Centers for Medicare & Medicaid Services

GUIDE Payment Methodology Paper

Including Overview of Patient Alignment

Version 3.0

Effective June 1, 2026

Version History

Version Number	Update	Date
1.0	First release	May 8, 2024
2.0	Second release. Includes updates to model payment methodology based on the Amended and Restated Participation Agreement, including revised assessment and alignment requirements, tiering updates for patients who reside in residential care communities, Population and Income Adjustment (PIA) score calculations, performance measurement details, and updated billing guidance.	May 5, 2025
2.1	Update to second release. Includes updated payment rates and respite cap for PY 2025.	June 11, 2025
3.0	Third release to reflect Participation Agreement Amendment of PY 2026. Includes new alignment tiering and payment information for patients who reside in RCCs, real-time patient alignment, new guidance for patients who voluntarily realign to other participants, patient consent policy and forms, GUIDE interaction with new CMMI models (e.g., ACO LEAD), hospice enrollment and GUIDE alignment, updated payment rates and respite cap, and the partial pay of the PBA through IPC.	June 1, 2026

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1 Model Introduction and GUIDE Participants

1.1 Introduction

> Throughout this document, "participant(s)" refers to GUIDE participant(s) and "aligned patient(s)" refers to GUIDE-aligned patient(s).

The Guiding an Improved Dementia Experience (GUIDE) Model is a Center for Medicare and Medicaid Innovation (Innovation Center) alternative payment model designed to enhance quality of life for people living with dementia, reduce strain on their caregivers, and enable people living with dementia to remain in their homes and communities. The GUIDE Model achieves these goals through participants who deliver a comprehensive package of care coordination and care management, caregiver education and support, and respite services. Participants are organizations that signed the Participation Agreement and are responsible for meeting all GUIDE Model requirements. Aligned patients receive care from an interdisciplinary care team (ICT) that identifies the patient's primary care provider and specialists and outlines the care coordination services needed to manage the patient's dementia and co-occurring conditions. For aligned patients who have primary caregivers, participants provide education, training, and support to reduce the burden that caregivers often experience.

This Payment Methodology Paper (PMP) is a companion document to the Amended and Restated Participation Agreement for Performance Year (PY) 2026 (referred to as "Participation Agreement"), explaining the process the Centers for Medicare & Medicaid Services (CMS) uses to align patients to a participant and providing operational guidance on how GUIDE payments are calculated and distributed. Participants should read this document alongside the Participation Agreement and other GUIDE Model operational guidance available in the GUIDE Connect Library.

1.2 GUIDE Performance Years

The GUIDE Model is an 8-year, voluntary, nationwide care model that runs from July 1, 2024, through June 30, 2032. **Exhibit 1** lists each GUIDE Model performance year and the respective time period by program track.

Exhibit 1: GUIDE Performance Years

Performance Year Established Program Track	Performance Year New Program Track	Start Date	End Date
PY 1	**Pre-Implementation Year**	July 1, 2024	June 30, 2025
PY 2	**PY 1**	July 1, 2025	June 30, 2026
PY 3	**PY 2**	July 1, 2026	June 30, 2027
PY 4	**PY 3**	July 1, 2027	June 30, 2028
PY 5	**PY 4**	July 1, 2028	June 30, 2029
PY 6	**PY 5**	July 1, 2029	June 30, 2030
PY 7	**PY 6**	July 1, 2030	June 30, 2031
PY 8	**PY 7**	July 1, 2031	June 30, 2032

1.3 Program Tracks

> For the GUIDE Model, 'dementia care program' refers to the participants and their partner organizations collectively.

The GUIDE Model has two program tracks: one for established dementia care programs (DCP) and one for new DCPs. The two-track structure allowed organizations in the Established Program Track to begin participating in the GUIDE Model on July 1, 2024. Meanwhile, organizations in the New Program Track received support for program development during the pre-implementation year, before the start of their first performance year on July 1, 2025. Participants remain in their program track for the duration of the model.

1.3.1 New Program Track

As shown in **Exhibit 1**, New Program Track Participants had a 1-year pre-implementation period, which began on July 1, 2024, and ended June 30, 2025. During this period, participants focused on program development, including hiring and training staff, establishing workflows and processes, developing referral networks, and building relationships with community-based organizations and respite providers.

During the pre-implementation period, New Program Track Participants could not bill the GUIDE-specific Healthcare Common Procedure Coding System (HCPCS) codes: Dementia Care Management Payment (DCMP) and GUIDE Respite Services G-codes. Where appropriate, New Program Track Participants could continue to bill Medicare Physician Fee Schedule (PFS) services provided to patients during the pre-implementation year. New Program Track Participants who met the GUIDE safety net provider definition were eligible for the one-time GUIDE Infrastructure Payment during the pre-implementation period (see Section 6 for additional details). The Infrastructure Payment was a one-time payment of $75,000, geographically adjusted using the Medicare PFS Geographic Adjustment Factor. Participants must repay any unspent Infrastructure Payment funds to CMS by the end of PY 2025 (June 30, 2026). New Program Track Participants began conducting initial comprehensive assessments and billing for aligned patients who receive GUIDE services on July 1, 2025.

1.3.2 Established Program Track

Participants in the Established Program Track began billing GUIDE G-codes for aligned patients receiving GUIDE services on July 1, 2024. The Established Program Track was not eligible to receive the Infrastructure Payment.

1.4 GUIDE Participant Structures and Agreements

Participants are Medicare Part B-enrolled providers and suppliers, excluding durable medical equipment and laboratory suppliers, that are eligible to bill for Medicare PFS services and agree to provide comprehensive dementia care services in accordance with GUIDE Model requirements. CMS identifies a participant by a single Tax Identification Number (TIN) and the National Provider Identifiers (NPI) of individual Medicare-enrolled physicians and other nonphysician practitioners who participate in the model. For detailed requirements, please refer to Section 3 of the Participation Agreement.

Each participant will provide ongoing, longitudinal care and support to people living with dementia, and their primary caregivers, if applicable, directly and/or through partner

organizations. See Section 1.4.2 for information about partner organizations. For detailed requirements, please refer to Sections 3.05 and 3.06 of the Participation Agreement.

Participants must ensure they have access to all records, data, and information necessary to comply with the monitoring activities described in Section 14.02 of the Participation Agreement, including documentation maintained by GUIDE Practitioners and Partner Organizations.

1.4.1 GUIDE Practitioners

A participant is composed of the NPIs of individual Medicare-enrolled physicians and other nonphysician practitioners who have accepted assignment of all Medicare claims (e.g., are Medicare Participating Physicians), reassigned their billing rights to the participant's billing TIN and who agree to meet the care delivery requirements of the model. Participants must maintain and keep current this list of physicians and nonphysician practitioners (the "GUIDE Practitioner Roster") throughout the course of the GUIDE Model. CMS uses the roster to determine which practitioners are eligible to provide dementia attestations related to patient alignment and are eligible to bill for GUIDE Model payments.

> Only practitioners listed on the GUIDE Practitioner Roster and approved by CMS may bill for GUIDE-specific G-codes for GUIDE Care Delivery Services. This requirement also applies to services provided by organizations listed on the Partner Organization Roster and approved by CMS.

Participants must maintain an ICT that includes, at a minimum, a care navigator and a clinician with dementia proficiency[1] who is eligible to bill Medicare Part B evaluation and management services. The dementia proficient clinician must be listed on the Practitioner Roster and approved by CMS.

For GUIDE Model billing codes (GUIDE-specific G-codes), CMS has waived the reduction in the payment amounts for nonphysician practitioners, which is typically at 85% of the PFS. For example, if the dementia-proficient clinician is a nurse practitioner or physician assistant and bills the GUIDE G-codes, these G-codes will not be subject to the reduction in payment rates under the PFS for services provided by nonphysician practitioners compared to those provided by physicians.

1.4.2 Partner Organizations

A participant may contract with one or more organizations to meet the GUIDE care delivery requirements. A Partner Organization is an entity that has agreed to perform at least one of the GUIDE care delivery services through a Partner Organization Arrangement. A Partner Organization is not required to be Medicare enrolled. See **Exhibit 2** for examples of participant and Partner Organization collaboration to deliver GUIDE services. CMS must review and

[1] **Clinician with dementia proficiency:** As defined in Article 2 of the Participation Agreement, a clinician will qualify as having dementia proficiency if they meet at least one of the following criteria:

- Attest to having at least 25% of their patient panel (regardless of payer) at some time in the past 5 years composed of adults with any cognitive impairment, including dementia
- Attest to having at least 25% of their patient panel (regardless of payer) at some time in the past 5 years composed of adults aged 65 years old or older
- Have a specialty designation of neurology, psychiatry, geriatrics, geriatric psychiatry, behavioral neurology, or geriatric neurology.

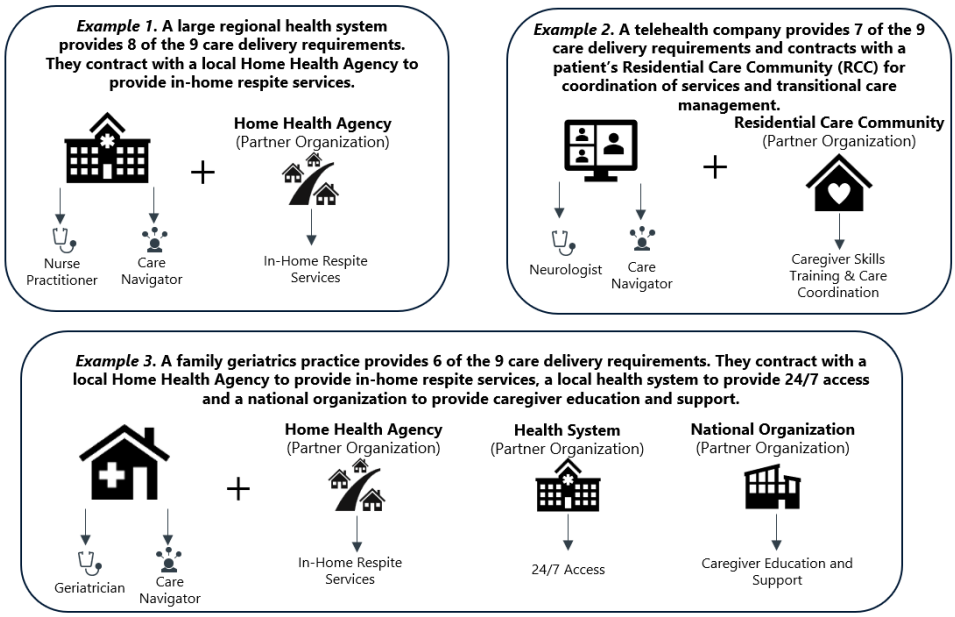
approve Partner Organizations, which includes conducting program integrity screening. Partner Organizations may not provide services under the GUIDE Model until CMS has approved their participation.

Residential care communities (RCCs) that partner with a participant to deliver GUIDE care delivery services to patients residing in the RCC must be approved as RCC Partners. RCC Partners are subject to enhanced disclosure, oversight, and patient protection requirements under Section 3.06 of the Participation Agreement. Participants must establish a compliant Partner Organization Arrangement with an RCC before aligning any patient residing in that RCC. See Section 2.8.1 and Section 2.12 for additional information about RCC partnerships and transition periods.

> Participants that align patients residing in an RCC must add the RCC to their Partner Organization Roster and submit it for CMS review and approval before providing GUIDE care delivery services. See Section 3.06 of the Participation Agreement for more information.

Participants are responsible for having contracts and other arrangements in place with their Partner Organizations to pay for any GUIDE care delivery services provided by those organizations and ensure that care delivery services meet model requirements. If a Partner Organization furnishes GUIDE Respite Services, the participant must bill for those services and pay the full amount of the respite payment from CMS to the Partner Organization (see Section 5 for information on GUIDE Respite Services). CMS does not directly reimburse Partner Organizations for services under the GUIDE Model because Partner Organizations are not participants. While participants are not required to report on Partner Organization activities on a claim-by-claim basis, participants are required to identify which activities are to be undertaken by the Partner Organization in the Partner Organization Arrangement (see Section 3.07 of the Participation Agreement for more information).

Exhibit 2: Examples of GUIDE Participants and Partner Organizations Forming DCPs



1.4.3 Participant Service Area

Participants are required to submit to CMS a zip code–based service area encompassing the zip codes from which they will accept patients. When defining a service area, participants should keep in mind that the GUIDE Model requires that they provide a home visit assessment and in-home GUIDE Respite Services to aligned patients in certain model tiers as well as make referrals to community-based services and supports. Participants may only align and bill for patients residing in their service area zip code. CMS may also update a participant's zip-code based service area based on data reported to CMS (for example, via the Patient Assessment and Alignment Forms (PAAF) described in Section 2).

Snowbird Policy

If an aligned patient temporarily moves to another location, participants may bill for the DCMP via telehealth if GUIDE care delivery services are provided during that period. While you do not need to add the temporary location to your zip code-based service area, you must note the duration of the temporary residence period in the patient's medical record.

Participants are responsible for maintaining accurate service area zip codes, including adding and removing zip codes as appropriate. Participants should submit updates through the Participant Portal. Once logged in to the Participant Portal, navigate to the Rosters Tile and select the Service Area Codes Tab to modify your list of zip codes.

Note that only the first 250 zip codes are visible in the Participant Portal. This display limitation does not affect the participant's complete zip code-based service area. A complete list of zip codes is available for download in the Participant Portal.

2 Patient Alignment to the GUIDE Model

2.1 Overview

CMS designed the GUIDE Model to serve community-dwelling, Original Medicare patients, including patients dually eligible for Medicare and Medicaid, who have dementia, and to provide support and education to their primary caregivers, if applicable. For the purposes of the GUIDE Model, a "primary caregiver" is the relative, or unpaid nonrelative, who assists the aligned patient with activities of daily living[2] and/or instrumental activities of daily living[3] and whose name is listed on the PAAF. Depending on the patient's needs, the assistance may be episodic, daily, or occasional.

Participants develop provider networks and conduct outreach and engagement to identify and voluntarily align eligible patients for the GUIDE Model. Participants must offer all potentially eligible patients the opportunity to voluntarily align and participate in the GUIDE Model (see Section 13.01(B) of the Participation Agreement for more information). Patients will learn about the GUIDE Model through a participant's engagement activities or through CMS outreach strategies that supplement participants' activities (see Section 2.2 more for details)

Participants will use the PAAF, an Excel spreadsheet available on the Health Data Reporting (HDR) application accessed via the CMS.gov Enterprise Portal ePortal, to gather and submit data collected from the initial comprehensive assessment to CMS (see Section 2.7 for more details). Participants must complete all elements of the initial comprehensive assessment, including the home visit assessment, and submit the completed PAAF to CMS within two months (60 days) of the date the dementia staging tool was administered. In addition, participants will include the patient's primary caregiver, listed by name, if applicable, and results of the caregiver burden assessment.

> The PAAF template available on GUIDE Connect is for reference only and shows the required data elements and general format. Participants must download the current PAAF template, also referred to as the Patient Assessment and Alignment (PAA) template, directly from the HDR application within the CMS.gov ePortal for data collection and submission.

CMS will use the information submitted on the PAAF to confirm the patient's eligibility for alignment to the participant.[4] If CMS finds that the patient is eligible, then CMS will align the patient to the participant and assign the patient to a model tier using data submitted on the PAAF (see Section 2.8 for more details). Participants can bill the GUIDE Model G-codes for the initial comprehensive assessment only after receiving confirmation from CMS through the Beneficiary Alignment Report available on the Expanded Data Feedback Reporting (eDFR) application, accessed via the CMS.gov Enterprise Portal (ePortal) (see Appendix H for details

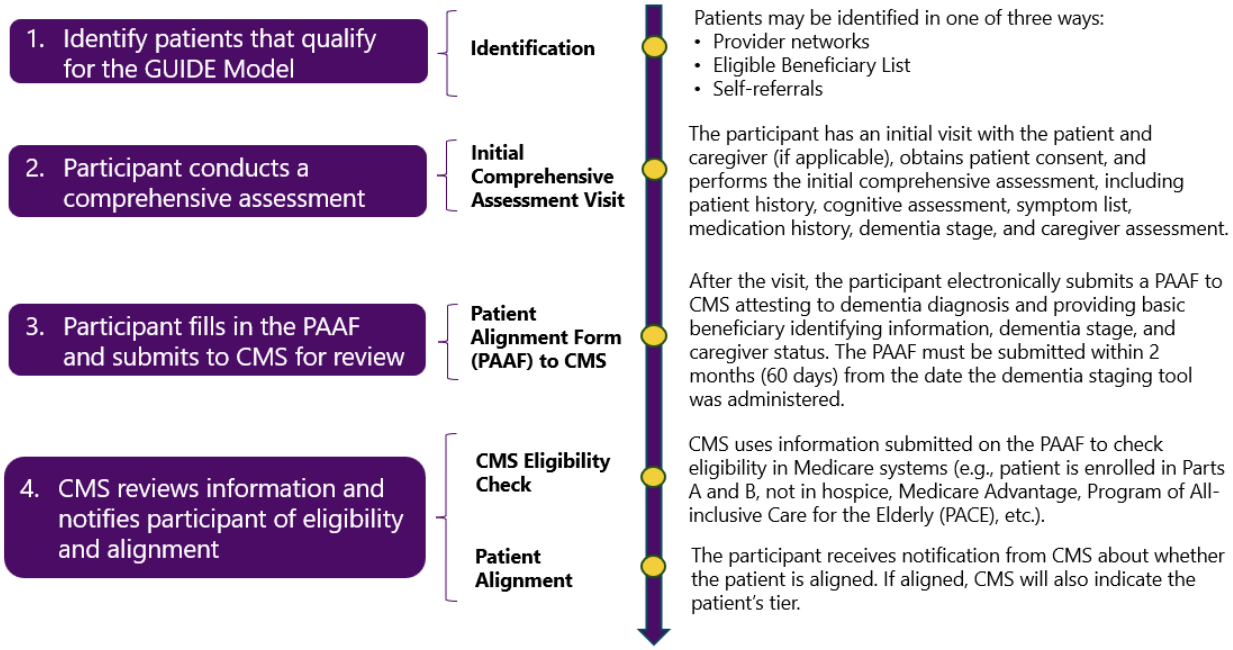
[2] Basic personal everyday activities include bathing, dressing, transferring, toileting, mobility, and eating.

[3] Activities related to independent living include preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework, and communication.

[4] CMS may update the PAAF periodically to adjust to model needs and to improve the process for participants. Participants developing an automated data entry process for the PAAF should be aware that periodic changes to the PAAF template will require updates to their automated solution. CMS will provide the details of each update so participants can easily identify changes.

on eDFR content) that the patient is eligible and aligned to the participant. **Exhibit 3** outlines the steps involved for voluntary alignment.

Exhibit 3: New Patient Identification, Eligibility Check, and Voluntary Alignment Process



2.2 Patient Outreach and Engagement

To maximize the number of patients who receive GUIDE care delivery services, the GUIDE Model will apply multiple approaches to identify and engage potentially eligible patients:

1) Provider Networks: Participants will develop provider networks with primary care providers, neurologists, hospitalists, hospital discharge planning staff, community-based organizations, and other relevant groups in the community. Organizations from those networks may recommend patients who already have a dementia diagnosis as well as patients with suspected dementia but no formal diagnosis to the participant (note that mild cognitive impairment does not meet dementia diagnosis criteria for voluntary alignment). Participants will work with network organizations to develop appropriate referral criteria and protocols. All networks, criteria, and protocols must comply with all applicable fraud and abuse laws.
2) Self-referrals: Patients and/or their caregivers may reach out to participants directly to obtain additional information about the model after learning of it through their current providers, family members, or friends. To support patient self-referrals, in PY 2025 CMS sent targeted Beneficiary Outreach Letters to potentially eligible patients with dementia diagnosis codes in their claims history. These letters informed patients about the GUIDE model and the process required to receive GUIDE Model services from participants in their area.
3) Eligible Beneficiary List: Participants had an opportunity to request a list of potentially eligible Medicare FFS patients through a Data Request & Attestation (DRA) form prior to

their first Performance Year. Once requested, CMS used claims data from a 3-year look-back period to identify patients who received Medicare services from the participant, had claims-based International Classification of Diseases, 10th edition (ICD-10) dementia diagnosis codes, and met eligibility criteria for the GUIDE Model (see Section 2.3 for more information).

2.3 Patient Voluntary Alignment

Patient alignment occurs on an ongoing basis for the first seven years of the GUIDE Model (July 1, 2024–June 30, 2031). Participants in the Established Program Track began submitting patients for alignment starting July 1, 2024, while participants in the New Program Track began submitting patients for alignment on July 1, 2025.

