Guiding an Improved Dementia Experience (GUIDE) Request for Applications (RFA) Webinar

Center for Medicare and Medicaid Innovation
November 30, 2023

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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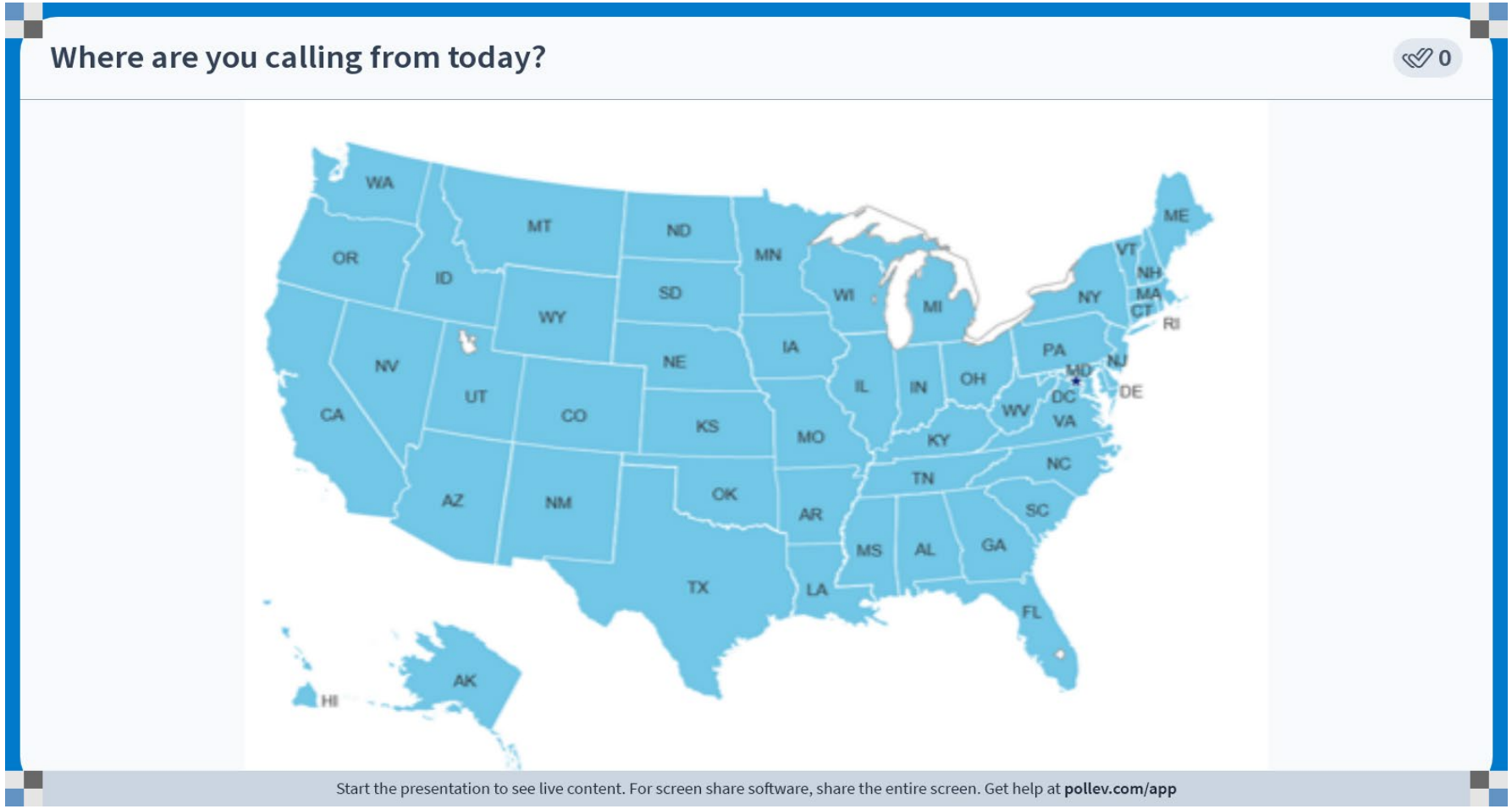
Agenda

This webinar provides an introduction to the GUIDE Model RFA. The following topics will be discussed:

1. GUIDE Model Background
2. GUIDE Model Request for Applications (RFA) Overview
3. Participant Eligibility Requirements
4. Alternative Payment Methodology
5. Care Delivery Requirements
6. Quality Measures
7. Application Process and Timeline

