MILLIMAN WHITE PAPER

Should providers steer toward or away from GUIDE?

Analyzing the requirements and financial implications of CMS's new model for dementia care

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The Centers for Medicare and Medicaid Services (CMS) recently released a request for application (RFA) for its new Guiding an Improved Dementia Experience (GUIDE) model.[1]

The purpose of the model is to test an alternative payment methodology for the support and treatment of Medicare fee-for-service (FFS) beneficiaries with dementia. The model's goals include reducing the total cost of care (TCC) of these beneficiaries while preserving or enhancing their quality of care; improving quality of life; reducing strain on unpaid caregivers; and enabling beneficiaries to remain in their homes and communities.[2]

- The GUIDE model offers a monthly per beneficiary per month (PBPM) capitation payment—the dementia care management payment (DCMP)—in place of a variety of FFS billings that are often provided to patients with dementia.
- There are substantial care delivery and other requirements that GUIDE Participants must adhere to and support in exchange for the DCMP payment.
- GUIDE-eligible beneficiaries with Alzheimer's or dementia diagnoses have substantially higher TCC claims than other Medicare FFS beneficiaries, even on a risk-adjusted basis.
- There is a wide range of potential medical savings estimates for this model, from nearly $0 to over $500 PBPM.
- Accountable Care Organizations (ACOs) that are considering GUIDE or whose providers are considering GUIDE should carefully consider the potential financial and other impacts of this model.
- Other stakeholders, particularly Medicaid managed care organizations (MCOs) and long-term care insurers (LTCIs), may be materially invested in the success of this model. whether and to what extent engagement with these stakeholders could be productive.

HOW IT WORKS

GUIDE Participants must be Medicare Part B-enrolled providers or suppliers, excluding durable medical equipment (DME) and lab, and must establish Dementia Care Programs (DCPs) to provide ongoing, longitudinal care to people with dementia. GUIDE Participants must maintain a list of physician and non-physician providers, and GUIDE beneficiaries must have an attestation of dementia from one of the Participant's physicians. Beneficiaries must also opt into the program and agree to receive services from the GUIDE Participant.

Once the beneficiaries have been aligned to the GUIDE Participants, the Participants will receive a PBPM DCMP for aligned beneficiaries. The DCMP payment amount to GUIDE Participants will vary based on caregiver status, complexity tier, and the number of months the beneficiary has been in the model, as shown in Figure 1.[3]

[1] CMS (November 7, 2023). Guiding an Improved Dementia Experience: Request for Applications (CMS RFA). Retrieved December 27, 2023, from https://www.cms.gov/files/document/guide-rfa.pdf.

[2] CMS. Guiding an Improved Dementia Experience (GUIDE) Model. Retrieved December 27, 2023, from https://www.cms.gov/priorities/innovation/innovation-models/guide.

[3] Figure 1 sourced from CMS at https://www.cms.gov/files/document/guide-participant-incentives-fs.pdf.

FIGURE 1: DCMP PAYMENT RATES

		MONTHLY PAYMENT RATES FOR BENEFICIARIES WITH CAREGIVER		MONTHLY PAYMENT RATES FOR BENEFICIARIES WITHOUT CAREGIVER	
	LOW COMPLEXITY TIER	MODERATE COMPLEXITY TIER	HIGH COMPLEXITY TIER	LOW COMPLEXITY TIER	MODERATE TO HIGH COMPLEXITY TIER
First 6 months (New Beneficiary Payment Rate)	$150	$275	$360	$230	$390
After 6 months (Established Beneficiary Payment Rate)	$65	$120	$220	$120	$215

Source: CMS

CMS will also adjust payments for performance and health equity; performance-based adjustments can range from +10% to -3.5%, and health equity adjustments can range from +$15 for beneficiaries in the top 20% of health equity scores to -$6 for beneficiaries in the bottom 50%.

These payments are intended to replace FFS billing for some existing physician fee schedule (PFS) services (including chronic care management, transitional care management, advance care planning, and technology-based check-ins) and to account for all additional GUIDE services provided to aligned beneficiaries (with the exception of respite care). Please see the section below for a discussion of the support services required to be provided by GUIDE Participants.

CMS will separately allow for billings of up to $2,500 annually for respite care for aligned beneficiaries.

