CMS 2024 Quality Conference
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Creating an Optimal Environment for Quality Healthcare for Individuals, Families, and Communities

Guiding Dementia Care Decisions: What Matters

Monday April 8, 2024

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Guiding an Improved Dementia Experience – The GUIDE Model

Can value based payment improve access to comprehensive dementia care?

COMMUNITIES

FAMILIES

INDIVIDUALS

RESILIENT

READY

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Objectives

1. What is the GUIDE model?

2. How will it translate into care that will effectively address the needs of people living with dementia and the people who furnish care and services?

3. How will we know it works?

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What is the GUIDE model?

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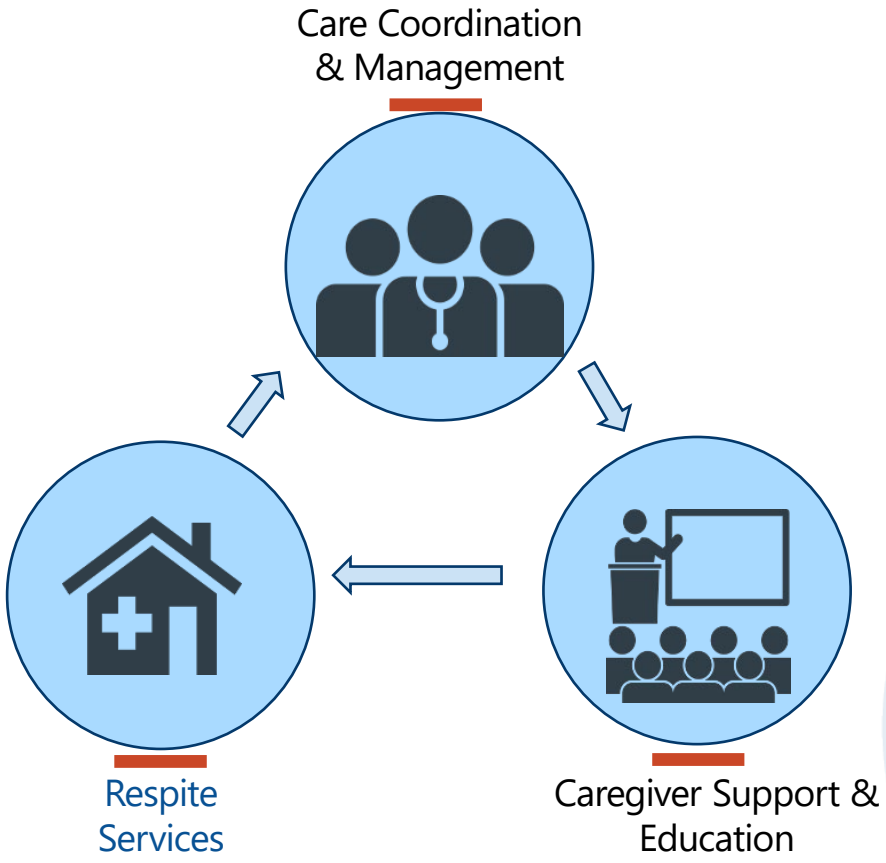
Model Purpose

The GUIDE Model will test whether a comprehensive package of care coordination and management, caregiver support and education, and respite services can **improve quality of life for people living with dementia and their caregivers** while **delaying avoidable long-term nursing home care** and **enabling more people to remain at home** through end of life.



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Scope and Duration

The GUIDE Model is an 8-year voluntary model offered in all states, D.C., and U.S. territories. The Model Performance Period will begin on July 1, 2024, and end on June 30, 2032.

Established Program Track and New Program* Track

The purpose of the two tracks is to allow established programs to begin their performance in the model on July 1, 2024, while giving organizations that do not currently offer a comprehensive community-based dementia care program, including safety net organizations, time and support to develop their program.

