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ZIEGLER INVESTMENT BANKING

# IMPACT OF MEDICARE'S “GUIDE “ MODEL ON LIFE PLAN COMMUNITIES

June 13, 2024

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# PRESENTATION OVERVIEW

- On July 1, 2024, CMS will launch a new voluntary nationwide model – Guiding and Improved Dementia Experience (GUIDE)

- GUIDE is a model that aims to support people living with dementia outside of a skilled nursing facility

- While its impact and relevance for Life Plan Communities remains relatively unknown, this presentation will cover the key attributes of the GUIDE program and include best practices to implement the model

# PRESENTERS

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# THE GUIDE MODEL

# AN INTRODUCTION

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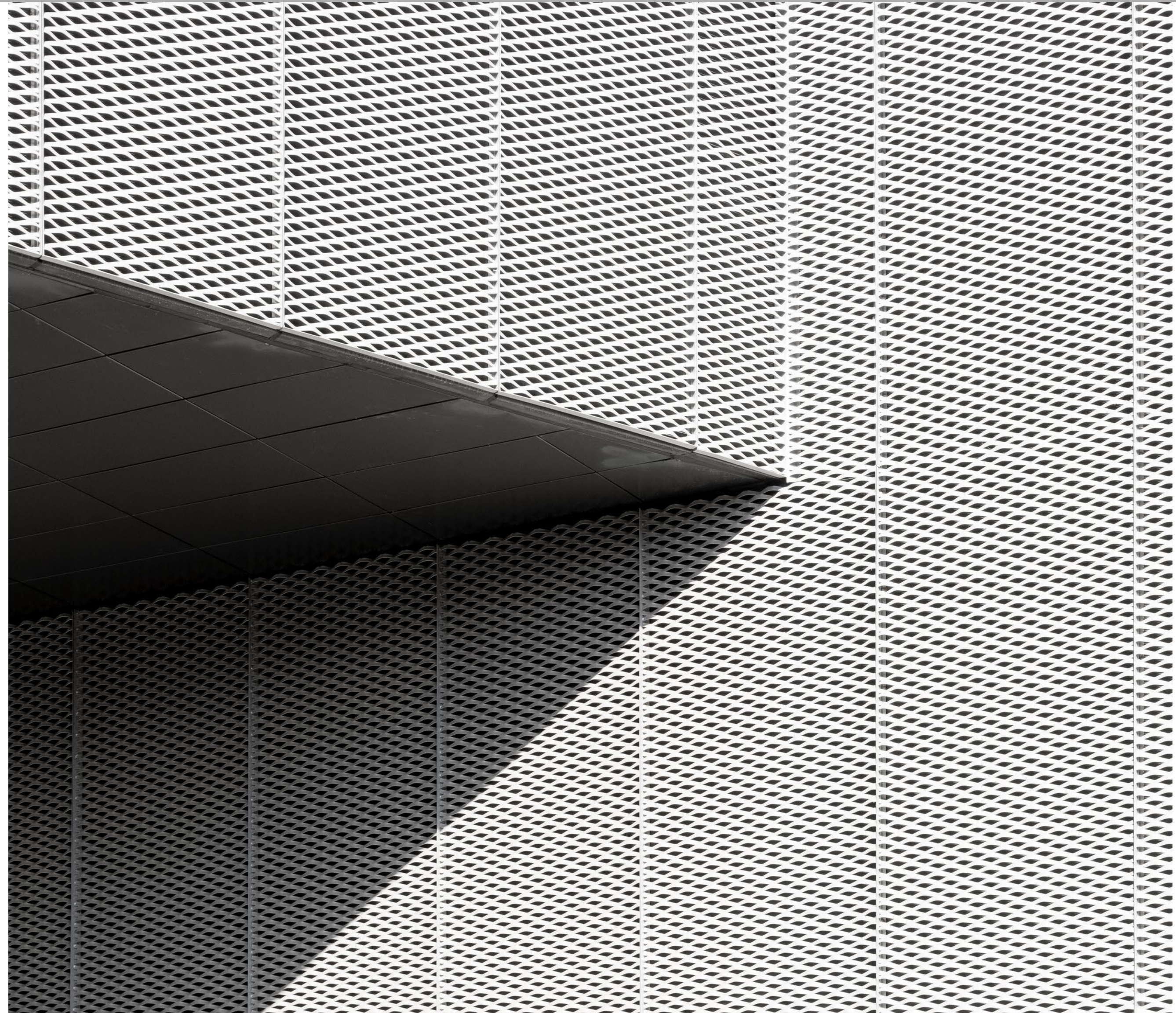
# The GUIDE Model