Participants will complete an initial comprehensive assessment visit for patients who may be eligible for the GUIDE Model and who have consented to receive GUIDE Model services exclusively from the participant (see Section 2.5 for more details). For those patients who consent, participants submit a PAAF to CMS via the HDR application within the CMS.gov Enterprise Portal (ePortal).

The aligned patient's start date in the GUIDE Model is the date on which the patient's dementia severity was evaluated during the initial comprehensive assessment using an approved dementia staging tool, e.g., the Clinical Dementia Rating (CDR)[5] or the Functional Assessment Staging Tool (FAST).[6] This date serves as the assessment date in the PAAF and reflects the date CMS uses for the purpose of determining when the participant conducted the initial comprehensive assessment.

Patients will remain aligned to a participant unless they become ineligible, the aligned patient or their caregiver requests to no longer receive GUIDE services, or the participant does not file DCMP or GUIDE Respite Services claims for the patient for a period of eight consecutive months. For example, an aligned patient would be deemed ineligible if they no longer meet one of the GUIDE Model eligibility requirements in Section 2.4 or stop receiving model services from the participant (e.g., they move out of the participant's service area, request to no longer receive services from the participant, or elect to voluntarily align to a different participant, as described in Section 2.14).

Participants can only bill the GUIDE Model G-codes for aligned patients. Once an aligned patient is found to be ineligible for GUIDE, and is unaligned and removed from the Beneficiary Alignment Report, a participant should no longer bill the model G-codes for that patient (see Section 2.13 for additional information on changes to patient eligibility, unalignment, and removal from the Beneficiary Alignment Report).

[5] Morris JC. Clinical Dementia Rating: A Reliable and Valid Diagnostic and Staging Measure for Dementia of the Alzheimer Type. International Psychogeriatrics. 10 January 2005.

[6] Sclan SG and Reisberg B. Functional Assessment Staging (FAST) in Alzheimer's Disease: Reliability, Validity, and Ordinality. International Psychogeriatrics. 07 January 2005.

2.4 Patient Eligibility

A patient must meet all GUIDE Model eligibility criteria to voluntarily align to a participant. CMS uses information submitted on the PAAF (see Section 2.7) to verify whether the patient is eligible for alignment. To be eligible, the patient must meet the following criteria:

- Has dementia, as confirmed by attestation from a clinician on the participant's GUIDE Practitioner Roster (see Section 2.6 for more information);
- Is enrolled in both Medicare Parts A and B;
- Is not enrolled in Medicare Advantage or another Medicare health plan, including Special Needs Plans (SNPs) and the Program of All-Inclusive Care for the Elderly (PACE); [7]
- Has Medicare as their primary payer;[8]
- Not enrolled in the Medicare hospice benefit;
- Is not a long-term[9] nursing home[10] resident; and
- Is not aligned to another GUIDE Model Participant.
- Resides within the participant's zip code-based service area[11] (see Section 1.4.3 for more information on Participant Service Area).

Beginning in PY 2026, the patient must reside in an eligible residence type, as confirmed by participant attestation. Eligible residence types include:

- A private residence or
- An RCC approved by CMS as a Partner Organization where a compliant Partner Organization Arrangement has been established with the participant within the applicable timeframes. (see Section 2.8.1 and Section 2.12 for more details).

[7] Patients enrolled in PACE or the Medicare hospice benefit will not be eligible for alignment to a participant because PACE and hospice services overlap significantly with the services provided under the GUIDE Model.

[8] Medicare is considered the primary payer when patients have worker's compensation and no-fault accident coverage.

[9] For purposes of the GUIDE Model, Long-Term Nursing Home Resident is defined as a patient whose nursing home stay is greater than or equal to 101 days. This day count encompasses stays in certain facilities meeting the Nursing Home definition, including Medicare skilled nursing facility benefit stays and non-Medicare-covered stays, or a combination thereof, but excludes swing bed stays, memory care units stays, and private-pay-only state-certified nursing homes stays.

[10] For purposes of the GUIDE Model a Nursing Home is defined as a facility that provides a wide range of health and personal care services, including but not limited to physician services, nursing care, rehabilitation services, 24-hour supervision, three meals a day, and assistance with ADLs, and is certified as such by one or more of Medicare, Medicaid, or the Veterans Administration, to include any facility which is located in a U.S. state or on an Indian reservation and is certified by the Secretary of HHS as meeting the requirements for nursing facilities. For facilities on campuses or communities that include multiple levels of care, determination as to a patient's level of care designation depends on the specific building, unit, or bed type in which the beneficiary resides, not the campus designation

[11] For purposes of the GUIDE Model, residence is determined based on the patient's most recent zip code as reported on the PAAF. To enhance efficiency for participants, CMS will automatically add a zip code to the participant's service area when the zip code reported on the PAAF is not already included in the participant's service area.

A patient is not eligible for voluntary alignment if the patient resides in one of the following ineligible residence types:

- An RCC where the RCC does not have both CMS approval as a Partner Organization and a compliant Partner Organization Arrangement established with the participant within the applicable timeframes (see Section 2.8.1 and Section 2.12 for more details).
- A Memory Care Unit. A specialized unit or facility, whether freestanding or located within another facility, that provides a secure environment and intensive supervision specifically designed for people living with dementia, regardless of its physical location or administrative structure.

2.5 GUIDE Initial Comprehensive Assessment Visit

After a participant identifies a potentially eligible patient, the next step is to schedule an initial comprehensive assessment visit for the person living with dementia, or suspected dementia. Before performing the initial comprehensive assessment, the participant must obtain the patient's and/or their caregiver's consent to receive GUIDE care delivery services exclusively from the participant. Participants must document both the discussion of GUIDE care delivery services and the patient and/or caregiver's consent or refusal to receive them exclusively from the participant in the patient's medical record. CMS has provided an optional Voluntary Alignment Consent Form (see Appendix G) that participants may use to document consent, though use of this specific form is not required.

During the initial comprehensive assessment, the participant's ICT will assess the patient and their caregiver (if applicable) across required domains, including cognitive function, functional status, clinical needs, behavioral and psychosocial needs, severity of dementia (using the CDR or FAST), and caregiver burden, if applicable (using the Zarit Burden Interview, ZBI-22)[12], with the goal of confirming a dementia diagnosis and creating a comprehensive, person-centered care plan.

After completing the initial comprehensive assessment, the participant will enter the required data into the PAAF and submit it to CMS via the HDR application within the CMS.gov Enterprise Portal (ePortal) for patient eligibility verification (see Section 2.7).

CMS requires the participant to collect and report certain patient and caregiver information (if applicable) along with the following comprehensive assessment data. Omission of this data may result in a failure to align the patient:

- The patient's CDR or FAST score;
- The Patient-Reported Outcomes Measurement Information System (PROMIS) Scale v1.2 Global Health; and
- If the patient has a primary caregiver, the ZBI-22 (see Section 2.8 for additional information).

[12] Bedard M, Molloy DW, Squire L, et. al. The Zarit Burden Interview: A New Short Version and Screening Version. The Gerontologist. October 2021. 41(5): 652-657.

2.6 Dementia Diagnosis Attestation

Patients must have dementia to be eligible for alignment to a participant. Patients may be at any stage of dementia: mild, moderate, or severe. Mild cognitive impairment **is not sufficient** to meet criteria for voluntary alignment.

> Participants should use the Participant Portal to add dementia-proficient practitioners to their Practitioner Roster.

To confirm a patient's dementia status, CMS relies on the attestation from a clinician rather than a claims-based ICD-10 diagnosis code for dementia. A dementia-proficient practitioner **on the participant's Practitioner Roster** may attest that, based on the comprehensive assessment, the patient meets the National Institute on Aging-Alzheimer's Association diagnostic guidelines for dementia[13] and/or the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-5) diagnostic guidelines for major neurocognitive disorder.[14] Alternatively, the dementia-proficient practitioner may attest that they have received a written report of a documented dementia diagnosis from another Medicare-enrolled practitioner. Participants document this attestation using the PAAF.

2.7 PAAF Submission and CMS Eligibility Check

> Beginning in PY 2026, participants must attest using the PAAF that the patient resides in an eligible residence type (see Section 2.4), and if the patient resides in an RCC, provide the applicable RCC Partner ID from the Participant Portal.

The PAAF submission process begins after a participant identifies a potentially eligible patient, obtains consent from the patient and their caregiver (if applicable) to receive GUIDE care delivery services from the participant, and completes the initial comprehensive assessment. (see Sections 2.3 through 2.6 for details).

The participant's data custodian(s) populate information gathered during the comprehensive assessment into the PAAF and submit the PAAF to CMS. CMS uses information from the PAAF to determine whether a patient is eligible and communicates those results back to the participant's data custodian(s). If the patient is eligible, CMS will use information from the PAAF to align the patient to the participant and assign the patient to a model tier (see Section 2.8).

Exhibit 4 outlines the PAAF submission and eligibility check process (including PAAF data population methods participants may choose to use to reduce administrative burden), communication of preliminary alignment determinations (to assist clinicians with care planning), and final confirmation of alignment results.

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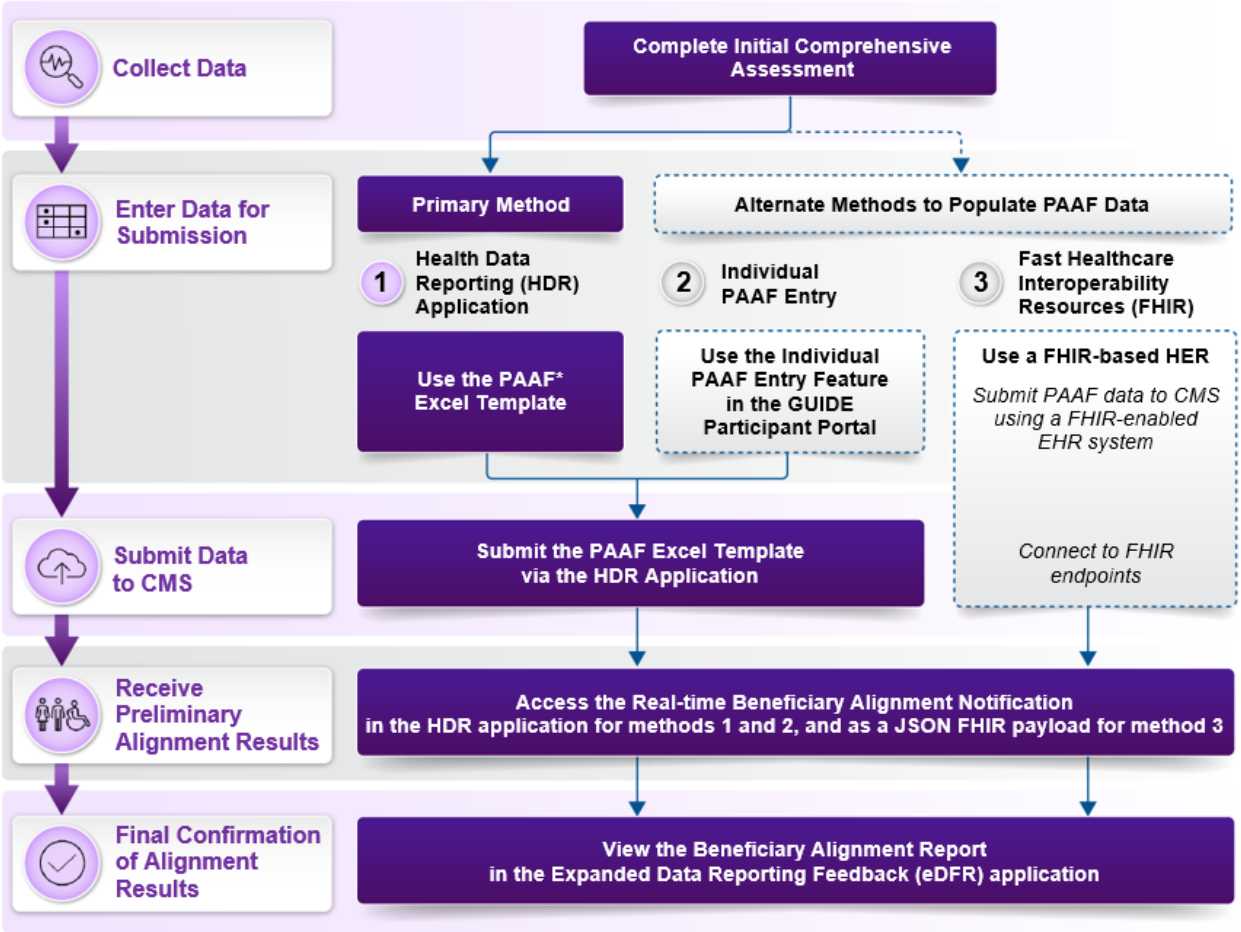
[13] McKhann, GM, Knopman DS, Chertkow H, et al. The diagnosis of dementia due to Alzheimer's disease: Recommendations from the National Institute on Aging-Alzheimer's Association workgroups on diagnostic guidelines for Alzheimer's disease. *Alzheimer's & Dementia*. May 2011; 7(3): 263–269.

[14] Sachdev PS, Blacker D, Blazer DG, et al. Classifying neurocognitive disorders: the DSM-5 Approach. *Nature Reviews Neurology*. 30 September 2014.

Exhibit 4: PAAF Submission Process and CMS Eligibility Check



**PAAF = Patient Assessment and Alignment Form*

2.7.1 PAAF Submission to CMS

The date on which the patient's dementia severity was evaluated using the dementia staging tool (e.g., CDR or FAST) during the initial comprehensive assessment serves as the assessment date on the PAAF. Participants must submit completed PAAFs to CMS within two months (60 days) after the assessment date.

Each participant's data custodian(s) will download the PAAF Excel Template from the HDR application, accessed via the CMS.gov Enterprise Portal (ePortal), enter the required information about the patient and their primary caregiver (see Sections 2.5 and 2.6), if applicable, save the file, and then upload the file to CMS through the HDR application.

CMS developed two alternative methods participants may use to populate PAAF data for submission to CMS. PAAFs must be submitted to CMS via the HDR application or via FHIR endpoints.

Individual PAAF Entry: PAAF data can be entered by up to ten approved users via the Individual PAAF Entry feature in the GUIDE Participant Portal and then uploaded into HDR by your data custodian(s). For more information on this option, please refer to the GUIDE Portal User Manual.

Fast Healthcare Interoperability Resources (FHIR): PAAF data can be shared with CMS through FHIR endpoints via an HL7 FHIR Questionnaire Response Resource. For more information on how to pursue this option, refer to the GUIDE Manual for ISP Users.

2.7.2 CMS Eligibility Check and Results Provided to Participant

CMS will analyze the uploaded PAAF information, such as patient name, Medicare Beneficiary Identifier (MBI), date of birth, dementia diagnosis and residence type attestations to determine whether the patient is eligible to align to the participant.

After a PAAF is submitted via the HDR application of the CMS.gov Enterprise Portal (ePortal), GUIDE data custodians will receive a real-time response called the *Real-time Beneficiary Alignment Notification Report*. This report can be found in the HDR application and contains preliminary eligibility, alignment, respite, and tiering determinations which clinicians may use to begin care planning. A preliminary alignment determination will indicate whether the patient is aligned or pending further review. Only PAAF submissions with a preliminary determination of being aligned to the participant will include information regarding model tiering and respite eligibility. PAAF submissions for patients that require further review from CMS may instead include information regarding the reasoning for the pending alignment determination. See Appendix I for more information on reading the Real-time Beneficiary Alignment Notification Report.

CMS will communicate final eligibility and alignment determinations for all PAAF submissions, including those pending review, through the *Beneficiary Alignment Report* found in the eDFR application, accessed via the CMS.gov Enterprise Portal (ePortal), within 15 business days from receiving the PAAF.

2.7.3 Participant Communication of Alignment Status to Patient

The participant must provide written notice of the alignment determination to each patient determined eligible and aligned to the participant within 45 days of receiving CMS' final alignment decision via the Beneficiary Alignment Report.

Participants may provide the notices described in this section in-person, by postal mail, by email, through a patient portal, or through another similar technology application.

Participants will use the CMS template letter in Appendix D to notify aligned patients. The participant may provide the non-alignment letter in Appendix E to patients who CMS determines are ineligible to participate in the model.

2.8 Assigning Model Tiers

After CMS confirms that a patient is eligible for the GUIDE Model and aligned to the participant, CMS assigns the aligned patient to one of six model tiers. Tier assignment is based on a combination of the patient's disease stage, residence type, and whether they have a caregiver and, if applicable, the degree of burden their caregiver is experiencing. Aligned patient and caregiver complexity, and correspondingly, care intensity and payment, increases by tier. See **Exhibit 5** for a description of the six tiers.

> **Update on RCC Model Tiers**
>
> Beginning in PY 2026, CMS will assign all aligned patients residing in RCCs to the new RCC-specific tier, as shown in **Exhibit 5**, regardless of caregiver status. Patients aligned before PY 2026 who reside in RCCs will be transitioned to the RCC-specific tier effective July 1, 2026. For information specific to aligned patients residing in an RCC, see Section 2.8.1.

To ensure consistent aligned patient assignment to tiers across participants, the participant must measure and report the dementia stage of the patient and the level of caregiver burden using approved screening tools. The approved tools include two tools to report dementia stage and one tool to report caregiver burden. Participants will select one of the two dementia staging tools, e.g., the CDR or the FAST, and will use the ZBI-22 to report the level of caregiver strain. **Exhibit 5** shows how the scores of each tool correspond to model tiers. CMS may, in its sole discretion, modify the approved screening tools and/or the criteria for the corresponding scores upon 30-days' written notice to participants.

Participants will administer the approved screening tools during the initial comprehensive assessment and submit the resulting scoring data as part of the PAAF, including the individual caregiver responses to the ZBI-22. CMS will use this data to assign aligned patients to a model tier, per the tiering criteria outlined in **Exhibit 5**. CMS will inform participants of an aligned patient's model tier assignment at the same time CMS informs the participant that the patient is eligible and has been aligned to them.

Participants have the option to seek CMS approval to use an alternative dementia staging tool by submitting to the GUIDE Help Desk (GUIDEModelTeam@cms.hhs.gov) the proposed tool, along with published evidence that the tool is valid and reliable, and a crosswalk for how the tool(s) corresponds to the Model's tiering thresholds outlined in **Exhibit 5**. Consistency of staging tools across all participants is critical to the evaluation of the model, therefore, participants should carefully consider seeking an alternative tool. CMS will approve or reject the use of the proposed alternative staging tool(s) within 90 days of CMS receiving all required documentation. CMS reserves the right to reject a proposed staging tool for any reason. *A participant may not submit scoring data on the PAAF using a proposed alternative staging tool until the participant receives written notice from CMS approving use of the alternative staging tool.*

Exhibit 5: Model Tiers (Effective July 1, 2026)

Patient Type	Tier	Criteria	Corresponding Assessment Tool Scores
Patients with a caregiver	Low complexity dyad tier	Mild dementia	CDR = 0-1, FAST = 1-4 *and* ZBI = 0-88
	Moderate complexity dyad tier	Moderate or severe dementia *and* Low to moderate primary caregiver strain (for patients with primary caregiver only)	CDR = 2–3, FAST = 5–7 *and* ZBI = 0-60
	High complexity dyad tier	Moderate or severe dementia *and* High primary caregiver strain (for patients with primary caregiver only)	CDR = 2–3, FAST = 5–7 *and* ZBI = 61–88
Patients without a caregiver	Low complexity individual tier	Mild dementia	CDR = 0-1, FAST = 1-4
	Moderate to high complexity individual tier	Moderate or severe dementia	CDR = 2–3, FAST = 5–7
Patients residing in a residential care community (RCC)	RCC tier	Any stage of dementia *AND* If applicable, any level of caregiver strain *AND* Resides in an approved RCC	CDR= 0-3, FAST= 1-7 *and* ZBI= 0-88, if applicable

Note: CMS will use the model tiers to determine the base DCMP rate and whether the patient is eligible to receive GUIDE Respite Services. Patients residing in RCCs are assigned to the RCC tier beginning July 1, 2026, regardless of caregiver status or dementia stage. Patients in the RCC tier are not eligible for GUIDE Respite Services. See Section 3 and Section 5.1.1 for additional information.

2.8.1 Residential Care Communities (RCC)

The GUIDE Model uses residence type as reported on the PAAF for purposes of assigning patients to the “RCC Tier”. An RCC is a congregate living setting that provides housing, meals, and supportive services to adult residents who need assistance with activities of daily living, medication management, supervision, and care coordination, but who do not require nursing home level of care.

