeline</i>	3
<i>Exhibit 2. Performance Measures Used in the GUIDE Model</i>	5
<i>Exhibit 3. Minimum Case Count and Continuous Alignment Criteria, by Measure, for PY 2025</i>	8
<i>Exhibit 4. Patient Assessment and Alignment Form (PAAF) Workbook Template</i>	9
<i>Exhibit 5. GUIDE PYs and PAAF Data Submission Windows</i>	10
<i>Exhibit 6. Overview of GUIDE Performance Measurement Calculation and Scoring Processes</i> 12	12
<i>Exhibit 7. PBA Potential, by Measure, for PYs 2025 and 2026</i>	13
<i>Exhibit 8. Timing for EPT and NPT Performance-Based Adjustments</i>	14
<i>Exhibit 9. Illustrative Mock Up of Data Feedback Tool (DFT)</i>	15
<i>Exhibit 10. GUIDE PY 2025 and PY 2026 Performance Benchmark Methodology</i>	16
<i>Exhibit 11. PY 2025 QoL-PLWD O/E Benchmark Classification</i>	18
<i>Exhibit 12. Percentile Distribution of QoL-PLWD Observed-to-Expected Ratios by Sub-Scale</i>	18
<i>Exhibit 13. PY 2025 TPCC O/E Benchmark Classification</i>	21
<i>Exhibit 14. TPCC Observed-to-Expected Ratios for Benchmarking Cohort</i>	21
<i>Exhibit 15. PY 2025 LTNH O/E Benchmark Classification</i>	22
<i>Exhibit 16. LTNH Observed-to-Expected Ratios for Benchmarking Cohort</i>	23

1 Introduction

The *Guiding an Improved Dementia Experience* (GUIDE) Performance Measurement Manual (PMM) provides GUIDE Model Participants with information on the performance measurement strategy for the GUIDE Model, including an overview of the model's measures, the process for data collection and reporting, the impact of measures on payment, detailed measure specifications, and benchmarks for measure scoring.

This version of the PMM focuses on Performance Year (PY) 2025 and PY 2026. This document contains the information described below:

- [Section 1](#) provides an overview of the GUIDE Model, its participants, patients, and payment methodology.
- [Section 2](#) presents an overview of the performance measures used within the GUIDE Model, including the process for participants to submit and monitor measure data and how performance measures impact payment.
- [Section 3](#) describes benchmarks for each measure, including how CMS will use them to calculate payments.
- [Section 4](#) includes additional GUIDE resources related to the model's performance measures (such as links to relevant websites and contact information for support).
- [Appendix A](#) includes a list of acronyms and initialisms used throughout the PMM.
- [Appendix B](#) describes how care delivery is connected to performance measurement.

CMS also has published five measure-specific appendices, available as standalone files, for the five measures used within the GUIDE Model.

CMS reserves the right to revise the information in this manual, as needed. CMS will publish an update to the PMM at least annually.

For GUIDE Model Participants, please see below for tips on how to use this document to support your success.

How to Use this Document to Support your Success

- **Collect and submit timely, accurate patient and caregiver data.** CMS uses data submitted by GUIDE Model Participants through the Patient Assessment and Alignment Form (PAAF) to calculate two measures. See **Section 2.2** for data reporting requirements and key deadlines.
 - Confirm your team workflow is prepared to use the most recent PAAF template.
 - Note that the measure *Use of High-Risk Medications in Older Adults* has transitioned from a participant-reported measure to a claims-based measure. Workbook submission is no longer required by participants. See **Section 2.3** for details.
- **Understand the financial impact of achieving measure benchmarks.** Get familiar with measure specifications for the five performance measures to understand what drives higher or lower performance (see **Section 2.1** and the measure appendices). Explore how each measure contributes to the performance-based adjustment (PBA) in **Section 2.4**, and note the performance measure benchmarks in **Section 3**.

How to Use this Document to Support your Success

- **Prioritize continuous quality improvement with your interdisciplinary team.**
 - Delivering high-quality care to patients and caregivers, and executing the requirements of the GUIDE care delivery model are key to strong performance. Use **Appendix B** to kickstart conversations on how care delivery affects performance.
 - Review historical performance (if available), and set performance goals and action plans. Monitor performance using the CMS Data Feedback Tool (see **Section 2.5** for details).
 - Celebrate progress and achievements.

1.1 Overview of the GUIDE Model

The GUIDE Model is a Centers for Medicare & Medicaid Services (CMS) alternative payment model designed to enhance quality of life for people with dementia, support their caregivers, and help people with dementia remain in their homes and communities; more information on the GUIDE Model is available [here](#). The GUIDE Model is an eight-year, voluntary alternative payment model, which is offered nationwide from July 1, 2024, through June 30, 2032. Through GUIDE, CMS expects to reduce Medicare and Medicaid expenditures primarily by delaying or preventing long-term nursing home stays, and secondarily by reducing utilization of inpatient hospital, emergency department, and post-acute care services.

1.2 Participant Tracks in the GUIDE Model

The GUIDE Model has two tracks for participants: an Established Program Track (EPT) and a New Program Track (NPT). A GUIDE Model Participant's track impacts which model requirements and policies for performance measures apply. Performance measure requirements for EPT Participants and NPT Participants will differ for PY 2025, as certain measures require sufficient lengths of participation for valid calculation. If there is a difference in requirements for EPT vs. NPT Participants, CMS provides language explaining the requirement for each track.

- **Participants in the EPT** began their first performance year on July 1, 2024 (PY 2024).
- **Participants in the NPT** began their first performance year on July 1, 2025 (PY 2025). NPT Participants had a one-year pre-implementation period that began on July 1, 2024.¹

Exhibit 1 summarizes the GUIDE Model performance years and their associated performance periods. Each performance year begins on July 1 and ends on June 30 of the following year.

¹ GUIDE Participants in the EPT had a practicing interdisciplinary team who provided at least six (of the nine) GUIDE care delivery services for people living with dementia for at least the 12 months prior to January 30, 2024. GUIDE Participants in the NPT were 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).

Exhibit 1. Performance Year Timeline

Performance Year	Performance Period
PY 2025	July 2025 – June 2026
PY 2026	July 2026 – June 2027
PY 2027	July 2027 – June 2028
PY 2028	July 2028 – June 2029
PY 2029	July 2029 – June 2030
PY 2030	July 2030 – June 2031
PY 2031	July 2031 – June 2032

1.3 Overview of Payment in the GUIDE Model

The three main GUIDE payment components available to GUIDE Model Participants include:

- 1) **The Dementia Care Management Payment (DCMP)** is a per-patient, per-month care management payment which replaces the traditional fee-for-service (FFS) payment for certain Medicare Physician Fee Schedule (PFS) services. Each patient aligned to a GUIDE Model Participant is assigned to a model tier based on their dementia complexity, caregiver status, and residence type. The DCMP is then adjusted for geographic region, population and income, and performance on quality metrics through the performance-based adjustment (PBA), detailed below.
- 2) **A payment for GUIDE Respite Services**, up to a per-patient annual cap (for eligible patients in the moderate and high complexity tiers and who have a caregiver); and
- 3) **A one-time infrastructure payment** (for eligible safety-net providers in the NPT).

For complete information on DCMP rates, billing requirements, and all payment adjustments, participants should refer to the GUIDE Payment Methodology Paper, available [here](#).

1.4 Patient Alignment within the GUIDE Model and for Performance Measurement

Patients (or beneficiaries) included in the GUIDE Model have been diagnosed with dementia, reside in the community, and receive medical coverage through Original Medicare² (including those who are covered by both Original Medicare and Medicaid). Patients are linked (or aligned) to GUIDE Model Participants through a voluntary alignment process, during which patients are informed about the GUIDE Model and undergo an *initial comprehensive assessment*—a required, multi-domain clinical evaluation that informs tier assignment, care planning, and performance measurement. Follow-up annual comprehensive assessments are then completed

² Original Medicare is a fee-for-service (FFS) health program run by the federal government, comprising Part A (Hospital Insurance) and Part B (Medical Insurance). Medicare Advantage (Part C) is a private insurance alternative to Original Medicare. Patients enrolled in Medicare Advantage are not eligible for alignment to a participant in GUIDE.

annually.³ At all times, aligned patients maintain freedom of choice regarding from whom they receive clinical services. More information on Medicare beneficiary eligibility for the GUIDE model and alignment processes will be available in the beneficiary alignment fact sheet on GUIDE Connect.

The Patient Assessment and Alignment Form (PAAF) is used for both patient alignment with the GUIDE Model and performance measurement. GUIDE Model Participants use the PAAF to submit data collected during comprehensive assessments.

Reminder: For performance measure reporting associated with PY 2026 assessments, GUIDE Model participants must use the most current version of the Patient Assessment and Alignment Form (PAAF) applicable to PY 2026. Data submitted using earlier versions of the PAAF may not be accepted for performance measurement.

Additional information on the PY 2026 PAAF template is available [here](#).