Additionally, CMS will provide a one-time infrastructure payment of $75,000 for Participants that are classified as safety net providers and are establishing a new dementia care program, to be paid at the beginning of the pre-implementation period. This will not need to be repaid to CMS unless the Participant withdraws or is terminated from GUIDE before the start of the second performance year.

WHAT ARE PARTICIPANTS REQUIRED TO DO?

Care delivery requirements

GUIDE has nine distinct sets of requirements for care delivery, as shown in Figure 2. Additional detail on these requirements can be found in Appendix B of the RFA.[4]

[4] CMS RFA, op cit.

FIGURE 2: CARE DELIVERY REQUIREMENTS

	REQUIRED ACTIVITIES BY DOMAIN
Comprehensive Assessment	▪ Comprehensive assessment to be performed initially; reassessment at least annually ▪ Participant shall also conduct a home visit assessment
Care Plan	▪ Develop a comprehensive person-centered care plan that addresses all assessment domains and is led by the beneficiary
24/7 Access	▪ Beneficiary has 24/7 access to an interdisciplinary care team member or help line, available to receive ad hoc one-on-one support calls from the caregiver
Ongoing Monitoring and Support	▪ GUIDE Participant maintains a minimum contact frequency with the beneficiary and/or their caregiver (via a care navigator). Minimal contact is at least once a month, except for: - Beneficiary with a caregiver, low complexity: at least quarterly - Beneficiary without a caregiver, moderate to high complexity: at least twice a month
Care Coordination and Transitional Care Management	▪ If the GUIDE Participant is not a primary care practice, ensure the primary care provider has access to the beneficiary's person-centered care plan ▪ Refer beneficiary to specialists to address co-occurring conditions, as needed ▪ Ensure receipt of information back from specialist to add to care plan ▪ Support the beneficiary in transitions between personal home and care settings
Referral and Coordination of Services and Supports	▪ Maintain or have access to inventory of local/community services ▪ Refer and connect beneficiaries to community-based services and supports ▪ Coordinate the delivery of community-based services and supports with dual-eligible beneficiaries' Medicaid home and community-based services (HCBS)/long-term services and supports (LTSS) case managers
Medication Management and Reconciliation	▪ Clinician with prescribing authority must review beneficiary's medications ▪ Any resulting medication changes must be shared and confirmed with the ▪ beneficiary's primary care physician (PCP) and other relevant specialists
Caregiver Education and Support	▪ Administer a caregiver support program, which must include: - Caregiver skills training, dementia diagnosis information - support group services, and ad hoc one-on-one support calls ▪ GUIDE Participant must provide dementia diagnosis information and ad hoc support calls directly, but may contract to provide caregiver skills training and/or refer caregivers to external support group services
Respite	▪ Referral and coordination of in-home respite care ▪ Option to refer to adult day centers or facility-based respite providers

Source: CMS

Other requirements

GUIDE also has additional requirements for Participants, including:

- Team composition: Participants must maintain interdisciplinary teams, including a care navigator and a clinician with dementia proficiency.
- Training: GUIDE requires a comprehensive training program completed by care navigators, with multiple distinct subcategories required, and a minimum of 20 hours of training time.
- Care delivery reporting: Participants must complete care delivery reporting at least annually.
- Health equity plan: Participants must develop, implement, and annually report on a health equity plan.[5]

[5] The health equity plan must identify disparities in outcomes in patient population and create strategies to reduce these disparities over the course of the GUIDE model. For additional discussion around health equity plans in the context of ACO REACH, please see https://www.milliman.com/en/insight/aco-reach-leveraging-data-to-reach-the-underserved.

HOW DOES OVERALL EXPERIENCE DIFFER BETWEEN BENEFICIARIES WITH AND WITHOUT A DEMENTIA DIAGNOSIS CODE?

In order to better understand the potential impacts of the GUIDE model, we evaluated the total cost profile of noninstitutionalized and non-end-stage renal disease (ESRD) beneficiaries with and without a dementia diagnosis code, as defined in the RFA.[6] The result of this analysis is shown in Figure 3.[7]

FIGURE 3: 2021 EXPERIENCE BY COHORT

	GUIDE-Eligible	Not GUIDE-Eligible
Member Months	1,129,384	16,451,220
Risk Score	1.930	0.974
Total Medical Allowed PBPM	$3,105	$958
Care Management Allowed PBPM	$11.14	$6.09

WHAT MIGHT REVENUES AND EXPENSES LOOK LIKE FOR PARTICIPATING PROVIDERS?

