GUIDE Model for Dementia Care Overview for ACOs

Background

Nearly 7 million Americans live with a form of dementia, including Alzheimer's disease. The Alzheimer's Association estimates that 11 percent of adults over age 65 have dementia, a number that's expected to grow in coming years. Yet caring for these patients is expensive; the average dementia patient will cost an extra $12,000 to $15,700 in Medicare expenses five years after diagnosis.

To help, the Biden administration is rolling out a new payment model through the CMS Innovation Center called the Guiding an Improved Dementia Experience (GUIDE) model. GUIDE will test the efficacy of paying for specialized care, including support through care management fees and respite services, in reducing expenditures and improving quality in dementia patients.

GUIDE is a voluntary, risk-free, 8-year model running from July 1, 2024, through June 30, 2032. There will be two tracks; one for established dementia care programs and one for new programs, which will have a one-year implementation period. GUIDE participants are Part B-enrolled providers or suppliers that establish defined dementia care programs to provide longitudinal care to people with dementia. More information can be found in this request for applications (RFA).

Overlap With ACO Models

CMS will allow TINs to participate in both GUIDE and all other CMS Innovation Center models and the Medicare Shared Savings Program (MSSP). Eligible beneficiaries may simultaneously be aligned to the GUIDE Model and other ACO models, including ACO REACH (Realizing Equity, Access, and Community Health) and the Kidney Care Choices models.

ACO Expenditures

Starting in 2024, GUIDE's care management fees and respite payments for aligned beneficiaries will count toward MSSP ACO's expenditures. In 2024, the Innovation Center's models will not count GUIDE's payments, including the performance-based adjustment, health equity adjustment, and the respite payments, toward ACO expenditures. However, they may start to be counted in July 2025 or July 2026.

Overlap with Other CMMI Models

Overlap will be allowed between GUIDE and other CMMI models including BPCI Advanced, the Comprehensive Care for Joint Replacement, Primary Care First, Making Care Primary, the Maryland Primary Care Program, the Enhancing Oncology Care Model, and Kidney Care First.

Alignment

The GUIDE Model will use a voluntary alignment process for aligning beneficiaries. A beneficiary must meet the below criteria to be eligible for alignment to GUIDE:

- Has dementia, as confirmed by attestation from a clinician on the GUIDE participant's roster;
- Enrolled in Medicare Parts A and B;
- Not enrolled in Medicare Advantage, including Special Needs Plans (SNPs);
- Have Medicare as their primary payer;
- Not enrolled in the Program of All-Inclusive Care for the Elderly;
- Has not elected the Medicare hospice benefit; and
- Not a long-term nursing home resident.

Eligible patients will be identified through participants' networks or claims history. CMS can identify through claims potentially eligible patients seen by GUIDE participants and send participants a list of those beneficiaries for them to reach out to. CMS will also conduct its own outreach to patients with a confirmed dementia diagnosis.

GUIDE participants must then conduct a comprehensive assessment, which is similar to Medicare's Cognitive Assessment and Planning (CPT code 99483), to assess cognitive function, functional status, clinical needs, behavioral and psychosocial needs, and caregiver burden, with the goal of confirming a dementia diagnosis and creating a comprehensive care plan. If the GUIDE participant attests the beneficiary has dementia and may be eligible to be aligned to the model, the care team must obtain the beneficiary's consent to voluntarily align to the participant. CMS will not rely on ICD-10 dementia diagnosis codes to confirm dementia, opting instead for a clinician attestation.

Alignment occurs on a rolling basis. CMS encourages at least 200 aligned beneficiaries by the end of their second performance year, but there is not a formal requirement for minimum alignment. Beneficiaries will remain aligned to the participant until they become ineligible.

Care Management Requirements

GUIDE participants must create and maintain a care plan for aligned beneficiaries. That plan should detail patients' goals, preferences, and needs; provide recommendations for services and supports; include caregivers' options for education and support; and identify primary care providers and specialists and care coordination needed for dementia and other conditions. In addition to the above requirements, GUIDE participants must provide 24/7 access to an interdisciplinary care team, a care navigator, and in-home respite care. Participants must at least offer ad hoc one-on-one support calls with a member of the care team and referral to support group services. Additional requirements are outlined in Table 3 of the RFA.

Care Teams

GUIDE participants must maintain an interdisciplinary care team which includes at least a care navigator and a clinician with "dementia proficiency" who is eligible to bill Medicare Part B services. The clinician with dementia proficiency must have at least 25 percent of their patient panel be adults with cognitive impairment, including dementia; have at least 25 percent of their patient panel be adults age 65 or older; or have a specialty designation of neurology, psychiatry, geriatrics, geriatric psychiatry, behavioral neurology, or geriatric neurology.