Welcome and Introductions

Poll #1



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Today's Presenters

Tonya Saffer
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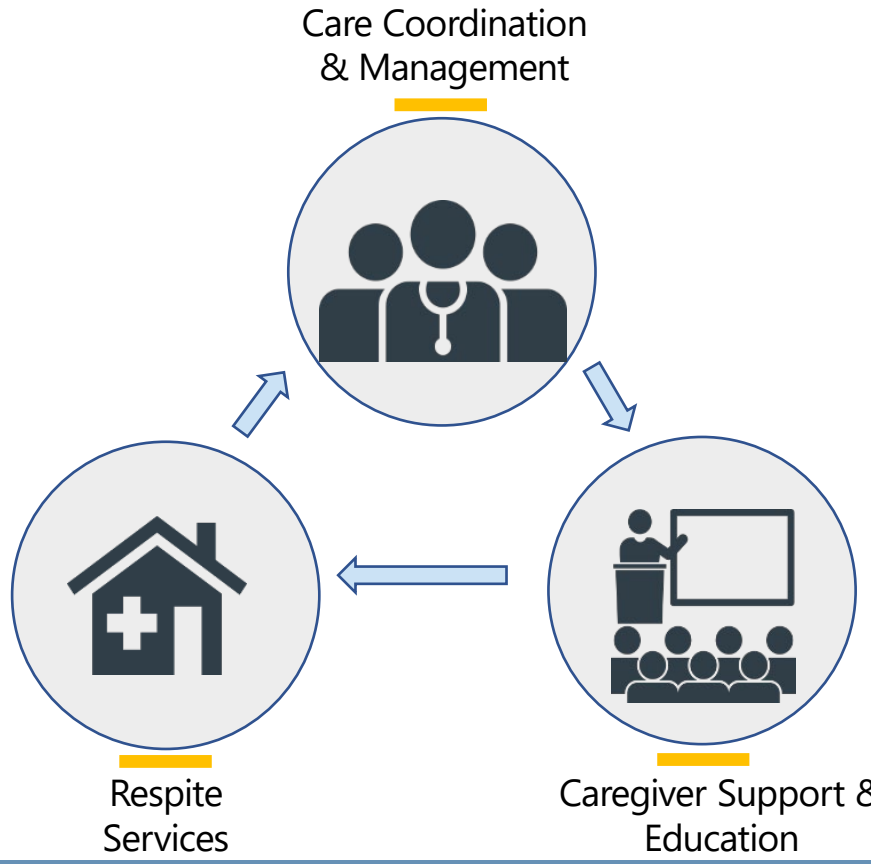
GUIDE Model Background

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.



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

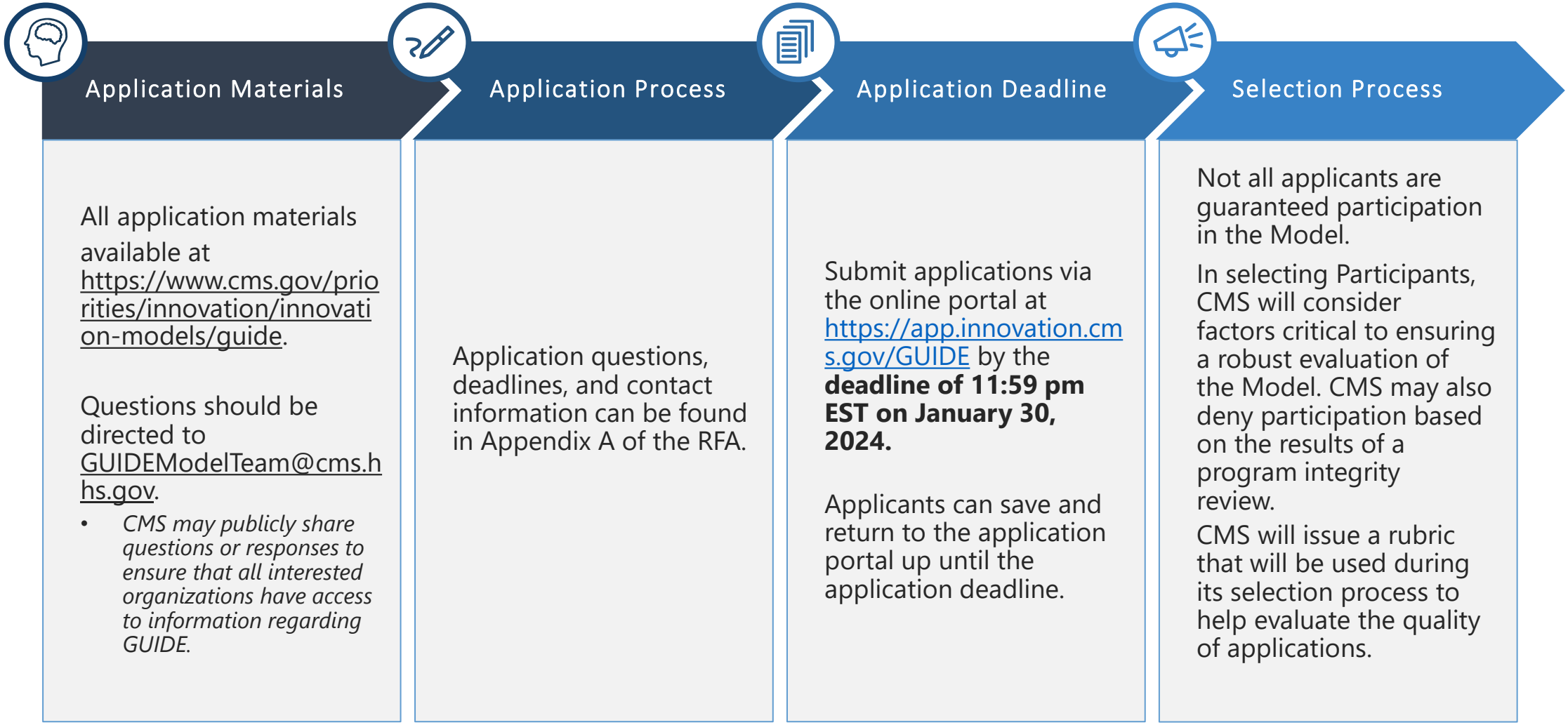
	Nov. 15 2023 - Jan. 30 2024	July 2024- June 2025	July '25- June '26	July '26- June '27	July '27- June '28	July '28- June '29	July '29- June '30	July '30- June '31	July '31- June '32
Established Program Track	Application Period	Performance Year (PY) 1	PY 2	PY 3	PY 4	PY 5	PY 6	PY 7	PY 8
New Program Track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

