Guiding an Improved Dementia Experience (GUIDE)

Oct 26, 2023

AMERICA'S PHYSICIAN GROUPS

Housekeeping Items

Please keep your microphone muted.

Type questions in the Q & A box or raise your hand to be unmuted.

The meeting materials will be sent to all registrants.

This webinar will be recorded and sent to all registrants.

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Today's Agenda

- Welcome- Jennifer Podulka 5 min
- Overview of model- Tonya Saffer - 20 min
- Value of model- Valinda Rutledge-10 min
- Decision points to consider in applying- Joy Chen- 10 min
- How to begin preparing- Jennifer Podulka- 5 min
- Q/A- 10 min

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Speakers

Tonya Saffer
Director,
Division of
Healthcare
Payment
Models

Joy Chen
Policy Director
Healthsperian

Valinda Rutledge
EVP Education
and Strategic
Initiatives

Jennifer Podulka
VP of Federal
Policy

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Overview of Model

Tonya Saffer

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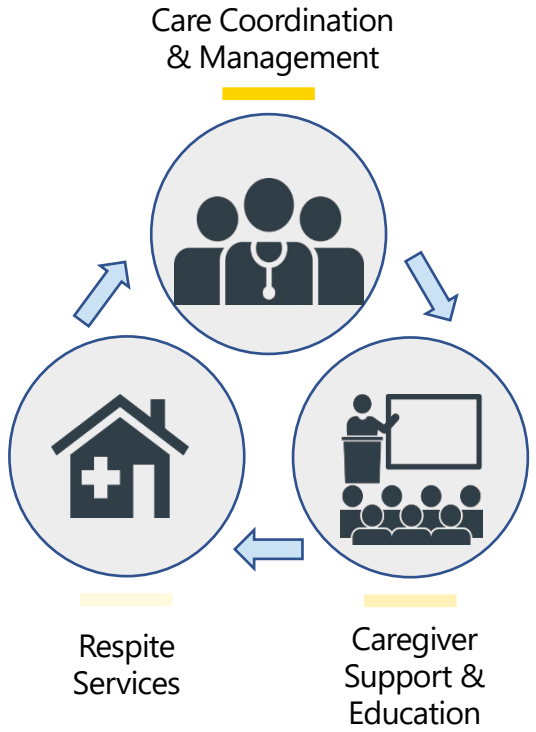
Guiding an Improved Dementia Experience (GUIDE)

Presentation for America's Physician Groups
October 26, 2023

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Model Purpose and Overview

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 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.



Care Coordination & Management

Beneficiaries will receive care from an **interdisciplinary team** that will develop and implement a comprehensive, person-centered care plan for **managing the beneficiary's dementia and co-occurring conditions** and provide **ongoing monitoring and support.**

Caregiver Support & Education

GUIDE participants will provide a **caregiver support program**, which must include caregiver skills training, dementia diagnosis education, support groups, and access to a personal care navigator who can help problem solve and connect the caregiver to services and supports.