Eligible RCC settings under the GUIDE Model include an assisted living facility, group home, adult family home, board and care homes, and similar congregate residential settings. RCCs do not include settings (including building, unit, or bed type) where the patient receives intensive nursing care or meets nursing home level of care (see Section 2.3 for details on ineligible residence types). Participants are responsible for determining the level of care provided in these settings to determine if they fall under the GUIDE Model definition of “RCC.”

The RCC must be approved by CMS as a Partner Organization and participants must have a compliant Partner Organization Arrangement with an RCC – making it an Approved RCC Partner – before aligning any patient residing in that RCC. RCC Partners are subject to enhanced disclosure, oversight, and patient protection requirements under Section 3.06 of the Participation Agreement. Participants should refer to Section 2.12 for information about transition periods that apply when a currently aligned patient moves to an RCC or when a patient resides in an RCC as of the effective date of the Participation Agreement.

2.9 Comprehensive Assessment Billing for Aligned Patients

After CMS confirms that a patient is eligible, aligned to the participant, and assigned to a model tier, the participant may begin billing GUIDE Model G-codes for that aligned patient. Participants must wait until they receive final confirmation through the Beneficiary Alignment Report (see Appendix H for details on its content) before billing the first month's DCMP for the month of the initial comprehensive assessment. Participants should bill the first month's DCMP for each aligned patient using the appropriate GUIDE G-code (see Section 3) listed in the Beneficiary Alignment Report with a date of service (DOS) equal to the date of alignment (e.g., the initial comprehensive assessment date submitted on the PAAF). The participant is not permitted to perform or bill for any of the GUIDE care delivery services under the model until CMS confirms alignment and should not bill CMS separately for any Medicare PFS services included in the initial comprehensive assessment for aligned patients.

> When billing, participants must include at least one ICD-10 diagnosis code for dementia on the claim (see Appendix B for a list of diagnosis codes for dementia).

If CMS determines the patient **does not** meet eligibility criteria, CMS will notify the participant via the Beneficiary Alignment Report, and the participant may then submit a claim for any Medicare PFS services that corresponds to the services rendered. If the ICT assesses a patient or refers a patient for additional diagnostic testing and determines that the patient does not have dementia or otherwise qualify for the GUIDE Model, the participant can bill for an appropriate Medicare PFS code that corresponds to the services rendered (such as Current Procedural Terminology (CPT) code 99483 for Cognitive Assessment and Planning).

> **Important billing consideration**
>
> Participants may receive a preliminary alignment decision via the Real-time Beneficiary Alignment Notification Report for care delivery planning purposes. However, **participants should wait to bill for the comprehensive assessment until the patient appears as aligned in the Beneficiary Alignment Report**, to prevent claim denials.

The DCMP covers all comprehensive assessments, including the initial, annual, and any necessary reassessments.

2.10 Reassessments

After a patient is aligned to a participant and assigned to a model tier, a reassessment submission to CMS is necessary only if certain patient circumstances change outside of the annual comprehensive assessment cycle (see Section 2.11).

Participants must submit reassessment data to CMS using the PAAF through the HDR application within the CMS.gov Enterprise Portal (ePortal) when there is a change in the aligned

patient's dementia stage, caregiver status and/or burden, or residence type that impacts model tiering and/or respite eligibility (e.g., a move to or from an RCC, gaining or losing a primary caregiver).

CMS will use reassessment data to determine whether changes to model tiering, respite eligibility, or payment are needed. Reassessment data will only be accepted, and changes enacted, every 30 days for a change in residence type, and every 180 days for a change in dementia severity or a change in the caregiver status and/or burden, as illustrated in **Exhibit 6**. A reassessment ***does not*** satisfy the requirement to conduct an annual comprehensive assessment.

Exhibit 6: Requirements and Timing of Patient Assessments

Requirement	Initial Comprehensive Assessment	Reassessment			Annual Comprehensive Assessment
		Change in Residence Type	Change in Dementia Severity	Change in Caregiver Status/Burden	
Submission Timing / Frequency	Submitted within 2 months (60 days) from the date the dementia staging tool was administered	May be submitted every 30 days	May be submitted every 180 days	May be submitted every 180 days	Required once every 12 months; must be conducted and submitted between 306 and 425 days after the previous comprehensive assessment
Patient Information	X	X	X	X	X
Caregiver Information (if applicable)	X	-	-	X	X
Clinician Information	X	X	X	X	X
Dementia Attestation	X	X	X	X	X
Eligible Residence Attestation	X	X	-	-	X
Dementia Staging Score	X	-	X	-	X
PROMIS-10	X	-	-	-	X
ZBI-22 (if applicable)	X	-	-	X	X
Residence Type	X	X	-	-	X
RCC Partner ID (if applicable)	X	X	-	-	X
Home Visit Assessment	X	-	-	-	-

Note: Beginning in PY 2026, participants must attest that the patient resides in an eligible residence type. If the patient resides in an RCC, participants must also provide the applicable RCC Partner ID.

2.11 Annual Assessments

After a patient is aligned to a participant, the participant is required to conduct and submit an annual comprehensive assessment once every 12 months, between 306 and 425 days, from the date of the previous comprehensive assessment date. After beginning an annual comprehensive assessment, a participant has a 60-day window to complete and submit. This means that an

annual comprehensive assessment must be started between 306 and 425 days from the date of the previous comprehensive assessment and submitted at the earliest of either 60 days from the start of the annual comprehensive assessment or by the 425th day from the date of the previous comprehensive assessment. Participants must submit annual assessment data to CMS using the PAAF through the HDR application within the CMS.gov Enterprise Portal ePortal.

CMS uses the annual assessment data for the purposes of appropriate tiering based on the patient's dementia severity, caregiver status, and residence type. In addition to supporting appropriate tiering, completing and submitting the annual comprehensive assessments serves three purposes: (1) a mechanism by which CMS gathers data on aligned patients for use in evaluating participant and model performance, (2) an avenue by which participants share updated information that may affect the aligned patient's tier and the amount the participant is paid, and (3) to create and update the patient-centered care plan to reflect the patient's changing circumstances, goals, preferences, and needs.

2.12 Residence Type Changes and Transition Periods

Beginning in PY 2026, distinct transition periods begin when an aligned patient changes residency to move to an RCC or Memory Care Unit. These transition periods allow time for the participant to take required actions as described below:

- *RCCs*. The participant will have a 60-day transition period after becoming aware the aligned patient has moved to an RCC where the RCC is not approved as a Partner Organization by CMS and the participant does not have a compliant Partner Organization Arrangement (see Section 2.8.1). Participants may use this period to gain CMS approval and to establish a compliant arrangement with the RCC. During the transition period, the participant may continue providing GUIDE services and billing GUIDE Payments. If a compliant arrangement with the RCC cannot be established within 60 days, the participant must coordinate the patient's care transition, assist with transition planning, and **submit an unalignment PAAF to CMS**. CMS will remove the patient from the Beneficiary Alignment Report effective the last day of the month in which the participant notifies CMS of the change.
- *Memory Care Units*. Participants will have a 15-day transition period after becoming aware that an aligned patient has moved to a Memory Care Unit. During the transition period, the participant may continue providing GUIDE services and billing GUIDE Payments, but must coordinate the patient's care transition, assist with transition planning, and **submit an unalignment PAAF to CMS**. CMS will remove the patient from the Beneficiary Alignment Report effective the last day of the month in which the participant notifies CMS of the change.

> **Important billing requirement**
>
> For patients who transition to Memory Care Units, participants must submit final claims for GUIDE Payments within 30 days from the effective date of the patient's unalignment.

2.13 Patient Unalignment or Removal from Alignment File

Participants are responsible for ensuring that their Beneficiary Alignment Report remains up-to-date and continues to represent the most current information about each aligned patient (see

Appendix H for details on the content of this report). CMS will unalign a previously aligned patient from the participant's Beneficiary Alignment Report, either because the patient no longer meets GUIDE Model eligibility requirements in Section 2.4 or the patient notifies the participant that they no longer wish to receive GUIDE services from the participant as outlined in Section 2.3.

2.13.1 CMS Claims-based Unalignment

CMS will conduct ongoing eligibility checks to identify aligned patients who no longer meet eligibility criteria and will remove these patients from the participant's Beneficiary Alignment Report. A patient may be unaligned for any of the following reasons:

> Once a patient is unaligned, the participant must cease billing GUIDE specific G-codes for that patient. Claims with dates of service on or after the patient's unalignment date will be rejected.

- The patient dies;
- Is no longer enrolled in both Medicare Parts A and B;
- Has enrolled in Medicare Advantage or another Medicare health plan, including SNPs and the PACE;
- No longer has Medicare as their primary payer;
- Has enrolled in the Medicare hospice benefit;
- Becomes a long-term nursing home resident; or
- The participant does not file claims for the DCMP or GUIDE Respite Services for the patient for a period of eight consecutive months.

2.13.2 Participant Reported Unalignment

When the participant notifies CMS of a change in a patient's eligibility status and submits an unalignment PAAF to CMS via the HDR application (accessed via the CMS.gov Enterprise Portal ePortal), CMS will remove the unaligned patient from the participant's Beneficiary Alignment Report.

Participants **must** submit an unalignment PAAF to CMS if any of the following occur:

- A patient, or their caregiver, requests to no longer receive services under the model from the participant. The patient's or caregiver's request must be documented in the patient's medical record. Participants must submit the unalignment PAAF via the HDR application within 15 business days of becoming aware of the request.
- Changes residence to reside in an ineligible residence type (e.g., Memory Care Unit; RCC without CMS approval as a Partner Organization and an established compliant Partner Organization Arrangement within the applicable timeframes) (see Section 2.12 for additional detail).
- Moves out of the participant's zip code-based service area.
- No longer has dementia, as confirmed by written attestation from a clinician on the participant's GUIDE Practitioner Roster (see Section 2.6 for more information).

Participants **may** submit an unalignment PAAF via the HDR application if they are aware of an aligned patient's death, enrollment in the Medicare hospice benefit, or scheduled permanent move to become a Long-Term Nursing Home resident. However, CMS will conduct ongoing

eligibility checks to identify and unalign patients who no longer meet these eligibility criteria (see Section 2.13.1).

2.13.3 Date of Unalignment

In general, once a patient is unaligned from a participant, the patient's alignment end date is set to the last day of the calendar month in which unalignment occurred, meaning the participant may not bill GUIDE G-codes beginning with the first day of the following calendar month. If the participant provided a GUIDE care delivery service or GUIDE Respite Services to the patient during the patient's final month of alignment, the participant may still bill for these services. The DCMP will not be prorated based on the length of time that the patient participates in a month. Claims with dates of service on or after the applicable unalignment date are subject to denial.

> Any DCMPs paid in error for unaligned patients are subject to reconciliation and settlement under Section 9.08 of the Participation Agreement.

For patients who unalign due to Medicare hospice benefit enrollment, the unalignment date is the last day of the month that the patient enrolled in hospice. Unalignment dates for patients enrolled in Medicare Advantage, PACE, and who are deceased may differ from the standard date (e.g., last day of the calendar month of unalignment) because Medicare will deny GUIDE claims made after these events. For patients who are unaligned due to Medicare Advantage enrollment, PACE enrollment, or death, the alignment end date is the day before Medicare Advantage or PACE coverage begins, or the date of death, respectively.

2.13.4 Participant Communication of Unalignment Status to Patient

Within 30 days after receiving notice or confirmation of a patient's unalignment via the Beneficiary Alignment Report, the participant must provide written notice of unalignment to the patient using the CMS template letter in Appendix F.

2.14 Voluntary Alignment to a Different GUIDE Participant

Patients have the right to voluntarily align to a different GUIDE participant at any time.[15] To initiate voluntary alignment to a different participant, the patient or their caregiver must simply notify the participant to which they are currently aligned that they no longer wish to receive GUIDE services from that participant, otherwise known as unalignment. The participant must then:

- Notify CMS within 15 business days of becoming aware that the patient, or their caregiver, requested to no longer receive GUIDE Model services from the participant; (see Section 2.13 for details);
- Acknowledge care coordination outreach from the new participant and make good faith efforts to determine the wishes of the patient, or their caregiver, within 15 days of a new pending alignment notification from CMS;
- Verify the patient's provider preference through direct conversations with the patient, or their caregiver;

[15] Neither participant nor their GUIDE Practitioners, Partner Organizations, or other individuals or entities performing functions or services on behalf of the participant shall attempt to influence the patient's alignment decision.

- Provide care transition information to the new participant within 15 days of receiving outreach from the new participant; and
- Complete any related required documentation in the medical record.

CMS will:

- Unalign the patient after receiving the unalignment PAAF via the HDR application; and
- Return the patient to an eligible patient status (see Section 2.3).

The new participant to whom the patient wishes to align with must:

- Ask the patient, or their caregiver, if they are currently receiving GUIDE services from another participant;
- Confirm with the patient, or their caregiver, that they have notified the participant to whom they are currently aligned of their wish to no longer receive GUIDE Model services from them;
- Request documentation of the unalignment notification, and coordinate and transition care from the previous participant; and
- Complete all components of the Patient Voluntary Alignment process, including obtaining voluntary consent documented in the medical record, along with any other required documentation.

3 Dementia Care Management Payment

The DCMP is the primary payment under the GUIDE Model, providing a per-patient, per-month care management payment in lieu of billing traditional HCPCS codes for covered GUIDE services. These services include annual wellness visits, chronic and principal care management, transitional care management, advance care planning, and technology-based check-ins. **Exhibit 7** provides the full list of services included under the DCMP. CMS may change the codes in **Exhibit 7** at its discretion based on updates to the Medicare PFS.

Exhibit 7: Medicare Physician Fee Schedule (PFS) Services Included Under the DCMP[16,17]

Service Type	Service Type HCPCS Codes
Advance care planning	99497, 99498
Welcome to Medicare and Annual Wellness Visits	G0402, G0438, G0439
Care Plan Oversight	G0181
Hospice Care Plan Oversight	G0182
Cognitive Assessment and Planning	99483
Technology-based check-in services	G2252, 98016
Transitional Care Management	99495, 99496
Chronic Care Management	99487, 99489-99491, 99437, 99439, G0506
Principal Care Management	99424–99427
Administration of patient-focused health risk assessment (HRA)	96160
Administration of caregiver-focused HRA	96161
Depression screening	G0444
Group Caregiver Behavior Management/ Modification Training Services	96202, 96203
Caregiver Training Services under a Therapy Plan of Care established by a PT, OT, SLP	97550, 97551, and 97552
Community Health Integration Services	G0019, G0022
Principal Illness Navigation Services	G0023, G0024, G0140, and G0146
Administration of a Standardized, Evidence-based Assessment of Physical Activity and Nutrition	G0136
Advanced Primary Care Management (APCM)	G0556, G0557, and G0558
Caregiver Training Services in Behavior Management/ Modification	G0539, G0540

Note: These HCPCS codes are current as of the CY 2026 Medicare PFS final rule[18] but are subject to change based on updates to the PFS. HCPCS = Healthcare Common Procedure Coding System; OT = occupational therapist; PT = physical therapist; SLP = speech and language pathologist

[16] Services included under the DCMP effective as of July 1, 2026.

[17] CPT® codes, descriptions and other data are copyright 2004–2026 American Medical Association. All rights reserved. CPT is a trademark of the American Medical Association. No fee schedules, basic units, relative values or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.

[18] CMS Federal Regulation CMS-1807-F.

The DCMP gives participants more flexibility to deliver personalized dementia care than traditional Medicare Fee-for-Service (FFS) billing, covering a broader set of services than existing care management codes. The DCMP is also less burdensome and enables payment to ICT members who are not otherwise eligible to bill Medicare directly.

Update on RCC Model Tiers

CMS updated the GUIDE DCMP base rates for PY 2026 (see **Exhibit 8**).

Beginning in PY 2026, all GUIDE patients residing in RCCs are assigned to the RCC Tier (Section 2.8) and must be billed using the new RCC-specific DCMP G-codes. Appendix D of the Participation Agreement contains details on GUIDE care delivery services required for patients in RCCs.

Participants use a set of HCPCS G-codes created specifically for the GUIDE Model to submit claims for the monthly DCMP. For each aligned patient, CMS uses the model tier assignment described in Section 2.8 to determine: (1) the DCMP rate and (2) whether the aligned patient is eligible to receive GUIDE Respite Services. Participants bill the codes in **Exhibit 8** based on the patient's tier. For services not covered under the DCMP or included in the required care delivery elements of the model (i.e., those HCPCS codes not listed in **Exhibit 7**), participants may continue to bill under original FFS, subject to existing FFS rules.

Exhibit 8: GUIDE Monthly DCMP Base Rates for PY 2026[19]

Patient Status	Monthly Payment Rates for Patients With Caregiver			Monthly Payment Rates for Patients Without Caregiver		Monthly Payment Rates for Patients Residing in an RCC
	Low Complexity Dyad Tier	Moderate Complexity Dyad Tier	High Complexity Dyad Tier	Low Complexity Individual Tier	Moderate to High Complexity Individual Tier	RCC Model Tier
First 6 Months (New Patient Payment Rate)	G0519: $157	G0520: $288*	G0521: $377*	G0522: $241	G0523: $409	G0574: $180
After First 6 Months (Established Patient Payment Rate)	G0524: $68	G0525: $126*	G0526: $231*	G0527: $126	G0528: $225	G0575: $70

* Indicates tiers that are eligible for GUIDE Respite Services. Note, patients residing in RCCs do not qualify for GUIDE Respite Services.

Participants may bill the correct DCMP HCPCS G-code for each aligned patient each month that the participant provides a GUIDE care delivery service. For example, a GUIDE Practitioner may see an aligned patient in the low complexity tier with a primary caregiver during the third month that the patient is aligned to the participant. In this case, the GUIDE Practitioner should bill G0519 for that visit because the aligned patient is considered a new patient for the first six months, they are aligned to the participant. Then, if the GUIDE Practitioner provides a qualifying GUIDE care delivery service for that same aligned patient in the seventh month that the patient is aligned to the participant (and there have been no changes to the patient's tier or caregiver

[19] Starting PY 2026, the RCC Tier includes patients residing in RCCs. See Section 2.8 for additional information on the model tiering criteria. GUIDE DCMP rates for PY 2025 were increased 2.2% from PY 2025. See Section 4.5 for additional details.

status), the GUIDE Practitioner should bill G0524 as the aligned patient is now considered an established patient.

Each month, CMS shares information to confirm each aligned patient's tier and corresponding DCMP G-code with participants through a monthly Beneficiary Alignment Report via the HDR application within the CMS.gov ePortal (see Appendix H for details on the contents). CMS updates the Beneficiary Alignment Report twice monthly; it will contain the most recent information regarding each aligned patient's tier, including any changes that occur, such as a reassessment (see Sections 2.10 and 2.11 for additional information). When CMS assigns the aligned patient to a new tier, CMS will update the Beneficiary Alignment Report and the participant must use the new G-code associated with the new tier beginning on the month following CMS's assignment of the aligned patient to the new tier to bill the DCMP. Participants should use the report to confirm each patient's alignment start date, tier, and corresponding G-code when billing for the DCMP.

> An aligned patient's 6-month "clock" begins in the first month of alignment, even if that is a partial month, and ends on the last day of the sixth month. For example, if an aligned patient in the low complexity tier who has a caregiver aligns with a participant on July 15, the participant may bill G0519 from July through December and then may bill G0524 beginning January 1.

The dollar amounts in **Exhibit 8** indicate the base rate for the respective GUIDE-specific G-codes listed. Actual payment rates will vary for each aligned patient in accordance with the adjustments detailed in Section 4. GUIDE G-codes cover all reimbursement under the model and GUIDE does not distinguish between facility and non-facility rates, since these G-codes will not be subject to the reduction in reimbursement rates for services provided in certain settings. As noted in Section 1.4.1, GUIDE G-codes do not include reductions in the payment amounts for nonphysician practitioners, which is typically at 85% of the physician's fee schedule. For example, if the dementia-proficient clinician is a nurse practitioner or physician assistant and bills the GUIDE G-codes, these G-codes will not be subject to the reduction in reimbursement rates for services provided by nonphysician practitioners compared to those provided by physicians. Unless otherwise stated, GUIDE DCMP claims are subject to all other adjustments (e.g., sequestration) and policies applicable to Medicare FFS claims.