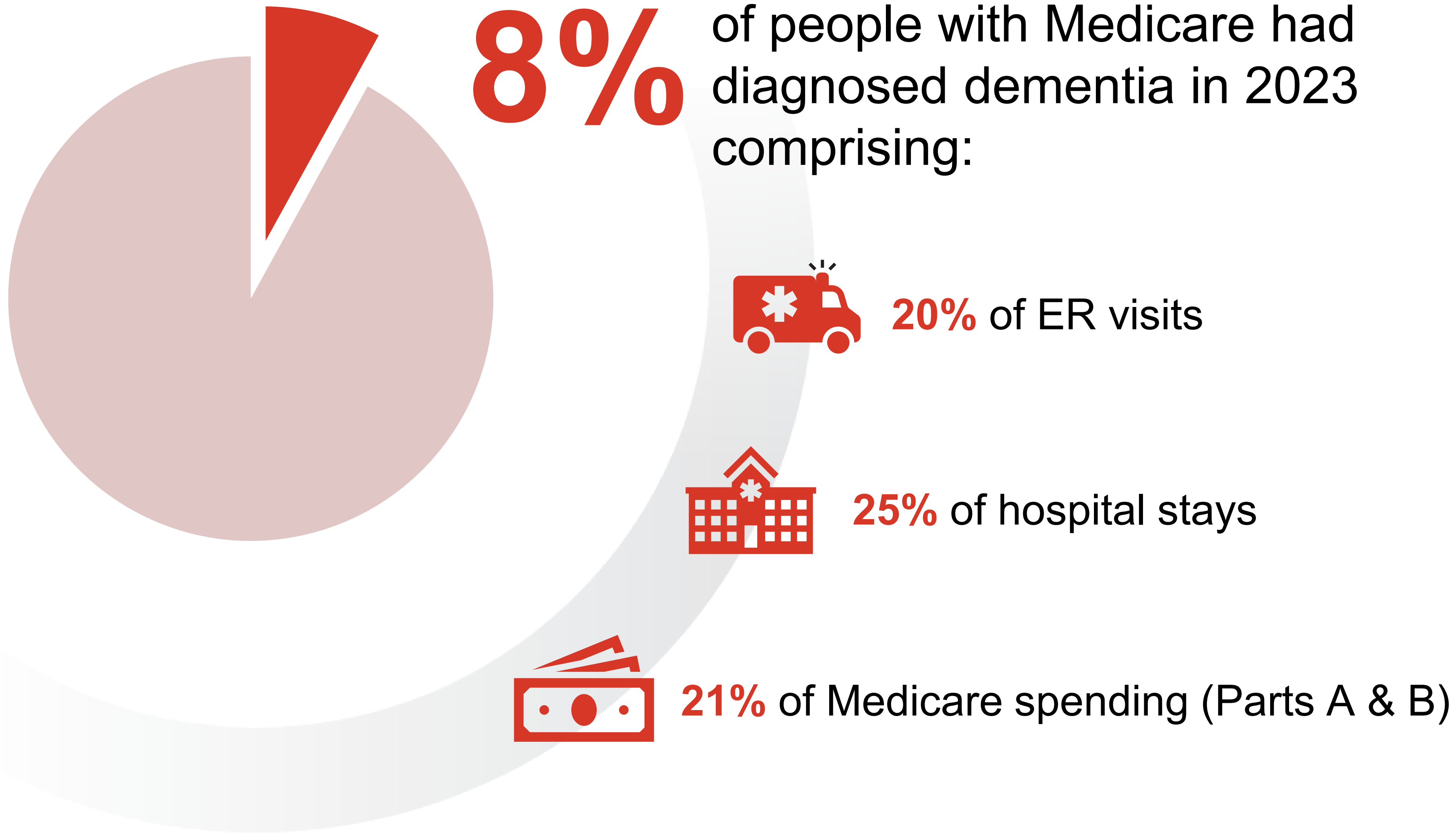
## An Introduction

June, 2024

ATI Advisory



# AT ANY POINT IN TIME, DEMENTIA PATIENTS ARE USING A LOT OF HEALTHCARE

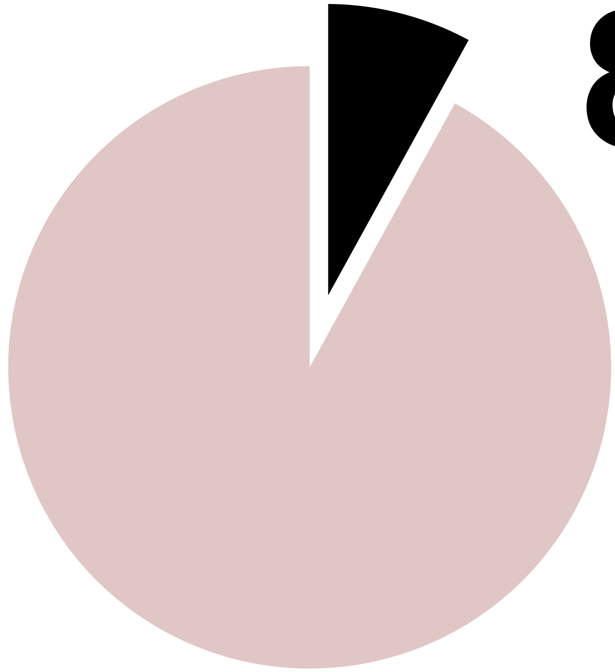



*Data reflect the Traditional Medicare population*

Diagnosed dementia accounts for an outsized share of the healthcare expenditures, hospitalizations, and ER visits.

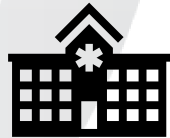


Source: ATI Advisory analysis of the Medicare MBSF and claims from April 2022 to March 