1.5 GUIDE and QPP MIPS Eligibility

GUIDE Participants who are eligible for QPP MIPS still need to meet MIPS requirements. CMS created the Quality Payment Program (QPP) to give CMS the ability to reward Medicare-enrolled clinicians, financially, for the provision of high-value care. The QPP's payment tracks include the Merit-based Incentive Payment System (MIPS) and the Advanced Alternative Payment Model (A-APM). Clinicians who participate in MIPS and meet certain performance thresholds can receive positive payment adjustments. Although GUIDE is an alternative payment model (APM), it does not qualify as an A-APM under the QPP.⁴ Therefore, GUIDE Model Participants who are eligible for QPP MIPS (either Traditional or MIPS Value Pathways) still need to meet MIPS requirements, which include reporting performance measure data directly to MIPS via the QPP platform.

Requirements related to performance measurement for the CMS GUIDE Model are distinct from requirements related to performance measurement for QPP MIPS. GUIDE Model Participants submit performance measure data to CMS to meet GUIDE requirements via GUIDE-specific processes as outlined in this PMM. For participants in GUIDE, this PMM serves as the definitive source for how GUIDE performance measures will be reported and calculated. For further questions about QPP, please visit the [QPP website](#) or contact the QPP team at QPP@cms.hhs.gov.

³ Additionally, a reassessment should be conducted if a participant becomes aware of a change that could impact the patient's tiering outside of the timing for the annual comprehensive assessment. Changes that impact tiering include: a patient's dementia stage, caregiver status and/or burden, and place of residence. A reassessment does not fulfill the requirement for an annual comprehensive assessment.

⁴ An A-APM has specific criteria, including certain minimum levels of financial risk, quality-related requirements, and other requirements. Participating in an A-APM can allow eligible clinicians to become QPs and potentially avoid MIPS.

2 GUIDE Performance Measures

CMS has selected five performance measures for use in the GUIDE Model, which align with the GUIDE Model's goals. The five GUIDE performance measures assess the quality and consistency of clinical care, monitor burden on caregivers over time, and evaluate trends in expenditures and utilization for patients living with dementia. Collectively, the performance measures and performance-based adjustment (PBA) methodology will reward participants financially for achieving or exceeding benchmarks for each measure and penalize participants financially for not meeting benchmarks for each measure.

2.1 Overview of Measures

The five performance measures map to the following four domains:

- 1) patient quality of life;
- 2) care coordination and management;
- 3) caregiver support; and
- 4) cost and utilization.

In selecting measures, CMS prioritized measurement of performance that reflects national priorities for quality improvement and whole-person care, consistent with Section 1890(b)(7)(B) of the Social Security Act and in alignment with the CMS and Center for Medicare and Medicaid Innovation quality strategy; more information is available on CMS' website [here](#). As appropriate, CMS will continually evaluate the usability and suitability of the performance measures included in the GUIDE Model, exploring opportunities to update the set over time. To the extent possible, the GUIDE Model utilizes existing data (such as claims data) to reduce reporting burden for participants.

Exhibit 2 provides an overview of the five performance measures used in GUIDE.

Exhibit 2. Performance Measures Used in the GUIDE Model

Title	Steward	GUIDE Domain	Data Source(s)	Population	Reporting Process	Reporting Deadline
<i>Use of High-Risk Medications in Older Adults (DAE)</i>	National Committee for Quality Assurance (NCQA) ⁵	Care coordination and management	Claims	GUIDE-aligned patients, aged 67+	None—CMS calculates using claims	Not applicable

⁵ Certain measures proposed in the GUIDE Model are owned and copyrighted by the National Committee for Quality Assurance (NCQA). Full copyright, disclaimer, and use provisions related to the NCQA measures can be found [here](#).

Title	Steward	GUIDE Domain	Data Source(s)	Population	Reporting Process	Reporting Deadline
<i>Quality of Life for Patients Living with Dementia (QoL-PLWD)</i>	CMS	Patient quality of life	Participant reported survey (PROMIS-10)	GUIDE-aligned patients	GUIDE Participant reports in PAAF	PAAF submitted within 60 days of both initial alignment and annual assessment(s) (no later than August 31)
<i>Caregiver-Reported Impact in Dementia (CID)</i>	CMS	Caregiver support	Participant reported survey (ZBI-22)	Caregivers of GUIDE-aligned patients	GUIDE Participant reports in PAAF	PAAF submitted within 60 days of both initial alignment and annual assessment(s) (no later than August 31)
<i>Total Per-Capita Cost (TPCC)</i>	CMS	Cost and Utilization	Claims	GUIDE-aligned patients	None—CMS calculates using claims	Not applicable
<i>Admissions to Long-Term Nursing Home Stay (LTNH)</i>	CMS	Cost and Utilization	Claims, MDS data ⁶	GUIDE-aligned patients	None—CMS calculates using claims	Not applicable

Measure descriptions for these five measures appear below:

- ***Use of High-Risk Medications in Older Adults (DAE)***: The DAE (formerly *HRRx*) measure assesses the percentage of patients 67 years of age and older for whom at least two high-risk medications from the same drug class were ordered. Lower scores suggest safer prescribing practices, reducing the risk of adverse drug events, hospitalizations, and functional decline.
- ***Quality of Life for Patients Living with Dementia (QoL-PLWD)***: The QoL-PLWD (formerly *QoL*) measure assesses the observed-to-expected ratio of patients whose PROMIS-10 assessment scores are maintained or improved during a 12-month (± 60 days) measurement period. Higher scores reflect that care teams are effectively maintaining or improving patients' physical and mental well-being over time.
- ***Caregiver-Reported Impact in Dementia (CID)***: The CID measure (formerly *Caregiver Burden [CB]*), a newly specified measure, assesses caregiver burden using data from the

⁶ MDS data are Minimum Data Set (MDS) 3.0 data or results from a health status screening and assessment tool used for all residents of long-term care nursing facilities and non-critical access hospital swing beds.

ZBI-22 assessment. The ZBI-22 assessment is required for identified caregivers.⁷ Lower scores suggest that care teams are helping caregivers sustain their role, which can improve patient outcomes, including reduced avoidable utilization.

- **Total Per-Capita Cost (TPCC):** The TPCC measure estimates a payment standardized, risk-adjusted measure of the overall cost of care provided to patients for each GUIDE Participant. Lower scores suggest more efficient, coordinated care that avoids unnecessary services.
- **Admissions to Long-Term Nursing Home Stay (LTNH):** The LTNH measure assesses the observed-to-expected ratio of patients having a long-term nursing home stay. Lower scores suggest successful management of patients in the community.

Detailed information on each measure is available within the appendices to this PMM, published as standalone files. Performance scores for measures in the GUIDE Model are calculated according to the specifications for each measure. Specifications for all measures have been tailored to align with the goals and data available through the GUIDE Model; this may involve adjusting measure data elements when compared to measures used in other CMS initiatives.

As summarized in **Exhibit 3**, each GUIDE Model performance measure includes specific minimum data requirements designed to ensure stable and interpretable performance results:

- **Minimum case count:** CMS only calculates a measure's score for a given GUIDE Model Participant if the participant meets the minimum case count for the measure (or minimum number of patients or cases in the performance year). If that minimum is not met, the GUIDE Model Participant is not eligible to receive the PBA associated with that measure. This minimum threshold helps ensure that reported scores reflect a statistically meaningful representation of performance.
- **Continuous alignment criteria:** In addition to a minimum case count, some measures include a continuous alignment criterion, which specifies the minimum duration of patient alignment to a given GUIDE Model Participant needed for inclusion in the measure denominator. Continuous alignment criteria vary by measure based on differences in measurement design to reflect the extent to which sustained engagement with the GUIDE Model is necessary to influence outcomes.

For example, the LTNH measure uses a 90-day continuous alignment criterion, recognizing that preventing or delaying long-term nursing home entry requires ongoing care coordination and that early institutionalization is often driven by patient severity rather than care quality.

⁷ "Caregiver" means the relative, or an unpaid nonrelative, who assists the GUIDE Beneficiary with activities of daily living and/or instrumental activities of daily living and is listed by name in the Patient Assessment and Alignment form.

Depending on needs for the patient aligned to a GUIDE Model Participant, the assistance may be episodic, daily, or occasional. For more information on requirements for identifying caregivers and providing caregiver education and support, please see the GUIDE Participation Agreement.

Exhibit 3. Minimum Case Count and Continuous Alignment Criteria, by Measure, for PY 2025

Measure	Minimum Case Count	Continuous Alignment Criterion
<i>Use of High-Risk Medications in Older Adults (DAE)</i>	20 denominator-eligible patients	90 days
<i>Quality of Life for Patients Living with Dementia (QoL-PLWD)</i>	20 denominator-eligible patients	12 months (± 60 days) ⁸
<i>Caregiver-Reported Impact in Dementia (CID)</i>	20 denominator-eligible patients	To be determined ⁹
<i>Total Per-Capita Cost (TPCC)</i>	240 denominator-eligible patient-months ¹⁰	None ¹¹
<i>Admissions to Long-Term Nursing Home Stay (LTNH)</i>	20 denominator-eligible patients	90 days

CMS will be monitoring the effectiveness of minimum data requirements in supporting accurate, comparable assessment of GUIDE participant performance, and may adjust these thresholds in future performance years.