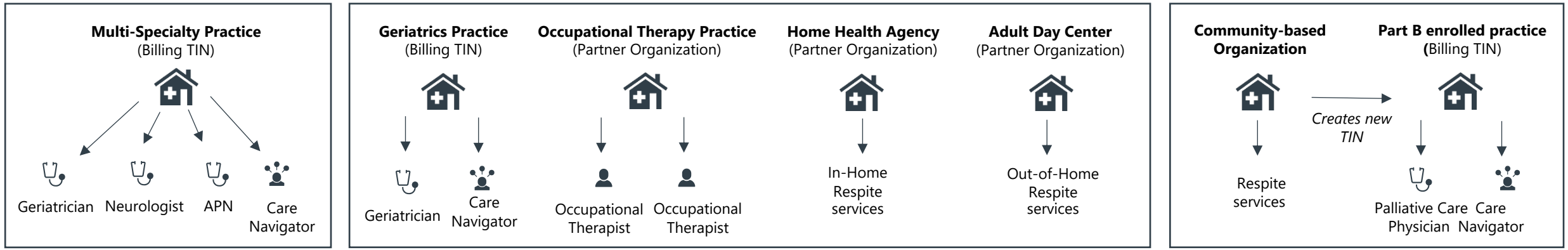
Respite Services

A subset of beneficiaries in the model will be eligible to receive payment for respite services with no cost sharing, up to a cap of **$2,500 per year**. These services may be provided to beneficiaries in a variety of settings, including **their personal home, an adult day center, and facilities that can provide 24-hour care** to give the caregiver a break from caring for the beneficiary.

Who is Eligible to Participate in GUIDE?

GUIDE participants will be Medicare Part B enrolled providers/suppliers, excluding durable medical equipment (DME) and laboratory suppliers, who are eligible to bill for Medicare Physician Fee Schedule service and agree to meet the care delivery requirements of the model. If the GUIDE participant can't meet the GUIDE care delivery requirements alone, they have the ability to contract with "Partner Organizations," which are other Medicare providers/suppliers, to meet the care delivery requirements

Example Dementia Care Program provider and supplier arrangements:



A single Medicare provider with multiple suppliers forms a GUIDE DCP

Several Medicare providers and multiple suppliers form a DCP

Medicare-enrolled provider establishes a new Part B enrolled TIN to form a GUIDE DCP

GUIDE is an 8-year voluntary model offered in all states, D.C., and the U.S. territories.

GUIDE Model Program Track Designation

In order to support the development of new dementia care programs, GUIDE has created two model tracks: a track for established programs that will launch on July 1, 2024, and a track for new programs that will launch on July 1, 2025 after a one-year pre-implementation period for participants to establish their new programs.

Model Participant Tracks	
ESTABLISHED PROGRAM	**NEW PROGRAM**
+ Designed for participants already providing comprehensive dementia care + Participants should be ready to immediately implement GUIDE's care delivery requirements	+ Designed for participants not operating a comprehensive outpatient dementia care program who are interested in scaling support + Participants must submit a detailed plan for implementing a dementia care program

Based on the information provided in their application, selected participants will be assigned to the established program track or the new program track. Track assignment will depend on whether a program is providing comprehensive dementia care at the time of model announcement.

Beneficiary Eligibility and Alignment

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

Beneficiary has dementia confirmed by attestation from clinician practicing within a participating GUIDE dementia care program

Enrolled in Medicare Parts A & B

Beneficiary must have Medicare as their primary payer and not enrolled in Medicare Advantage, including Special Needs Plans (SNPs)

Not Residing in Long-Term Nursing Home

Not Enrolled in Medicare Hospice

Services overlap significantly with the services that will be provided under the GUIDE model

Not Enrolled in PACE

Services overlap significantly with the services that will be provided under the GUIDE model

Voluntary Alignment Process

The GUIDE model will use a voluntary alignment process for aligning beneficiaries to model participants. Participants must inform beneficiaries about the model and the services that they can receive through the model, and document that a beneficiary (or their legal representative if applicable) consents.

Care Delivery Requirements

Participants must provide specified services across the domains outlined below. Participants will tailor the exact mix of services based on each beneficiary's individual care plan.

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.