2023 for people with two years of continuous enrollment in Traditional Medicare, Parts A & B.

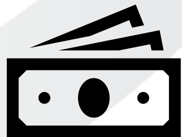


**8%** of people with Medicare had diagnosed dementia in 2023 and experienced high utilization and spending:

**61%** had an ER visit, averaging 1.7 ER visits per year.



**42%** had a hospital stay, averaging 0.8 hospital stays per year.

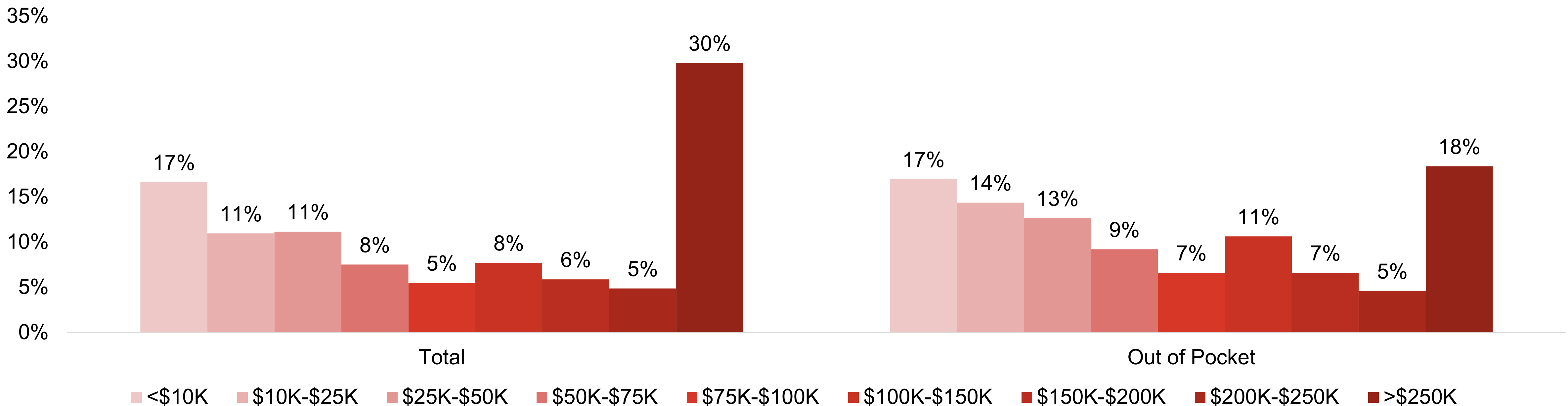


People with dementia averaged **$36,883** in Medicare Parts A & B spending per year