GUIDE Model Request for Applications (RFA) Overview

Application Submission

CMS strongly recommends that you do not wait until the application due date to begin the application submission process.



Participant Eligibility Requirements

Eligible Participants

The GUIDE Model eligibility criteria for Participants is described below:

Who is Eligible?

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 services and agree to meet the care delivery requirements of the Model.

Who Can Participate?

Participants must meet the care delivery requirements described in the care delivery section of the RFA but may choose to partner with other organizations, including both Medicare-enrolled providers and suppliers, and non-Medicare enrolled entities, such as community-based organizations, to meet these requirements.

Participation Requirements

Participants must meet the below requirements throughout the performance period of their assigned track (e.g., July 1, 2024 - June 30, 2032, for the established program track and July 1, 2025 - June 30, 2032, for the new program track).

GUIDE Participation Requirements:

Meet the interdisciplinary care team, care delivery, and training requirements (see the Care Delivery section and Appendix B of the RFA).

Use an electronic health record platform that meets CMS and Office of the National Coordinator for Health Information Technology (ONC) standards for Certified Electronic Health Record Technology (CEHRT).

May provide care delivery services virtually or in-person but must have the ability to conduct an initial home visit in-person for aligned beneficiaries who have moderate to severe dementia.

Must make available for eligible beneficiaries GUIDE Respite Services in the beneficiary's home. Participants have the option to offer eligible beneficiaries GUIDE Respite Services at an adult day center or a facility that can provide 24-hour care.

Maintain an up-to-date GUIDE Practitioner Roster and Partner Organization Roster (if applicable).

Comply with all model reporting requirements, including care delivery, sociodemographic data, and quality reporting.

Applicants do not need to have a Medicare Part B enrolled TIN that is eligible to bill under the PFS at the time of application but must have one when they sign the GUIDE Participation Agreement (PA) due Spring 2024.

Participant Track Selection

Model Participant Tracks

ESTABLISHED PROGRAM

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

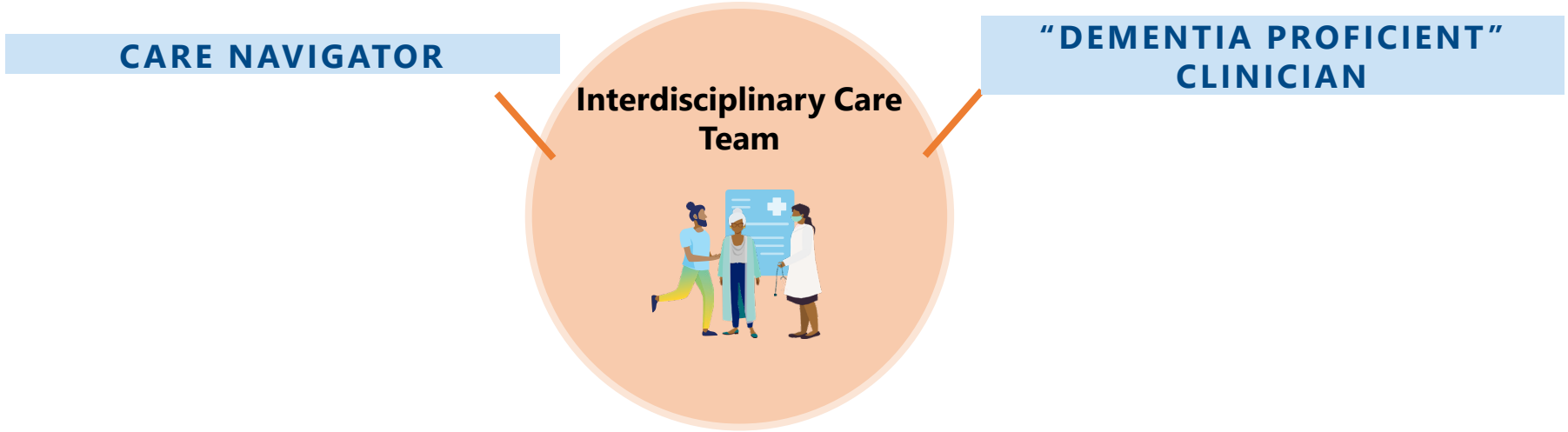
NEW PROGRAM

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

Track assignment will depend on whether, at the time of application, the applicant has an interdisciplinary team that has provided comprehensive dementia care to people living with dementia (defined as at least 6 of the 9 care delivery domains described in the Care Delivery section of the RFA) for at least the past 12 months.