3.1 Billing for the DCMP

Participants may bill the correct DCMP HCPCS G-code for each aligned patient each month that the participant provides a GUIDE care delivery service, other than the GUIDE Respite Services. For aligned patients in the moderate and high complexity dyad tiers, and the low complexity individual tier, the minimum contact frequency requirements dictate that participants will contact these patients at least once a month; for the moderate to high complexity individual tier, participants will contact these patients at least twice a month. Touchpoints are always billable each month under the DCMP.

> **Important billing considerations**
>
> Participants must not bill a DCMP G-code for any month in which no GUIDE care delivery service was provided to an aligned patient.
>
> Participants may not bill the DCMP for an aligned patient if the participant only maintained the infrastructure to deliver a GUIDE Care Delivery Service - for example, by providing access to a 24/7 helpline or developing caregiver trainings.

These services need not include clinical encounters, and are, for example, inclusive of ongoing

contact and support, transitional care management, and medication management. If the participant performs the required touchpoints, they can bill the DCMP each month.

For aligned patients in the **low complexity dyad or RCC model tier**, the minimum contact frequency requirements dictate that participants will contact these patients either at least quarterly or at least bimonthly, respectively. These requirements for touchpoints are based on calendar months and reset after each touchpoint, so there may be some months that the participant does not contact the patient. In such cases, if the participant still provides a non-contact-based care delivery service, they may bill the DCMP as long as the participant has complied with the quarterly or bimonthly contact frequency required under Section 4.3.1 of Appendix C or Section 4.4.1 of Appendix D of the Participation Agreement.

> Participants who fail to meet the touchpoint requirements (e.g., do not conduct a quarterly touchpoint with a patient assigned to the low complexity dyad tier) may not bill the DCMP for **any** GUIDE care delivery service for that patient until the required touchpoint has been completed.

Exhibit 9 shows a sample of GUIDE DCMPs billed by a participant for a single patient for the first seven months of alignment. This example assumes that the initial comprehensive assessment was provided on July 15, 2026, and the patient was aligned to the low complexity dyad tier. The participant did not provide a GUIDE care delivery service to the patient in October and was unable to bill for the DCMP. Beginning in January 2027, the patient would move to the established tier rate ($68) because the patient had been aligned to the participant for 6 months, despite the participant not billing in October 2026. This illustrates how GUIDE DCMP Payments are calculated by CMS.

Exhibit 9: Sample Billing for GUIDE DCMP

Month	GUIDE Care Delivery Service Provided?	Date of Service	G-Code Billed	DCMP Base Rate
July 2026	Yes (Initial comprehensive assessment)	07/15/2026	G0519	$157
August 2026	Yes	08/03/2026	G0519	$157
September 2026	Yes	09/01/2026	G0519	$157
October 2026	No	None	None	N/A
November 2026	Yes	11/06/2026	G0519	$157
December 2026	Yes	12/01/2026	G0519	$157
January 2027	Yes	01/03/2027	G0524	$68
			Totals for PY 3:	**$853**

Note: DCMP base rates are used for illustration purposes; actual payments are subject to GUIDE DCMP adjustments (see Section 4) and all other adjustments and policies applicable to other fee for service claims.

Participants are required to bill GUIDE-specific G-codes, including both the DCMP (see Exhibit 8) and GUIDE Respite Services G-codes (see Exhibit 18), on a standalone claim with no other HCPCS codes. Participants may bill multiple GUIDE-specific G-codes for one patient on the same standalone claim, as needed. Participants can bill two or more calendar months on the same claim for a patient with service dates in separate months.

Participants will submit GUIDE claims just as they would for any other Medicare Part B claim using the **CMS-1500 claim form**. This is primarily done via electronic claims (using an Electronic Data Interface).[20] There is no one-size-fits-all solution to submitting electronic claims because there are several different Medicare Administrative Contractors (MACs) who operate differently, and there are many different "set ups" that Medicare providers use to submit electronic claims. Please contact your MAC for additional information.

When a participant bills for a DCMP, the claim must include the required information shown in **Exhibit 10**.

Exhibit 10: GUIDE DCMP Billing Requirements

Required Information	Description
GUIDE-specific HCPCS G-Code	Using the Beneficiary Alignment Report, which is available via the HDR application within the CMS.gov ePortal, confirm each patient's tier and corresponding G-code to include on the claim. See Appendix H for details on its contents.
Date of Service (DOS)	DOS is the earliest day of the calendar month in which the participant or GUIDE Partner Organization provided GUIDE care delivery services. For the first month of a patient's alignment, the DOS should be the date of alignment (i.e., the initial Comprehensive Assessment date). DOS must be within the effective Start and End dates for both the GUIDE Practitioner and patient alignment records. If a Partner Organization administers the care delivery service, the Partner Organization should record the service date and provide that information to the participant to bill the DCMP for that service.
GUIDE TIN and rendering NPI	The entered TIN must match the TIN on file with the GUIDE Model. The rendering NPI must be part of a participant's Practitioner Roster.
Patient's Health Insurance Claim Number/MBI	From the Beneficiary Alignment Report, input the aligned patient's MBI.
Patient's Dementia Diagnosis Code (see Appendix B) in any position	Enter the aligned patient's diagnosis or condition to the highest level of specificity for the Date of Service. For the claim to be accepted, one or more of the diagnoses listed in this field must appear in the list of GUIDE ICD-10 Diagnosis Codes (see Appendix B). Note that additional ICD-10 Diagnosis Codes may be included on the claim as appropriate so long as the claim contains at least one of the GUIDE ICD-10 Diagnosis Codes.
Servicing Facility Location	This should reflect the location of the participant or Partner Organization staff member at the time of the contact/service. If the staff member was present at the aligned patient's home, use the patient's home address.

If a claim fails to meet these requirements, or is submitted with incomplete or invalid information, CMS may deny or return the claim to the submitter as unprocessable, which may cause a delay in payment. For example, if a participant bills the incorrect G-code that reflects the incorrect tier for an aligned patient, CMS will not process the claim and will send it back to the participant for resubmission. Please refer to the Billing Fact Sheet in Appendix K (also available in the Connect Library) for additional details regarding claim requirements and troubleshooting guidance.

[20] Participants can only file paper claims if an allowed exception is met (for more information see Administrative Simplification Compliance Act Waiver Application.

Participants will be able to track their GUIDE billing and payment data through the Payment Report, which is updated monthly and available via the HDR application within the CMS.gov ePortal. It includes information on DCMP claims, GUIDE Respite Services claims and payments, and remaining GUIDE Respite Services cap for aligned patients. Participants can use this report to reconcile actual and expected payments and to facilitate the payment of Partner Organizations who provide GUIDE Respite Services. See Appendix J for more details.

3.1.1 Setting Charge Amounts for DCMP Claims

In setting charge amounts for services provided for DCMP claims, participants should follow their own process to establish a fee schedule. CMS does not provide specific advice on what amount to charge. However, participants may want to consider that CMS will pay the lesser of the participant's charge amount and the allowed amount. Each participant's allowed amount will be the DCMP base rate adjusted based on the participants' geographic region, Performance-Based Adjustment (PBA), and Population and Income Adjustment (PIA) which are described in Section 4). At most, a DCMP base rate could receive a +75% adjustment after considering all adjustments, or 1.75 times the base rate. As such, participants should consider incorporating potential adjustments into DCMP charge amounts.

3.2 Waiver of Patient Cost Sharing for the DCMP

Medicare FFS patients are typically required to pay a 20% coinsurance for Medicare Part B physician services. GUIDE waives this required 20% cost sharing for the DCMP, and Medicare will pay 100% of the DCMP amount. The Medicare FFS system will automatically handle this and there is no need for claims level action. *Participants shall not subject aligned patients to any additional cost sharing for the DCMP or GUIDE Respite Services*.

3.3 Medicare Physician Fee Schedule Services Included Under the DCMP

The DCMP will replace FFS payment for certain existing Medicare PFS services listed in **Exhibit 7**. Therefore, participants serving aligned patients are not permitted to bill separately for these services. For example, a participant may not bill a Chronic Care Management code (e.g., 99487) for an aligned patient as it is considered duplicative with the DCMP. CMS considers Medicare PFS Services claims filed by participants for aligned patients duplicative with the DCMP and will reject the claim. If a participant does bill for services listed in **Exhibit 7** and receives payment for an aligned patient, CMS may recoup the amount of the payment for that claim from a future Medicare payment. Please refer to Section 9.02(D) of the Participation Agreement for more information. CMS may recoup duplicative payments in accordance with Section 9.08 of the Participation Agreement.

3.4 Interaction with Other Innovation Center Models and Payments

Participants and aligned patients may overlap with all other CMS Innovation Center models where it is possible to account for the financial impact of the overlap. Please refer to Section 9.09 of the Participation Agreement for more information.

3.4.1 Other CMMI Shared Savings Models Overlap

Participants, providers, and aligned patients may participate in both the GUIDE Model and CMMI shared savings models, such as the Accountable Care Organization (ACO) Realizing Equity, Access, and Community Health (REACH) Model. DCMP expenditures are included in the model's total cost of care calculations and factor into shared savings/shared losses. Providers participating in multiple overlapping models (e.g., GUIDE practitioners also enrolled in ACO REACH or Long-term Enhanced ACO Design, LEAD) must adhere to **GUIDE billing requirements**, including the discontinuation of billing for Medicare PFS services covered under the DCMP (see **Exhibit 7**).

GUIDE Respite Services expenditures (see **Exhibit 17**) are excluded from the total cost of care calculations for overlapping CMMI shared savings models (see Section 5.3 for additional information). For specific model information, please review the Innovation Center website at https://www.cms.gov/priorities/innovation/models.

3.4.2 Medicare Shared Savings Program

Participants may also simultaneously participate in the GUIDE Model as an ACO participant under any track in the Medicare Shared Savings Program. DCMP expenditures are included in Shared Savings Program expenditures and count in the applicable benchmark year. Participants must adhere to **GUIDE billing requirements**, including the discontinuation of billing for Medicare PFS services covered under the DCMP (see **Exhibit 7**).

GUIDE Respite Service claims are excluded from ACO expenditures, shared savings, and benchmarking for the duration of the GUIDE Model (see Section 5.3 for additional information).

4 DCMP Adjustment Methodology

4.1 Performance-Based Adjustment

To incentivize high-quality care, CMS will adjust the DCMP for participant performance using a performance-based adjustment (PBA). To derive the PBA, CMS first calculates performance rates for GUIDE Model measures. For PY 2025, CMS will use four (of five) measures to derive the PBA. CMS will compare participant performance on each measure to a benchmark (or reporting threshold); if participants meet or exceed the benchmark (or reporting threshold), they receive an individual measure positive contribution to the PBA; if participants fail to meet the benchmark (or reporting threshold), they receive a null (0%) or negative individual measure contribution to the PBA. CMS then sums the individual measure contributions to the PBA to derive the total PBA. The PBA will apply annually at the participant level; this means that the same percentage amount will be applied for all patients aligned to a participant.

Important Update

Medicare's FFS system currently processes only whole-number percentage adjustments to DCMP claims. If a participant's PBA includes a decimal (e.g., 2.5%), the system applies only the whole-number portion (e.g., 2%) to claims at this time. Participants whose PBA includes a non-whole number adjustment will initially receive only the whole-number portion via FFS claims and will receive the remaining decimal portion via the Innovation Payment Contractor (IPC) portal. Participants should verify that their banking information, within the IPC, is correct; those participants already onboarded to the IPC do not need to take any action to receive the IPC portion of their PBA—CMS will process this payment automatically.

CMS will calculate and assign the PBA to participants each performance year. These adjustments will be applied to the DCMP in January and will be in place for the 12 months following their issue date. The first total PBA, for Established Program Track Participants, was applied beginning in January 2026 (midway through PY 2025); the first total PBA, for New Program Track Participants, will be applied beginning in January 2027. See Section 4.2 for more information on PBA timing.

The list of all measures and their data source appears in **Exhibit 11**.

Exhibit 11. GUIDE Performance Measures

Measure Title	Domain	Data Source	Type of Reporting by Participant
Use of High-Risk Medications in Older Adults (DAE)[21]	Care coordination and management	Claims	No participant reporting required, as CMS will calculate using claims data.
Quality of Life for Patients Living with Dementia (QoL-PLWD)[22]	Patient quality of life	Participant reported survey (PROMIS-10)	Participant will enter results for each GUIDE-aligned patient or caregiver via the PAAF. PAAFs are submitted on an ongoing basis, with final data due by end of August to be included in measure calculation for each PY.
Caregiver-Reported Impact in Dementia (CID)	Caregiver support	Participant reported survey (ZBI-22)	

[21] The DAE measure has replaced the chart-abstracted *Use of High-Risk Medications in Older Adults* (HRRx) measure for PY 2025 and beyond. See the PMM for more information on the change and the new measure.

[22] The QoL-PLWD measure has replaced the *Quality of Life Outcome for Patients with Neurologic Conditions* (QoL) measure for PY 2025 and beyond. See the PMM for more information on the change and the new measure.

Measure Title	Domain	Data Source	Type of Reporting by Participant
Total Per-Capita Cost (TPCC)	Cost and utilization	Claims	No participant reporting required, as CMS will calculate using administrative and claims data.
Admissions to Long-Term Nursing Home Stay (LTNH)	Cost and utilization	Claims; Minimum Data Set (MDS) 3.0[23]	

Information about the scoring strategies used to evaluate a participant's performance on the measures incorporated into the PBA is available in Section 4.1.1. More information appears in the GUIDE Performance Measurement Manual (PMM) available in the Connect Library in the Model Data Folder.

4.1.1 PY 2025 Total PBA

For PY 2025, the total PBA can range from -2% to +6% for the Established Program Track and -1 to +5% for the New Program Track. When all five performance measures are fully implemented, the PBA amount will range from -3.5% to +10%. For PY 2025, the total PBA methodology is summarized in **Exhibit 12** and detailed below.

For more information on performance benchmarks for each measure for PY 2025 and PY 2026, please see version 3.0 of the PMM (Section 3, *GUIDE Performance Measure Benchmarks*).

Quality of Life for Patients Living with Dementia (QoL-PLWD)

For PY 2025, CMS will use the *Quality of Life for Patients Living with Dementia* (QoL-PLWD) measure in different ways for participants in the Established Program Track and the New Program Track:

- For Established Program Track participants, participants' individual PBA contribution from QoL-PLWD will be derived based on participant performance compared to a benchmark. Established Program Track participants shall receive a +3% individual PBA contribution for the QoL-PLWD measure if their performance score meets or exceeds the benchmarks for both sub-scales; a +1.5% individual PBA contribution for the QoL-PLWD measure if their performance meets or exceeds the benchmark for one sub-scale (not both); or a -1% individual PBA contribution for the QoL-PLWD measure if their performance score falls below the benchmark for both subscales.
- For New Program Track participants, participants' individual PBA contribution from QoL-PLWD will be derived based on the percentage of data that are reported to CMS by the deadline. New Program Track participants must submit PROMIS-10 data, from the initial comprehensive assessment conducted during alignment, for at least 90% of the patients aligned to them at any point in PY 2025. All data must be submitted to CMS by Monday, August 31, 2026. If New Program Track participants submit at least 90% of PROMIS-10 data for all patients aligned to them in PY 2025, they will receive a +2% individual PBA contribution for QoL-PLWD. If fewer than 90% of data are submitted for all patients aligned to them in PY 2025, they will receive a 0% individual PBA contribution for QoL-PLWD.

[23] MDS data are Minimum Data Set (MDS) 3.0 data, or results from a health status screening and assessment tool used for all residents of long-term care nursing facilities and non-Critical Access Hospital swing beds.

Caregiver-Reported Impact in Dementia (CID)

For PY 2025, for the *Caregiver-Reported Impact in Dementia* (CID) measure, participants will not receive a performance-based adjustment based on measure performance, as a benchmark could not be derived. The CID measure is new—its specifications were released for the first time in version 3.0 of the PMM—and an additional year of data are needed before a valid benchmark can be calculated.

Beginning in PY 2026, CID will have an individual PBA contribution of -1% to +3%, relative to the applicable measure benchmark or reporting threshold that CMS shall establish.

Use of High-Risk Medications in Older Adults (DAE)

For PY 2025, the *Use of High-Risk Medications in Older Adults* measure was referred to as HRRx (a chart-abstracted measure). Beginning in PY 2026, CMS will discontinue use of the HRRx clinical quality measure within the GUIDE performance framework and replace it with the National Committee for Quality Assurance's (NCQA *Use of High-Risk Medications in Older Adults* (DAE) claims-based measure. **Participants will not need to submit an HRRx Excel workbook for PY 2025 data (previously communicated for July–August 2026 reporting period), nor for any future performance year.** CMS will calculate the DAE measure using claims data already available; no additional reporting is required by GUIDE participants. For PY 2025, CMS will apply a "null adjustment" (0% individual PBA contribution) for the *Use of High-Risk Medications in Older Adults* measure (referred to as *HRRx* for PY 2025). Therefore, for PY 2025, there will be no impact on the PBA based on participant performance on HRRx.

Within the PMM, CMS provides more information about the transition from use of HRRx, a chart-abstracted measure, to DAE, calculated using claims data.

Beginning in PY 2026, the individual PBA contribution for DAE ranges from -0.5% to +1%. More information on the benchmark for the DAE measure will be released in a future version of the PMM.

Total Per-Capita Cost (TPCC)

For PY 2025, participants' individual PBA contribution from TPCC will be calculated based on participant performance compared to a benchmark. Participants shall receive a +1.5% individual PBA contribution for the TPCC measure if their performance score meets or exceeds the benchmark; conversely, participants shall receive a -0.5% individual PBA contribution for the TPCC measure if their performance score falls below the benchmark.

Admissions to Long-Term Nursing Home Stay (LTNH)

For PY 2025, participants' individual PBA contribution from LTNH will be calculated based on participant performance compared to a benchmark. Participants shall receive a +1.5% individual PBA contribution for the LTNH measure if their performance score meets or exceeds the benchmark; conversely, participants shall receive a -0.5% individual PBA contribution for the LTNH measure if their performance score falls below the benchmark.

Exhibit 12: PBA Domains, Measures, and Individual Contributions for PY 2025

Domain	Measure	PY 2025		PY 2026
		Established Program Track	*New Program Track*	*Both Tracks*
Care Coordination and Management	*Use of High-Risk Medications in Older Adults* (DAE beginning PY 2026; formerly HRRx in PY 2024 and PY 2025)	0%	0%	-0.5%–+1%
Patient Quality of Life	*Quality of Life for Patients Living with Dementia* (QoL-PLWD beginning in PY 2025; formerly QoL in PY 2024)	-1% (both Physical Health and Mental Health benchmarks not met) +1.5% (one benchmark met) +3% (both benchmarks met)	0% (non-reporting) +2% (reporting)	-1%–+3%
Caregiver Support	*Caregiver-Reported Impact in Dementia* (CID beginning in PY 2025; formerly CB in PY 2024)	0%	0%	-1%-+3%
Cost and Utilization	*Total Per-Capita Cost* (TPCC)	-0.5% (benchmark not met) +1.5% (benchmark met)	-0.5% (benchmark not met) +1.5% (benchmark met)	-0.5%–+1.5%
	Admissions to Long-Term Nursing Home Stay (LTNH)	-0.5% (benchmark not met) +1.5% (benchmark met)	-0.5% (benchmark not met) +1.5% (benchmark met)	-0.5%–+1.5%
Total PBA Potential		-2%–+6%	-1%–+5%	-3.5%–+10%

4.2 Timeline for Performance-Based Adjustment Application

A participant's performance during a given performance year will affect their payment in future years. Specifically, the participant's performance will be calculated beginning three months after the end of the performance year to allow time for reporting and claims run-out. The resulting total PBA will be applied to the participant's DCMP beginning six months after the end of the performance year and will continue for 12 months. In other words, there is a six-month period between the end of the performance year and when the total PBA begins to affect payment.

- The Established Program Track had its first total PBA applied to the DCMP in January 2026, reflecting performance from PY 2024 (July 2024 through June 2025). The same total PBA remains in place from January 2026 through December 2026.
- The New Program Track will have its first total PBA applied to the DCMP beginning in January 2027, reflecting performance from PY 2025 (July 2025 through June 2026). The same total PBA will remain in place from January 2027 through December 2027.

Exhibit 13 demonstrates this timeline for both program tracks throughout the entire model.