Model Timeline

	Nov. 15 2023 - Jan. 30 2024	July 2024- June 2025	July '25- June '26	July '26- June '27	July '27- June '28	July '28- June '29	July '29- June '30	July '30- June '31	July '31- June '32
Established Program Track	Application Period	Performance Year (PY) 1	PY 2	PY 3	PY 4	PY 5	PY 6	PY 7	PY 8
New Program Track	Application Period	Pre-Implementation (PI) Period	PY 1	PY 2	PY 3	PY 4	PY 5	PY 6	PY 7

New program development is intended to help increase beneficiary access to specialty dementia care, particularly in underserved communities.

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Eligible Beneficiaries Voluntarily Align to GUIDE

The GUIDE Model is designed for community-dwelling Medicare FFS beneficiaries, including beneficiaries dually eligible for Medicare and Medicaid. Eligibility criteria for Model beneficiaries are outlined below:

GUIDE Beneficiary Eligibility Criteria

- **Dementia Diagnosis**
- **Enrolled in Medicare Parts A & B**
- **Not Residing in Long-Term Nursing Home**
- **Has Not Elected the Medicare Hospice Benefit**
- **Not Enrolled in PACE**

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Model Tiers

Beneficiaries who align to model participants will be assigned to one of five "tiers," based on a combination of their disease stage and caregiver status. Beneficiary needs, and correspondingly, care intensity and payment, will 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

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How will GUIDE Improve Dementia Care?

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Care Delivery Approach

The GUIDE Model will promote high-quality dementia care by defining and requiring a comprehensive, standardized care delivery approach.

1 Standardized Care Delivery

Standardized care delivery services that participants must provide to beneficiaries and their caregivers

2 Interdisciplinary Care Team

Interdisciplinary care team to deliver standardized care delivery services

3 Standardized Training

Standardized training requirement for care navigators who are part of the interdisciplinary care team

Establishing standard minimum requirements with adequate model payments to support these requirements will transform dementia related care for beneficiaries.

Interdisciplinary Care Team Requirements

Participants must have an interdisciplinary care team that includes, at a minimum, a care navigator and a clinician with dementia proficiency who is eligible to bill Medicare Part B evaluation and management services (E/M).

The interdisciplinary care team will assess the beneficiary and their caregiver across a number of required domains, including cognitive function, functional status, clinical needs, behavioral and psychosocial needs, and caregiver burden, with the goal of confirming a dementia diagnosis and creating a comprehensive care plan.

CARE NAVIGATOR

Interdisciplinary Care Team

"DEMENTIA PROFICIENT" CLINICIAN

Interdisciplinary Care Teams may include additional members at the participant's discretion.

Dementia proficiency is defined as:

- At least 25% of a clinician's patient panel comprised of adults with any cognitive impairment, including dementia; or
- At least 25% of a clinician's patient panel aged 65 years old or older; or
- Have a specialty designation of neurology, psychiatry, geriatrics, geriatric psychiatry, behavioral neurology, or geriatric neurology.

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Care Delivery Requirements

COMPREHENSIVE ASSESSMENT
Beneficiaries and caregivers receive separate assessments to identify their needs and a home visit to assess the beneficiary's safety.

CARE PLAN
Beneficiaries receive care plans that address their goals, preferences, and needs, which helps them feel certain about next steps.

24/7 ACCESS
Beneficiaries and caregivers can call a member of their care team or a third-party representative using a 24/7 helpline.

ONGOING MONITORING & SUPPORT
Care navigators provide long-term help to beneficiaries and caregivers so they can revisit their goals and needs at any time and are not left alone in the process.

REFERRAL & SUPPORT COORDINATION
Beneficiaries' care navigator connects them and their caregivers to community-based services and supports, such as home-delivered meals and transportation.

CAREGIVER SUPPORT
Caregivers take educational classes and beneficiaries receive respite services, which helps relieve the burden of caregiving duties.

MEDICATION MANAGEMENT
Clinician reviews and reconciles medication as needed; care navigators provide tips for beneficiaries to maintain the correct medication schedule.

CARE COORDINATION & TRANSITION
Beneficiaries receive timely referrals to specialists to address other health issues, such as diabetes, and the care navigators coordinate care with the specialist.

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Health Equity Plan

The Health Equity Plan will allow each GUIDE participant to identify disparities in outcomes in their patent populations and implement initiatives to measure and reduce these disparities over the course of the model.