Minimum 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).



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

Dementia proficiency is defined as:

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

GUIDE Model Rosters

Participant will be required to maintain a GUIDE Practitioner Roster and a Partner Organization Roster (if applicable) and keep each list up to date throughout the course of the GUIDE Model.

GUIDE Practitioner Roster

1) Must include the National Provider Identifiers (NPIs) of individual Medicare-enrolled physicians and other non-physician practitioners who have re-assigned their billing rights to the Participant's billing TIN.

2) Must include at a minimum a clinician with "dementia proficiency".

Partner Organization Roster

1) If Participant contracts with either Medicare-enrolled or non-Medicare enrolled entities, the Participant must submit a Partner Organization Roster.

2) Both Medicare-enrolled and non-Medicare enrolled entities may contract with more than one Participant.

Eligible Beneficiaries

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

Has Not Elected the Medicare Hospice Benefit
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

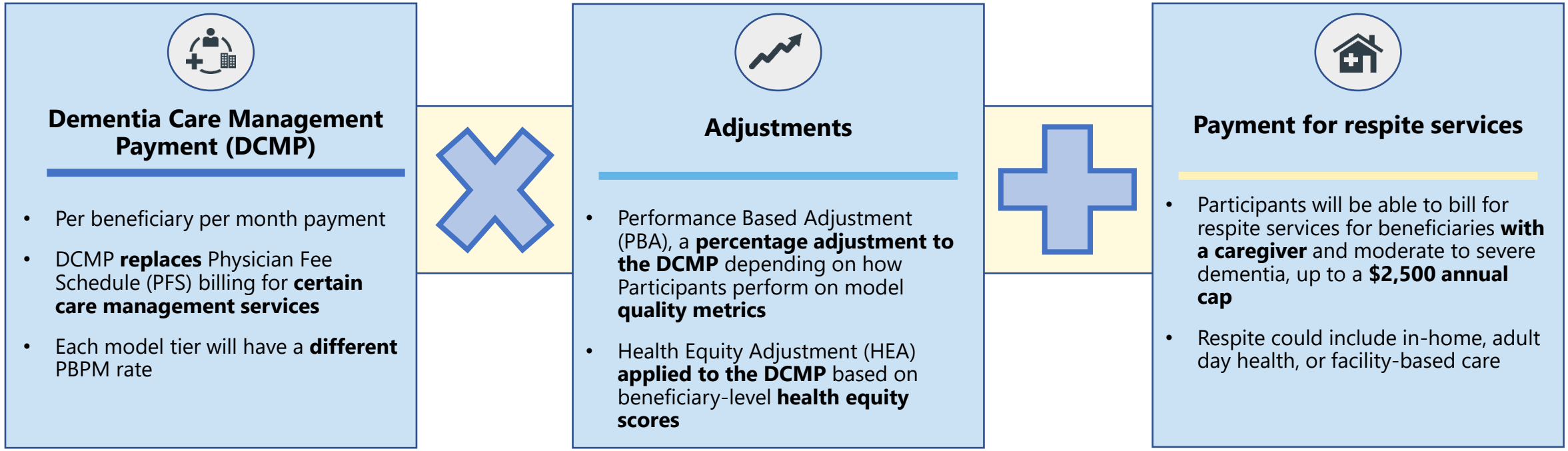
Voluntary Alignment Process

The GUIDE Model will use a voluntary alignment process. Participants must document that a beneficiary (or their legal representative if applicable) consents to align to the Participant.

Participants may request a list of potential beneficiaries who may be eligible for voluntary alignment. Additionally, Participants may have beneficiaries self-referred to them based on letters sent by CMS, or by other provider referrals.

Alternative Payment Methodology

Payment Methodology



Participants classified as safety-net providers may also be eligible for a one-time infrastructure payment.

Performance Based Adjustment

The DCMP Performance Based Adjustment (PBA) will increase or decrease Participants' monthly DCMPs, depending on how they perform during the previous performance year. Participants will be required to submit quality data annually.

GUIDE Quality Measures	Use of High-Risk Medications in Older Adults (eCQM/CQM)	Quality of Life Outcome for People with Neurological Conditions (Survey-based)	Caregiver Burden (Survey-based)	Total Per Capita Cost (Claims-based)	Long-term Nursing Home Stay Rate (Claims-based)	**Total:**
PBA Potential	-0.5% – +1%	-1% – +3%	-1% – +3%	-0.5% – +1.5%	-0.5% – +1.5%	**-3.5% – +10%**