Exhibit 13: Performance-Based Adjustment Timing

Year	2024	2025	2026	2027	2028	2029	2030	2031	2032
Established Program Track	PY 2024 7/1/2024 – 6/30/2025	**PY 2025 7/01/2025 – 6/30/2026**	PY 2026 7/1/2026 – 6/30/2027	PY 2027 7/1/2027 – 6/30/2028	PY 2028 7/1/2028 – 6/30/2029	PY 2029 7/1/2029 – 6/30/2030	PY 2030 7/1/2030 – 6/30/2031	PY 2031 7/1/2031 – 6/30/2032	
			PBA 1 1/1/2026 – 12/31/2026	PBA 2 1/1/2027 – 12/31/2027	PBA 3 1/1/2028 – 12/31/2028	PBA 4 1/1/2029 – 12/31/2029	PBA 5 1/1/2030 – 12/31/2030	PBA 6 1/1/2031 – 12/31/2031	PBA 7 1/1/2032 – 6/30/2032
New Program Track	Pre-Implementation Period	**PY 2025 7/1/2025 – 6/30/2026**	PY 2026 7/1/2026 – 6/30/2027	PY 2027 7/1/2027 – 6/30/2028	PY 2028 7/1/2028 – 6/30/2029	PY 2029 7/1/2029 – 6/30/2030	PY 2030 7/1/2030 – 6/30/2031	PY 2031 7/1/2031 – 6/30/2032	
				PBA 1 1/1/2027 – 12/31/2027	PBA 2 1/1/2028 – 12/31/2028	PBA 3 1/1/2029 – 12/31/2029	PBA 4 1/1/2030 – 12/31/2030	PBA 5 1/1/2031 – 12/31/2031	PBA 6 1/1/2032 – 6/30/2032

PBA = performance-based adjustment; PY = performance year

4.3 Population and Income Adjustment

To support and incentivize participants in providing care to particular communities, CMS will adjust each aligned patient's DCMP using a Population and Income Adjustment (PIA). CMS began applying the PIA to aligned patients' base DCMPs for Established Program Track Participants beginning on July 1, 2025, and will apply for New Program Track Participants beginning on July 1, 2026.

The PIA is a fixed dollar amount that applies at the patient level and is based on the aligned patient's PIA score percentile. The PIA is calculated using a composite methodology that includes both community-level and patient-level measures of deprivation. Specifically, the PIA is composed of three measures: Community Deprivation Index (CDI),[24] which is measured at the census block group level based on the aligned patient's residence, and Low-Income Subsidy (LIS) status and dual eligibility (DE) for Medicare and Medicaid, which are patient-level measures. CMS will calculate a *PIA Score* for every aligned patient (*b)* and their corresponding geography (*g)* in the aligned population:

$$PIA\ Score_{b.g} = (0.1 \times CDI_g) + (10 \times LIS_b \text{ or } De_b)$$

In the formula, CDI_g is the CDI percentile for the census block group in which the aligned patient resided on their first day of eligibility and can range from 1 to 100. CDI exhibits strong correlations with several health outcome and utilization measures. CDI also uses statistical shrinkage to account for imprecise measurement of factors, standardizes deprivation factors to be unit-neutral, and reweights factors using the most recently available data.[25]

LIS_b represents LIS status and is equal to 1 if the aligned patient is enrolled in the Medicare Part D LIS program and 0 otherwise. Similarly, DE_b represents dual eligibility and is equal to 1 if the aligned patient is dually eligible and 0 otherwise.

[24] The previously published adjustment methodology used the Area Deprivation Index instead of CDI; CMS may continue to update measures in future performance years.

[25] Robst J, Cogburn R, Forlines G, et al. The development of the Community Deprivation Index and its application to accountable care organizations. *Health Affairs Scholar*. 27 November 2024.

The possible range of PIA scores is from 0 to 20. In the case of a maximum score, an aligned patient's CDI would contribute 50% to the overall PIA score and LIS or DE status would contribute the other 50% to the overall score. CMS may revisit this weighting at its discretion.

4.4 Timeline for Population and Income Adjustment Application

CMS will calculate aligned patient's PIA scores and percentiles annually before the start of the performance year in which they are applied. Because patients were not aligned to participants at the time of model launch, CMS did not apply the PIA to the DCMP until July 1, 2025. CMS calculated the adjustment based on aligned patients' data from the first year of the GUIDE Model Performance Period. CMS applies each aligned patient's PIA to their base DCMP for the duration of the performance year, including applying PIA scores upon alignment for patients who align to an Established Program Track participant during the performance year. The Established Program Track receives the PIA from July 2025 through June 2026 based on all aligned patients in the prior year (e.g., July 2024 through June 2025). Beginning in July 2026, both Established Program Track and New Program Track participants will receive the PIA based on all aligned patients in both tracks in the prior year (e.g., July 2025 through June 2026). The reassessment of the PIA will occur each subsequent year. Information regarding the PIA scores and PIA percentiles will be provided as they become available.

The PIA methodology design provides a material incentive for participants to care for particular patients and to be budget neutral while limiting the magnitude of any downward adjustments.[26]

Exhibit 14 shows how PIA scores translate into an adjustment to the monthly DCMP. The PIA amount can range from -$6 to +$15 and will apply at the patient level. This means that PIA amounts and adjusted DCMP payments will vary by patient aligned to a participant. **Exhibit 15** demonstrates the timing PIA percentile calculations and the annual application of the adjustment.

Exhibit 14: PIA Score Percentiles and Associated Population and Income Adjustment

PIA Score Percentile	Population and Income Adjustment to DCMP
≥ 80 percentile of patients	+$15
51–79 percentile of patients	$0
0–50 percentile of patients	−$6

[26] CMS may elect to add other measures to the GUIDE Model's PIA in future performance years.

Exhibit 15: PIA Calculation and Application Timeline

Calendar Year	2025	2026	2027	2028	2029	2030	2031	2032
PIA	**PIA 1** 7/2025 – 6/2026	**PIA 2** 7/2026 – 6/2027	**PIA 3** 7/2027 – 6/2028	**PIA 4** 7/2028 – 6/2029	**PIA 5** 7/2029 – 6/2030	**PIA6** 7/2030 – 6/2031	**PIA 7** 7/2031 – 6/2032	
Program Track(s)	**EPT Only**	**EPT & NPT**	**EPT & NPT**	**EPT & NPT**	**EPT & NPT**	**EPT & NPT**	**EPT & NPT**	
Basis for Percentiles	**All aligned EPT patients** 7/2025 – 6/2026	**All aligned EPT patients** 7/2026 – 6/2027	**All aligned EPT patients** 7/2027 – 6/2028	**All aligned EPT patients** 7/2028 – 6/2029	**All aligned EPT patients** 7/2029 – 6/2030	**All aligned EPT patients** 7/2030 – 6/2031	**All aligned EPT patients** 7/2031 – 6/2032	

4.5 Medicare Economic Index Adjustment

To account for cost growth over time, CMS adjusts the GUIDE DCMP base rates using the Medicare Economic Index (MEI). The MEI measures price changes in the inputs (goods and services) required to operate a physician practice in the United States. These inputs are aggregated into two broad categories: the physician's own time and their practice expenses. The MEI measures year-to-year changes in prices for these various inputs based on appropriate price proxies.

CMS applied the MEI adjustment to the PY 2025 DCMP base amounts to establish the PY 2026 DCMP base rates, reflecting a 2.2% increase. Updates to the MEI will apply to the DCMP base rates at the beginning of each performance year and will be reflected in **Exhibit 8** (see Section 3). MEI updates are applied at the beginning of each performance year and will apply for the entirety of the performance year. For example, GUIDE monthly DCMP base rates were updated for PY 2026 using the forecasted growth in the MEI from July 1, 2026, through June 30, 2027. Additional information regarding the MEI is available on the CMS webpage for Market Basket Data.

4.6 Geographic Adjustment

To account for geographic variation in costs, CMS adjusts the DCMP base rates by the Medicare PFS Geographic Adjustment Factor[27] (GAF) for each DCMP claim submitted by a participant. The GAF applied to the DCMP is a weighted geographic adjustment based on all services in the Medicare PFS. It summarizes the combined impact of the three Geographic Practice Cost Index (GPCI) expense categories (work, practice expense, malpractice) on a locality's (state or metropolitan region's) physician reimbursement level. The intent of the GAF is to ensure that the Medicare program does not overpay participants in certain areas and underpay in others because of geographic differences in prices for resources such as clinical and administrative staff salaries and benefits, office or hospital space (rent), medical supplies, and malpractice insurance.

[27] Updated GAF amounts are published annually as part of the Medicare Physician Fee Schedule Final Rule Addenda.

CMS updates GAFs annually as part of the update to Payment Policies under the PFS.[28] GAF updates will be applied at the beginning of each performance year and will be consistently applied to the DCMP for the entirety of the performance year. For example, 2025 GAFs were applied to GUIDE payments effective July 1, 2025, and will be in effect until June 30, 2026. The 2026 GAFs will go into effect on July 1, 2026.

The GAF applied to each DCMP claim is based on the Service Facility Zip Code submitted on the claim form. In the case of services provided at an aligned patient's home, the Service Facility Location should be the patient's home. As a result, a given participant may be subject to different geographic adjustments if they serve aligned patients across multiple localities or if they provide services to the same aligned patient in different localities each month (e.g., if they provide DCMP services in their office location in one month and in the patient's home the next month).

For examples of how to calculate the GAF, see Appendix C.

4.7 Payment Examples with Adjustments

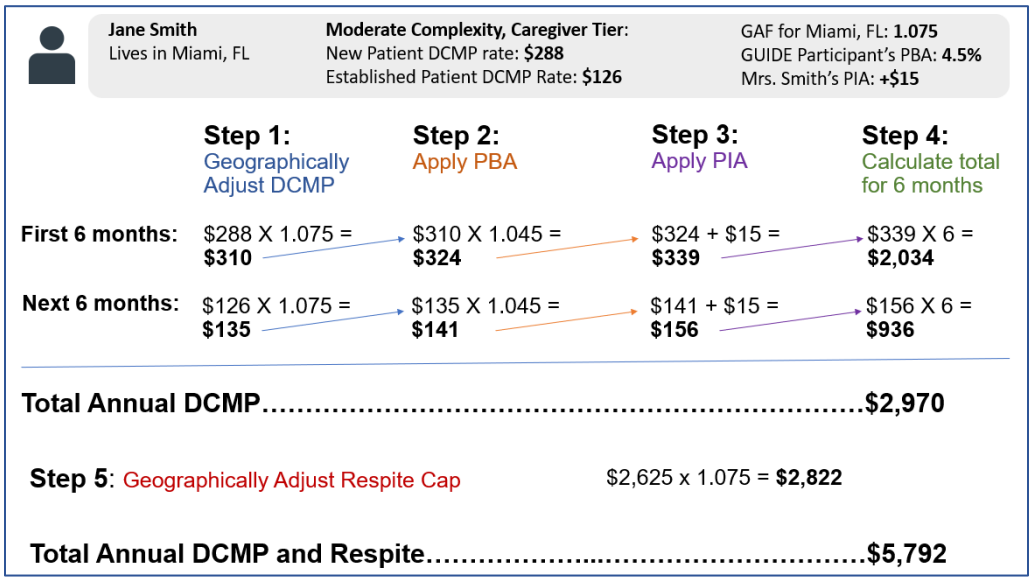
The first two payment examples in **Exhibit 16** show the calculation of total GUIDE Model payments for an individual-aligned patient over the course of a full performance year. The third example shows the calculation of total GUIDE Model payments for a participant's total aligned patient population.

Note that these examples are for illustration only and include several assumptions, including that all patients are initially aligned in the first month of the performance year and therefore are eligible for the new patient DCMP rate for the first six months of the performance year and the established patient DCMP rate for the next six months of the performance year. All examples reflect the PY 2026 DCMP base rates but are assumed to occur after the PBA and PIA are fully phased in and may not account for the most recent updates to MEI and GAF. Examples are rounded to the nearest dollar.

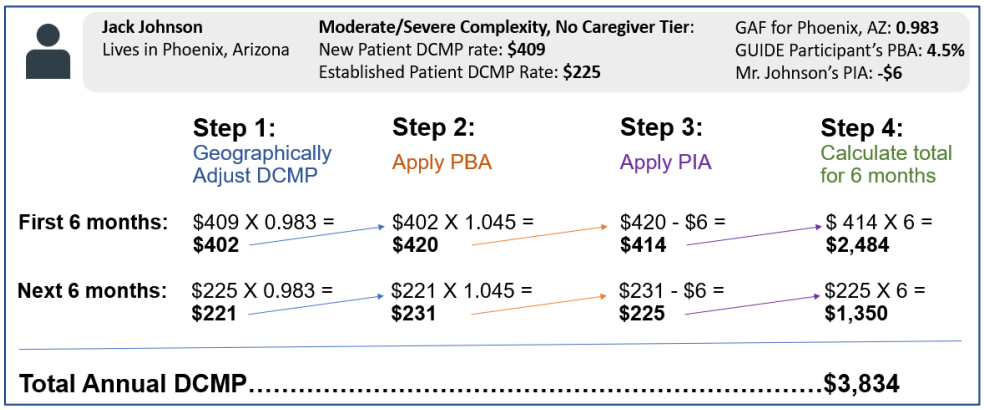
[28] The annual Geographic Adjustment Factors can be found in Addendum D.

Exhibit 16: Payment Examples

In the first example, the aligned patient is in a tier that is eligible for GUIDE Respite Services, and the example assumes that the patient reaches the GUIDE Respite Services cap for the year.



In the second example, the aligned patient is in a tier that is not eligible for GUIDE Respite Services.



The third example assumes that all patients eligible for GUIDE Respite Services reach their respite cap for the year.

Dementia Care Program
Located in Philadelphia, PA

GAF for Philadelphia, PA: **1.043**
GUIDE Participant's PBA: **4.5%**

Model Tier	Patient Count		**Step 1:** Geographically Adjust DCMP (DCMP x 1.043)	**Step 2:** Apply PBA (Step 1 x 1.045)	**Step 3:** Calculate total for 6 months (Step 2 x 6)	**Step 4:** Geo. adjust respite (Cap x 1.043)	**Step 5:** Calculate Total (DCMP + respite) x patient count
Mild Caregiver	**10**	New Est.	$164 $71	$171 $74	$1,027 $445	N/A	**$14,714**
Moderate Caregiver	**30**	New Est.	$300 $131	$314 $137	$1,883 $824	$2,625	**$245,494**
Severe Caregiver	**20**	New Est.	$393 $241	$411 $252	$2,465 $1,511	$2,625	**$189,037**
Mild No Caregiver	**10**	New Est.	$251 $131	$263 $137	$1,576 $824	N/A	**$24,000**
Moderate/ Severe No Caregiver	**15**	New Est.	$427 $235	$446 $245	$2,675 $1,471	N/A	**$62,192**
RCC Tier	**5**	New Est.	$188 $73	$196 $76	$1,177 $458	N/A	**$8,175**
Total Annual GUIDE Payments…….……..……$543,612							

Notes: GAFs presented in the Payment Examples are for demonstration purposes only.

Please refer to CMS Final Rule CMS 1832-F Addendum D for specific GAF information.

Example 3 is a stylized example and does not include the PIA, which is a patient level adjustment. The PIA could increase or decrease participants' total payment. It also assumes all patients are aligned at the beginning of the year as new patients.

5 GUIDE Respite Payments

To alleviate caregiver burden, aligned patients in the moderate and high complexity dyad tiers are eligible for GUIDE Model Respite Services (see **Exhibit 5**). GUIDE Respite Services are temporary services provided to an aligned patient and made available by participants, which include:

1. Respite services provided in the patient's home
2. Respite services provided in an adult center, including both medical and social programs
3. Respite services provided in a 24-hour facility

Important update

CMS has updated the GUIDE Respite Services base rates and the per-patient annual cap for PY 2026 (see **Exhibit 17**).

The annual respite cap is $2,625.

Participants must provide, or contract with a Partner Organization to provide, in-home GUIDE Respite Services to respite-eligible patients (those in the moderate and high complexity dyad tiers). Participants also have the option to provide services in an adult center, including both medical and social programs, and/or in a 24-hour facility

Partner Organizations are not permitted to perform any GUIDE Care Delivery Services – including GUIDE Respite Services – until the respective participant has received written notice from CMS that CMS approved and added the Partner Organization to the participant's Partner Organization Roster, in accordance with Section 3.08(C) of the Participation Agreement.

Exhibit 17 shows the updated PY 2026 base rates and service units for the three settings in which GUIDE Respite Services participants can provide.

Exhibit 17: GUIDE Respite Services G-codes and Rates for PY 2026[29]

Respite Services Setting	G-Code	Service-Unit	Base Rate
In Home	G0529	4-hour unit	$138
Adult Day Center	G0530	Per Day	$104
Facility Based	G0531	24-hour unit	$321

Participants must bill CMS in accordance with the GUIDE Respite Services respite payment base rates based on the unit of service associated with each GUIDE Respite Services G-Code. The services rendered should represent the full hourly service units listed for the three service options and participants should bill the appropriate G-code that represents the services provided. The in-home respite G-code G0529 will cover a 4-hour unit of service and be paid at $138; the adult day respite G-code G0530 will cover a daily unit paid at $104; and the facility-based respite G-code G0531 will cover a 24-hour unit paid at $321.

If participants contract with a Partner Organization, CMS requires participants and their Partner Organizations to have a compliant Partner Organization Arrangement and make GUIDE Respite Services available in the increments listed in **Exhibit 17**. However, extenuating circumstances may make it difficult to meet the full hourly service unit requirements (e.g., a caregiver ends an in-home respite service after only 3 hours). In these circumstances, if the Partner Organization

[29] GUIDE respite rates were increased 2.4% from PY 2025.

is contracted to meet the requirements for the service, and both intended to and provided a substantive portion of the time requirements for the full unit, participants are allowed to bill the appropriate G-code. However, the full unit counts toward the aligned patient's annual GUIDE Respite Services cap.

Participants can bill as many or as few of the codes for a respite-eligible, aligned patient, up to a per-patient annual cap of $2,625.[30] Participants are responsible for managing the available funds for GUIDE Respite Services and alerting aligned patients when they reach the $2,625 cap.

The GUIDE Model does not require participants to continue offering GUIDE Respite Services to an aligned patient after the patient reaches the $2,625 cap. Providers may continue to recommend respite outside of the GUIDE Model when GUIDE Respite Services funds are expended, but GUIDE Respite Services beyond the $2,625 cap will not be covered by GUIDE Model payments. Participants or aligned patients are free to personally pay for respite services beyond the $2,625 cap; however, participants cannot require an aligned patient to pay for additional respite or balance bill for amounts not covered by CMS.

When a newly aligned patient aligns to the GUIDE Model during the calendar year, they will receive the full $2,625 for the rest of the performance year. Each aligned patient's respite cap resets at the beginning of each new performance year (e.g., July 1). The GUIDE Model does not prorate the annual cap. Unused funds from the prior performance year do not carry over into the new performance year.

The GUIDE Respite Services cap is calculated on a per-patient basis. If a patient changes alignment from one participant to another, the patient's remaining respite balance transfers to the new participant. The new participant can find the patient's most up-to-date respite balance in the eDFR application within the CMS.gov ePortal.

CMS annually updates the GUIDE Respite Services base rates to account for geographic variation in costs and price inflation. Using the same PFS GAF that is used to adjust the DCMP (see Section 4.6), CMS geographically adjusts the respite base rates. To account for cost growth over time, CMS adjusts the GUIDE Respite Services base rates using the Home Health Agency Market Basket percentage increase reduced by the productivity adjustment calculated by the CMS Office of the Actuary. This metric is used in the Home Health Prospective Payment System to measure input price growth for home health agencies.

As shown in **Exhibit 17**, CMS applied the adjustments to the PY 2025 GUIDE Respite Service base rates to create the PY 2026 GUIDE Respite Services base amount. Updates to the PFS GAF and the inflation adjustment are applied to the GUIDE Respite Services base rates at the beginning of each performance year and apply for the entirety of the performance year. For example, GUIDE Respite Services base rates have been updated for PY 2026 using the forecasted growth in the Home Health Market Basket reduced by a productivity adjustment from July 1, 2026, through June 30, 2027. Additional information regarding the Home Health Agency

[30] The GUIDE respite allotment of $2,563 was increased 2.5% for PY 2025 from PY 2024. The $2,563 per year equates to roughly 76 hours of in-home GUIDE Respite Services per year, paid at a rate of $33.75 per hour. If the GUIDE respite allotment were used solely at an adult day center, it would cover 25 days of adult day per year; if it were used solely for facility-based care, it would cover roughly 8 days of facility-based care per year.

Market Basket and productivity adjustment is available on the CMS webpage for Market Basket Data.