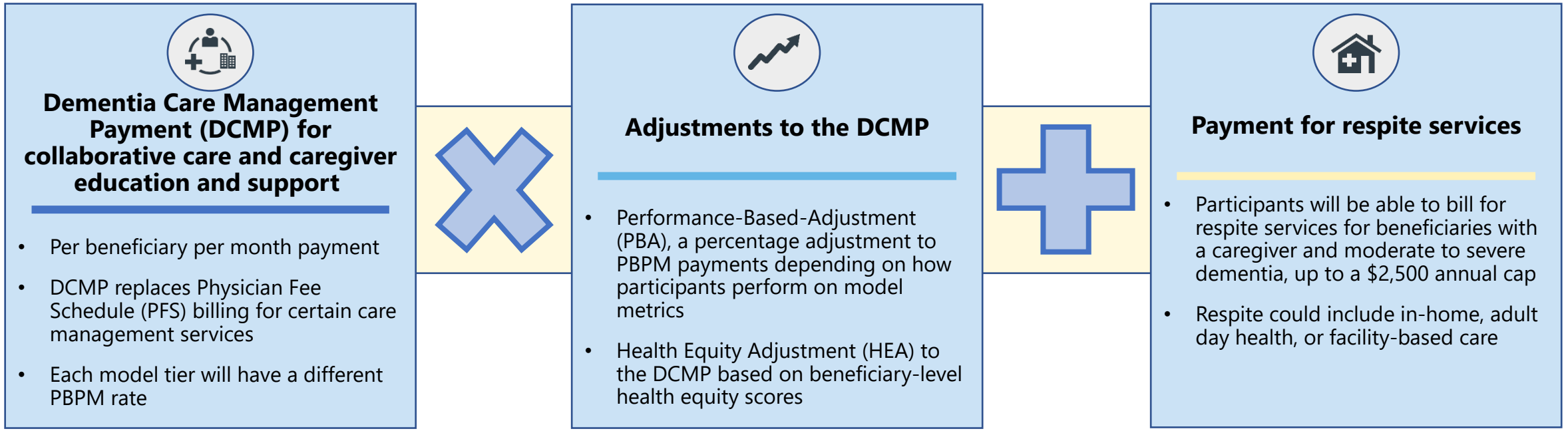
CAREGIVER SUPPORT
Caregivers take educational classes and beneficiaries receive respite services, which helps relieve the burden of caregiving duties.

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.

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.



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 Amounts

Model participants will use a set of new G-Codes created for the GUIDE model in order submit claims for the monthly Dementia Care Monthly Payment (DCMP). The DCMP is intended to cover the model's required care delivery activities.

Per Beneficiary Per Month Payment Rates

	Monthly payment rates for beneficiaries with caregiver			Monthly payment rates for beneficiaries without caregiver	
	Low complexity dyad tier	**Moderate complexity dyad tier**	**High complexity dyad tier**	**Low complexity individual tier**	**Moderate to high complexity individual tier**
First 6 months (New Beneficiary Payment Rate)	$150	$275	$360	$230	$390
After first 6 months (Established Beneficiary Payment Rate)	$65	$120	$220	$120	$215

In order to support accurate billing, CMS will provide each participant with a monthly beneficiary alignment file that lists all beneficiaries aligned to that participant, their model tier assignment, and the length of their alignment to the participant.

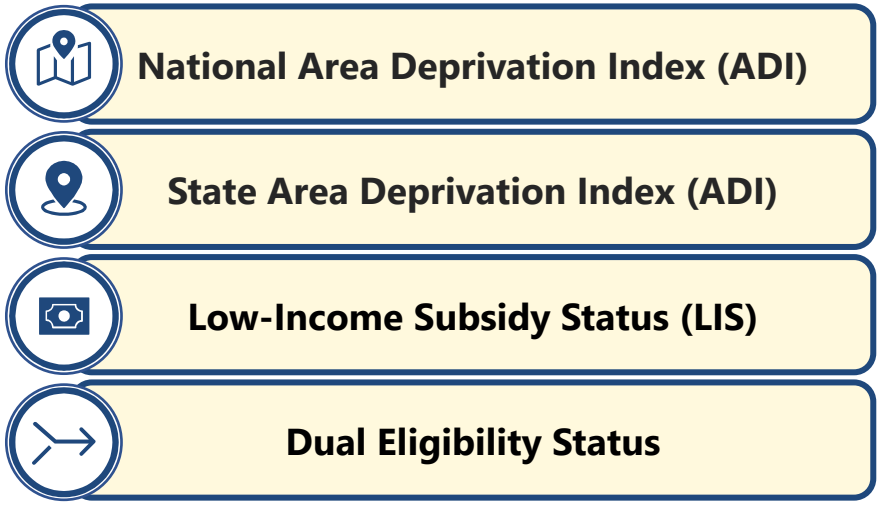
Payment Adjustments

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:



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

DOMAIN	METRICS
Care Coordination and Management	High-risk medications (eCQM/CQM)
Beneficiary quality of life	Quality of life outcome (Survey-based)
Caregiver Support	Caregiver Strain (Survey-based)
Utilization	Total Per Capita Cost (Claims-based)
	Long-term nursing home stay rate (Claims-based)

GUIDE Model Timeline

The model application period will start in Fall 2023 and the performance period for the established program track and pre-implementation period for the new program track will begin on July 1, 2024

	Fall '23-Winter '24	July '24-June '25	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	Application Period	Performance Year (PY) 1	PY 2	PY 3	PY 4	PY 5	PY 6	PY 7	PY 8
NEW PROGRAM	Application Period	Pre-Implement-ation (PI) Period	PY 1	PY 2	PY 3	PY 4	PY 5	PY 6	PY 7

Prospective applicants are strongly encouraged to submit a non-binding Letter of Intent (LOI) by September 15, 2023.

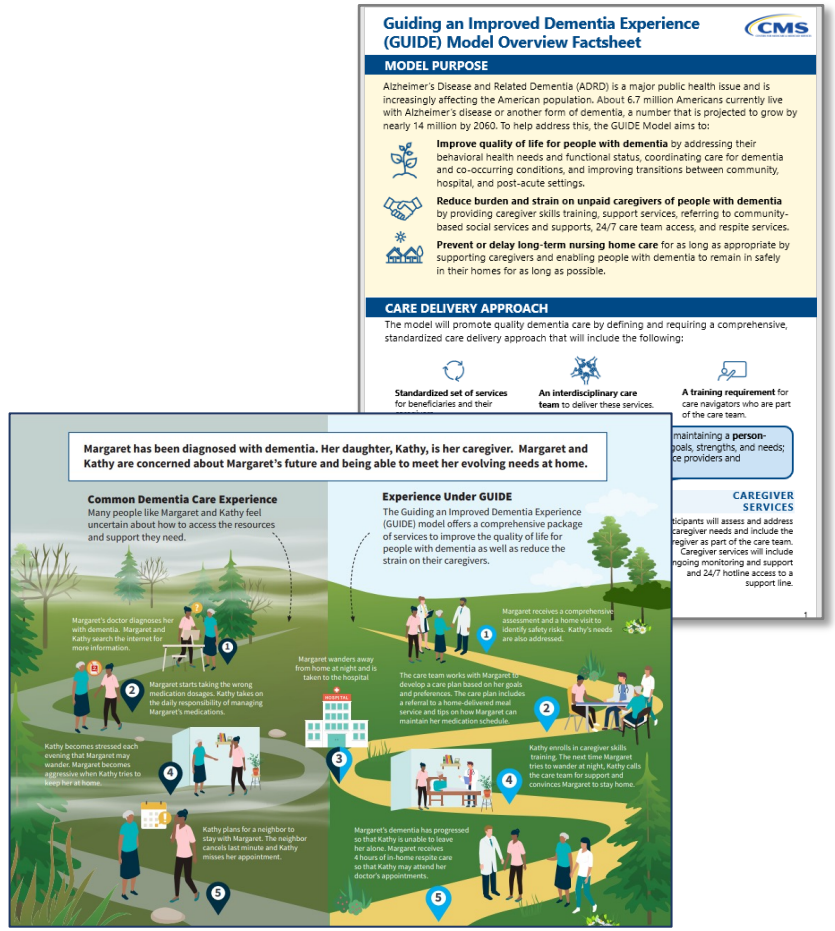
Model Resources

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 and GUIDE Model Dementia Pathways Infographic may be found on the Model's website.