2.2 Data Submission

GUIDE performance measure data come from two sources: administrative data (Medicare claims and Minimum Data Set [MDS] data¹²) and data reported directly to CMS by participants.

There are three claims-based measures used in the GUIDE Model: DAE, LTNH, and TPCC. GUIDE Participants are not responsible for reporting any data related to these performance measures. CMS will calculate performance scores for these three measures using Medicare claims data. Additionally, for the LTNH measure, CMS utilizes MDS 3.0 data.

There are two participant-reported measures used in the GUIDE Model: QoL-PLWD and CID. The following section details data submission requirements for those measures.

Participant-Reported Measures and the PAAF

For the participant-reported measures, QoL-PLWD and CID, participants are required to report data via the Patient Assessment and Alignment Forms (PAAF) on an ongoing basis throughout

⁸ The QoL-PLWD measure denominator requires two survey responses collected 12 months (± 60 days) apart for the same patient, inherently ensuring sufficient longitudinal exposure.

⁹ Continuous alignment thresholds for the CID measure are under consideration and will be specified in a future version of this PMM.

¹⁰ The TPCC measure uses 240 patient-months (equivalent to 20 patients contributing 12 months of data, each, to the denominator) as its minimum case count.

¹¹ The TPCC measure does not require a continuous alignment criterion threshold because the 240 patient-month minimum case count, along with risk adjustment and outlier truncation, already supports estimate stability; additionally, its exposure-based design appropriately accounts for partial-year alignment.

¹² MDS data are Minimum Data Set (MDS) 3.0 data or results from a health status screening and assessment tool used for all residents of long-term care nursing facilities and non-critical access hospital swing beds.

the performance year. Participants' reporting of data via the PAAF allows CMS to score the QoL-PLWD and CID measures and adjust payment using the PBA methodology.

The PAAF includes worksheets for entering data from caregivers and patients:

- **Data from caregivers**, in response to the 22-item Zarit Burden Interview (ZBI-22) survey (submitted in the *ZBI-22* worksheet), and required supplemental questions (submitted in the *PAA* worksheet). For more information about the ZBI-22, visit [here](#).
- **Data from patients** in response to the Patient-Reported Outcomes Measurement Information System Global Health 10 (PROMIS-10) survey (submitted in the *PROMIS-10* worksheet) and required supplemental questions (submitted in the *PAA* worksheet). For more information about the PROMIS-10, visit [here](#).

A preview of the PAAF workbook appears in **Exhibit 4**.

Exhibit 4. Patient Assessment and Alignment Form (PAAF) Workbook Template

Data Element Name	Data Element Label	Initial Assessment	Re-assessment	Unalignment	Annual Assessment
Model ID	model_id	Input "GUIDE" for all assessment types.	Input "GUIDE" for all assessment types.	Input "GUIDE" for all assessment types.	Input "GUIDE" for all assessment types.
GUIDE Participant ID	entity_id	Input your GUIDE participant ID. The format should be GUIDE-####.	Input your GUIDE participant ID. The format should be GUIDE-####.	Input your GUIDE participant ID. The format should be GUIDE-####.	Input your GUIDE participant ID. The format should be GUIDE-####.
Date of Assessment	assessment_date	Date the GUIDE clinician conducted the Patient Assessment and Alignment form. The date format must be numeric YYYY-MM-DD. PAAF must be submitted within 2 months of the assessment date.	Date the GUIDE clinician conducted the Patient Assessment and Alignment form. The date format must be numeric YYYY-MM-DD. PAAF must be submitted within 2 months of the assessment date.	Must be blank.	Date the GUIDE clinician conducted the Patient Assessment and Alignment form. The date format must be numeric YYYY-MM-DD. PAAF must be submitted within 2 months of the assessment date.
Assessment Type	assessment_type	Indication of the type of assessment for the patient. For initial assessment, input: "Initial assessment"	Indication of the type of assessment for the patient. For mid-year reassessments to communicate updates relevant to the tiering decision, input: "Re-assessment"	Indication of the type of assessment for the patient. For notifying CMS of beneficiary unalignment, input: "Unalignment"	Indication of the type of assessment for the patient. For annual assessments, input: "Annual assessment"
Initial Assessment Patient Type	initial_patient	Is this patient an existing patient of the practice or a new patient?	Must be blank.	Must be blank.	Must be blank.
Initial Assessment Patient Referral Source	pt_referral_source	Referred by a healthcare provider, Referred by a community based organization, or Self-referral.	Must be blank.	Must be blank.	Must be blank.
Re-Assessment Reason	reassessment_reason	Must be blank.	This item indicates the reason for re-assessment of a currently aligned beneficiary. Answer options include: Re-assessment due to change in severity of patient's dementia, Re-assessment due to change in caregiver status, Re-assessment due to change in both severity of patient's dementia and change in caregiver status, Re-assessment due to change in patient's residence type, Re-assessment due to change in both caregiver status and change in patient's residence type, Re-assessment due to change in both severity of patient's dementia and change in patient's residence type, OR Re-assessment due to change in severity of patient's dementia, change in patient's residence type, and change in caregiver status.	Must be blank.	Must be blank.
Change in Caregiver Status	caregiver_status	Must be blank.	If you indicated that the reassessment_reason involved a change in caregiver status (Re-assessment due to change in caregiver status, Re-assessment due to change in both severity of patient's dementia and change in caregiver status, Re-assessment due to change in both caregiver status and change in patient's residence type, OR Re-assessment due to change in severity of patient's dementia, change in patient's residence type, and change in caregiver status) then this item must indicate the nature of the change; must be blank otherwise. Answer options include: New primary caregiver, Loss of caregiver so patient is without a caregiver, Same caregiver but change in ZBI score, or Other (please specify).	Must be blank.	Must be blank.

The data from the ZBI-22 survey are used by CMS to calculate the CID measure. The data from the PROMIS-10 survey are used by CMS to calculate the QoL-PLWD measure.

GUIDE Model Participants must document data gathered during each comprehensive assessment and reassessment¹³ in the PAAF and submit the PAAF to CMS via the HDR application or, for participants with FHIR-enabled EHRs, a FHIR-based API. For more information about reporting procedures for required data elements for the QoL-PLWD and CID measures, please review guidance on completing the PAAF within the beneficiary alignment fact sheet, available on GUIDE Connect.

¹³ A reassessment should be conducted if a participant becomes aware of a change that could impact the patient's tiering outside of the timing for the annual comprehensive assessment. Changes that impact tiering include: a patient's dementia stage, caregiver status and/or burden, and place of residence. A reassessment does not fulfill the requirement for an annual comprehensive assessment. If there is a change in caregiver or change in caregiver burden, administration of the ZBI-22 and submission of results, is required. Submission of PROMIS-10 data is not required during reassessments.

Submission Window for Participant-Reported Measures by GUIDE PYs

To receive the individual PBA contribution for the participant-reported measures, participants should ensure data are delivered on time with complete documentation. The final date for submissions to be included in measure calculations for a given performance year is the **end of August** (for example, August 31, 2026, for PY 2025 data). For CID and QoL-PLWD measure requirements, participants should submit PAAF data continuously throughout the performance year, as required. The dates below represent the final submission period for data to be accepted for measure calculation for each performance year. The final date on which PAAF data (including PROMIS-10 and ZBI-22 data) will be accepted, for purposes of calculating CID and QoL-PLWD measures in a given performance year, appear in **Exhibit 5**.

Exhibit 5. GUIDE PYs and PAAF Data Submission Windows¹⁴

Performance Year	PY Date Range	PAAF Submission Window
PY 2025	July 1, 2025 – June 30, 2026	July 01, 2026 – August 31, 2026
PY 2026	July 1, 2026 – June 30, 2027	July 01, 2027 – August 31, 2027
PY 2027	July 1, 2027 – June 30, 2028	July 03, 2028 – August 31, 2028
PY 2028	July 1, 2028 – June 30, 2029	July 02, 2029 – August 31, 2029
PY 2029	July 1, 2029 – June 30, 2030	July 01, 2030 – August 30, 2030
PY 2030	July 1, 2030 – June 30, 2031	July 01, 2031 – August 29, 2031
PY 2031	July 1, 2031 – June 30, 2032	July 01, 2032 – August 31, 2032

2.3 Key Measure Updates

Key Updates to the HRRx Measure

Beginning in PY 2026, CMS is replacing the participant-reported *Use of High-Risk Medications in Older Adults* (HRRx) measure (specifications available [here](#)) with a claims-based measure *Use of High-Risk Medications in Older Adults* (DAE), developed by NCQA.¹⁵ CMS calculates the DAE measure directly from available claims data; no additional reporting is required by GUIDE Model Participants.

For PY 2025, Participants are not required to submit an HRRx Excel Workbook (previously communicated for a July – August 2026 reporting period), nor are participants required to submit any data for DAE.

¹⁴ For years in which August 31 falls on a weekend, the deadline shall fall on the last weekday preceding the 31st.