Calendar Year	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**	**2031**	**2032**
Established Program Track	**PY 1** 7/2024 – 6/2025	**PY 2** 7/2025 – 6/2026	**PY 3** 7/2026 – 6/2027	**PY 4** 7/2027 – 6/2028	**PY 5** 7/2028 – 6/2029	**PY 6** 7/2029 – 6/2030	**PY 7** 7/2030 – 6/2031	**PY 8** 7/2031 – 6/2032	
		PBA 1 1/2026 – 12/2026	**PBA 2** 1/2027 – 12/2027	**PBA 3** 1/2028 – 12/2028	**PBA 4** 1/2029 – 12/2029	**PBA 5** 1/2030 – 12/2030	**PBA 6** 1/2031 – 12/2031	**PBA 7** 1/2032 – 6/2032	
New Program Track	Pre-Implement-ation Year	**PY 1** 7/2025 – 6/2026	**PY 2** 7/2026 – 6/2027	**PY 3** 7/2027 – 6/2028	**PY 4** 7/2028 – 6/2029	**PY 5** 7/2029 – 6/2030	**PY 6** 7/2030 – 6/2031	**PY 7** 7/2031 – 6/2032	
			PBA 1 1/2027 – 12/2027	**PBA 2** 1/2028 – 12/2028	**PBA 3** 1/2029 – 12/2029	**PBA 4** 1/2030 – 12/2030	**PBA 5** 1/2031 – 12/2031	**PBA 6** 1/2032 – 6/2032	

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 Rates

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

	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 Patient Payment Rate)	$150	$275	$360	$230	$390
After first 6 months (Established Patient Payment Rate)	$65	$120	$220	$120	$215

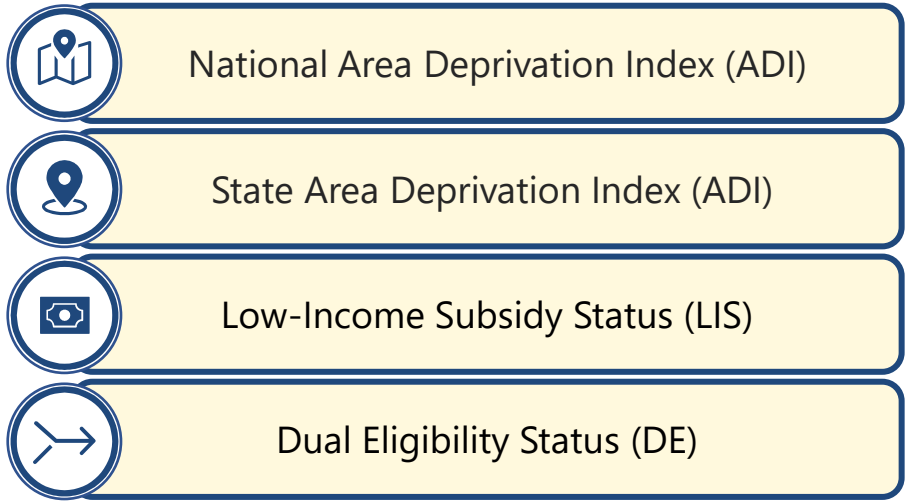
The DCMP rates above represent base payment rates and will be adjusted for geographic variation in costs as well as cost growth over time.

Health Equity Adjustment

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.

The HEA is applied to the DCMP based on beneficiary-level health equity scores and is designed to decrease the resource gaps in serving historically underserved communities.

HEA will be based on the following social risk factors:



Health equity score =

0.1 x National ADI + State ADI + 20 x LIS/DE

Where:

- *National ADI = 1-100*
- *State ADI = 1-10*
- *LIS/DE = 1 if yes, 0 if no*

Equity Score Percentile	HEA
≥80th percentile of equity scores	**+$15**
51st-79th percentile of equity scores	**$0**
0-50th percentile of equity scores	**-$6**

Participant Payment Example Per Beneficiary

The two payment examples below show how total GUIDE Model payments will be calculated for an individual aligned beneficiary over the course of a full performance year.

Payment Example #1

Beneficiary in the Moderate Complexity Tier with a Caregiver

Jane Smith
Lives in Miami,FL

Moderate Complexity, Caregiver Tier:
New patient DCMP rate: **$275**
Established Patient DCMP Rate: **$120**

GAF for Miami, FL: **1,067**
GUIDE Participant's PBA: **4%**
Mrs. Smith's HEA: **+$15**

	Step 1: Geographically Adjust DCMP	**Step 2:** Apply PBA	**Step 3:** Apply HEA	**Step 4:** Calculate total for 6 months
First 6 months:	$275 X 1.067 = **$293**	$293 X 1.04 = **$304**	$304 + $15 = **$320**	$320 X 6 = **$1,920**
Next 6 months:	$120 X 1.067 = **$128**	$128 X 1.04 = **$133**	$133 + $15 = **$148**	$148 X 6 = **$888**

Total Annual DCMP.....$2,808

Step 5: Geographically Adjust Respite Cap $2,500 x 1.067 = **$2,668**

Total Annual DCMP and Respite..... $5,476

Payment Example #2

Beneficiary in the Moderate/Severe Complexity Tier without a Caregiver

Jack Johnson
Lives in Phoenix, Arizona

Moderate/ Severe Complexity, No Caregiver Tier:
New patient DCMP rate: **$390**
Established Patient DCMP Rate: **$229**

GAF for Phoenix, AZ: **0.973**
GUIDE Participant's PBA: **7%**
Mr. Johnson's: **-$6**

	Step 1: Geographically Adjust DCMP	**Step 2:** Apply PBA	**Step 3:** Apply HEA	**Step 4:** Calculate total for 6 months
First 6 months:	$390 X 0.973 = **$379**	$379 X 1.07 = **$406**	$406 - $6 = **$400**	$400 X 6 = **$2,400**
Next 6 months:	$215 X 0.973 = **$209**	$209 X 1.07 = **$224**	$224 - $6 = **$218**	$218 X 6 = **$1,308**

Total Annual DCMP.....$3,708

Care Delivery Requirements

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 have 24/7 access to a member of their care team or help line (may be a 3rd party vendor during off-duty hours).