FOCUS

Beneficiary Outreach and Engagement

GOAL

Encourage Participants to develop and implement health equity recruitment strategies from model start

Health Equity Plan Requirements

- Regularly update and report progress on their Health Equity Plan, as an element of the model's annual care delivery reporting
- Set goals and monitor progress over time
- Identify and select evidence-based interventions for addressing health disparities and achieving equitable outcomes

Example Health Equity Plan Questions

- What specific outreach strategies for model recruitment will you use that are tailored to the underserved populations you are seeking to engage?
- What metrics and targets will you use to measure the success of your engagement and outreach strategies?
- Please list the data source you used to identify disparities and the primary intervention strategies you are planning in order to address the disparities you have identified.

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Infrastructure Payment

Participants in the new program track that are classified as safety net providers will also be eligible to receive an infrastructure payment to cover some of the upfront costs of establishing a new dementia care program.

- The infrastructure payment will be a one-time payment of $75,000 made at the beginning of the pre-implementation period (July 2024).
- The infrastructure payment is intended to assist GUIDE safety net providers with 1) hiring, 2) training, 3) developing program workflows, protocols, community partnerships, and materials, 4) community outreach and engagement, and 5) electronic health record technology adaptations.
- The payment will be geographically adjusted using the same Physician Fee Schedule geographic adjustment factor that was used to adjust the DCMP.
- To qualify, applicants must have a Medicare FFS beneficiary population comprised of at least 36% beneficiaries receiving the Part D LIS or 33.7% of beneficiaries who are dually eligible for Medicare and Medicaid. These thresholds are based on the safety net definition that CMMI has developed to assess and track safety net provider participation in its models.

Payment Methodology

The Model's core payment methodology is a per beneficiary per month care management payment, called the Dementia Care Management Payment (DCMP), that is adjusted for health equity and performance on a set of quality metrics, plus a separate payment for respite services.

Dementia Care Management Payment (DCMP) for collaborative care and caregiver education and support

- Per beneficiary per month payment
- DCMP replaces Physician Fee Schedule (PFS) billing for certain care management services
- Each model tier will have a different PBPM rate

Adjustments to the DCMP

- Performance-Based-Adjustment (PBA), a percentage adjustment to PBPM payments depending on how participants perform on model metrics
- Health Equity Adjustment (HEA) to the DCMP based on beneficiary-level health equity scores

Payment for respite services

- Participants will be able to bill for respite services for beneficiaries with a caregiver and moderate to severe dementia, up to a $2,500 annual cap
- Respite could include in-home, adult day health, or facility-based care

Participants in the new program track that are classified as safety net providers will also be eligible to receive an infrastructure payment to cover some of the upfront costs of establishing a new dementia care program. Safety net provider status will be defined based on the share of a provider's patient population that receives the Medicare Part D Low Income Subsidy or is dually eligible for Medicare and Medicaid

Payment Adjustments tied to Quality and Health Equity

When participants bill the per beneficiary per month Dementia Care Management Payment (DCMP), the DCMP will be adjusted by a Performance-Based Adjustment (PBA), as well as a Health Equity Adjustment (HEA).

The Health Equity Adjustment (HEA) is designed to decrease the resource gaps in serving historically disadvantaged communities.

The Performance Based Adjustment (PBA) will increase or decrease participants' monthly DCMPs, depending on how they perform during the previous performance year.

HEA will be based on certain social risk factors, which may include:

- **National Area Deprivation Index (ADI)**
- **State Area Deprivation Index (ADI)**
- **Low-Income Subsidy Status (LIS)**
- **Dual Eligibility Status**

PBA will calculate five model performance metrics across four domains that include:

DOMAIN	METRICS
Care Coordination and Management	Use of High-Risk Medications in Older Adults
Beneficiary quality of life	Quality of Life Outcome for People with Neurological Conditions
Caregiver Support	Caregiver Burden Measure
Utilization	Total Per Capita Cost (TPCC)
	New: Rate of beneficiaries entering a long-term nursing home stay

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How Will We Know if GUIDE Works?