¹⁵ The GUIDE Model's DAE measure is based on the HEDIS® *Use of High-Risk Medications in Older Adults* measure developed by the National Committee for Quality Assurance (NCQA), the specifications for which are available [here](#). This measure is owned and copyrighted by the National Committee for Quality Assurance (NCQA). Full copyright, disclaimer, and use provisions related to the NCQA measures can be found [here](#).

The DAE measure assesses the percentage of adults aged ≥ 67 who have two or more fills for specified high-risk medications. DAE, like HRRx, is an inverse measure, where lower values indicate better performance. CMS is making this change for the following reasons:

- DAE is a claims-based measure, which reduces reporting burden for participants by leveraging existing administrative data while also improving consistency, completeness, and overall data quality.
- Further, the existing HRRx measure used Rate 1 of the original clinical quality measure (similar in structure to the DAE measure's Rate 1). Switching to the claims-based DAE measure allows CMS to use both Rate 1 *and* Rate 2; Rate 2 tracks use of antipsychotics and benzodiazepines, two key drug classes that are potentially inappropriate for patients living with dementia.

Consistent with the prior HRRx measure, DAE is specifically designed to identify patterns of chronic or sustained use (given that it assesses two or more dispensing events), rather than isolated or short-term exposure.

Please note that CMS will be utilizing the allowable modification of the existing DAE measure, capturing measure data for patients who die or who enter hospice or palliative care during the performance year, thereby providing a more comprehensive and representative assessment of high-risk medication use among aligned patients.

The complete calculation methodology for the numerator and denominator is detailed in the DAE technical specifications (see **Appendix C**).

Key Updates to the Quality of Life Measure

CMS has respecified the *Quality of Life Outcome for Patients with Neurologic Conditions* (QoL) measure to better reflect the clinical and analytical needs of the GUIDE Model. The respecified measure, now under CMS stewardship, is titled *Quality of Life for Patients Living with Dementia* (QoL-PLWD).

Key changes include:

- **Separately evaluating Global Physical Health and Global Mental Health sub-scales of the PROMIS-10 instrument.** While the PROMIS-10 sub-scales are moderately correlated, changes in one sub-scale do not consistently coincide with changes in the other. By scoring the sub-scales separately, CMS ensures that clinically meaningful changes in each sub-scale are appropriately captured and reflected in performance measurement of GUIDE Participants.
- **Incorporating risk adjustment for patient characteristics associated with quality of life.** CMS restructured the measure to use an observed-to-expected (O/E) ratio, which compares a participant's actual patient outcomes to the outcomes that would be expected given the characteristics of their patient population. An O/E ratio at or above 1.0 indicates that a participant's patients are performing as well as or better than expected. CMS calculates *expected* rates of maintenance (PROMIS-10 score equal to index) or improvement (PROMIS-10 score better than index) separately for each subscale using logistic regression models that predict outcomes based on patient-specific factors. The

model adjusts for baseline PROMIS-10 score, dementia severity, presence of caregiver, and residence type. The patient-level predicted probabilities for maintaining or improving PROMIS-10 scores, are then aggregated to participant-level expected rates. For each participant, two O/E ratios are calculated: Global Physical Health O/E ratio, and Global Mental Health O/E ratio.

These updates reflect meaningful departures from the original specifications for QoL; they were necessary to support valid and fair performance assessment for participants within the GUIDE Model. Please see **Appendix D** for the QoL-PLWD measure specifications.

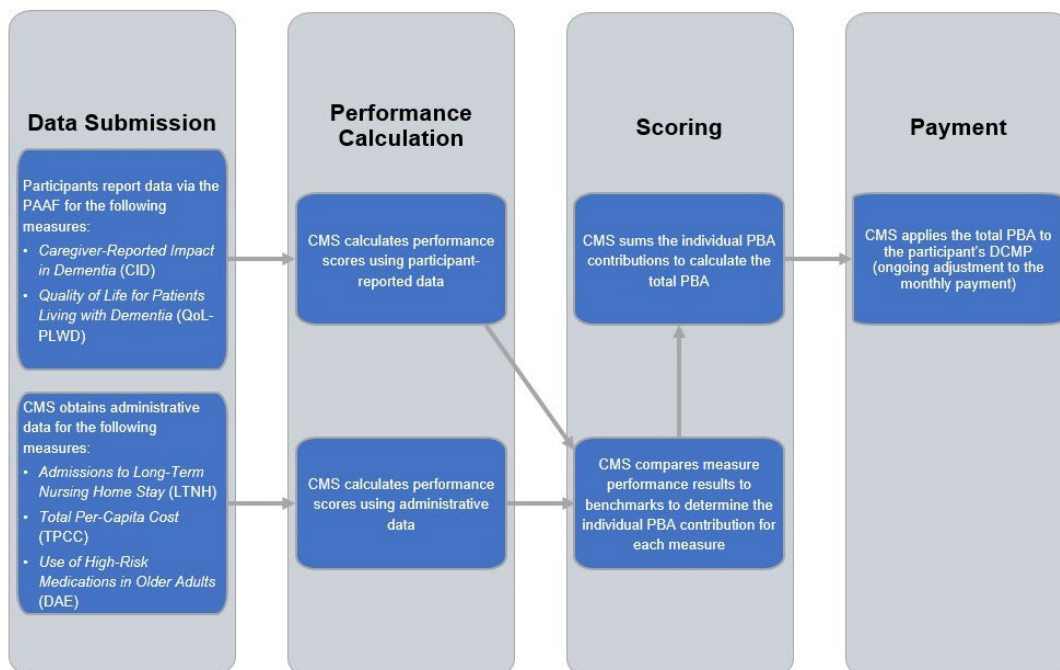
2.4 Performance Measures and the PBA

CMS uses performance measures to assess patient health outcomes and appropriate coordination of care, and to ensure continued improvement in or maintenance of quality of care for patients and their caregivers.

To incentivize high-quality care, a performance-based adjustment (PBA), applied to the Dementia Care Management Payment (DCMP), allows CMS to reward GUIDE Model Participants financially when they achieve these goals for their aligned patients and to hold them accountable when they do not. CMS will adjust GUIDE Model Participants' DCMP payments based on the PBA annually (beginning in January of each year).

Exhibit 6 provides an overview of the GUIDE performance measurement submission, calculation, scoring, and payment process.

Exhibit 6. Overview of GUIDE Performance Measurement Calculation and Scoring Processes



To derive the PBA for each GUIDE Model Participant, at the close of each performance year, CMS executes the following steps:

- 1) CMS first calculates performance scores for each measure for each participant.

- 2) Then, CMS compares participant performance scores to a benchmark (or reporting threshold) for each measure (that is, a performance value identified specifically for the GUIDE Model).

If a participant's performance score meets or exceeds the benchmark (or reporting threshold), that participant receives a positive adjustment for the measure (via the PBA); if the participant's performance score does not meet the benchmark (or reporting threshold), that participant receives no adjustment or a negative adjustment (via the PBA).

- 3) CMS sums the individual PBA contribution for each measure to calculate the total PBA for each participant.

Information about the measures, domains, associated PBA potential, and benchmarks, by performance year, appears in **Exhibit 7**.

Exhibit 7. PBA Potential, by Measure, for PYs 2025 and 2026

Measure	PY 2025 <i>EPT</i>	PY 2025 <i>NPT</i>	PY 2026 <i>Both Tracks</i>
<i>Care Coordination and Management</i>			
<i>Use of High-Risk Medications in Older Adults</i> (DAE beginning PY 2026; formerly HRRx in PY 2025)	0%	0%	-0.5% – +1%
<i>Patient Quality of Life</i>			
<i>Quality of Life for Patients Living with Dementia</i> (QoL-PLWD)	-1.0% (both benchmarks not met) +1.5% (one benchmark met) +3.0% (both benchmarks met) <i>Benchmark (Global Physical Health sub-scale)=0.91</i> <i>Benchmark (Mental Health sub-scale)=0.91</i>	0% (non-reporting) +2.0% (reporting) <i>Reporting=PROMIS-10 data submitted for at least 90% of aligned patients</i>	-1% – +3%
<i>Caregiver Support</i>			
<i>Caregiver-Reported Impact in Dementia</i> (CID)	0%	0%	-1% – +3%
<i>Cost and Utilization</i>			
<i>Total Per-Capita Cost</i> (TPCC)	-0.5% (benchmark not met) +1.5% (benchmark met) <i>Benchmark=0.95</i>	-0.5% (benchmark not met) +1.5% (benchmark met) <i>Benchmark=0.95</i>	-0.5% – +1.5%
<i>Admissions to Long-Term Nursing Home Stay</i> (LTNH)	-0.5% (benchmark not met) +1.5% (benchmark met) <i>Benchmark=0.47</i>	-0.5% (benchmark not met) +1.5% (benchmark met) <i>Benchmark=0.47</i>	-0.5% – +1.5%
Total PBA Potential	-2% – +6%	-1% – +5%	-3.5% – +10%

The following additional details highlight how select measures contribute to the PBA for PY 2025, with more information on benchmarks available in **Section 3**:

- For PY 2025, for the *Quality of Life for Patients Living with Dementia* (QoL-PLWD) measure, EPT Participants will be scored based on measure performance, while NPT Participants will be scored based on the submission of required data.
- For PY 2025, neither the *Use of High-Risk Medications in Older Adults* (HRRx) nor the *Caregiver-Reported Impact in Dementia* (CID) measure will contribute to the PBA, as no performance benchmark could be derived for either measure. For HRRx, the PY 2024 participant-reported data were insufficient to establish a valid benchmark. For CID, the measure specifications are newly released in this PMM, and an additional year of data is needed before a benchmark can be calculated.