ONGOING MONITORING & SUPPORT
Care navigators provide long-term help to beneficiaries and caregivers so they can revisit their goals and needs at any time.

REFERRAL & SUPPORT COORDINATION*
Beneficiaries' care navigator connects them and their caregivers to community-based services and supports.

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

RESPITE SERVICES*
Eligible beneficiaries with caregivers may receive GUIDE respite services.

MEDICATION MANAGEMENT
Clinician reviews and reconciles medication as needed.

CAREGIVER EDUCATION & SUPPORT*
Caregivers are given education and support via ad hoc calls and caregiver training.

*The Participant has the option to contract with a Partner Organization to make these services available to their beneficiaries.

Approved Screening Tools

To ensure consistent beneficiary assignment to tiers across Participants, the Participant must use a tool from a set of approved screening tools to measure dementia stage and caregiver burden. Approved tools have scoring thresholds that correspond to mild, moderate, and severe disease stage or caregiver burden.

	Tier	Criteria	Corresponding Assessment Tool Scores
Beneficiaries with a caregiver	• Low complexity dyad tier	Mild dementia	CDR=1, FAST=4
	• Moderate complexity dyad tier	Moderate or severe dementia *AND* Low to moderate caregiver strain	CDR=2-3, FAST=5-7 *AND* ZBI=0-60
	• High complexity dyad tier	Moderate or severe dementia *AND* High caregiver strain	CDR=2-3, FAST=5-7 *AND* ZBI=61-88
Beneficiaries without a caregiver	• Low complexity individual tier	Mild dementia	CDR=1, FAST=4
	• Moderate to high complexity individual tier	Moderate or severe dementia	CDR=2-3, FAST=5-7

Quality Measures

Performance Measure Set

CMS intends to eventually include five measures in the GUIDE performance measure set: one clinical quality process measure, two patient-reported outcome measures, one cost measure, and one utilization measure.

Measure Name	Aligned Model Goals	MIPS, NQF Measure?
Use of High-Risk Medications in Older Adults	Improve beneficiary quality of life; reduce hospital and ED utilization	MIPS: Yes, #238 NQF: Yes, #0022
Quality of Life Outcome for People with Neurological Conditions	Improve beneficiary quality of life	MIPS: Yes, #AAN22 NQF: No
Caregiver Burden Measure	Reduce caregiver burden	MIPS: No NQF: No
Total Per Capita Cost (TPCC)	Reduce cost of care	MIPS: Yes NQF: Yes, #3575
New: Rate of beneficiaries entering a long-term nursing home stay	Prevent or delay long-term nursing home stays; reduce cost of care (or maintain budget neutrality)	MIPS: No NQF: No

The five measures in the performance measure set will be used to adjust GUIDE Participants' monthly payments. CMS plans to phase in the use of these measures over time.

GUIDE Data Reporting Requirements

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

- Caregiver Burden survey
- Quality of Life survey
- High-risk medication measure

Care Delivery Data

- Care delivery reporting survey

Beneficiary and Caregiver Assessment Data

- Zarit Burden Interview
- Clinical Dementia Rating *or* Functional Assessment Staging Tool

Sociodemographic & Health Related Social Needs Data

- Accountable Health Communities HRSN Tool
- Protocol for Responding to and Assessing Patient's Assets, Risks, and Experiences

Program Overlap

CMS will allow organizations to participate in both the GUIDE Model and any other current Innovation Center models, as well as the Medicare Shared Savings Program. Both beneficiaries and participants may overlap in any of the below models.

Shared Savings Program and Innovation Center ACO Model			Advanced and Comprehensive Care for Joint Replacement (CJR) Models		Innovation Center Models with Care Management Payment*			
ACO Reach	**Shared Savings Program**	**Kidney Care Choices**	**BCPI Advanced**	**Comprehensive Care for Joint Replacement**	**Primary Care First**	**Making Care Primary**	**Maryland Primary Care Program**	**Enhancing Oncology Care Model**