5.1 Billing and Payment for GUIDE Respite Services

Three GUIDE Respite Service G-codes are available for participants to bill, one for each setting and unit of care (in home, adult day, and facility based), as described in **Exhibit 17**. Participants bill for GUIDE Respite Services by submitting claims using these GUIDE Respite Services G-codes. Billing GUIDE Model Services is the same as billing Medicare Part B services. Participants will use the CMS-1500 claim form and submit their GUIDE Respite Services claims to the MAC servicing the jurisdiction in which the services are provided. Participants are required to bill GUIDE-specific G-codes, including both the DCMP (see **Exhibit 8**) and GUIDE Respite Services (see **Exhibit 17**), on a standalone claim with no other non-GUIDE HCPCS codes. As described in Section 3.1, multiple GUIDE-specific G-codes may be billed on the same standalone claim, as needed.

> To help ensure successful processing of GUIDE respite claims, participants may report the name of their approved Partner Organization that provided the GUIDE Respite Service in the Additional Claim Information field (Box 19a) on the CMS-1500 claim form.

While GUIDE Respite Services claims are submitted via Medicare Part B, GUIDE Respite Services claims are paid by the Innovation Payment Contractor (IPC), a CMS-contracted entity that is separate from the MACs. Participants must input banking information in the IPC Portal[31] (https://portal.cms.gov/) to receive payment for GUIDE Respite Services. Respite claims are not reimbursed on a claim-by-claim basis; instead, CMS aggregates all qualifying GUIDE Respite Services billed in the preceding month and makes a lump-sum payment. Respite payments for approved claims are typically made 2 to 3 months after billing. Detailed information regarding submitted respite claims and corresponding monthly payments can be found in the GUIDE Payment Report within the eDFR application in the CMS.gov ePortal. Note that because GUIDE Respite claims are paid via IPC, the FFS claim submission often receives a remittance code indicating the claim has been processed as part of a prearranged project demonstration that receives no FFS payment. This code is expected and indicates that your claim is under consideration for payment via IPC.

Based on the respite-eligible patient's preferences and needs, participants may bill for GUIDE Respite Services until the patient reaches the $2,625 annual cap. To help participants track progress toward the annual cap, CMS will provide a monthly payment report via CMS.gov ePortal showing the amount of GUIDE Respite Services that each aligned patient has used in the year to date.

Participants must bill for all GUIDE Respite Services rendered to aligned patients. If a participant provides GUIDE Respite Services by contracting with a Partner Organization, the participant must pay the Partner Organization the full amount of the GUIDE Respite Payment received from CMS.

[31] For additional information on how to access the IPC Portal and input banking information, refer to the GUIDE Systems Access Tip Sheet.

When a participant bills for a GUIDE Respite Service, the claim must include the following, as shown in **Exhibit 18**.

Exhibit 18: GUIDE Respite Services Billing Requirements

Required Information	Description
GUIDE-specific HCPCS G-Code	This should be one of the three GUIDE Respite Service G-codes for either in home, adult day, or facility-based respite services.
Date of Service (DOS)	This should be the date on which a GUIDE Practitioner or Partner provides GUIDE Respite Services to the aligned patient. The DOS must be within the effective Start and End dates for both the GUIDE Practitioner or Partner and patient alignment records. If a Partner Organization provides the service, the Partner Organization should record the service date and provide that information to the participant to bill for that service.
GUIDE TIN and rendering NPI	The entered TIN must match the TIN on file with the GUIDE Model. The rendering NPI must be part of a participant's Practitioner Roster
Patient's Health Insurance Claim Number/MBI	From the Beneficiary Alignment Report, input the aligned patient's MBI.
Patient's Dementia Diagnosis Code (see Appendix B) in any position	Enter the aligned patient's diagnosis or condition to the highest level of specificity for the Date of Service. For the claim to be accepted, one or more of the diagnoses listed in this field must appear in the list of GUIDE ICD-10 Diagnosis Codes (see Appendix B).
Servicing Facility Location	Enter your main office or headquarters. The location you provide will not affect the geographic adjustment to GUIDE Respite Services; the patient's home address is used to automatically GAF-adjust the GUIDE Respite Service payment.

If a claim fails to meet these requirements, or is submitted with incomplete or invalid information, CMS may deny or return the claim to the submitter as unprocessable, which may cause a delay in payment. For example, if a participant submits a claim for GUIDE Respite Services but the aligned patient is not assigned to the moderate or high complexity dyad tiers with a caregiver, CMS will not process the claim and will send the claim back to the participant for resubmission. If your claim is returned with remittance advice other than that of prearranged project demonstration, it is likely your claim was returned as unprocessable and requires revisions. Participants may use the Beneficiary Alignment Report, which is available via the eDFR application within the CMS.gov ePortal, to confirm each aligned patient's tier and eligibility for GUIDE Respite Services. See Appendix H for details on its contents. Please refer to the Billing Fact Sheet in Appendix J or available in the Connect Library for additional details regarding claim requirements and troubleshooting guidance.

Exhibit 19 shows a sample of GUIDE Respite Services provided by a participant to a single patient over one month. This illustrates how CMS calculates GUIDE Respite Payments.

Exhibit 19: Sample Billing for GUIDE Respite Services

Date of Service	Type of Care	Units	Price
08/01/2026	In-home care	4 hours (1 unit)	$138
08/24/2026	In-home care	4 hours (1 unit)	$138
08/28/2026–08/29/2026	Facility based	48 hours (2 units)	$642
	Totals for August 2026:	**56 hours**	**$918**

Note: Patient has a caregiver and is in the moderate or high complexity tier. This claim is for all GUIDE Respite Services provided to the patient during the month of August 2026.

Using the example in **Exhibit 19**, to determine the amount of the GUIDE respite payment available for providing GUIDE Respite Services for the rest of the performance year (in this example, until June 30, 2027), the participant would use the following calculation: $2,625 − $918 = $1,707. Note that while GUIDE Respite Services payments are made in GAF-adjusted dollars, the annual cap is expressed and tracked in base dollars. The GAF for GUIDE Respite Services claims is assigned based on the aligned patient's home address. In the example in **Exhibit 19**, if the GAF adjustment is 1.1, the participant would receive a GAF-adjusted payment of $1,009.80 ($918 multiplied by 1.1). However, only the base rate would be subtracted from the cap, leaving the aligned patient with $1,707 remining on the cap ($2,625 minus $918).

Participants should track their GUIDE billing and payment data through the Payment Report, which is updated monthly and available via the eDFR application within the CMS.gov ePortal. This report includes information on DCMP claims, GUIDE Respite Services claims and payments, and remaining GUIDE Respite Services cap for each aligned patient. Participants can use this report to reconcile actual and expected payments and to facilitate the payment of Partner Organizations who provide GUIDE Respite Services. See Appendix J for more details.

For dually-eligible, aligned patients who receive respite care through a state Medicaid program, participants shall contact and attempt to coordinate the delivery of GUIDE Respite Services with the patient's Medicaid state agency and/or Medicaid managed care plan's case manager. The intent of GUIDE Respite Services is to be additive to, and not duplicative of, any available Medicaid respite care benefit offered to dually eligible, aligned patients. Participants are prohibited from billing under both the GUIDE Model and Medicaid for the same unit of respite (e.g., billing under both the GUIDE Model and Medicaid for the same 24-hour facility respite stay).

5.1.1 RCCs and GUIDE Respite Services

For PY 2025, aligned patients residing in RCCs without an identified Primary Caregiver were ineligible for GUIDE Respite Services. Patients residing in an RCC and who have an identified Primary Caregiver were eligible for GUIDE Respite Services during PY 2025.

Effective July 1, 2026 (PY 2026), all aligned patients residing in RCCs are ineligible for GUIDE Respite Services, regardless of whether they have a primary caregiver. Should a patient move from a private residence to an RCC during the performance year, participants must discontinue GUIDE Respite Services and may not bill for GUIDE Respite Services provided after the date of the move. Should a patient move from an RCC to a private residence, the patient may become eligible for GUIDE Respite Services, depending on their new model tier, and participants should refer to their Beneficiary Alignment Report for the most up-to-date respite eligibility information.

5.2 Waiver of Patient Cost-Sharing for GUIDE Respite Services

Medicare FFS patients are typically required to pay a 20% coinsurance for Medicare Part B physician services. The GUIDE Model waives the required 20% cost sharing for both the DCMP and GUIDE Respite Services. Medicare will pay 100% of both the DCMP amount and the GUIDE Respite Payment. The FFS system automatically handles the waiver and no claims level action is required.

As defined in Section 9.05(B)(5) of the Participation Agreement, the GUIDE Respite Payment is not subject to patient cost sharing. Therefore, participants shall not subject aligned patients to any additional cost sharing for GUIDE Respite Services. As described above, participants cannot require an aligned patient to pay for additional GUIDE Respite Services or balance bill for amounts not covered by CMS beyond the $2,625 annual cap.

5.3 Interaction with Other Innovation Center Models and Payments

As described in Section 3.4, participants and aligned patients may overlap with other CMS Innovation Center models where it is possible to account for the financial impact of the overlap.

5.3.1 Other CMMI Shared Savings Models' Overlaps

Participants, providers, and aligned patients may participate in both the GUIDE Model and CMMI shared savings models, such as the ACO REACH Model. Unlike DCMP expenditures (see Section 3.4), GUIDE Respite Service expenditures (see **Exhibit 17**) are not included in the model's total cost of care expenditures, shared savings/shared losses, or benchmark calculations throughout the entire GUIDE Model Performance Period (July 1, 2024 – June 30, 2032). Providers participating in multiple overlapping models (e.g., GUIDE practitioners also enrolled in ACO REACH or LEAD) must adhere to **GUIDE billing requirements**. ACO REACH claim reductions will not apply to GUIDE Respite Payments. For specific model information, please review the CMMI website at https://www.cms.gov/priorities/innovation/models.

5.3.2 Medicare Shared Savings Program

Participants may also simultaneously participate in the GUIDE Model as an ACO participant under any track in the Medicare Shared Savings Program. For GUIDE participants who simultaneously participate as an ACO participant in an ACO participating under any track in the Shared Savings Program, GUIDE Respite Services expenditures will not count toward ACO expenditures, shared savings, nor benchmarking. GUIDE Respite Services will continue to be paid to GUIDE participants but will not count as aligned patient identifiable final payments in the Shared Savings Program.

6 Infrastructure Payment

6.1 Safety Net Providers

> Throughout this section, "participants" refers only to those participants who were eligible for the Infrastructure Payment.

In addition to technical assistance and support, participants in the New Program Track that qualified as GUIDE safety net providers were eligible to receive an Infrastructure Payment to cover some of the upfront costs of establishing a DCP. CMS notified applicants of their eligibility for this payment in April 2024. The Infrastructure Payment was a one-time payment of $75,000 made during the pre-implementation period. The payment was geographically adjusted using the same PFS GAF that is used to adjust the DCMP. The GAF adjustment corresponded to the state and county GAF associated with the participant's main address.

6.2 Allowed Uses

The Infrastructure Payment was intended to assist participants with their efforts in the following four categories:

- Hiring or training of members of its ICT or administrative staff;
- Developing DCP workflows, protocols, community partnerships, and educational or outreach materials;
- Community outreach and engagement related to its DCP; and
- Electronic health record technology adaptations.

Participants were only allowed to use Infrastructure Payment funds for costs in these four categories. Participants were required to submit a Spend Plan to CMS in June 2024 describing how they intended to use infrastructure funds. Additionally, participants are required to submit a Spend Report during PY 2025.

Participants are required to repay any portion of the Infrastructure Payment that remains unspent at the end of PY 2025.

6.3 Reconciliation of Infrastructure Payment

Participants that withdrew or were terminated before the start of the New Program Track's first performance year (i.e., prior to July 1, 2025) were required to repay 100% of the Infrastructure Payment to CMS. Participants that withdraw from the GUIDE Model or were terminated during the New Program Track's first performance year (between July 1, 2025, and June 30, 2026) are required to repay half (50%) of the Infrastructure Payment or the entirety of any unspent funds, whichever is greater.

Participants that use the Infrastructure Payment for purposes other than those in Section 6.2 are required to repay some or all of the payment. Please refer to Section 9.06(E) of the Participation Agreement for more information.

Appendix A: Glossary of Acronyms

Acronym	Definition
ACO	Accountable Care Organization
CDI	Community Deprivation Index
CDR	Clinical Dementia Rating
CID	Caregiver-Reported Impact in Dementia Measure
CMMI	Center for Medicare and Medicaid Innovation (also known as the Innovation Center)
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
DAE	Use of High-Risk Medications in Older Adults Measure (PY 2026 and Beyond)
DCMP	Dementia Care Management Payment
DCP	Dementia Care Program (GUIDE participant and partner organizations)
DE	Dual Eligibility (for Medicare and Medicaid)
DOS	Date of Service
DRA	Data Request & Attestation Form
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, 5th edition
eDFR	Expanded Data Feedback Reporting
ePortal	CMS.gov Enterprise Portal
FAST	Functional Assessment Staging Tool
FFS	Fee-for-Service
GAF	Geographic Adjustment Factor
GPCI	Geographic Practice Cost Index
GUIDE	Guiding an Improved Dementia Experience Model
HCPCS	Healthcare Common Procedure Coding System
HDR	Health Data Reporting application
HRRx	Use of High-Risk Medications in Older Adults Measure (PY 2024 and PY 2025)
ICD-10	International Classification of Diseases, 10th edition
ICT	Interdisciplinary Care Team
IPC	Innovation Payment Contractor
LEAD	Long-term Enhanced ACO Design
LTNH	Admissions to Long-Term Nursing Home Stay Measure
MAC	Medicare Administrative Contractor
MBI	Medicare Beneficiary Identifier
MEI	Medicare Economic Index

Acronym	Definition
NPI	National Provider Identifier
PAAF	Patient Assessment and Alignment Forms (also known as Patient Assessment and Alignment (PAA))
PACE	Program of All-Inclusive Care for the Elderly
PBA	Performance-Based Adjustment
PFS	Physician Fee Schedule
PIA	Population and Income Adjustment
PROMIS	Patient-Reported Outcomes Measurement Information System Scale v1.2 Global Health
PY	Performance Year
QoL-PLWD	Quality of Life for Patients Living with Dementia Measure
RCC	Residential Care Community
REACH	Realizing Equity, Access, and Community Health Model
SNPs	Special Needs Plans
TIN	Taxpayer Identification Number
TPCC	Total Per Capita Cost Measure
ZBI-22	Zarit Burden Interview - 22

Appendix B: GUIDE ICD-10 Dementia Diagnosis[32] Codes

Note that at the time of billing, participants must record the aligned patient's dementia diagnosis on each DCMP and GUIDE Respite Services claim for it to be paid; claims without one or more of these ICD-10 diagnosis codes will be denied. Please refer to Sections 2, 3, and 5 for additional information.

ICD-10 Dementia Codes	ICD-10 Dementia Code Definition
F01.50	Vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F01.511	Vascular dementia, unspecified severity, with agitation
F01.518	Vascular dementia, unspecified severity, with other behavioral disturbance
F01.A0	Vascular dementia, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F01.A11	Vascular dementia, mild, with agitation
F01.A18	Vascular dementia, mild, with other behavioral disturbance
F01.A2	Vascular dementia, mild, with psychotic disturbance
F01.A3	Vascular dementia, mild, with mood disturbance
F01.A4	Vascular dementia, mild, with anxiety
F01.B0	Vascular dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F01.B11	Vascular dementia, moderate, with agitation
F01.B18	Vascular dementia, moderate, with other behavioral disturbance
F01.B2	Vascular dementia, moderate, with psychotic disturbance
F01.B3	Vascular dementia, moderate, with mood disturbance
F01.B4	Vascular dementia, moderate, with anxiety
F01.C0	Vascular dementia, severe, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F01.C11	Vascular dementia, severe, with agitation
F01.C18	Vascular dementia, severe, with other behavioral disturbance
F01.C2	Vascular dementia, severe, with psychotic disturbance
F01.C3	Vascular dementia, severe, with mood disturbance
F01.C4	Vascular dementia, severe, with anxiety
F02.80	Dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F02.811	Dementia in other diseases classified elsewhere, unspecified severity, with agitation
F02.818	Dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance
F02.A0	Dementia in other diseases classified elsewhere, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety

[32] ICD-10 is copyright 2025 World Health Organization. All Rights Reserved.

ICD-10 Dementia Codes	ICD-10 Dementia Code Definition
F02.A11	Dementia in other diseases classified elsewhere, mild, with agitation
F02.A18	Dementia in other diseases classified elsewhere, mild, with other behavioral disturbance
F02.A2	Dementia in other diseases classified elsewhere, mild, with psychotic disturbance
F02.A3	Dementia in other diseases classified elsewhere, mild, with mood disturbance
F02.A4	Dementia in other diseases classified elsewhere, mild, with anxiety
F02.B0	Dementia in other diseases classified elsewhere, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F02.B11	Dementia in other diseases classified elsewhere, moderate, with agitation
F02.B18	Dementia in other diseases classified elsewhere, moderate, with other behavioral disturbance
F02.B2	Dementia in other diseases classified elsewhere, moderate, with psychotic disturbance
F02.B3	Dementia in other diseases classified elsewhere, moderate, with mood disturbance
F02.B4	Dementia in other diseases classified elsewhere, moderate, with anxiety
F02.C0	Dementia in other diseases classified elsewhere, severe, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F02.C11	Dementia in other diseases classified elsewhere, severe, with agitation
F02.C18	Dementia in other diseases classified elsewhere, severe, with other behavioral disturbance
F02.C2	Dementia in other diseases classified elsewhere, severe, with psychotic disturbance
F02.C3	Dementia in other diseases classified elsewhere, severe, with mood disturbance
F02.C4	Dementia in other diseases classified elsewhere, severe, with anxiety
F03.90	Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F03.911	Unspecified dementia, unspecified severity, with agitation
F03.918	Unspecified dementia, unspecified severity, with other behavioral disturbance
F03.A0	Unspecified dementia, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F03.A11	Unspecified dementia, mild, with agitation
F03.A18	Unspecified dementia, mild, with other behavioral disturbance
F03.A2	Unspecified dementia, mild, with psychotic disturbance
F03.A3	Unspecified dementia, mild, with mood disturbance
F03.A4	Unspecified dementia, mild, with anxiety
F03.B0	Unspecified dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F03.B11	Unspecified dementia, moderate, with agitation
F03.B18	Unspecified dementia, moderate, with other behavioral disturbance
F03.B2	Unspecified dementia, moderate, with psychotic disturbance
F03.B3	Unspecified dementia, moderate, with mood disturbance
F03.B4	Unspecified dementia, moderate, with anxiety

ICD-10 Dementia Codes	ICD-10 Dementia Code Definition
F03.C0	Unspecified dementia, severe, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
F03.C11	Unspecified dementia, severe, with agitation
F03.C18	Unspecified dementia, severe, with other behavioral disturbance
F03.C2	Unspecified dementia, severe, with psychotic disturbance
F03.C3	Unspecified dementia, severe, with mood disturbance
F03.C4	Unspecified dementia, severe, with anxiety
F10.27	Alcohol dependence with alcohol-induced persisting dementia
F10.97	Alcohol use, unspecified with alcohol-induced persisting dementia
F13.27	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting dementia
F13.97	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced persisting dementia
F18.97	Inhalant use, unspecified with inhalant-induced persisting dementia
F19.17	Other psychoactive substance abuse with psychoactive substance-induced persisting dementia
F19.27	Other psychoactive substance dependence with psychoactive substance-induced persisting dementia
F19.97	Other psychoactive substance use, unspecified with psychoactive substance-induced persisting dementia
G30.0	Alzheimer's disease with early onset
G30.1	Alzheimer's disease with late onset
G30.8	Other Alzheimer's disease
G30.9	Alzheimer's disease, unspecified
G31.01	Pick's disease
G31.09	Other frontotemporal dementia
G31.1	Senile degeneration of brain, not elsewhere classified
G31.2	Degeneration of nervous system due to alcohol
G31.83	Neurocognitive disorder with Lewy bodies

Notes: Codes presented in the table are based on the ICD-10-CM code sets, are current as of the effective date of this document and are subject to change based on future ICD-10-CM updates. While these diagnosis codes are used for claims processing, patient eligibility for alignment to the GUIDE Model relies on the attestation from a clinician rather than a claims-based ICD-10-CM diagnosis code for dementia.