CMS has grouped the five measures in the GUIDE Model into four measure domains—care coordination and management, patient quality of life, caregiver support, and cost and utilization. CMS has assigned each domain a certain percentage of the total PBA, which impacts the percentage of PBA contribution available for each measure.

For PY 2025, the total PBA potential ranges from -2% to 6% for EPT Participants and -1% to 5% for NPT Participants. The total PBA potential is the sum of the individual measure PBA contribution. Once CMS fully phases in all the performance measures, the total PBA potential will change; GUIDE Model Participants in both tracks can receive an upward adjustment of up to 10% through meeting (or exceeding) all benchmarks or receive a downward adjustment of up to -3.5% for not meeting any of the benchmarks.

A participant’s performance in a given PY affects their future payment. The DCMP is adjusted annually. CMS applies the PBA as an ongoing percentage adjustment to each GUIDE Model Participant’s monthly DCMP. The PBA for each year is applied beginning in January and continues for 12 months. For example, for a GUIDE Model Participant in the EPT, their performance measure data for PY 2024 were used to calculate the PBA first applied in January 2026, remaining in effect through December 2026. The first PBA began in January 2026 for EPT Participants and begins in January 2027 for NPT Participants.

Exhibit 8 illustrates this timeline across both program tracks over the course of the model.

Exhibit 8. Timing for EPT and NPT Performance-Based Adjustments

Year	2024	2025	2026	2027	2028	2029	2030	2031	2032
Established Program Track	PY 2024 07/01/2024– 06/30/2025	PY 2025 07/01/2025– 06/30/2026	PY 2026 07/01/2026– 06/30/2027	PY 2027 07/01/2027– 06/30/2028	PY 2028 07/01/2028– 06/30/2029	PY 2029 07/01/2029– 06/30/2030	PY 2030 07/01/2030– 06/30/2031	PY 2031 07/01/2031– 06/30/2032	
			PBA 1 01/01/2026– 12/31/2026	PBA 2 01/01/2027– 12/31/2027	PBA 3 01/01/2028– 12/31/2028	PBA 4 01/01/2029– 12/31/2029	PBA 5 01/01/2030– 12/31/2030	PBA 6 01/01/2031– 12/31/2031	PBA 7 01/01/2032– 06/30/2032
New Program Track	Pre- Implementation Period	PY 2025 07/01/2025– 06/30/2026	PY 2026 07/01/2026– 06/30/2027	PY 2027 07/01/2027– 06/30/2028	PY 2028 07/01/2028– 06/30/2029	PY 2029 07/01/2029– 06/30/2030	PY 2030 07/01/2030– 06/30/2031	PY 2031 07/01/2031– 06/30/2032	
				PBA 1 01/01/2027– 12/31/2027	PBA 2 01/01/2028– 12/31/2028	PBA 3 01/01/2029– 12/31/2029	PBA 4 01/01/2030– 12/31/2030	PBA 5 01/01/2031– 12/31/2031	PBA 6 01/01/2032– 06/30/2032

Each December, CMS will provide GUIDE Model Participants with a PBA workbook showing their performance measure results for the prior performance year. Participants can review their

performance results by downloading the workbook through the Custom Export Tool (CET) within the Expanded Data Feedback Reporting (eDFR), which is accessible through the Participant Portal ([ePortal](#)). The PBA workbook includes the participant’s specific performance results, showing measure performance rates and how each measure contributes to the total PBA. The workbook also provides background information and a comparison of performance to other GUIDE Participants. This information helps GUIDE Model Participants understand how their organization performed in relation to GUIDE’s quality goals.

2.5 Performance Measures and Ongoing Monitoring in the DFT

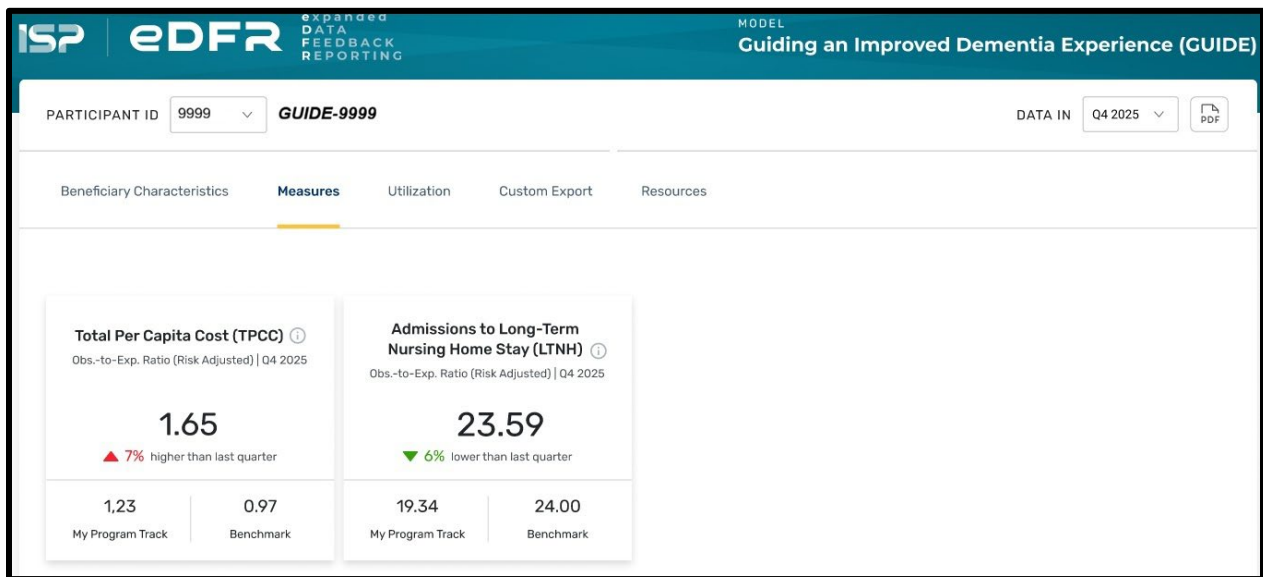
GUIDE Participants can view their progress on performance measures via the Data Feedback Tool (DFT). The DFT of the eDFR application is accessible through the Participant Portal ([ePortal](#)). Performance results reflect a 12-month performance period and are updated on a quarterly basis.

As of May 2026, the performance results for the *Total Per-Capita Cost (TPCC)* and *Admissions to Long-Term Nursing Home Stay (LTNH)* measures are available for EPT Participants in the DFT. EPT Participants can view their performance value, an EPT-specific average, and a benchmark comparator. Performance data for NPT Participants will be made available in 2027.

These quarterly results in the DFT help participants monitor their performance on key quality and cost measures and assess whether performance is on track to meet the benchmarks used for the PBA. As performance is monitored, consider how changes in the underlying care delivery structure are impacting performance outcomes, as described in the measure framework in **Appendix B**. CMS will add measures to the DFT over time to assist GUIDE Model Participants with quality monitoring and improvement.

An example of the DFT, featuring how results appear for the TPCC and LTNH measures, appears in **Exhibit 9**.

Exhibit 9. Illustrative Mock Up of Data Feedback Tool (DFT)



3 GUIDE Performance Measure Benchmarks

After calculating participant-level performance scores, CMS compares each score to GUIDE-specific measure benchmarks or reporting thresholds. Meeting a benchmark or reporting threshold results in a measure-specific positive contribution to the PBA; not meeting the benchmark or reporting threshold may result in no contribution or a negative contribution to the PBA for that measure. CMS then sums the measure-specific adjustments to derive the total PBA. Benchmark methodology for each measure is summarized below in **Exhibit 10** and detailed in this section.