Starting with the proposed DCMP, to estimate the expected DCMP PBPM amount that an average GUIDE Participant may receive, we used a National Center for Biotechnology Information (NCBI) study that showed the distribution of dementia patients by severity.[8] We also assumed that 90% of the GUIDE population would have a caregiver.[9] The results of this calculation can be seen in Figure 4.

[6] GUIDE excludes institutionalized beneficiaries from participation—this is important to projections given that a material portion of beneficiaries with dementia are institutionalized. CMS also will require clinician attestation of dementia status on a per member basis—we used the ICD-10 dementia codes provided by CMS for initial beneficiary identification as a proxy for this.

[7] This analysis covers 2021 experience, with a three-year lookback period (2019-2021) for eligible diagnosis codes.

[8] Shin, J.-H. (April 30, 2022). Dementia Epidemiology Fact Sheet 2022. Ann Rehabil Med. Retrieved December 27, 2023, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9081392. Note that we used the NCBI study ratio of moderate (CDR 2) to severe (CDR 3) dementia as a proxy for the GUIDE model's differentiator between moderate (ZBI 0-60) and high (ZBI 61-88) caregiver strain.

[9] Kasper, J.D., Freedman, V.A., Spillman, B.C., & Wolff, J.L. (October 2015). The Disproportionate Impact of Dementia on Family and Unpaid Caregiving to Older Adults. Health Aff (Millwood);34(10):1642-9. doi: 10.1377/hlthaff.2015.0536. PMID: 26438739; PMCID: PMC4635557.

FIGURE 4: DCMP PBPM PAYMENT RATE BY BENEFICIARY STATUS

	MONTHLY PAYMENT RATES FOR BENEFICIARIES WITH CAREGIVER			MONTHLY PAYMENT RATES FOR BENEFICIARIES WITHOUT CAREGIVER		COMBINED AVERAGE
First 6 months (new beneficiary)	$150	$275	$360	$230	$390	$222
After First 6 Months (established Beneficiary)	$65	$120	$220	$120	$215	$102
Estimated share of total guide population	48%	38%	4%	5%	5%	

We can then compare this expected DCMP (revenue) value to expected expenses. To do this, we first examined the historical FFS cost of the care management Healthcare Common Procedure Coding System (HCPCS) codes that are no longer going to be paid FFS and instead are going to be covered by the DCMP payment. We performed this analysis using the CMS 5% sample to model the cost of the specific HCPCS codes listed, based on 2021 data.[10] The result of this analysis is shown in Figure 5.[11]

FIGURE 5: CARE MANAGEMENT PBPM BY POPULATION GROUPING

POPULATION	CARE MANAGEMENT PBPM
All GUIDE-Eligible Beneficiaries	$11.14
Only GUIDE-Eligible Beneficiaries Receiving Care Management	$22.75

Here we can see relatively small costs of these specific care management services among the existing population with dementia. However, a substantial portion of these beneficiaries currently receive no such services at all. If we instead consider just those beneficiaries who do currently receive care management, costs rise to approximately $22.75 PBPM. Given that care management services will be a requirement of the GUIDE model, we think that this number represents a reasonable baseline for currently administered care management services.

We can also compare the care management services PBPMs to the DCMP. While the GUIDE model will cover substantially more services than what Medicare FFS has covered in the past, this difference is nevertheless significant. Current care management PBPMs, even excluding the population who currently does not receive these services, are less than 20% of the expected DCMP value for an average GUIDE Participant.

While any participating provider will need to consider the additional costs associated with the newly required services, both on the professional side and the caregiving support side, the scale of this gap suggests that GUIDE may well be a profitable endeavor for efficient and effective providers with sufficiently large dementia populations to justify program expenses.

WHAT KIND OF SAVINGS MIGHT GUIDE CREATE?

Many providers are already affiliated with organizations, such as ACOs, that already have some form of risk-sharing arrangements with CMS, such as the Medicare Shared Savings Program (MSSP) or ACO Realizing Equity, Access, and Community Health (REACH). We therefore consider the potential for this program to either result in additional or reduced savings from CMS's perspective, which then would spill over into existing risk-sharing arrangements.

[10] Care management claim codes are listed in the RFA.

[11] Figure 3 shows the total cost of care for this population.

In its RFA, CMS noted that GUIDE is expected to reduce Medicare and Medicaid expenditures through reductions in nursing home stays as well as hospital, emergency room (ER), and post-acute medical expenses. With this expectation in mind, what are realistic savings outcomes for this program, both for nursing home stays and medical expenses?