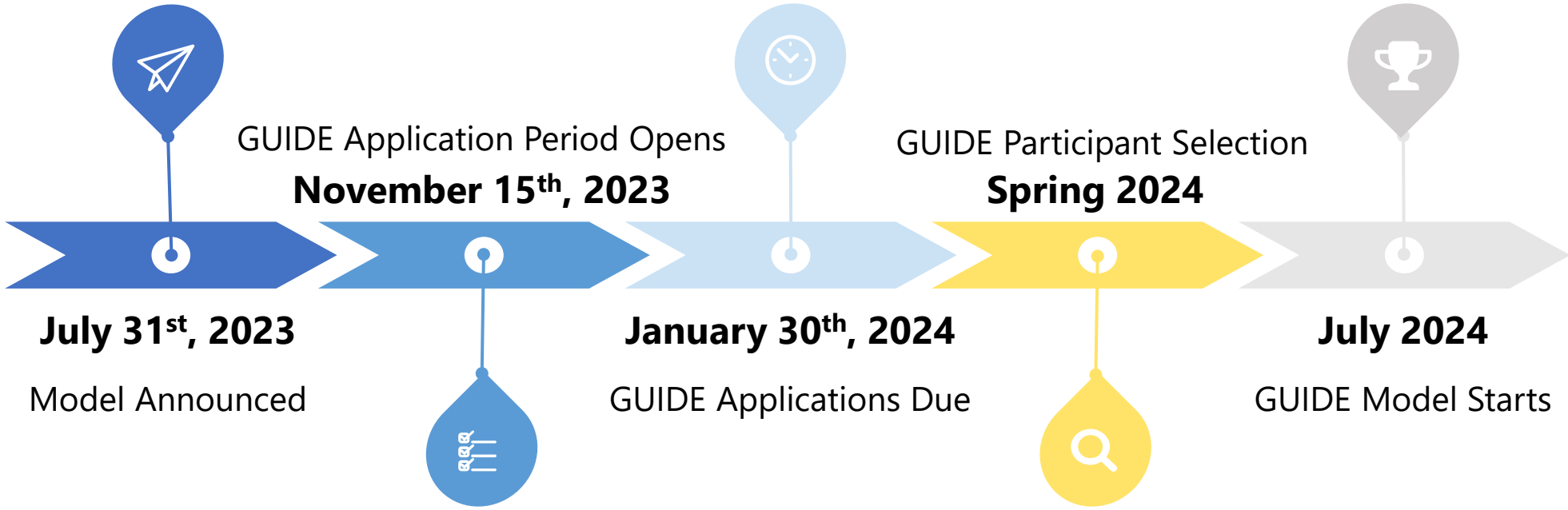
*CMS may recoup parts of the DCMP if deemed duplicative of the same payments for the same provider and beneficiary combination in a different Innovation Center model.

Application Process and Timeline

Application Overview

All GUIDE applications must be submitted through the online application portal by 11:59pm Eastern Daylight Time on January 30, 2024. CMS may request additional information post-application and deny participation based on program integrity review of GUIDE Model applicants.

Interested organizations may prepare to apply to the GUIDE Model considering the timeline* outlined below.



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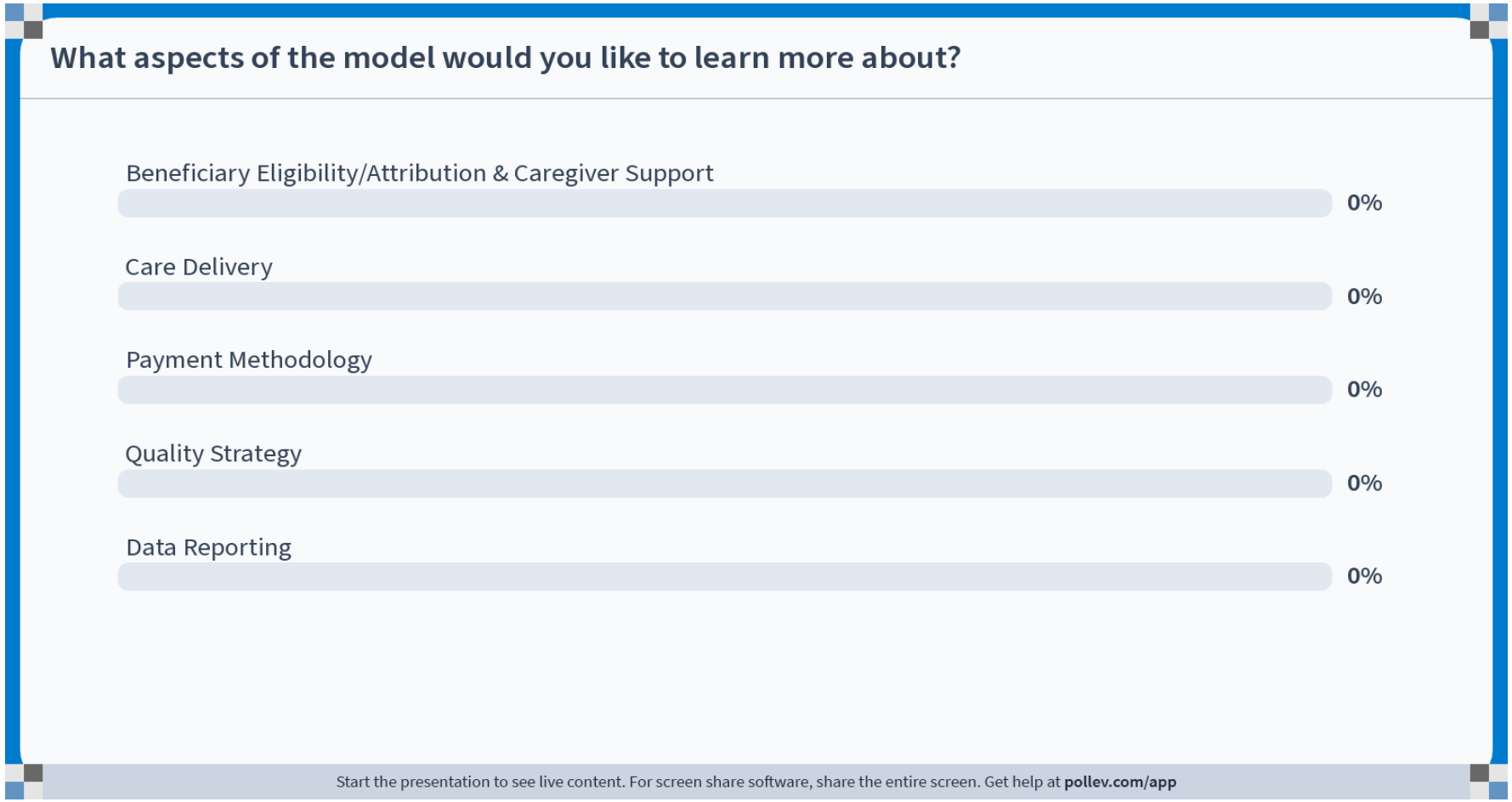
Question and Answer Session