Exhibit 10. GUIDE PY 2025 and PY 2026 Performance Benchmark Methodology

Measure Name	Benchmark Cohort	Benchmark or Reporting Threshold Methodology by PY
<i>Use of High-Risk Medications in Older Adults (DAE)</i>	Claims-based benchmarking cohort	<p>PY 2025: No benchmark produced; null (0%) adjustment</p> <p>PY 2026: Performance benchmark will be released in a future version of this PMM</p>
<i>Quality of Life for Patients Living with Dementia (QoL-PLWD)</i>	GUIDE Model Participants	<p>PY 2025 (EPT): Performance benchmark of 0.91 for the Global Physical Health sub-scale and 0.91 for the Global Mental Health sub-scale (30th percentile of each sub-scale) using PY 2024 and PY 2025 data</p> <p>PY 2025 (NPT): Reporting threshold of ≥90% of aligned patients reporting complete, timely PROMIS-10 data</p> <p>PY 2026: Performance benchmark using PY 2025 and PY 2026 data</p>
<i>Caregiver-Reported Impact in Dementia (CID)</i>	GUIDE Model Participants	<p>PY 2025: No benchmark produced; null (0%) adjustment</p> <p>PY 2026: Performance benchmark will be released in a future version of this PMM</p>
<i>Total Per-Capita Cost (TPCC)</i>	Claims-based benchmarking cohort	<p>PY 2025: Performance benchmark of 0.95 (50th percentile) using prior year (July 2024 – June 2025) data</p> <p>PY 2026: Performance benchmark using PY 2025 data</p>
<i>Admissions to Long-Term Nursing Home Stay (LTNH)</i>	Claims-based benchmarking cohort	<p>PY 2025: Performance benchmark of 0.47 (50th percentile) using prior year (July 2024 – June 2025) data</p> <p>PY 2026: Performance benchmark using PY 2025 data</p>

For each subsequent performance year, CMS will inform the participant of the performance benchmarks through the PMM by June 1 at the latest (that is, at least 30 days prior to the beginning of the performance year) in which CMS will use such benchmarks to determine the PBA. For future performance years, CMS may assess whether to hold benchmarks constant or update them based on additional data.

3.1 Participant-Reported Measures

Benchmarks for measures that rely on participant-reported data—QoL-PLWD and CID—will be derived from data submitted by GUIDE Participants.

Caregiver-Reported Impact in Dementia

The specifications for *Caregiver-Reported Impact in Dementia* (CID) are newly developed (please see **Appendix E** for full specifications). As a result, CID will not be included in the calculation of the PBA for PY 2025, as an additional year of data are needed to calculate a performance benchmark. The CID measure will be included in PBA calculations in PY 2026 (that is, July 2026 through June 2027), with further details, including benchmarking, to be provided in a future version of this PMM.

Although the CID measure contributes 0% to the PBA in PY 2025, participants are still required to submit ZBI-22 survey data for caregivers of their aligned patients via the PAAF, as part of GUIDE Model requirements (see the GUIDE Participation Agreement for more details).

Quality of Life for Patients Living with Dementia

QoL-PLWD is a positively oriented measure, meaning higher observed-to-expected (O/E) ratios indicate better performance. For each sub-scale of the measure, Global Physical Health and Global Mental Health, an O/E ratio of greater than 1.0 indicates that the participant's observed rate of quality-of-life maintenance or improvement exceeds what would be expected given the participant's patient characteristics. *The complete calculation methodology for the numerator and denominator is detailed in the QoL-PLWD technical specifications (see Appendix D).*

For PY 2025, QoL-PLWD will be assessed on a pay-for-performance basis for EPT Participants and on a pay-for-reporting basis for NPT Participants (see details below).

Beginning in PY 2026 and continuing through PY 2031, all participants will be evaluated for the QoL-PLWD measure using a pay-for-performance methodology; CMS may use data from the preceding performance year to calculate benchmarks. CMS will provide additional guidance on QoL-PLWD measure benchmarks for PY 2026 and subsequent performance years.

The final date for PAAF submissions to be included in the measure evaluation for PY 2025 is August 31, 2026. To receive the full individual measure PBA contribution for the QoL-PLWD measure, participants should ensure that PROMIS-10 data are submitted on time with complete documentation. Please see [Section 2.2](#) for more information.

New Program Track Participants

Given that the QoL-PLWD measure requires two data points collected approximately 12 months (± 60 days) apart to be scored, CMS will apply a pay-for-reporting approach for the QoL-PLWD measure for NPT Participants in PY 2025. Under a pay-for-reporting approach, participants are rewarded for submitting required measure data.

- NPT Participants who successfully report the QoL-PLWD measure by submitting PROMIS-10 assessment data for at least 90% of aligned patients in PY 2025 will receive a +2% contribution to the PY 2025 PBA.
- NPT Participants who fail to submit PROMIS-10 assessment data for at least 90% of aligned patients will receive a 0% contribution to the PY 2025 PBA (see **Exhibit 3** for more information).

Established Program Track Participants

EPT Participants will be evaluated using a pay-for-performance basis for the QoL-PLWD measure in PY 2025. Under a pay-for-performance approach, participants are rewarded or penalized based on performance relative to GUIDE-specific benchmarks.

For PY 2025, the benchmark for both the Global Physical Health and Global Mental Health sub-scales of the QoL-PLWD measure is 0.91, which corresponds to the 30th percentile of GUIDE participant performance (see **Exhibit 11**).

Exhibit 11. PY 2025 QoL-PLWD O/E Benchmark Classification

Status	Global Physical Health Sub-Scale	Global Mental Health Sub-Scale
Meeting Benchmark	O/E ratio greater than or equal to 0.91	O/E ratio greater than or equal to 0.91
Not Meeting Benchmark	O/E ratio less than 0.91	O/E ratio less than 0.91

For QoL-PLWD measure scoring, CMS compares each participant's O/E ratio to the corresponding benchmark derived from the GUIDE Model Participant population to determine the participant's PBA contribution. Each sub-scale is evaluated separately for the Global Physical Health and Global Mental Health sub-scales; the resulting PBA contribution depends on the number of benchmarks met:

- -1% if neither sub-scale benchmark is met;
- +1.5% if one sub-scale benchmark is met; and
- +3% if both sub-scale benchmarks are met.

For informational purposes, **Exhibit 12** presents the distribution of the QoL-PLWD measure O/E ratios across GUIDE Model Participants, derived from cumulative GUIDE data available (PY 2024 and PY 2025, as of April 2026), for participants meeting the measure minimum case count of 20 patients.

Exhibit 12. Percentile Distribution of QoL-PLWD Observed-to-Expected Ratios by Sub-Scale

Performance Percentile	Global Physical Health Sub-Scale Performance (O/E Ratio)	Global Mental Health Sub-Scale Performance (O/E Ratio)
0	0.71	0.61
5	0.74	0.70
10	0.77	0.76
15	0.83	0.81
20	0.88	0.88
25	0.90	0.90
30	0.91	0.91
35	0.95	0.91
40	0.98	0.94
45	1.02	0.97
50	1.03	0.98

Performance Percentile	Global Physical Health Sub-Scale Performance (O/E Ratio)	Global Mental Health Sub-Scale Performance (O/E Ratio)
55	1.06	1.02
60	1.08	1.03
65	1.09	1.05
70	1.11	1.06
75	1.15	1.07
80	1.17	1.11
85	1.22	1.18
90	1.25	1.25
95	1.28	1.37
100	1.35	1.65

3.2 Claims Measures

The following section outlines how benchmarks are derived for the three measures that rely on claims and administrative data: DAE, TPCC, and LTNH.

Claims Measures Benchmarking Cohort

For the TPCC and LTNH measures, CMS will derive PY 2025 benchmarks from post-adjudicated Medicare FFS claims data from a benchmarking cohort, spanning July 1, 2024, through June 30, 2025. The LTNH measure also will use administrative data from MDS 3.0. These benchmarks will be used for PY 2025 for both program tracks. CMS will release updated guidance on how GUIDE Model Participant benchmarks will be determined in future years as part of an update to this PMM.

CMS uses a benchmarking cohort, composed of a blend of GUIDE Participants and non-model providers identified in the Medicare FFS claims, to calculate benchmarks for use in PBA calculation. The benchmarking cohort is constructed in four steps.

- Step 1:** First, CMS identifies the patient population using Medicare FFS claims. Patients are included if they have at least one qualifying dementia diagnosis code (see the GUIDE PMP for more information). The dementia diagnosis code may appear in any position on the claim and must be associated with a Medicare Part B professional physician or supplier claim with a date of service between July 1 and June 30 of the year prior to the performance year being evaluated.
- Step 2:** Next, CMS determines monthly GUIDE eligibility for each patient within the identified dementia population. Eligibility is assessed on a month-by-month basis using GUIDE Model criteria. A patient is considered eligible for a given month only if all of the following conditions are met: the patient is enrolled in both Medicare Part A and Part B; Medicare is the primary payer; the patient is not enrolled in Medicare Advantage or the Program of All-Inclusive Care for the Elderly (PACE); the patient is not receiving Medicare hospice benefit during the month; the patient is not in a long-term nursing home stay (defined as a length of stay of 101 days or more); and the patient is alive at the start of the month.

- **Step 3:** Among the patients identified through the monthly eligibility process, CMS retains those who are eligible for at least one month and are also eligible at the start of the performance period (July 1). CMS then identifies eligible taxpayer identification numbers (TIN) that serve these eligible patients living with dementia, and subsequently identifies the total population served by these TINs using Medicare FFS claims, without restricting to dementia or any specific diagnosis code. This approach allows CMS to assess the concentration of dementia care within each TIN by comparing the total number of eligible patients living with dementia to the total number of eligible patients served overall. TINs are retained in the analytic cohort if they serve at least 50 eligible patients living with dementia and if at least 25% of their eligible panel consists of patients living with dementia. These thresholds ensure that the benchmarking cohort reflects providers with meaningful experience in dementia care, supporting valid and fair comparisons.
- **Step 4:** Finally, CMS builds the final analytic cohort by restricting the eligible dementia population to patients served by qualifying TINs and assembling the demographic and clinical characteristics needed for risk adjustment. These characteristics include demographic information, original reason for Medicare entitlement, indicators of prior healthcare utilization, Medicare-Medicaid dual eligibility status, hierarchical condition categories (HCC), and measures of dementia severity.