CMS also referenced a synthesis of evaluation results conducted by the Innovation Center's Research and Rapid Cycle Evaluation Group (RREG).[12] In this synthesis, five different dementia care projects were evaluated. Three of these studies provided results on long-term care facility use: one of the studies showed a statistically significant 34% reduction, while the other two showed no change. Additionally, four of the studies showed results on Medicare spending, including a breakout of ER visits and inpatient (IP) admissions. None of the results were statistically significant, though one of the four studies did show a 5% overall reduction in Medicare spending, along with a 10% reduction in IP and a 9% reduction in ER utilization.

We can also consider other sources on the subject. In 2021, Ceresti published the results of a pilot study using Harvard Pilgrim's Medicare Advantage population, finding a relative difference of $569 medical PBPM between enrolled study beneficiaries and a selection of matched control beneficiaries, with much of the reduction coming from IP spending. A smaller but still statistically significant relative difference in medical spend was also observed for spousal caregivers.[13] Additionally, in September 2023, the University of California, San Francisco (UCSF) published the results of a March 2015 through March 2018 randomized control trial on Medicare FFS beneficiaries with dementia, finding a cost difference of $526 PBPM.[14]

Overall, the difference between the savings cited in CMS's synthesis of evaluation results and the savings found by both Ceresti and UCSF is large. On the lower end we see results of little or no savings, while on the higher end we see results upwards of $500 PBPM. With this divergence in mind, we can consider a potential range in cost impacts of GUIDE.

Figure 6 illustrates the potential aggregate medical cost impact of GUIDE from CMS's perspective, with the low-impact scenario representing no savings impact at all, and the high-impact scenario representing a similar value just below UCSF's observed savings. Care management costs represent current costs of the care management procedure codes noted by CMS in its RFA, while DCMP and respite care represent estimates of the payments.[15]

[12] 5 CMS. Dementia Care Projects: Synthesis of Evaluation Results, 1989-2020. Retrieved December 27, 2023, from https://innovation.cms.gov/data-and-reports/2022/dementia-care-synthesis-1989-2020.

[13] Ceresti Health (November 4, 2021). Digital Caregiver Empowerment Program Reduces Utilization and Costs for Medicare Advantage Members With Alzheimer's Disease and Other Dementias (ADOD). Retrieved December 27, 2023, from https://www.seactuary.com/files/meetings/2021Fall/2021SEACAnnualCeresti.pdf. Note that the exhibit shows a $666 per member per month (PMPM) difference—$666 represented the amount for months 2 through 7, with $569 being the month 1 through 12 difference.

[14] Guterman, E.L., Kiekhofer, R.E., Wood, A.J. et al. (2023). Care Ecosystem Collaborative Model and Health Care Costs in Medicare Beneficiaries With Dementia: A Secondary Analysis of a Randomized Clinical Trial. JAMA Intern Med;183(11):1222–1228. doi:10.1001/jamainternmed.2023.4764

[15] For DCMP we used the Figure 5 estimate, while for respite care we used $200 as a round number that represented nearly 100% utilization of the respite care benefit.

FIGURE 6: PBPM PROGRAM COSTS, SAVINGS, AND OVERALL PROGRAM IMPACT COMPARING CURRENT VALUES FOR GUIDE-ELIGIBLE BENEFICIARIES TO LOW- AND HIGH-IMPACT SCENARIOS

	CURRENT FFS COSTS FOR GUIDE-ELIGIBLE BENEFICIARIES	GUIDE PROJECTIONS LOW-IMPACT SCENARIO	GUIDE PROJECTIONS HIGH-IMPACT SCENARIO
Costs of Guide Program Services			
Care Management Claims	$11	(included in DCMP)	(included in DCMP)
DCMP	(does not exist in FFS currently)	$102	$102
Respite Care	(not currently covered by FFS)	$200	$200
Total Costs	$11	$302	$302
Savings Resulting from GUIDE Program	(n/a, no savings in absence of GUIDE)	$0	$500
Change in Aggregate cost of care, including GUIDE Costs and Resulting Savings	$0	$291	($209)

The program's DCMP replaces the care management costs currently incurred and, with the respite care costs (up to $2,500 per year, rounded down slightly to $200 PBPM), together make up the direct costs of the program. These costs can then be compared to potential savings ($0 for low, $500 for high).

