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Guiding an Improved Dementia Experience Model

The Guiding an Improved Dementia Experience (GUIDE) model is an 8-year voluntary national model starting on July 1, 2024. The model offers:

- A standardized approach to care
- 24/7 access to an interdisciplinary care team member or help line
- Caregiver training, education, and support services, including respite services

Together we can advance health equity and help eliminate health disparities for all minority and underserved groups. The GUIDE model will adjust payments by a health equity adjustment factor. The model participants must submit health related social needs information and plans to address health equity to CMS annually. Visit the GUIDE webpage for GUIDE specific health equity information. Find additional resources and more from the CMS Office of Minority Health:

- Health Equity Technical Assistance Program
- Disparities Impact Statement

What Are the Model's Goals?

- Enhance quality of care by improving quality of life for people with dementia
- Enhance quality of care by reducing burden and strain of caregivers
- Reduce hospital, emergency department, and post-acute care use
- Reduce Medicare and Medicaid spending by preventing or delaying long-term nursing home stays

Who Can Apply to Participate in the Model?

The application and selection period to participate in the model has ended. We selected participants to participate in either the Established Program Track (starting July 1, 2024) or New Program Track (starting July 1, 2025). Participants must be all of these:

- Medicare Part B-enrolled provider or supplier (excluding DME and laboratory suppliers)
- Eligible to bill under the Medicare Physician Fee Schedule (PFS) under a single Part B-enrolled Taxpayer Identification Number (TIN)
- Meet the care delivery requirements of the model

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- Use an electronic health record platform that meets our and Office of the National Coordinator for Health Information Technology standards for Certified Electronic Health Record Technology

What's the Target Participation for the Model?

The target participation is 390 model participants. We encourage each participant to voluntarily align an average of 200 Medicare Fee-for-Service (FFS) patients by the end of their second performance year. Participants will inform patients about the model and obtain their consent to get services under the model. This includes people living with dementia who are dually eligible for Medicare and Medicaid.

Participants will maintain a GUIDE Practitioner Roster of aligned providers that will bill under the participant TIN.

How Do We Pay the Model's Participants?

We'll pay participants a per beneficiary per month (PBPM) amount known as a dementia care management payment (DCMP). The DCMP covers certain services, including:

- Care management and coordination
- Caregiver education
- Support services

We'll adjust the DCMP rates by a health equity adjustment (HEA) and performance-based adjustment (PBA) to provide an incentive for high-quality care. The HEA and PBA adjustments won't start until the second Performance Year (PY2).

We'll also pay for a defined amount of respite services for a subset of model patients.

We'll adjust the DCMP and respite service base rates by the Medicare Geographic Adjustment Factor (GAF) for each DCMP and respite service claim you submit to account for geographic variation in costs. GAFs are a weighted composite of each PFS localities work, practice expense (PE) and malpractice (MP) expense geographic practice cost indices (GPCIs). Appendix E of CR 13412 is the GAF file layout for the DCMP and respite service codes.

DCMP G-Codes

You'll use a set of 10 new G-codes, G0519-G0528, created for the 10 model tiers to submit claims to your Medicare Administrative Contractor (MAC) for the monthly DCMP. Model tiers are assigned based on the GUIDE Comprehensive Assessment. Each model tier has a different DCMP rate to reflect that covered services and care intensity vary across the tiers. We'll base the rates for the model tiers on:

- Whether the patient is part of a patient-caregiver pair
- The severity or complexity of the patient's dementia

- Whether the patient is within their first 6-months of participating in the model or has been in the model for more than a 6-month period

Appendix A of CR 13412 shows these G codes along with their:

- Descriptors
- Tier numbers
- Eligibility for respite care

Respite Service G-Codes

There are 3 new G-codes, G0529-G0531, for billing respite services, which vary in unit costs dependent on the type of respite service you use. Appendix B of CR 13412 shows these codes with their descriptors.

You'll bill respite services on an ad hoc basis to your MAC for certain eligible patients. The annual cap is $2,500, per patient, per year. We'll aggregate and pay monthly for the respite service code amounts through the Innovation Payment Contractor.

How Do the Model's Participants Submit Claims?

You must bill all GUIDE-specific G-codes, including both the DCMP and respite service G-codes, on a standalone claim with no other HCPCS codes. All DCMP claims must include a diagnosis code in the ICD-10 List in Appendix D of CR 13412.

If a GUIDE claim comes in with other codes, your MAC won't process it. Your MAC will return the claim to the participant for resubmission. You should continue to bill HCPCS codes for all other services delivered to GUIDE patients on other claims as you normally do under Original Medicare (also called FFS Medicare). Don't include the A6 demonstration code on claims that aren't for GUIDE services.

> Normal FFS detail lines, any other demonstration codes, and demonstration detail lines should never be on a GUIDE model claim. GUIDE model claims are standalone claims. Only detail lines with HCPCS codes from Appendices A and B should be on GUIDE model claims. Your MAC will deny claims with any of the GUIDE excluded codes in Appendix C of CR 13412.

The GUIDE payments won't include non-physician practitioner's payment reduction. We're waiving patient coinsurance and deductible payments on DCMP and respite services under the model and Medicare will pay 100% of the DCMP amount. Unless noted, GUIDE claims are subject to all other adjustments, like sequestration, and policies applicable to other FFS claims. Your MAC will verify patient attribution and provider eligibility for the GUIDE DCMP code eligibility.

Billing criteria for DCMP claims:

- Claim is for a patient included in the GUIDE patient alignment file, identified by MBI
- Claim is an appropriate date of service for patient attribution dates
- The Participant only billed for the DCMP once per calendar month for that patient
- TIN and NPI are both in the provider alignment file
- The claim contains a diagnosis code from Appendix D of CR 13412

Billing criteria for respite service claims:

- Claim is for a patient in the GUIDE patient alignment file, identified by MBI, and eligible for respite services
- TIN and NPI are both in provider alignment file
- The claim contains a diagnosis code from Appendix D of CR 13412
- Only patients with a caregiver in high to moderate complexity tiers will be eligible for respite services

We may retroactively add or remove GUIDE participating providers and patients. This may result in claims processing incorrectly. Your MAC may reprocess these claims with a retroactive effective date, adding or removing payments as necessary.

Resources

- CR 13412
- GUIDE Model FAQs
- GUIDE Model Overview Fact Sheet
- GUIDE Payment Methodology Paper