As described in Section 2, the participant's dementia-proficient practitioner may attest that, based on their Comprehensive Assessment, a patient meets the National Institute on Aging-Alzheimer's Association diagnostic guidelines for dementia and/or the DSM-5 diagnostic guidelines for major neurocognitive disorder; or the practitioner may attest that they have received a written report of a documented dementia diagnosis from another Medicare-enrolled practitioner. Participants document this attestation using the PAAF.

Appendix C: Examples of GAF Adjustment to DCMP Base Rates by Locality

CMS adjusts the DCMP base rates by the Medicare PFS GAF for each DCMP claim submitted by a participant. CMS determines the GAF for each claim using the state and locality of the rendering provider zip code on the claim. This table demonstrates how actual payments will incorporate GAFs.

State	Locality Number	Locality Name	GAF	GAF + Low Complexity Dyad Tier (G0519)	GAF + Moderate Complexity Dyad Tier (G0520)	GAF + High Complexity Dyad Tier (G0521)	GAF + Low Complexity Individual Tier (G0522)
AL	0	Alabama	0.923	$138.45	$253.83	$332.28	$212.29
AK	1	Alaska	1.271	$190.65	$349.53	$457.56	$292.33
AZ	0	Arizona	0.983	$147.45	$270.33	$353.88	$226.09
AR	13	Arkansas	0.916	$137.40	$251.90	$329.76	$210.68
CA	54	Bakersfield	1.037	$155.55	$285.18	$373.32	$238.51
CA	55	Chico	1.031	$154.65	$283.53	$371.16	$237.13
CA	71	El Centro	1.032	$154.80	$283.80	$371.52	$237.36

Note: GAFs presented in the table are for demonstration purposes only and do not reflect current rates or show all possible adjustments. Updated GAF amounts are published annually as part of the Medicare Physician Fee Schedule Final Rule Addenda. Please reference the CMS Zip Code to Carrier Locality File to learn more about which zip codes are contained in each locality.

Appendix D: Alignment Notification Letter Template

[Insert GUIDE provider logo here]

[$BENENAME]
[$ADDRESS]
[$CITY, STATE, ZIP]

Dear [$BENENAME]:

We are pleased to inform you that, effective [ALIGNMENT DATE], you may begin receiving services through the Guiding an Improved Dementia Experience (GUIDE) Model from [PARTICIPANT NAME], GUIDE ID [GUIDE ID].

[PARTICIPANT NAME] is participating in the GUIDE Model, a Medicare model designed to support people living with dementia and, if applicable, their caregivers. The GUIDE Model includes care coordination, education, and support services intended to help patients remain safely in their homes and communities.

Under the GUIDE Model, only one participant may provide services to you during a calendar month. Your participation is voluntary. If you no longer want to receive GUIDE services from [PARTICIPANT NAME], you may notify [PARTICIPANT NAME] at any time by calling [PARTICIPANT NUMBER], emailing [PARTICIPANT EMAIL ADDRESS], or contacting your GUIDE care team through [PATIENT PORTAL/OTHER CONTACT METHOD].

[PARTICIPANT MAY INSERT INFORMATION ABOUT THE NEXT STEPS THE PATIENT SHOULD EXPECT WITH THE PARTICIPANT'S GUIDE PROGRAM.]

Your Medicare benefits will not change. You remain eligible to receive the same Medicare benefits, and you still have the right to use any doctor, other health care professional, or hospital that accepts Medicare, at any time.

If you have questions about the GUIDE Model or this alignment, please contact [PARTICIPANT NAME] at [PARTICIPANT NUMBER]. You may also contact CMS at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Sincerely,

[PROVIDER NAME]

Appendix E: Non-Alignment Letter Template

[Insert GUIDE provider logo here]

[$BENENAME]
[$ADDRESS]
[$CITY, STATE, ZIP]

Dear [$BENENAME]:

We regret to inform you that Medicare determined that you are not eligible for alignment to [PARTICIPANT NAME] under the Guiding an Improved Dementia Experience (GUIDE) Model at this time. The GUIDE Model is a Medicare model designed to support people living with dementia and, if applicable, their caregivers.

Medicare made this determination for the following reason: [PATIENT-FACING REASON/EXPLANATION FOR NON-ALIGNMENT].

If this reason changes and you later meet the requirements for alignment, you may be reevaluated for the GUIDE Model. To request reevaluation, please contact [PARTICIPANT NAME] at [PARTICIPANT NUMBER], any GUIDE Model Participant serving your area listed at the web address below, or speak with your doctor.

A current list of GUIDE Model Participants and contact information is available at: https://www.cms.gov/files/document/guide-participant-list.xlsx

Your Medicare benefits will not change. You remain eligible to receive the same Medicare benefits, and you still have the right to use any doctor, other health care professional, or hospital that accepts Medicare, at any time.

If you have questions, please contact [PARTICIPANT NAME] at [PARTICIPANT NUMBER]. You may also contact CMS at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Sincerely,

[PROVIDER NAME]

Appendix F: Unalignment Notification Letter Template[33]

[Insert GUIDE provider logo here]

[$BENENAME]
[$ADDRESS]
[$CITY, STATE, ZIP]

Dear [$BENENAME]:

We are writing to inform you that, effective [UNALIGNMENT DATE], you are no longer aligned to [PARTICIPANT NAME], GUIDE ID [GUIDE ID], for purposes of the Guiding an Improved Dementia Experience (GUIDE) Model. The GUIDE Model is a Medicare model designed to support people living with dementia and, if applicable, their caregivers.

Reason: [REASON FOR UNALIGNMENT]

As of [UNALIGNMENT DATE], [PARTICIPANT NAME] will no longer provide GUIDE Model services to you through the GUIDE Model.

If the reason for your unalignment changes in the future and you believe you may meet the eligibility requirements for the GUIDE Model, you or your caregiver may contact any GUIDE Model Participant in your area, including [PARTICIPANT NAME] if applicable, to ask about receiving GUIDE Model services. As a reminder, under the GUIDE Model, only one GUIDE Model Participant may provide GUIDE Model services to you during a calendar month.

A current list of GUIDE Model Participants and contact information is available at: https://www.cms.gov/files/document/guide-participant-list.xlsx

Other GUIDE Model Participants in your area, if applicable:
[PARTICIPANT NAME / CONTACT INFORMATION]
[PARTICIPANT NAME / CONTACT INFORMATION]
[PARTICIPANT NAME / CONTACT INFORMATION]

Your Medicare benefits will not change. You remain eligible to receive the same Medicare benefits, and you still have the right to use any doctor, other health care professional, or hospital that accepts Medicare, at any time.

If you have questions, please contact [PARTICIPANT NAME] at [PARTICIPANT NUMBER]. You may also contact CMS at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Sincerely,

[PROVIDER NAME]

---

[33] If the patient is deceased or if the patient elects the Medicare hospice benefit, the participant should not issue the notification letter.

Appendix G: GUIDE Model – Voluntary Alignment Consent Form[34]

1. CONFIRM

By signing below, I confirm that [PARTICIPANT NAME] explained the GUIDE Model services to me. I voluntarily agree to receive GUIDE Model services from [PARTICIPANT NAME] and to be aligned to [PARTICIPANT NAME] for purposes of the GUIDE Model.

I understand that:

- Participation in the GUIDE Model is voluntary;
- Only one GUIDE Model participant may provide GUIDE Model services to me at a time;
- I may stop receiving GUIDE Model services from [PARTICIPANT NAME] at any time by notifying [PARTICIPANT NAME];
- Receiving GUIDE Model services does not limit my ability to receive health care services from other providers or suppliers; and
- This consent will be documented in my medical record.

[$BENENAME]

_____ _____
Signature **Print Name**

___ /_ /_____
Date

[Caregiver or authorized representative]

_____ _____
Signature **Print Name**

___ /_ /_____
Date

[THE PROVIDER MAY REMOVE THIS SECTION IF SIGNED IN PERSON]

2. RETURN

Return this form in the envelope that we provided.
Note: Completing and returning this form is voluntary. It will not affect your Medicare benefits.

34 This form is optional. CMS makes this form available as a resource for participants who wish to use it to document the eligible patient's and/or caregiver's consent to receive GUIDE care delivery services. Participants are not required to use this specific form. Regardless of the method used to obtain consent, the participant must document consent in the patient's medical record before performing the comprehensive assessment, as required by Section 5.02(C) of the Participation Agreement.

Appendix H: GUIDE Beneficiary Alignment Report

CMS GUIDE Patient Assessment and Alignment Form Results Tracker

CMS Sensitive Information – Special Handling Required

GUIDE Participant ID	GUIDE-9999
GUIDE Participant Name	Participant Name
Report Date	6/9/2026

ISO	Submission Date/Time	Beneficiary						Alignment					
		First Name	Last Name	Date of Birth	Sex	MBI	Active MBI	Attesting NPI	Assessment Type	Decision	Rationale	Tier	Effective Date
1	2026-04-14-12:15_EST	Jane	Doe	1949-04-19	Female	5RK3TE6MR20	2X59TE1KP10	1231231231	Initial assessment	Rejected	Beneficiary Ineligible Due to: Hospice Care		
2	2025-10-14-12:15_EST	John	Doe	1948-01-31	Male	4MH4TE4XT90		1231233451	Initial assessment	Aligned		High Complexity Dyad Tier	2025-09-25

Note: The PAAF Results Tracker of the GUIDE Beneficiary Alignment Report, found in the Expanded Data Feedback Reporting (eDFR) application, provides a list of all patients recently submitted on Patient Assessment and Alignment Forms (PAAFs) which have been processed by CMS, referenced by the date/time they were submitted. The data provided on this sheet gives the alignment decision as well as the tier the patient was aligned to, if applicable. Aligned patients will also appear on the Beneficiary Alignment File sheet. Refer to that sheet for complete information on currently aligned patients.

CMS GUIDE Beneficiary Alignment File

CMS Sensitive Information – Special Handling Required

GUIDE Participant ID	GUIDE-9999
GUIDE Participant Name	Participant Name
Report Date	6/9/2026

You can use this table to inform what DCMP HCPCS billing code to use for each beneficiary at a given time. Select the DCMP HCPCS Code that applies as of the date of service.
Filter Current = "Y" to limit to beneficiaries aligned as of the Report Date.

ISO	Current	Beneficiary					Alignment								Annual Assessment		Claims
		First Name	Last Name	Date of Birth	Sex	Active MBI	Attesting NPI	Tier	DCMP HCPCS Code	Respite Eligible ?	Start Date	End Date	End Reason (if Applicable)	Residence Type	Last Assessment Date	Date Range to Conduct and Submit Next Annual Assessment	No Filed Claim for 6 or More Months
1	N	John	Doe	1942-09-20	Male	4MH4TE4XT90	1231233451	Moderate Complexity Dyad Tier	G0520	Y	2025-09-25	2026-02-28	Moved to Established Patient Code				
2	Y	John	Doe	1942-09-20	Male	4MH4TE4XT90	1231233451	Moderate Complexity Dyad Tier	G0525	Y	2026-03-01	2026-06-30	Moved to RCC Tier	RCC - Assisted living facility	2025-09-25	2026-07-28 - 2026-11-24	
3	N	John	Doe	1942-09-20	Male	4MH4TE4XT90	1231233451	RCC Tier	G0575	N	2026-07-01						

Note: The Beneficiary Alignment File of the GUIDE Beneficiary Alignment Report, found in the Expanded Data Feedback Reporting (eDFR) application, provides a list of all patients aligned to your organization from model start to current date. The table has one row per patient and tier. Patients may move between tiers over time, and as a result appear multiple times. You can use this table to inform what DCMP HCPCS billing code to use for each patient at a given time.

Appendix I: Real-time Beneficiary Alignment Notification Report

excelRow Number	first_ name	last_ name	date_of_birth	MBI	active_MBI	decision	reasoning	tiering	respite_ eligible	aligned_date	NPI
1	Susan	Mire	1949-01-11	4RY9TE4QY30	4MH4TE4XT90	Aligned		3 - Low Complexity Dyad Tier	No	2026-04-02	1231233455
2	Leo	Bron	1960-01-02	5RK3TE6MR20		Pending	Beneficiary Ineligible Due to: Hospice Care				
3	Kim	Long	1955-05-05	2X59TE1KP10		Pending					

How to Read the Real-time Beneficiary Alignment Notification:

Each row of the Real-time Beneficiary Alignment Notification corresponds to a row in the PAAF submission, with the “excelRowNumber” column identifying the corresponding row in the PAAF submission that was uploaded to HDR.

If a patient has been assigned a new Medicare Beneficiary Identifier (MBI), the Real-time Beneficiary Alignment Notification report will match the MBI submitted on the PAAF with the patient's new MBI. If applicable, the patient's new, active MBI will appear in the "active_MBI” column. If the MBI submitted on the PAAF remains active, then the “active_MBI” field will be blank.

If CMS determines a patient is preliminarily eligible to be aligned to your organization, the value “Aligned” will appear in the “decision” column. Aligned patient’s model tier will be provided in the “tiering” column, their respite eligibility will be provided in the “respite_eligible” column, and their alignment start date will be provided in the “aligned_date” column of the report.

If CMS determines a patient is ineligible for alignment to your organization, a preliminary rejection reason will appear in the "reasoning" column.

For all reassessment, annual assessment, and unalignment PAAFs, the value “Pending” will appear in the “decision” column. In these cases, a “Pending” decision is expected and does not indicate an error. For initial assessment PAAFs that receive an Aligned decision the "reasoning" column will be blank.

CMS will provide final eligibility and alignment determinations for all PAAF submissions within 15 business days through the Beneficiary Alignment Report (BAR), available in the Expanded Data Feedback Reporting (eDFR) application of the ePortal. All PAAF results, including those for reassessments, annual assessments, and unalignments, will be available in the PAAF Results Tracker tab of the BAR. Recent submissions not reflected in the BAR will be included in a subsequent BAR uploaded to eDFR within 15 business days of submission.

Appendix J: GUIDE Payment Report

CMS GUIDE DCMP Claim and Payment File

CMS Sensitive Information – Special Handling Required

GUIDE Participant ID	GUIDE-0521
GUIDE Participant Name	Memory Care Practice
Report Date	2024-10-21

This sheet shows your paid DCMP claims as of the above report date. Claims paid within 4 weeks of the report date may not display until the next report due to data lags.
All DCMP claim questions and discrepancies should be first directed toward your Medicare Administrative Contractor.
The PBA supplement amounts shown here aggregate to the monthly payments made by the Innovation Payment Contractor (IPC) as displayed in the IPC Payment File sheet.
You can use the "IPC Paid Date" field, which is represented on both sheets, to understand which claims were aggregated into a given monthly payment.
You may use the Medicare Administrative Contractor ID and the Claim Control Number below to tie claims back to your original claim submissions.
You can look up your Medicare Administrative Contractor ID using this map: https://www.cms.gov/files/document/ab-jurisdiction-map03282023pdf.pdf

	Beneficiary					Claim & Payment (via FFS)														Claim & Payment (via IPC)	
Sort Order	Year/Month	MBI	First Name	Last Name	Date of Birth	Service Date	Claim Paid Date	Rendering Provider NPI	Medicare Administrative Contractor ID	Claim Control Number	Claim Line Number	DCMP HCPCS Code	Charge Amount	DCMP Base Rate	Sequestration Adjustment Amount	Population and Income Adjustment (PIA) Amount	Performance Based Adjustment (PBA) Amount	Geographic Adjustment Factor (GAF) Amount	Paid Amount	Performance Based Adjustment (PBA) Supplement Amount	IPC Paid Date
1	2024-08	1TE0ST1ZZ22	John	Smith	1/5/1949	8/1/2024	8/22/2024	1231234561	JF	1472788	1	G0523	$500.00	$390.00	($8.45)	$0.00	$18.19	$14.23	$413.97		
2	2024-08	1TE0ST1ZZ25	Jane	Doe	2/10/1950	8/5/2024	8/23/2024	1231231231	JH	202657775	1	G0520	$1,000.00	$275.00	($5.87)	$15.00	$11.98	($8.70)	$287.42		
3	2024-08	1TE0ST1ZZ30	Frank	Malone	6/8/1944	8/2/2024	8/18/2024	2342345641	JL	1527447	1	G0519	$250.00	$150.00	($2.80)	($6.00)	$6.29	($10.12)	$137.37		
4	2024-08	2TE0ST1ZZ22	Betty	Jones	3/24/1952	8/1/2024	8/30/2024	1212121212	JK	1534559	1	G0521	$550.00	$360.00	($7.56)	$0.00	$16.28	$1.68	$370.40		
5	2024-08	5TE0ST1ZZ25	Drake	Brady	11/7/1953	8/3/2024	8/25/2024	4444466666	J15	1558033	1	G0522	$1,000.00	$230.00	($5.19)	$15.00	$10.53	$3.96	$254.30		

Note: The GUIDE DCMP Claim and Payment File of the GUIDE Payment Report, located in the Expanded Data Feedback Reporting (eDFR) application, displays your paid DCMP claims as of the report date.

CMS GUIDE Respite Claim File

CMS Sensitive Information – Special Handling Required

GUIDE Participant ID	GUIDE-0521
GUIDE Participant Name	Memory Care Practice
Report Date	2024-10-21

This sheet shows respite claims you have submitted and that CMS has processed.
The amounts shown here aggregate to the monthly payments made by the Innovation Payment Contractor (IPC) as displayed in the Respite Payment File sheet.
You can use the "IPC Paid Date" field, which is represented on both sheets, to understand which claims were aggregated into a given monthly payment.
You may use the Medicare Administrative Contractor ID and the Claim Control Number below to tie claims back to your original claim submissions.
You can look up your Medicare Administrative Contractor ID using this map: https://www.cms.gov/files/document/ab-jurisdiction-map03282023pdf.pdf

	Beneficiary					Claim and Payment												
Sort Order	MBI	First Name	Last Name	Date of Birth	Performance Year	Date of Service	Respite HCPCS	Units	Rendering NPI	Medicare Administrative Contractor ID	Claim Control Number	Claim Line Number	Payment status	IPC Paid Date	Base Rate	Exceeds Cap Adjustment	GAF adjustment	Paid Amount
1	1TE0ST1ZZ22	Justin	Smalls	1/5/1949	7/1/2024-6/30/2025	8/1/2024	G0529	1	1231234561	JF	1472788	1	Processed	2024-09-25	$120.00	$0.00	$14.23	$134.23
2	1TE0ST1ZZ25	Dave	Champ	2/10/1950	7/1/2024-6/30/2025	8/5/2024	G0529	1	1231231231	JH	202657775	1	Processed	2024-09-25	$120.00	$0.00	($8.70)	$111.30
3	1TE0ST1ZZ30	Mary	Wallace	6/8/1944	7/1/2024-6/30/2025	8/2/2024	G0530	1	2342345641	JL	1527447	2	Processed	2024-09-25	$78.00	$0.00	($20.12)	$57.88
4	2TE0ST1ZZ22	Patty	Ward	3/24/1952	7/1/2024-6/30/2025	8/1/2024	G0531	1	1212121212	JK	1534559	1	Processed	2024-09-25	$260.00	$0.00	$1.68	$261.68
5	5TE0ST1ZZ25	Stewart	Morgan	11/7/1953	7/1/2024-6/30/2025	8/3/2024	G0530	1	4444466666	J15	1558033	1	Processed	2024-09-25	$78.00	$0.00	$3.96	$81.96
6	5TE0ST1ZZ27	James	Douglas	12/30/1940	7/1/2024-6/30/2025	8/3/2024	G0530	1	4444466666	J15	1558037	1	Processed; Partially Exceeds Ca	2024-09-25	$78.00	($18.00)	$3.96	$63.96
7	5TE0ST1ZZ27	James	Douglas	12/30/1940	7/1/2024-6/30/2025	8/3/2024	G0530	1	4444466666	J15	1558038	1	Rejected; Exceeds Cap					

Note: The GUIDE Respite Services Claim File of the GUIDE Payment Report, located in the Expanded Data Feedback Reporting (eDFR) application, details each accepted GUIDE Respite Services claim billed by the participant. It details the type of respite code billed and tracks GAF and non-GAF adjusted payment amounts.

CMS GUIDE IPC Payment File

CMS Sensitive Information – Special Handling Required

GUIDE Participant ID	*GUIDE-0521*
GUIDE Participant Name	*Memory Care Practice*
Report Date	*2024-10-21*

This report shows the total amount received into GUIDE participants' bank accounts from IPC respite services on a monthly basis for respite services and PBA payments.
The respite amounts aggregate the individual services processed in the Respite Claim File sheet. The PBA amounts aggregate the individual claims processed in the DCMP Claim Payment File sheet.
You can use the "IPC Paid Date" field, which is represented on both sheets, to understand which claims were aggregated into a given monthly payment.
The amounts shown here are final payable amounts to participants, and should match to transactions in your bank accounts.
In months where you have no respite claims or DCMP claims with PBA amounts processed, you will have no payment in the table below.