The overall result of this comparison shows that Participants generating little to no savings would generate overall increases in costs, while Participants generating savings comparable to those from Ceresti's or UCSF's study would generate overall decreases in costs. Potential Participants that are exposed to financial risk based on total spend (such as ACOs) and that have material populations with dementia should carefully consider what level of program savings are realistic to achieve, as GUIDE could materially increase or decrease total gross savings and in turn shared savings or shared losses. We discuss ACO-specific implications further in the next section.

SHARED SAVINGS AND INNOVATION CENTER ACO MODELS

CMS indicated that the DCMP and respite payments made to GUIDE Participants for aligned beneficiaries will count toward shared savings and losses in MSSP starting July 1, 2024. CMS also noted that GUIDE payments may be included in ACO benchmark payments.

This means that MSSP ACOs that are considering entry into GUIDE, or that have participating providers who are considering entry into GUIDE, will need to plan for the financial impacts of the GUIDE model. As noted in Figure 6 above, the respite payments of up to $2,500 per year (which would not have been covered historically by Medicare FFS) could have major impacts on overall savings, and ACOs will need to compare the impact of respite payments to the potential impact of reduced medical expenditures generated from GUIDE.

Depending on the results of these estimates, ACOs may wish to reconsider participation in GUIDE, as well as how to handle providers inside the ACO network who may elect to participate in GUIDE.

We also note that MSSP ACOs will have GUIDE program costs affect their shared savings starting July 1, 2024, while REACH ACOs will not have GUIDE program costs affect shared savings until July 1, 2025, or July 1, 2026. ACOs in these programs should carefully consider the potential impacts of GUIDE on shared savings, including the potential in REACH for program costs to be excluded from shared savings for at least a full year.

DOES IT MAKE FINANCIAL SENSE TO APPLY FOR GUIDE?

The extent to which it makes financial sense depends in part on the nature of the applying entity. The simplest example is a provider group that is not part of any other risk-sharing entity (such as an ACO).

In that case, the main consideration would likely be a simple calculation of expected costs versus revenues. As discussed earlier in this paper, the DCMP is intended to pay for a number of services, well beyond the current management codes that Medicare FFS pays for. Organizations that are confident in their ability to provide quality care at expense levels equal to or below DCMP may find GUIDE attractive, while others that do not expect to have costs below revenues may find GUIDE less attractive.

Other considerations could include potential shifts in membership and gaining additional capabilities to better serve the overall patient base. Additionally, in its RFA, CMS announced that Participants would meet the alternative payment model (APM) standard of the Merit-Based Incentive Payment System (MIPS), though they would not meet the financial risk standard for advanced APM status.[16] To the extent that potential Participants value meeting this standard (and do not otherwise meet it), this could be an additional reason to consider GUIDE.

Finally, CMS has stated its goal to have 100% of Medicare FFS beneficiaries in accountable care relationships by 2030.[17] Participants who are not yet in such relationships could potentially use GUIDE as a way to build up organizational risk-taking capacity and capabilities.

ACO Participants (or Participants that are part of an ACO) must consider direct program costs versus revenues as well as impacts on gross and shared savings. Here, the timing of when shared savings would consider GUIDE costs becomes important, as does the level of shared savings. An ACO in MSSP Track A, for example, with 40% shared savings and 0% shared losses, would be much less sensitive to year 1 impacts on gross savings levels than would be an ACO in MSSP Enhanced Track, with 75% shared savings and 40% shared losses.[18]

Similarly, a Professional Track REACH ACO, with 50% of first dollar shared savings and losses (grades down to 5%), would be less sensitive to potential gross savings impacts than an ACO in the Global Track, with 100% first dollar shared savings and losses (grades down to 10%).

Financial projections, including scenario testing around materially favorable or adverse outcomes, will be important for any interested Participants. Key variables to consider would include:

- Number of affected beneficiaries
- The current level of care provided to dementia patients, and how much room there may be to improve on this performance
- Expected implementation and other program costs
- Expected respite care costs (for providers engaged in risk-sharing arrangements with CMS)

IMPACT ON LTCIS AND MEDICAID

In its RFA, CMS noted that it expected its primary impact on Medicaid and Medicare expenditures to come from preventing or delaying long-term nursing home stays. Should this program be successful, it would therefore have a substantial positive financial impact on Medicaid, as well as on LTCIs. Because these parties have substantial financial interest in the success of this program, it is worth considering whether interested program Participants could in some form cooperate with state Medicaid agencies or LTCIs in some fashion.