Poll #2



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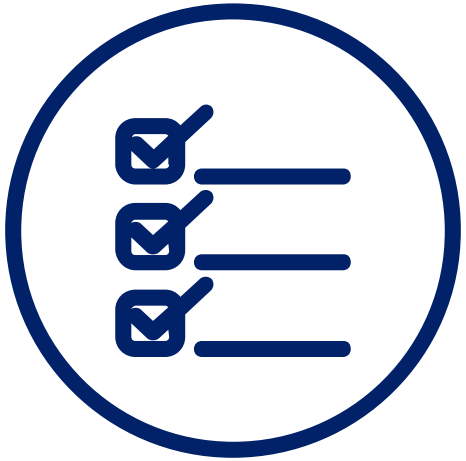
Please Complete Our Survey



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We would love to learn how to make our events better.

Question & Answer Session

Open Q&A

Please **submit questions via the Q&A pod** to the right of your screen.

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.

Application Link

All application materials, will be available on the Model's Website.
The application period is open from November 15, 2023 to January 30, 2024.

Model Factsheets

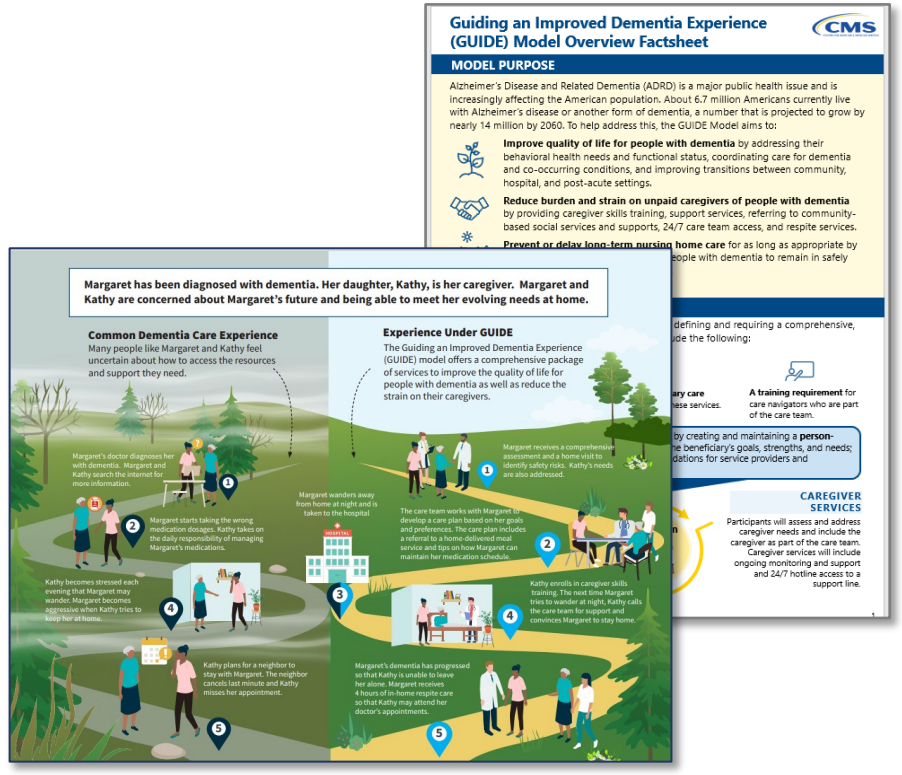
Model Overview , GUIDE Model Dementia Pathways Infographic, and Participant Incentives Factsheet may be found on the Model's website.

Request for Applications (RFA)

Practices interested in applying can access the RFA and application portal on 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.



Closing

Thank You for Attending this Webinar

We appreciate your time and interest!

Please take the survey following this webinar so we can learn how to make our events better.

Upcoming Events: GUIDE Office Hour Webinar on January 11th, 2024.

Do you have questions? Email your comments and feedback to GUIDEModelTeam@cms.hhs.gov with subject line ***GUIDE RFA Application Support Webinar***

THANK YOU!