Use of High-Risk Medications in Older Adults

HRRx and DAE are inverse measures, where lower values indicate better performance. *The complete calculation methodology for the numerator and denominator is detailed in the DAE technical specifications (see **Appendix C**).*

The HRRx measure, which was participant-reported in PY 2024, transitions to a claims-based measure, DAE, beginning in PY 2026. The participant-reported data received for HRRx in PY 2024 could not be used, reliably, to establish a performance benchmark for PY 2025 scoring. Therefore, for PY 2025, for both NPT and EPT Participants, CMS will apply a null adjustment (0% contribution) to the PBA for the HRRx measure.

For PY 2025, HRRx and DAE will not contribute to the PBA. Participants are not required to submit an HRRx Excel workbook or any DAE-related data. CMS will calculate PY 2025 DAE performance using claims data for informational purposes, including those results in the December 2026 PBA workbooks (before DAE begins contributing to the PBA in PY 2026).

CMS will provide additional guidance on performance benchmarking for DAE for PY 2026 in a future update to the PMM.

Total Per-Capita Cost

TPCC is an inverse measure, where lower values indicate better performance. *The complete calculation methodology for the numerator and denominator is detailed in the TPCC technical specifications (see **Appendix F**).*

TPCC measure results are reported as observed-to-expected (O/E) ratios, where observed costs are compared to expected costs. CMS will use a pay-for-performance approach to assess TPCC performance for both program tracks in PY 2025. GUIDE Participants' TPCC scores will

be compared to performance benchmarks, which determine the measure-specific contribution to their PBA.

For PY 2025, the benchmark for the TPCC measure is 0.95, which corresponds to the 50th percentile of the benchmarking cohort (see **Exhibit 13**).

Exhibit 13. PY 2025 TPCC O/E Benchmark Classification

Meeting Benchmark	O/E ratio of less than or equal to 0.95
Not Meeting Benchmark	O/E ratio of greater than 0.95

For scoring, CMS compares each participant's TPCC measure O/E ratio to the benchmark. Because TPCC is an inverse measure, participants with an O/E ratio at or below the benchmark value of 0.95 meet the benchmark and receive a positive PBA contribution (+1.5%). Participants with an O/E ratio above 0.95 do not meet the benchmark and receive a negative PBA contribution (-0.5%).

To establish the benchmark for PY 2025, CMS used data from July 1, 2024, through June 30, 2025, to derive a risk-adjusted O/E ratio score distribution that reflects performance for both GUIDE Model Participants and non-model providers.

The TPCC measure's benchmarking cohort for PY 2025 consists of both patients aligned to a GUIDE Model Participant and eligible patients from identified non-model providers (see [Claims Measures Benchmarking Cohort](#) section for more information). For the TPCC measure, CMS uses all patient-months identified as eligible within the benchmarking cohort and aggregates standardized Medicare FFS claims payments for those months. Expected spending for each patient-month was estimated using an ordinary least squares (OLS) regression model that accounted for patient risk factors. Observed and expected monthly costs are then aggregated at the TIN level to calculate an O/E ratio for each provider in the benchmarking cohort.

For informational purposes, **Exhibit 14** shows the distribution of O/E ratios within the benchmarking cohort. For TPCC (and other inverse measures), higher performance percentiles correspond to better performance and, therefore, lower O/E ratios.

Exhibit 14. TPCC Observed-to-Expected Ratios for Benchmarking Cohort

Performance Percentile	Benchmark Cohort TPCC Performance (O/E Ratio)
0	4.62
5	2.13
10	1.84
15	1.63
20	1.43
25	1.29
30	1.19
35	1.12
40	1.05
45	1.00

Performance Percentile	Benchmark Cohort TPCC Performance (O/E Ratio)
50	0.95
55	0.92
60	0.87
65	0.84
70	0.78
75	0.73
80	0.69
85	0.64
90	0.58
95	0.50
100	0.20

Admissions to Long-Term Nursing Home Stay

LTNH is an inverse measure, where lower values indicate better performance. *The complete calculation methodology for the numerator and denominator is detailed in the LTNH technical specifications (see Appendix G).*

LTNH measure results are reported as observed-to-expected (O/E) ratios, where the observed number of patients that transition to a long-term nursing home stay is compared to the expected number of patients that transition to a long-term nursing home stay. The LTNH measure requires MDS data from a timeframe that exceeds the duration of a performance year. Specifically, an LTNH stay requires 101 or more days of admittance to qualify for the measure's numerator, meaning some stays extend more than three months beyond the end of the performance year.

CMS will use a pay-for-performance approach to assess LTNH measure performance for both program tracks in PY 2025. GUIDE Model Participants' LTNH measure scores will be compared to performance benchmarks which determine the measure-specific contribution to their PBA.

For PY 2025, the benchmark for the LTNH measure is 0.47, which corresponds to the 50th percentile of the benchmarking cohort (see Exhibit 15).

Exhibit 15. PY 2025 LTNH O/E Benchmark Classification

Meeting Benchmark	O/E ratio of less than or equal to 0.47
Not Meeting Benchmark	O/E ratio of greater than 0.47

For scoring, CMS compares each participant's LTNH O/E ratio to the benchmark to determine whether they received a positive or negative contribution to the overall PBA. Because LTNH is an inverse measure, participants with an O/E ratio at or below the benchmark value of 0.47 meet the benchmark and receive a positive PBA contribution (+1.5%). Participants with an O/E ratio above 0.47 do not meet the benchmark and receive a negative PBA contribution (-0.5%).

To establish the benchmark for the LTNH measure for PY 2025, CMS used Medicare FFS and MDS 3.0 data from July 1, 2024, through April 30, 2025 (with a look-forward period for

transitions to long-term status through August 9, 2025), to derive a risk-adjusted O/E score distribution that reflects performance for the benchmarking cohort, composed of a blend of GUIDE Participants and non-GUIDE providers. August 9, 2025 is 101 days after April 30, 2025, the final date on which new nursing facility admissions could begin and still be observed long enough to determine if they would transition to long-term stays.

The LTNH measure's benchmarking cohort consists of both patients aligned to a GUIDE Model Participant and eligible patients from identified non-model providers (see [Claims Measures Benchmarking Cohort](#) section for more information). Provider groups are identified at the TIN level, with the group's observed value being the aggregation of all observed LTNH stays attributed to their patients, and the expected value being the aggregation of all calculated expected transitions for their associated patients. After aggregating observed and expected values at the TIN level, an O/E ratio is calculated for each provider group.

For informational purposes, **Exhibit 16**, below, shows the distribution of O/E ratios within the benchmarking cohort. For LTNH (and other inverse measures), higher performance percentiles correspond to better performance and, therefore, lower O/E ratios.

Exhibit 16. LTNH Observed-to-Expected Ratios for Benchmarking Cohort

Performance Percentile	Benchmark Cohort LTNH Performance (O/E Ratio)
0	5.79
5	2.44
10	2.01
15	1.75
20	1.55
25	1.30
30	1.06
35	0.84
40	0.69
45	0.57
50	0.47
55	0.39
60	0.32
65	0.27
70	0.22
75	0.17
80	0.11
85	0.00
90	0.00
95	0.00
100	0.00

4 GUIDE Performance Measure Resources

For additional information on the GUIDE Model, including the performance measurement approach, please see the following resources:

- **CMS GUIDE Website:** The [GUIDE website](#) serves as the definitive public-facing resource for information about the GUIDE Model.
- **GUIDE Connect:** The Connect application serves as a forum for GUIDE Participants to access model resources and post questions (and answers) for fellow Participants and the CMS team.
- **CMS GUIDE Payment Methodology Paper (PMP):** The GUIDE PMP describes the methodologies that CMS uses to align patients to a GUIDE Participant and pay for services delivered under the GUIDE Model. The PMP is available on GUIDE Connect.

For additional information on the systems used for reporting performance measures, please see the following:

- **GUIDE Patient Assessment and Alignment Form (PAAF) Template:** The PAAF template is a standardized workbook through which GUIDE Participants submit patient-level clinical, demographic, and survey data to CMS, including caregiver responses to the ZBI-22 and patient responses to the PROMIS-10, along with required supplemental questions for each. The PAAF template is available on GUIDE Connect.
- **CMS Enterprise Portal (ePortal):** The [CMS ePortal](#) houses both the eDFR and HDR applications. The eDFR application includes the DFT, which participants use to track performance measure progress, as well as the CET, which supports exporting data and reports such as claims, quarterly measures data, alignment and payment reports, and the annual PBA report. The HDR application is used for submitting participant-reported data for performance measures and alignment to CMS, including comprehensive assessment and reassessment data through the PAAF.
- **GUIDE ISP User Manual:** This manual describes participant operations across the CMS ePortal applications, as well as the optional FHIR-based Application Programming Interface (API) to submit participant-reported data for performance measures and alignment.