*Data reflect the Traditional Medicare population*

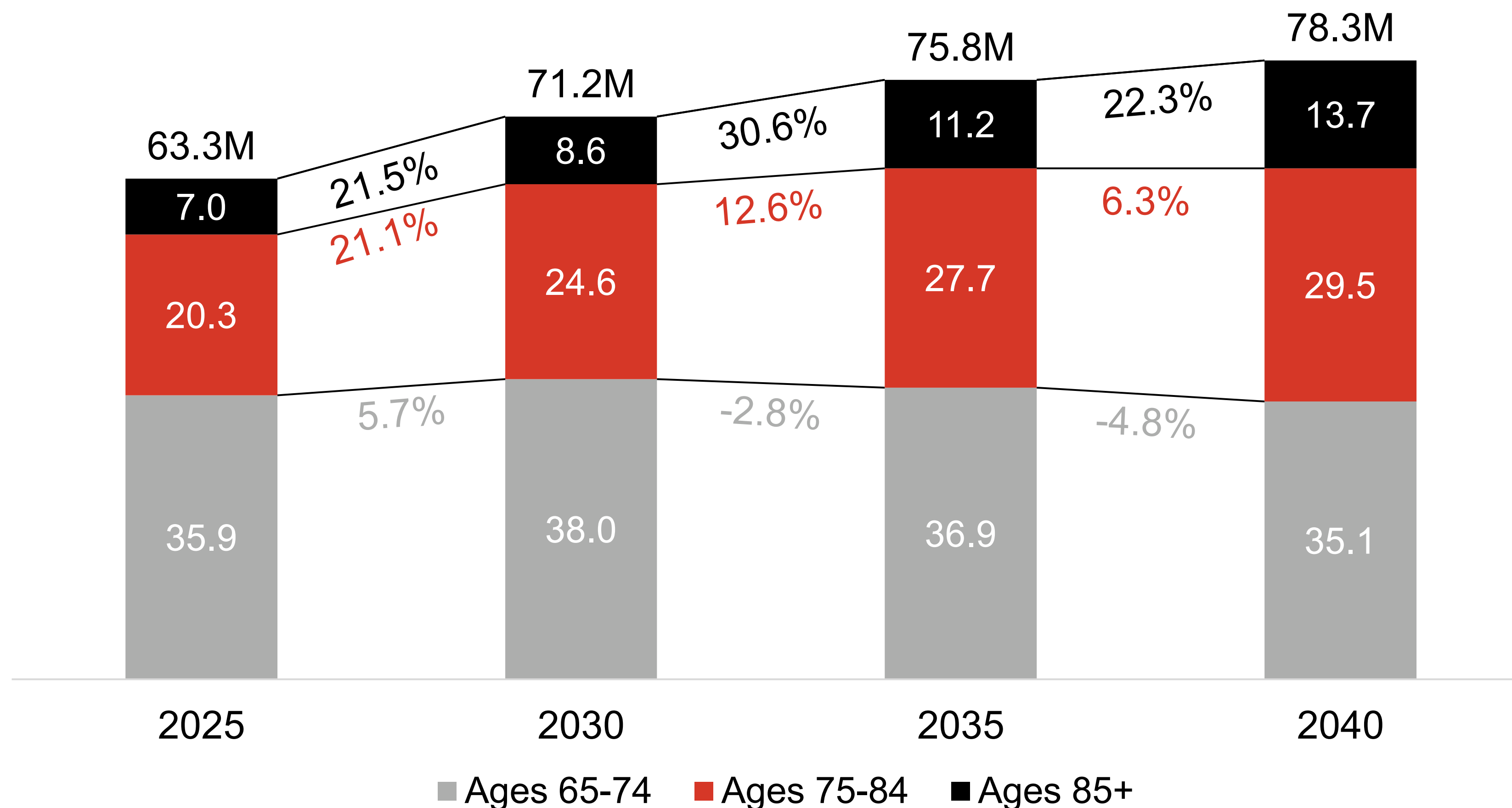
Source: ATI Advisory analysis of the Medicare MBSF and claims from April 2022 to March 2023 for people with two years of continuous enrollment in Traditional Medicare, Parts A & B.

→ Those with using formal LTSS can expect to incur $245,400 of lifetime LTSS spending, on average, with $93,500 (38%) spent out-of-pocket.




Text Source: Table 4, "Long-Term Services and Supports for Older Americans: Risks and Financing, 2022," Johnson and Dey. US DHHS ASPE, 2022.
Chart Source: ATI Advisory analysis of Tables 7 and 9 from same.

# AS A RESULT, DEMENTIA IS NOW IN THE CROSS-HAIRS OF POLICYMAKERS




## Prevalence of complex care needs will climb rapidly this decade and beyond

- Healthcare utilization, social and support needs much higher as well
- There is no infrastructure to support older adults and families organize and access services around the vast array of care needs
- Growing recognition of family caregivers as essential part of care ecosystem



Source: U.S. Census Bureau, 2023 National Population Projections.