[16] CMS RFA, op cit.

[17] Rawal, P. et al. (June 9, 2023). The CMS Innovation Center's Strategy to Support High-quality Primary Care. CMS Blog. Retrieved December 27, 2023, from https://www.cms.gov/blog/cms-innovation-centers-strategy-support-high-quality-primary-care.

[18] CMS (March 2023). Shared Savings Program Participation Options for Performance Year 2024. Retrieved December 27, 2023, from https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ssp-aco-participation-options.pdf. Note that, for Enhanced Track, quality scores also impact the percentages for shared savings and shared losses.

Of the two, LTCIs may present the most straightforward overlap in financial interest, as well as the most straightforward drawback. LTCIs collectively have a very clear and strong financial interest in the success of this program. Every dollar's worth of nursing home stays avoided for a member holding an LTC policy is a dollar saved for the LTCI and, because individuals lose eligibility for GUIDE once they become institutionalized, GUIDE Participants have a structural incentive to keep people out of nursing homes as well.

GUIDE Participants subject to other risk-sharing arrangements with CMS, including ACOs, may also directly benefit from overlapping coverage. LTC policyholders may already have respite care coverage and, while CMS did not discuss primary versus secondary coverage, it is realistic to expect that GUIDE would be secondary to LTC coverage for funding respite care. GUIDE Participants whose covered beneficiaries tend to have overlapping LTCI coverage could therefore potentially incur lower respite care costs and a smaller resulting adjustment to shared savings.

However, many LTCIs in individual markets have relatively low penetration rates; presuming random distributions of beneficiaries, there may not be any material population overlap between a given GUIDE Participant and a given LTCI.

Two things could increase those overlap percentages.

1. LTCIs could actively market GUIDE participation to their policyholders, potentially highlighting the respite care benefit (even if CMS is secondary, the additional respite care benefit may be more than what LTCI alone covers), or the larger suite of dementia-specific services that the GUIDE model provides to beneficiaries.
2. There may be specific markets where an individual LTCI has particularly high penetration and could in turn expect to cover a substantial portion of a given GUIDE provider's patient base.

Where there is a substantial overlap between the customers served by an individual LTCI and the beneficiaries for an individual GUIDE Participant, the LTCI's potential savings purely in terms of reduced nursing home spend could incentivize them to enter into a formal partnership of some sort with the GUIDE Participant. In such an arrangement, the GUIDE Participant might no longer need to achieve direct profitability (and, indeed, could well operate at a loss), provided that the resulting savings to the LTCI are large enough.

For state Medicaid agencies, however, the relationships may be more complicated, as both Medicaid-only beneficiaries and dual-eligible special needs plan (D-SNP) beneficiaries are not eligible for the program. Only beneficiaries in Medicare FFS may participate. States with substantial populations of dual-eligible beneficiaries in Medicare FFS may find themselves with similar incentives as LTCIs; states may also take an interest in the potential impact of GUIDE on non-dual beneficiaries.[19]

State Medicaid agencies may also want to consider the potential market impact of GUIDE on D-SNP penetration rates for beneficiaries with dementia. The $2,500 respite benefit by itself may be a greater value than benefits offered under some D-SNPs, with the additional dementia support further enhancing the value proposition for dual-eligible beneficiaries currently enrolled in D-SNPs. Should state agencies prefer this outcome, they have a larger incentive to support GUIDE Participants directly. However, should this be considered an adverse outcome, they might consider funding respite care or other dementia supports through Medicaid, reducing or eliminating the incentive for dual-eligible beneficiaries to consider moving from D-SNPs to FFS.

WHAT ABOUT MEDICARE ADVANTAGE?

CMS has stated explicitly that there will not be any direct support for Medicare Advantage (MA) from this model, and that MA beneficiaries will be ineligible for this program.

However, MA plans may want to take note of this model, and they likely can mimic some or all aspects of this program through supplemental benefits via the Special Supplemental Benefits for the Chronically Ill (SSBCI) or Value-Based Insurance Design (VBID) programs, especially if they have GUIDE Participants in their service areas already set up to implement the GUIDE model of care.[20]

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[19] Dual-eligible beneficiaries refers to those eligible for both Medicare and Medicaid. Many dual-eligibles participate in dual-eligible special needs plans (D-SNPs). Due to CMS's GUIDE criteria, dual-eligibles who are part of a D-SNP may not qualify for GUIDE.