Sort Order	*IPC Paid Date*	*Total Amount Paid*	*Subtotal: Respite Amount Paid*	*Subtotal: PBA Amount Paid*
1	2024-09-25	$675.00	$550.00	$125.00

Note: The GUIDE Respite Services Payment File of the GUIDE Payment Report, located in the Expanded Data Feedback Reporting (eDFR) application, details the total amount received into the participants' bank accounts for GUIDE Respite Services on a monthly basis.

CMS GUIDE Respite Cap Remaining

CMS Sensitive Information – Special Handling Required

GUIDE Participant ID	*GUIDE-0521*
GUIDE Participant Name	*Memory Care Practice*
Report Date	*2024-10-21*

This report shows total respite services processed and the remaining spend available before reaching the respite cap by performance year.
Respite spending and remaining respite spending until reaching the cap is reported in non-GAF adjusted dollars. For actual GAF-adjusted payment amounts, refer to the "Respite Claim File" tab.
All values are as of the above report date. Only currently aligned beneficiaries as of the above report date are displayed.

Sort Order	*Performance Year*	*MBI*	*First Name*	*Last Name*	*Date of Birth*	*Respite Cap*	*Respite Spend*	*Remaining Spend Until Reaching Cap*
1	7/1/2024-6/30/2025	1TE0ST1ZZ22	Justin	Smalls	1/5/1949	$2,500	$120	$2,380
2	7/1/2024-6/30/2025	1TE0ST1ZZ25	Dave	Champ	2/10/1950	$2,500	$120	$2,380
3	7/1/2024-6/30/2025	1TE0ST1ZZ30	Mary	Wallace	6/8/1944	$2,500	$78	$2,422
4	7/1/2024-6/30/2025	2TE0ST1ZZ22	Patty	Ward	3/24/1952	$2,500	$260	$2,240
5	7/1/2024-6/30/2025	5TE0ST1ZZ25	Stewart	Morgan	11/7/1953	$2,500	$78	$2,422
6	7/1/2024-6/30/2025	5TE0ST1ZZ27	James	Douglas	12/30/1940	$2,500	$63	$2,437

Note: The GUIDE Respite Services Cap Remaining of the GUIDE Payment Report, located in the Expanded Data Feedback Reporting (eDFR) application, details the total GUIDE Respite Services spending, by patient and performance year-to-date, as well as remaining spend available before reaching the cap.

Appendix K: GUIDE Model Billing Fact Sheet

GUIDE Model Billing Fact Sheet

This fact sheet provides GUIDE Model participants with the information needed to successfully complete and submit a GUIDE claim. You should follow the guidance provided below to ensure proper payment for services provided to aligned patients. The GUIDE Payment Methodology Paper presents additional details on payment and billing under the GUIDE Model. Additional information is available in the Medicare Claims Processing Manual.

Gathering Materials to Begin Your Claim

Important Required Materials for Your Claim:

Identifying your Medicare Administrative Contractor

The Centers for Medicare & Medicaid Services (CMS) has divided the United States into 12 geographic jurisdictions. A Medicare Administrative Contractor (MAC) associated with each jurisdiction processes Medicare claims. As a GUIDE participant, you will submit your GUIDE claims to the MAC servicing the jurisdiction where you provide GUIDE services. Your electronic health record (EHR) system may interface directly with MACs.

Locating your MAC's CMS-1500 Claim Form

You will submit GUIDE claims using the CMS-1500 claim form, submitted electronically to your jurisdiction's MAC through your EHR system. MAC websites typically provide detailed instructions for completing the form. The CMS Medicare Claims Processing Manual provides helpful information on Medicare billing requirements.

Accessing your Beneficiary Alignment Report

You will receive eligibility, alignment, respite, and tiering determinations for patients submitted for alignment via the Beneficiary Alignment Report. Results are typically available within 15 business days. You can access this file through the Custom Export Tool (CET) of the Expanded Data Feedback Report (eDFR) application via the CMS.gov Enterprise Portal (ePortal).

Billing for GUIDE Model Services

The illustrative CMS-1500 form in **Appendix A** highlights required fields that are important for a GUIDE claim. ***If a GUIDE Model claim fails to meet billing requirements or contains incomplete or invalid information in these highlighted fields, CMS may reject and return the claim as unprocessable,*** which may cause payment delays. To ensure the timely processing and payment of your claims, follow the instructions provided below for each highlighted field.

Billing for GUIDE-specific G-codes, including both the DCMP and for GUIDE Respite Services G-codes, must be done as a STANDALONE claim with no other Healthcare Common Procedure Coding System (HCPCS) codes

To submit claims for the monthly Dementia Care Management Payment (DCMP) and GUIDE Respite Services, you will use HCPCS codes, also known as G-codes that are specific to the GUIDE Model. The DCMP codes, including those for patients residing in a Residential Care Community (RCC), are available in **Table 1** and the GUIDE Respite Services codes are available in **Table 2**. You may only bill the codes listed in these tables to the GUIDE Model. Patients residing in RCCs are not eligible for GUIDE Respite Services.

Table 1: GUIDE-Specific HCPCS Codes for DCMP Claims

Patient Status	Monthly Payment Rates for Patients with a Caregiver			Monthly Payment Rates for Patients Without a Caregiver		Monthly Payment Rates for Patients Residing in an RCC
	Low Complexity Dyad Tier	Moderate Complexity Dyad Tier	High Complexity Dyad Tier	Low Complexity Individual Tier	Moderate to High Complexity Individual Tier	RCC Model Tier
First 6 Months (New Patient Payment Rate)	G0519: $157	G0520: $288*	G0521: $377*	G0522: $241	G0523: $409	G0574: $180
After First 6 Months (Established Patient Payment Rate)	G0524: $68	G0525: $126*	G0526: $231*	G0527: $126	G0528: $225	G0575: $70

Table 2: GUIDE-Specific G-Codes for GUIDE Respite Services Claims

Respite Services Setting	G-Code	Service Unit
In-Home	G0529	4-hour unit
Adult Day Center	G0530	Per day
Facility Based	G0531	24-hour unit

Completing and Submitting a Claim Form

Patient Identification (Item 1a. Insured's ID Number)

From the **Beneficiary Alignment Report**, input the aligned patient's Medicare Beneficiary Identifier (MBI). For an initial claim, you should wait until the patient appears as aligned in the Beneficiary Alignment Report to submit a claim to prevent claim denials.

While many alignment decisions are now provided to you in real time, beneficiary alignments are still only submitted to MACs every two weeks. As such, you will need to wait to submit GUIDE claims for newly aligned patients until one week after they see the new patient listed as aligned on their **Beneficiary Alignment Report**.

Diagnosis Information (Item 21. Diagnosis or Nature of Illness or Injury)

Enter the aligned patient's dementia diagnosis using the highest level of specificity available for the Date of Service. At least one of the diagnoses listed in this field must appear in the list of GUIDE ICD-10 Diagnosis Codes found in Appendix B. Claims without valid dementia diagnosis codes will be denied.

Date(s) of Service (Item 24.A.)

The Date(s) of Service (DOS) must occur while you are participating in the GUIDE Model and while the patient identified in **Item 1a** is aligned to your Dementia Care Program.

Billing more than one DCMP HCPCS code with DOS in the same calendar month for the same patient will result in claim denial.

- For GUIDE Respite Services, the DOS should reflect the actual date(s) when respite care was provided.
- For DCMP, the DOS should be the earliest day in the calendar month when you provided non-respite GUIDE Care Delivery Services; however, you may select a different DOS in which you provided services as appropriate.

Place of Service (Item 24.B.)

For DCMP, enter the Place of Service (POS) location where the GUIDE care delivery services took place during that month. If any care delivery services were rendered in person, you may use POS codes including but not limited to 11 (Office), 12 (Home), or 13 (Assisted Living Facility). If all care delivery services were rendered via telehealth, you may use POS codes 02 (Telehealth Provided Other than in Patient's Home) or 10 (Telehealth Provided in Patient's Home). For GUIDE Respite Services, you can use the POS code that best describes either your main office or headquarters location or where the respite service was delivered, including but not limited to 11 (Office), 12 (Home), or 13 (Assisted Living Facility).

> You should ensure the POS location aligns with any other concurrent care (e.g., inpatient/SNF stays) to reduce unnecessary claim rejections. If any DCMP claims are rejected and returned to you due to conflicts with other care, you may wish to submit the claim using a different DOS.

Procedure Codes (Item 24.D. Procedures, Services or Supplies)

From the most recent **Beneficiary Alignment Report**, identify the aligned patient's tier assignment for the DOS entered in **Item 24.A**.

- For DCMP, the **Beneficiary Alignment Report** provides the tier's associated DCMP HCPCS code (also shown in Table 1); enter this code on the claim form.
- For GUIDE Respite Services, the **Beneficiary Alignment Report** provides a flag indicating eligibility for Respite Services. Only aligned patients in moderate or high complexity dyad tiers who have identified a relative or unpaid nonrelative as a primary caregiver are eligible for GUIDE Respite Services. Use Table 2 to determine the correct HCPCS code.

> **Example:** If an aligned patient is in the moderate complexity dyad tier and the service occurs within the first 6 months of initial alignment, the correct HCPCS code for this entry would be **G0520**.

Service Units (Item 24.G. Days or Units)

Enter the number of days or units of service provided to the aligned patient for each DOS. You must always use whole number units. For GUIDE Respite Services,

- For the DCMP, always enter "1" unit regardless of the number of services provided during the month.
- For GUIDE Respite Services, see **Table 2** for the service time of each unit of GUIDE Respite Service. You may bill for multiple units of respite on a single claim or claim line in a given day as appropriate, but each day's respite usage should be reported separately. G0529 should have a maximum of 6 units per day, while G0530 and G0531 should have a maximum of 1 unit per day.

> Do not include any non-GUIDE HCPCS codes on your GUIDE claim – this will result in a denial. DCMP and GUIDE Respite Services codes may be combined on the same GUIDE claim but may not include any non-GUIDE HCPCS codes.

Provider Information (Item 24.J. Rendering Provider ID)

Enter a valid National Provider Identifier (NPI) from your **GUIDE Practitioner Roster**. You should determine which NPI is best associated with this claim. For example, this could be the practitioner who administered, coordinated, or supervised the GUIDE Care Delivery Service(s) on the claim. The NPI must be active on your **GUIDE Practitioner Roster** for the date of service.

Tax Identification (Item 25. Federal Tax ID Number)

Enter your GUIDE Participant Federal Tax ID Number (TIN) and check the appropriate box. The entered TIN must match the TIN on file with the GUIDE Model. *Do not include hyphens or spaces*. **Using an incorrect TIN will result in an automatic denial of your GUIDE claim.**

Use the GUIDE Practitioners NPI to bill all GUIDE claims, even when services are provided by Partner Organizations or care navigators.

Service Location (Item 32. Service Facility Location Information)

Enter the location where you or the Partner Organization staff member was present during the time of the contact/service delivery. If the staff member was present at the aligned patient's home at the time of service, use the patient's home address. If staff delivered services during an in-person office visit, use the office location. Otherwise, use your main location address.

The service location will affect the geographic adjustment to GUIDE Model payments.

Billing Provider (Item 33.a. Billing Provider NPI)

Enter the NPI of the billing provider or group. The NPI in this entry must be associated in the Provider Enrollment, Chain, and Ownership System (PECOS) with the TIN (entered in **Item 25**).

Common Billing Issues and Solutions

Remittance Advice	Issue Summary	Common Resolutions
The diagnosis is inconsistent with the procedure	GUIDE DCMP or Respite Services claim is missing a diagnosis code from Appendix B. GUIDE claims must contain a diagnosis code from Appendix B.	Ensure that GUIDE claims use at least one of the most applicable ICD-10 diagnosis codes from the approved list.
Non-covered charge(s)	Report indicates that the service or procedure is not covered under the GUIDE Model. Often indicates incorrect coding, a coordination of benefits issue, or combining a GUIDE service with a non-GUIDE service on the same claim.	Ensure that you submit GUIDE claims on standalone claims forms with no other FFS codes. Verify that GUIDE claim dates of service do not overlap with inpatient or skilled nursing facility (SNF) stays. See "Quick Tip" in Item 24.B for details.
Prearranged demonstration project adjustment	Prearranged demonstration project adjustment will be applied to GUIDE Respite Services claims. Because these claims are paid via the Innovation Payment Contractor (IPC), they are adjusted as "zero pay" in FFS.	No action needed.
The rendering provider is not eligible to perform the service billed	The rendering provider may not be enrolled or registered with Medicare to perform the service that was billed or the rendering provider may not be eligible to bill GUIDE codes.	Confirm the rendering NPI is active on your GUIDE Practitioner Roster and has reassigned billing rights to the GUIDE TIN. Consult your Medicare Administrative Contractor (MAC) to confirm their rendering provider billing requirements for GUIDE claims.

Remittance Advice	Issue Summary	Common Resolutions
Patient not aligned to the GUIDE Model **Patient ineligible for this service** **Patient identified as a demonstration participant, but was not enrolled in the demonstration at the time services were rendered**	This can occur if you submit a GUIDE claim with a date of service prior to the patient's alignment to the GUIDE Model (e.g., the date of the initial comprehensive assessment).	Verify that the date of service is on or after the patient's start date using your Beneficiary Alignment Report.
Missing/incomplete/invalid HCPCS	This can occur if you bill the wrong GUIDE G-code for their aligned patient.	Use your current Beneficiary Alignment Report to confirm the correct G-code was assigned to the aligned patient, as tier assignments can change over time.
Claim/service has submission/billing errors, which are needed for adjudication	This can occur for a variety of reasons, including, but not limited to, using the incorrect number of units on a claim, or a GUIDE G-code appears with a non-GUIDE HCPCS code.	Ensure DCMP claims use exactly "1" unit and that respite is billed using whole units only. Ensure GUIDE G-codes appear on standalone claims with no other FFS codes.

Appendix A: CMS-1500 Claim Form

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org *PLEASE PRINT OR TYPE* APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

SAMPLE

Appendix B: Dementia Diagnosis Codes for GUIDE Claims

Note that at the time of billing, you must record the aligned patient's dementia diagnosis on each DCMP and GUIDE Respite Services claim for it to be paid; claims without one or more of these ICD-10 diagnosis codes will be denied.

ICD-10 Dementia Codes		ICD-10 Dementia Code Definition
Vascular Dementia (F01 Series)	F01.50	Vascular dementia
	F01.511	Vascular dementia, unspecified severity, with agitation
	F01.518	Vascular dementia, unspecified severity, with other behavioral disturbance
	F01.A0	Vascular dementia, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
	F01.A11	Vascular dementia, mild, with agitation
	F01.A18	Vascular dementia, mild, with other behavioral disturbance
	F01.A2	Vascular dementia, mild, with psychotic disturbance
	F01.A3	Vascular dementia, mild, with mood disturbance
	F01.A4	Vascular dementia, mild, with anxiety
	F01.B0	Vascular dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
	F01.B11	Vascular dementia, moderate, with agitation
	F01.B18	Vascular dementia, moderate, with other behavioral disturbance
	F01.B2	Vascular dementia, moderate, with psychotic disturbance
	F01.B3	Vascular dementia, moderate, with mood disturbance
	F01.B4	Vascular dementia, moderate, with anxiety
	F01.C0	Vascular dementia, severe, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
	F01.C11	Vascular dementia, severe, with agitation
	F01.C18	Vascular dementia, severe, with other behavioral disturbance
	F01.C2	Vascular dementia, severe, with psychotic disturbance
	F01.C3	Vascular dementia, severe, with mood disturbance
	F01.C4	Vascular dementia, severe, with anxiety
Dementia in Other Diseases Classified Elsewhere (F02 Series)	F02.80	Dementia in other diseases classified elsewhere
	F02.811	Dementia in other diseases classified elsewhere, unspecified severity, with agitation
	F02.818	Dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance
	F02.A0	Dementia in other diseases classified elsewhere, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
	F02.A11	Dementia in other diseases classified elsewhere, mild, with agitation
	F02.A18	Dementia in other diseases classified elsewhere, mild, with other behavioral disturbance
	F02.A2	Dementia in other diseases classified elsewhere, mild, with psychotic disturbance
	F02.A3	Dementia in other diseases classified elsewhere, mild, with mood disturbance
	F02.A4	Dementia in other diseases classified elsewhere, mild, with anxiety

ICD-10 Dementia Codes		ICD-10 Dementia Code Definition
Dementia in Other Diseases Classified Elsewhere (F02 Series) continued	F02.B0	Dementia in other diseases classified elsewhere, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
	F02.B11	Dementia in other diseases classified elsewhere, moderate, with agitation
	F02.B18	Dementia in other diseases classified elsewhere, moderate, with other behavioral disturbance
	F02.B2	Dementia in other diseases classified elsewhere, moderate, with psychotic disturbance
	F02.B3	Dementia in other diseases classified elsewhere, moderate, with mood disturbance
	F02.B4	Dementia in other diseases classified elsewhere, moderate, with anxiety
	F02.C0	Dementia in other diseases classified elsewhere, severe, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
	F02.C11	Dementia in other diseases classified elsewhere, severe, with agitation
	F02.C18	Dementia in other diseases classified elsewhere, severe, with other behavioral disturbance
	F02.C2	Dementia in other diseases classified elsewhere, severe, with psychotic disturbance
	F02.C3	Dementia in other diseases classified elsewhere, severe, with mood disturbance
	F02.C4	Dementia in other diseases classified elsewhere, severe, with anxiety
Unspecified Dementia (F03 Series)	F03.90	Dementia (degenerative (primary)) (old age) (persisting)
	F03.911	Unspecified dementia, unspecified severity, with agitation
	F03.918	Unspecified dementia, unspecified severity, with other behavioral disturbance
	F03.A0	Unspecified dementia, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
	F03.A11	Unspecified dementia, mild, with agitation
	F03.A18	Unspecified dementia, mild, with other behavioral disturbance
	F03.A2	Unspecified dementia, mild, with psychotic disturbance
	F03.A3	Unspecified dementia, mild, with mood disturbance
	F03.A4	Unspecified dementia, mild, with anxiety
	F03.B0	Unspecified dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
	F03.B11	Unspecified dementia, moderate, with agitation
	F03.B18	Unspecified dementia, moderate, with other behavioral disturbance
	F03.B2	Unspecified dementia, moderate, with psychotic disturbance
	F03.B3	Unspecified dementia, moderate, with mood disturbance
	F03.B4	Unspecified dementia, moderate, with anxiety
	F03.C	Unspecified dementia, severe, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety
	F03.C11	Unspecified dementia, severe, with agitation
	F03.C18	Unspecified dementia, severe, with other behavioral disturbance
	F03.C2	Unspecified dementia, severe, with psychotic disturbance
	F03.C3	Unspecified dementia, severe, with mood disturbance
	F03.C4	Unspecified dementia, severe, with anxiety

ICD-10 Dementia Codes		ICD-10 Dementia Code Definition
Substance-Induced Persisting Dementia (F10-F19 Series)	F10.27	Alcohol dependence with alcohol-induced persisting dementia
	F10.97	Alcohol use, unspecified with alcohol-induced persisting dementia
	F13.27	Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting dementia
	F13.97	Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced persisting dementia
	F18.97	Inhalant use, unspecified with inhalant-induced persisting dementia
	F19.17	Other psychoactive substance abuse with psychoactive substance-induced persisting dementia
	F19.27	Other psychoactive substance dependence with psychoactive substance-induced persisting dementia
	F19.97	Other psychoactive substance use, unspecified with psychoactive substance-induced persisting dementia
Alzheimer's Disease and Related Conditions (G30-G31 Series)	G30.0	Alzheimer's disease
	G30.1	Alzheimer's disease with late onset
	G30.8	Other Alzheimer's disease
	G30.9	Alzheimer's disease, unspecified
	G31.01	Pick's disease
	G31.09	Other front temporal dementia
	G31.1	Senile degeneration of brain, not elsewhere classified
	G31.2	Degeneration of nervous system due to alcohol
	G31.83	Neurocognitive disorder with Lewy bodies

Note: Codes presented in the table are from 2024 and are effective as of the date of publication. CMS may change the codes at its discretion based on updates to diagnosis codes. While these diagnosis codes are used for claims processing, patient eligibility for alignment to the GUIDE Model relies on the attestation from a clinician rather than a claims-based ICD-10 diagnosis code for dementia.