Request for Applications (RFA)
Coming in Fall 2023

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



Value of Model

Valinda Rutledge

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Current VBM Challenges

Slowing adoption:

- Limited resources for addressing complex conditions like dementia
- Implementation challenges (payments, education, pathways)
- Ongoing workforce issues
- Caregiver needs not addressed
- Inability to address SDOH variables through Traditional Medicare
- Risk tolerance of provider organizations

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Value of Model

8-year length with unique provider arrangements available. Non TCOC or shared savings model

Allow virtual assessment and intervention (other than one in person visit)

PBPM Payment for comprehensive set of services (DMCP) with no co-pay. Can increase due to quality performance

Address Caregiver Needs through respite payment, separate assessment, and dedicated training

Survey unique performance metrics – beneficiary quality of life and caregiver burden

Support activities to partner with CBO and FQHC

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CBO: Community Based Organizations
PBPM: per beneficiary per month
TCOC- Total cost of care

Decision Points to Consider in Applying

Joy Chen

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Inspired Health Solutions

Decision Points to Consider In Applying to the GUIDE Model

JOY CHEN, POLICY DIRECTOR

OCTOBER 26, 2023

Agenda

- Key Considerations for Success
- Infrastructure Needs

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Key Considerations for Success

- ✓ **Existing dementia program**: Do you have an existing dementia care program? Or would you be starting an entirely new program?
- ✓ **Caregiver supports**: Does your patient population have caregiver needs and can you connect them to support services?
- ✓ **Assessing your patient population**: What percentage have dementia? Are many of them low-income beneficiaries from underserved communities?
- ✓ **Engagement in other models:** What alternative payment models are you and/or your practice actively engaged in currently?
- ✓ **Upstream experience:** Does your organization have existing expertise and capacity to deliver care to patients dealing with serious illness but upstream from end-of-life care?

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Key Considerations for Success

- ✓ **Capacity and services to coordinate dementia care:** Where are the gaps? Do you work with an interdisciplinary team across multiple lines of business?
- ✓ **Care coordination capabilities**: How well can you and your practice integrate care across settings?
- ✓ **Reimbursement incentives:** Is your existing reimbursement adequate (as the model may alter payment incentives)? Can you provide high-quality care at the proposed reimbursement levels in the model?
- ✓ **Training needs**: Does staff need to be trained to provide high-quality, empathetic dementia care?

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Key Considerations for Success

- ✓ **Health IT/data sharing capabilities:** Are these in place to enable smooth care transitions? Can your practice collect and report data on aligned beneficiaries' sociodemographic characteristics and health-related social needs?
- ✓ **Existing partnerships**: Does your practice have relationships with community-based organizations that can help supplement a patient's medical and non-medical needs?
- ✓ **Quality data**: Is your practice able to report quality data for three non-claims-based performance metrics (high-risk medication use, beneficiary quality of life, and caregiver burden)?
- ✓ **Timeline reflection**: Can your practice be ready for implementation/pre-implementation by July 1, 2024?

Infrastructure Needs

Electronic health records with interoperability between physicians and the health care team to share medical history, medications, test results, care plans, etc.

Care coordination platforms to securely share care plans and allow communication between all members of the care team.

Patient portals and remote monitoring tools to keep tabs on patients' needs between visits.

Digital tracking systems for referrals, appointments, transitions between facilities.

Infrastructure Needs

Integration of social determinants data to coordinate medical and social services.

Use of predictive analytics to identify rising risk patients and trigger care interventions proactively.

Data integration with public health agencies/health information exchanges to obtain comprehensive medical history.

Telehealth platforms to provide virtual care access points and consistent connections between patients, families, and providers.

How to Begin Preparing

Jennifer Podulka

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RFA Submission Tips

- Identify team to complete RFA
- Confirm participation criteria (Part B provider)
- Begin conversations with potential partners
- Review screening tools and discuss process for implementation (workflows, staff needs)
- Assess health IT requirements for reporting
- Develop a plan to meet minimum beneficiary numbers
- Financial modeling of DMCP Services


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