[20] For additional discussion around SSBCI and VBID benefits in the D-SNP market, see https://www.milliman.com/en/insight/prevalence-supplemental-benefits-d-snp-medicare-advantage-marketplace-2023.

This may be particularly important for MA plans given the revenue pressures the program is facing from the Star Ratings changes CMS is implementing.[21]

If the GUIDE program can pay for itself via reduced TCC claims costs for beneficiaries with dementia in an FFS context, then it may be able to do that in an MA context as well. This would then allow MA plans the ability to offer and market an innovative benefit at little net cost and possibly at an overall reduction in costs.

MA plans considering implementing some or all of the GUIDE program features will want to consider each of the individual components and determine which will be most valuable to beneficiaries and which have more or less potential to bend the cost curve.

For instance, a one-county D-SNP whose beneficiaries are already low-income or dual-eligible may not be interested in adjusting individual provider payments for the Health Equity Adjustment (HEA), but might still find the GUIDE adjustments for performance metrics valuable, especially if they are contracting with providers who are already engaging in those metrics with CMS in the actual GUIDE program.

MA plans may also want or need to adjust the payments and program features for their own populations and needs. It may be appropriate to vary the specific PBPM rates paid to providers based on member complexity, risk scores, specifically covered services, caregiver status, or area.

KEY DEADLINES AND TERMINATION POLICIES

Applications for GUIDE will be due on January 30, 2024, with notifications for applicants to be provided in spring 2024.

Participants may elect to terminate their participation in GUIDE upon advance written notice at least 180 days prior to the effective date of termination. CMS may also elect to terminate Participation agreements at any time for reasons such as poor performance, program integrity issues, or noncompliance with terms and conditions. Participants must repay any received infrastructure payments should they withdraw or are terminated before the start of the second performance year, and must repay half of the infrastructure payments should they withdraw or are terminated during the second performance year.

CLOSING REMARKS

The GUIDE model represents a new opportunity for providers to better manage beneficiaries with Alzheimer's Disease or other dementias, with meaningful engagement and financial support from CMS. This model also creates an opportunity for other stakeholders to see reductions in nursing home stays and resulting expenses.

However, there are substantial risks involved in this model, especially for providers who are already in a risk-sharing arrangement with CMS, or for ACOs in such arrangements that have providers considering this model.

It will be important for any organization with a material exposure to GUIDE-eligible beneficiaries to carefully consider the risks and opportunities that this model represents. Such analysis should include a projection of the size of the GUIDE-eligible population, its current experience, how effectively the population is already served by existing processes, the costs of implementing GUIDE's requirements, and the potential for additional improvement given the GUIDE model of care.

Potential GUIDE Participants should also consider the opportunities to meaningfully engage with other affected stakeholders who may have aligned interests in the success of this model.

[21] Rogers, H.M., Smith, M., Nelson, P., & Yurkovic, M. (October 2023). The Future Is Now: 2024 Star Ratings Release. Milliman White Paper. Retrieved December 27, 2023, from https://www.milliman.com/en/insight/the-future-is-now-2024-star-ratings-release.

LIMITATIONS AND DATA RELIANCE

We primarily relied on information and data provided by CMS, including both publicly released experience data and projections for model impacts. We also relied on other information provided by additional sources, primarily relating to policy analysis. Throughout this analysis, Milliman relied on data and other information provided by publicly available data sources. The estimates included in this paper are not predictions of the future; they are estimates based on the assumptions and data analyzed at a point in time. If the underlying data or other listings are inaccurate or incomplete, then the results may also be inaccurate or incomplete. Milliman has not audited or verified this data and other information but has reviewed it for reasonableness.

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We have developed certain models to estimate the values included in this white paper. The intent of the models was to estimate historical Medicare FFS costs associated with beneficiaries projected to be eligible for GUIDE. We have reviewed the models, including their inputs, calculations, and outputs, for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP). The models, including all input, calculations, and output, may not be appropriate for any other purpose.

The views expressed in this research paper are made by the authors and do not represent the opinions of Milliman, Inc. Other Milliman consultants may hold alternative views and reach different conclusions from those shown.

QUALIFICATIONS

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Matthew Smith, Noah Champagne, Robert Eaton, and Nancy Gu are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses in this paper.

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