Payment

There are five main components to the GUIDE model's payment methodology.

1. Monthly care management fee, called the Dementia Care Management Payment (DCMP);
2. A health equity adjustment to the DCMP;
3. A performance-based payment adjustment to the DCMP;
4. A payment for GUIDE Respite Services; and
5. A one-time infrastructure payment for safety net providers in the new program track (if eligible).

Dementia Care Management Payment

These monthly payments intend to cover care delivery services for aligned beneficiaries. The model will employ new G-Codes created for GUIDE that participants will use to submit claims for the monthly care management fees. The monthly payments will replace certain fee-for-service payments for some existing services, including chronic care management and principal care management, transitional care management, advance care planning, and technology-based check-ins. Payments will be higher for the first six months a beneficiary is aligned to reflect the additional work to stand up services, including creating and implementing a new care plan. Below are the base payment rates.

Per Beneficiary Per Month (PBPM) Base Payment Rates

	Beneficiaries with Caregiver: Low Complexity	Beneficiaries with Caregiver: Moderate Complexity	Beneficiaries with Caregiver: High Complexity	Beneficiaries without Caregiver: Low Complexity	Beneficiaries without Caregiver: Moderate to High Complexity
First 6 months (New Patient Payment Rate)	$150	$275	$360	$230	$390
After first 6 months (Established Patient Payment Rate)	$65	$120	$220	$120	$215

The DCMP rates above represent base payment rates and will be adjusted for geographic variation in costs as well as cost growth over time.

Respite Services

GUIDE Participants will be able to bill up to $2,500 per aligned beneficiary per year for respite services. Only certain aligned beneficiaries will be eligible for respite services payments.

Performance-Based Adjustment

GUIDE Participants' monthly DCMPs will increase or decrease based on performance on the model's five metrics during the previous year. Payments can increase by up to 10 percent or decrease by as much as -3.5 percent. The five metrics include:

1. Use of High-Risk Medications in Older Adults;
2. Quality of Life Outcome for People with Neurological Conditions;
3. Caregiver Burden;
4. Total Per Capita Cost; and
5. Long-Term Nursing Home Stay rate.

The caregiver burden and long-term nursing home stay rate are new metrics that will be developed for use in the GUIDE Model.

Health Equity Adjustment
A health equity adjustment will be calculated and applied annually to the monthly DCMP payments. Adjustments are made at the beneficiary level and are budget neutral. The adjustment will include state-and national-level Area Deprivation Index measured at the census block group level, and Low-Income Subsidy status and dual eligibility, which are beneficiary-level measures. CMS will calculate an Equity Score for every beneficiary and their corresponding geography.

Equity Score Percentiles and Associated Health Equity Adjustment Amounts

Equity Score Percentile	Health Equity Adjustment to DCMP
≥80th percentile of equity scores	+$15
51st-79th percentile of equity scores	$0
0-50th percentile of equity scores	-$6

Health Equity
The CMS Innovation Center will require participants to develop and implement a health equity plan. The Plan will identify disparities in their patient populations and draft strategies to reduce such disparities. Participants must collect and report data on beneficiaries' sociodemographic and health-related social needs. The aim of these requirements is to identify and address disparities within their patient population and track their progress towards health equity goals over time.

Established Vs. New Programs
Applicants will be deemed to have "established programs" if they currently have an interdisciplinary care team that has provided at least 6 of the 9 care delivery domains described for at least 12 months prior to the deadline for application submissions. Participants in the new program track must either not have such a care team or their care team is less than a year old. If no care team exists, the application must describe plans to implement such a care team. New program applicants that are safety-net providers will be eligible to receive a one-time payment of $75,000 to help cover the costs of establishing a new dementia care program.

Quality Payment Program Status
GUIDE is expected to be a MIPS APM. As such, any GUIDE participant will be eligible for voluntary scoring under the APM Performance Pathway. Because GUIDE will be a risk-free model, it will not qualify as an Advanced APM.

Additional ACO Impact
As outlined above, GUIDE's care management fees and respite payments for aligned beneficiaries will count toward MSSP ACO's expenditures. The respite payments alone can be up to $2,500 per patient, making a significant contribution that ACOs should be aware of whether they plan to participate in GUIDE or not. NAACOS has heard ACOs are exploring the idea of developing their own dementia care programs as a way to better serve these patients.