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Pathways to Model Expansion

Achieve savings as certified by the Office of the Actuary

Improve quality without increasing spending

Ideally, we achieve both

Evaluations are required by statute and inform whether we achieved these goals

Evaluation Purpose

To assess model implementation, the experience of participants and beneficiaries over time, and effects on model outcomes including **3 primary GUIDE objectives**.

1. Improve the quality of care and **quality of life** for people with dementia
2. Reduce **caregiver burden and strain**
3. Help people **remain in their homes and communities**, while reducing Medicare and Medicaid expenditures

Note: Measures for these two outcomes, quality of life and caregiver burden and strain, are not available in claims data. Quality data will need to be collected from model participants and non-participants serving as a comparison group.

Data Reporting

All Innovation Center model participants are required to collect and report data deemed necessary to monitor and evaluate the model, including "protected health information". GUIDE will require participants to report the following:

Quality Data*

Care Delivery Data

Beneficiary and Caregiver Assessment Data

Sociodemographic and Health Related Social Needs (HRSN) Data

*Participants will annually report quality data for the three non-claims-based performance metrics (high-risk medication use, beneficiary quality of life, and caregiver burden).

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How To Get Involved

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How to Learn More and Track our Progress

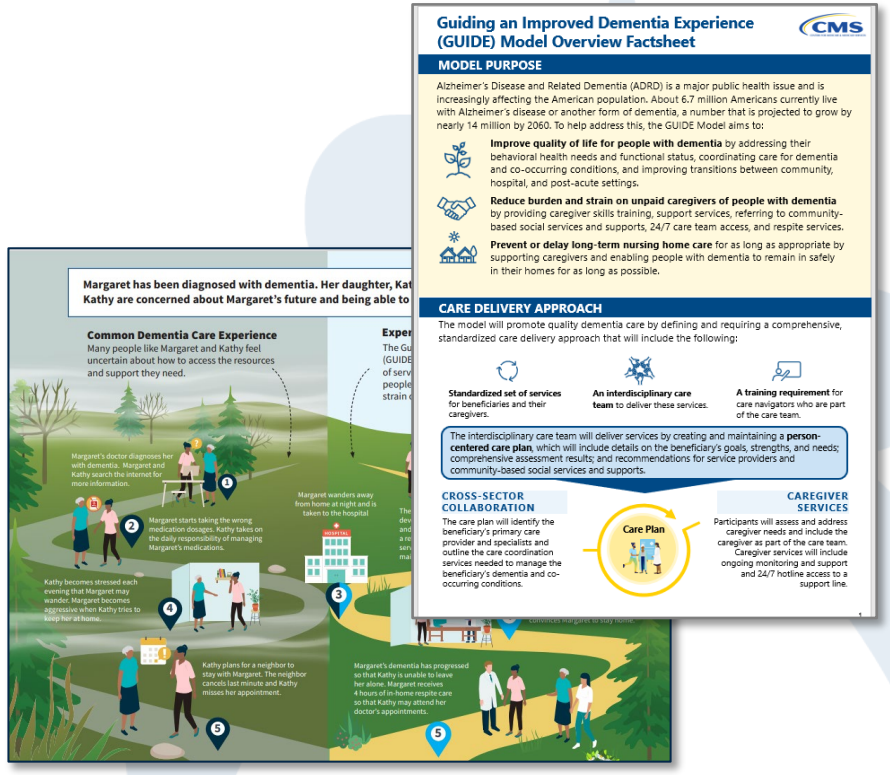
The GUIDE Model team has a host of resources to support interested organizations. To see the latest resources, visit the Model's Website at https://innovation.cms.gov/innovation-models/guide.

Model Factsheets
Model Overview , GUIDE Model Dementia Pathways Infographic, and Participant Incentives Factsheet may be found on the Model's website.

Participants
Once participants have been selected and signed participation agreements they will be listed on the Model's website

Annual Evaluations
Annual evaluations will be posted to the Model's website

Helpdesk
If you have questions for the GUIDE Model team, please reach out to us via email at GUIDEModelTeam@cms.hhs.gov.



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THANK YOU AND DISCUSSION

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