For questions about performance measurement or any aspect of the GUIDE Model, participants may contact the GUIDE help desk at GUIDEModelTeam@cms.hhs.gov or by calling 1-888-734-6433, option 7.

Appendix A. Acronyms and Initialisms

Acronym or Initialism	Definition
APM	Alternative payment model
A-APM	Advanced alternative payment model
CID	<i>Caregiver-Reported Impact in Dementia</i> measure
CMS	Centers for Medicare & Medicaid Services
CY	Calendar year
DAE	<i>Use of High-Risk Medications in Older Adults</i> measure (claims-based version)
DCMP	Dementia care management payment
eDFR	Expanded Data Feedback Reporting application
EHR	Electronic health record
ePortal	CMS.gov Enterprise Portal
EPT	Established program track
FAQ	Frequently asked question
FFS	Fee-for-service
GUIDE	Guiding an Improved Dementia Experience Model
HDR	Health Data Reporting application
HRRx	<i>Use of High-Risk Medications in Older Adults</i> measure (clinical quality measure version requiring chart abstraction)
LTNH	<i>Admissions to Long-Term Nursing Home Stay</i> measure
MDS	Minimum Data Set
MIPS	Merit-based Incentive Payment System
NPT	New program track
O/E	Observed-to-expected ratio
PAAF	Patient Assessment and Alignment Form
PACE	Program of All-Inclusive Care for the Elderly
PBA	Performance-based adjustment
PMM	Performance Measurement Manual
PFS	Physician Fee Schedule
PMP	Payment Methodology Paper
PROMIS-10	Patient-Reported Outcomes Measurement Information System® Global Health-10
PY	Performance year
QoL-PLWD	<i>Quality of Life for Patients Living with Dementia</i> measure
QPP	Quality Payment Program

Acronym or Initialism	Definition
<i>TIN</i>	Taxpayer identification number
<i>TPCC</i>	<i>Total Per-Capita Cost</i> measure
<i>ZBI-22</i>	22-item Zarit Burden Interview

Appendix B: Connecting Care Delivery to Performance Measurement

Performance measurement in the GUIDE Model is grounded in care delivery. When participants consistently deliver care that meets GUIDE requirements, the results are reflected in stronger performance scores and, ultimately, in higher DCMP payments through the PBA.

The table below connects specific GUIDE care delivery activities to the five performance measures to help interdisciplinary care teams understand how their day-to-day work influences performance scores. It is meant to inform strategies for care delivery, recognizing that approaches may vary based on patient and caregiver needs, context, clinical judgment and other factors specific to a given GUIDE Model Participant. The information is intended as a supportive reference tool and should *not* be interpreted as an exhaustive list of the care delivery requirements, or a formal protocol. Additionally, while many of the activities described are applicable to all aligned patients and caregivers, some may not apply for patients living in residential care communities (RCC). For more information on care delivery requirements, please reference the GUIDE Participation Agreement, Appendix D.

Talk with your Teams about...	Relevant GUIDE Care Delivery Requirements
<i>Use of High-Risk Medications in Older Adults (DAE)</i>	
Medication Reconciliation during Comprehensive Assessments: When care teams complete medication reconciliation and review at the initial comprehensive assessment, this is the first opportunity to identify potentially inappropriate medications and proactively address medication-related risks to optimize safety and therapeutic outcomes.	Comprehensive Assessment
Medication Reconciliation during Transitions of Care: Completing medication reconciliation when patients transition between their residence and other care settings helps prevent errors and reduces risk of adverse drug events often related to duplicative or high risk medications used in acute care settings.	Care Coordination and Transitional Care Management
Ongoing Medication Management and Reconciliation: Consistent medication review, optimization (including appropriate prescribing and deprescribing), care coordination, and patient medication support collectively impact performance by improving safety, enhancing clinical outcomes, and reducing avoidable utilization.	Medication Management and Reconciliation
<i>Quality of Life for Patients Living with Dementia (QoL-PLWD)</i>	
Holistic Assessment to Support Quality of Life: Behavioral health, screening of upstream drivers of health needs, and the home visit assessment all directly relate to understanding and identifying opportunities to improve or maintain quality of life.	Comprehensive Assessment
Person-Centered Care Plans: When care plans are tailored to each patient's priorities and care preferences, care teams are better able to maintain or improve quality of life on an individual, personalized basis.	Care Plan

Talk with your Teams about...	Relevant GUIDE Care Delivery Requirements
<p>Care Coordination across Providers and Services: When care teams regularly and proactively coordinate across care providers on behalf of patients, they are more likely to identify additional referrals or services that can maintain or improve a patient's quality of life. This coordinated approach also helps alleviate caregiver burden by reducing the need for caregivers to navigate complex systems, manage communication across multiple providers, and coordinate services on their own.</p>	Care Coordination and Transitional Care Management
<p>Coordination of Home and Community-Based Services: Similar to care coordination, care teams are responsible for being proactive about connecting patients to Medicaid services or community-based services (such as home-delivered meals or personal care services) that can improve their quality of life.</p>	Referral and Coordination of Services and Supports
<i>Caregiver-Reported Impact in Dementia (CID)</i>	
<p>Caregiver Assessment: The caregiver assessment is a critical opportunity for the care team to assess the caregiver's knowledge, needs, and social supports as well as the caregiver's well-being, stress level, ability, and willingness to provide assistance to the patient. You must first understand the caregiver in order to support them.</p>	Comprehensive Assessment
<p>24/7 Access to the Care Team: Providing 24/7 access to the care team ensures timely identification of potential crises, reducing avoidable acute care use and strengthening support for patients and caregivers. Participants should routinely assess whether this access is sufficient and responsive to caregiver needs.</p>	24/7 Access
<p>Care Navigators: As their primary point of contact, ongoing care navigator contact directly impacts how caregivers experience participation in GUIDE. By providing high-quality ongoing support, your care teams are ensuring caregivers receive timely support, guidance, and access to needed services, preventing gaps in care and overwhelm.</p>	Ongoing Monitoring and Support
<p>Person-Centered Coordination during Transitions: By staying closely involved and truly knowing the patient, caregiver, and their person-centered care plan, the care team can guide families through care transitions with clearer coordination, less confusion, and timely support, easing the stress, confusion, and burden that caregivers often feel during these critical moments.</p>	Care Coordination and Transitional Care Management
<p>Tailored Skills Training, Dementia Diagnosis Information, and Other Supports: Tailoring the requirements for skills training, dementia diagnosis information, and support groups to each caregiver is one simple way care teams can drive performance for this performance measure. When caregivers receive practical training, clear information, and someone they can turn to for support, they feel more confident and less alone, making the day-to-day challenges of caregiving more manageable and easing their overall stress.</p>	Caregiver Education and Support
<p>Maximizing the Respite Benefit: Respite gives caregivers a real break, reducing burnout and making the demands of caregiving more sustainable over time. Discuss as a care team how to drive use of this important benefit, which participants can either provide in the home, a 24-hour care facility, or through adult day centers.</p> <p><i>*Respite benefits are not available for patients residing in RCCs</i></p>	Respite

Talk with your Teams about...	Relevant GUIDE Care Delivery Requirements
<i>Total Per-Capita Cost (TPCC)</i>	
<p>Access to the Care Team: When patients and caregivers can reach the care team with their questions or concerns and receive high-quality support, they are able to make informed decisions. High-quality 24/7 access to care can prevent unnecessary hospital visits and stays by addressing issues promptly and thoroughly as they arise in real time.</p>	<p>24/7 Access</p>
<p>Proactive Care Coordination and Referrals: Strong care coordination, especially around medication management, smooth transitions between care settings, and prompt referrals to the right specialists for physical or behavioral health needs, helps address patient and caregiver needs proactively, leading to more effective care and potentially lower overall costs.</p>	<p>Care Coordination and Transitional Care Management</p>
<i>Admissions to Long-Term Nursing Home Stay (LTNH)</i>	
<p>Advance Care Planning: While the entire comprehensive assessment is critical to understanding patient and caregiver needs to help maintain living in the community, advance care planning (ACP) helps align care with a patient's goals and preferences, reducing crisis-driven decisions that often result in transitioning to a nursing home. It is strongly encouraged to include caregivers in these critical conversations.</p>	<p>Comprehensive Assessment</p>
<p>Providing Consistent and Responsive Support: Care navigators play a critical role in helping families stay afloat, serving as a consistent, trusted point of contact who checks in, anticipates needs, and connects caregivers to the right support at the right time. This ongoing support helps prevent caregiver burnout and gaps in care that can otherwise lead to avoidable nursing home placement.</p>	<p>Ongoing Monitoring and Support</p>
<p>Routine Use of Respite: Care teams should proactively promote and integrate this benefit, whether in-home or through adult day services, as a key strategy to support caregivers and delay institutionalization. Regular access to respite care helps caregivers recharge and sustain their role over time making it more likely their loved one can remain safely at home rather than transitioning to a nursing facility.</p> <p><i>*Respite benefits are not available for patients residing in RCCs</i></p>	<p>Respite</p>