# Guiding an Improved Dementia Experience (GUIDE)

# CMS MAKING A BIG BET WITH GUIDING AN IMPROVED DEMENTIA EXPERIENCE (GUIDE)

- Paying for services directly for family caregivers
- Allowing for significant flexibility within the model
- First time for caregivers to access care coordination and management

Whether GUIDE succeeds or fails, it has disruptive potential

# GUIDE STARTS THIS JULY BUT WILL CONTINUALLY GAIN STEAM THROUGH 2025

| | MODEL OVERVIEW |
|---|---|
| **Payer** | Traditional Medicare |
| **Type of VBP Model** | Condition-specific model for dementia care management |
| **Method of Payment** | Capitated payment (not total cost of care) for dementia care management and annual respite amount |
| **Timeline** | July 1, 2024-June 2032 (8 years); Applications closed January 2024 |
| **Location** | Applicants were eligible nationwide |
| **Tracks** | → Established Track: Existing dementia care management programs (launch July 1, 2024)<br>→ New Program Track: New dementia care management programs (launch pre-implementation period July 1, 2024 and go-live on July 1, 2025) |



Source: https://www.cms.gov/priorities/innovation/innovation-models/guide

# MUST BE MEDICARE PART B PROVIDER/SUPPLIER TO BILL MEDICARE FOR GUIDE

- The GUIDE Model offers alternative payment for participants delivering a comprehensive package of dementia care coordination and care management, caregiver education and support, and respite services.
- Eligibility: Medicare Part B enrolled providers/suppliers who are eligible to bill the Physician Fee Schedule

CMS announced the GUIDE Model on July 31, delivering on the commitment in President Biden's April 2023 Executive Order on caregiving

There are two program tracks, depending on applicant experience:

| Established Programs | New Program |
|---|---|
| → Designed for participants already providing comprehensive dementia care<br>→ Applicants should be ready to immediately implement GUIDE's care delivery requirements | → Designed for participants not operating a comprehensive outpatient dementia care program who are interested in scaling support<br>→ Participants will have a one-year pre-implementation period to establish their programs |

- The RFA was released November 15, 2023
- Applications were due January 30, 2024
- The model will launch on July 1, 2024, and run for 8 years through June 30, 2032

# GUIDE OFFERS MONTHLY PER MEMBER PER MONTH PAYMENTS PLUS RESPITE

## Infrastructure Payment

→ Certain safety net providers will be eligible for a one-time, lump sum infrastructure payment of $75,000 to support program development activities

## Dementia Care Monthly Payment

→ Participants will receive a monthly per-beneficiary-per-month (PBPM) payment for providing care management, coordination and caregiver education and support services to beneficiaries and caregivers

→ Adjusted by geographic region, performance, and a Health Equity Adjustment

→ PBPM will replace certain other billing codes (such as Chronic Care Management)

## Respite Care Payment

→ Participants will be able to bill for respite services for beneficiaries with moderate to severe dementia who also have a caregiver, up to an annual **$2,500** respite cap amount:

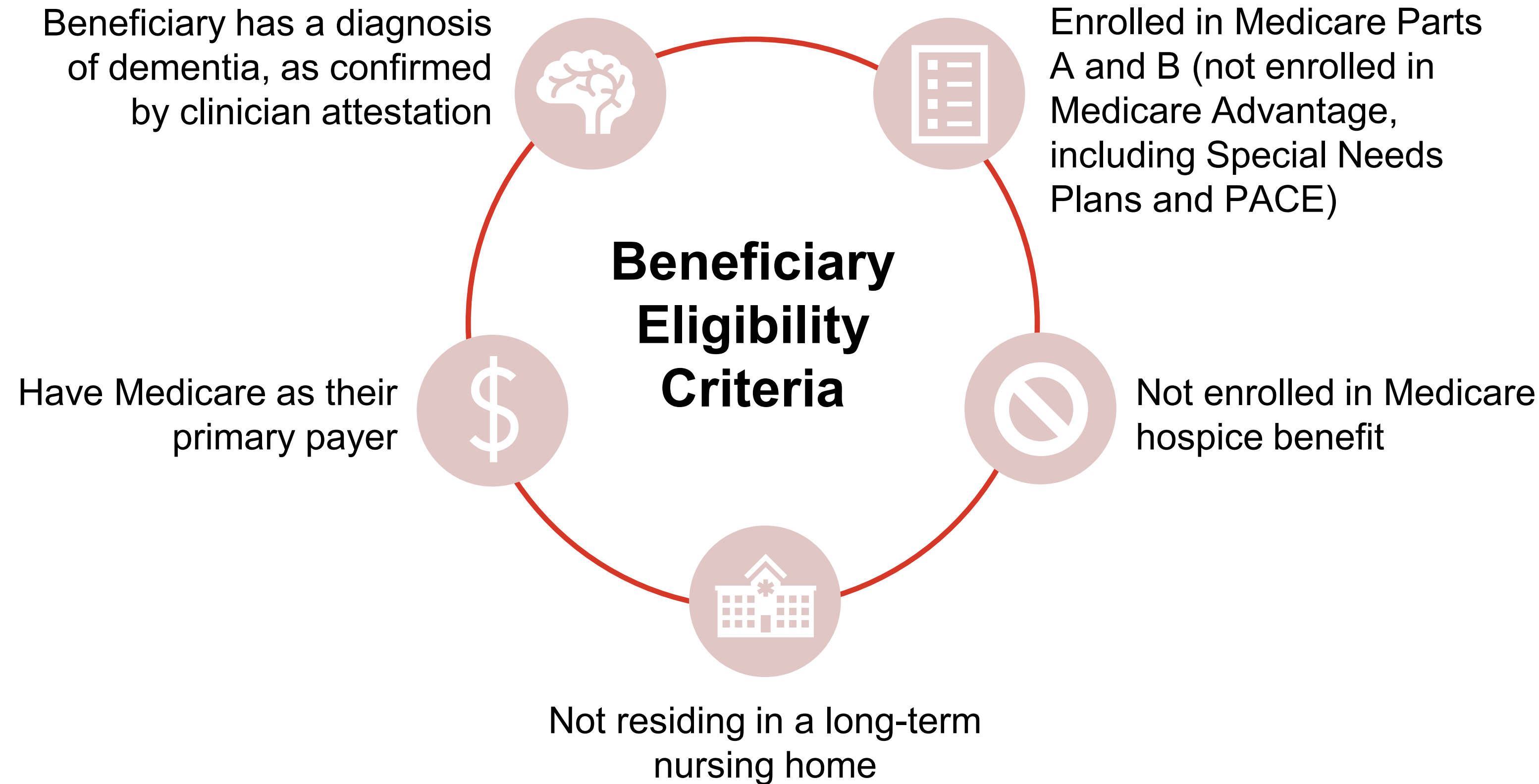
- **In-home respite (required):** 4-hour unit of service ($104)
- **Adult day respite (optional):** 8-hour unit of service ($78)
- **Facility-based respite (optional):** 24-hour unit of service ($260)

| | Monthly Payment Rates for Beneficiaries With Caregiver | | | Monthly Payment Rates for Beneficiaries Without Caregiver | |
|---|---|---|---|---|---|
| | Low complexity dyad tier | Moderate complexity dyad tier | High complexity dyad tier | Low complexity individual tier | Moderate to high complexity individual tier |
| **First 6 months (New Bene Payment Rate)** | $150 | $275 | $360 | $230 | $390 |
| **After first 6 months (Established Bene Payment Rate)** | $65 | $120 | $220 | $120 | $215 |



Source: https://innovation.cms.gov/innovation-models/guide

# MANY SENIOR LIVING RESIDENTS WILL BE ELIGIBLE FOR GUIDE




The GUIDE Model's intended beneficiary population is **community-dwelling** Medicare fee-for-service beneficiaries, including beneficiaries dually eligible for Medicare and Medicaid, living with dementia



Source: https://innovation.cms.gov/innovation-models/guide

**The GUIDE care delivery approach includes:**

→ An **interdisciplinary care team** including a care navigator and a clinician with "dementia proficiency" eligible to bill Medicare Part B evaluation and management (E/M) services

→ A standardized **training requirement** for care navigators

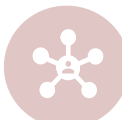
→ A standardized package of "**GUIDE Care Delivery Services**":

Beneficiary and caregiver **Comprehensive Assessments**

**Ongoing Monitoring and Support** to meet dyad goals

**Medication Management** and Reconciliation

Person-centered **Care Plan**



**Care Coordination** and Transitional Care Management

**Caregiver Education and Support**

**24/7 Access** to support

Referrals And **Coordination of Services And Supports**

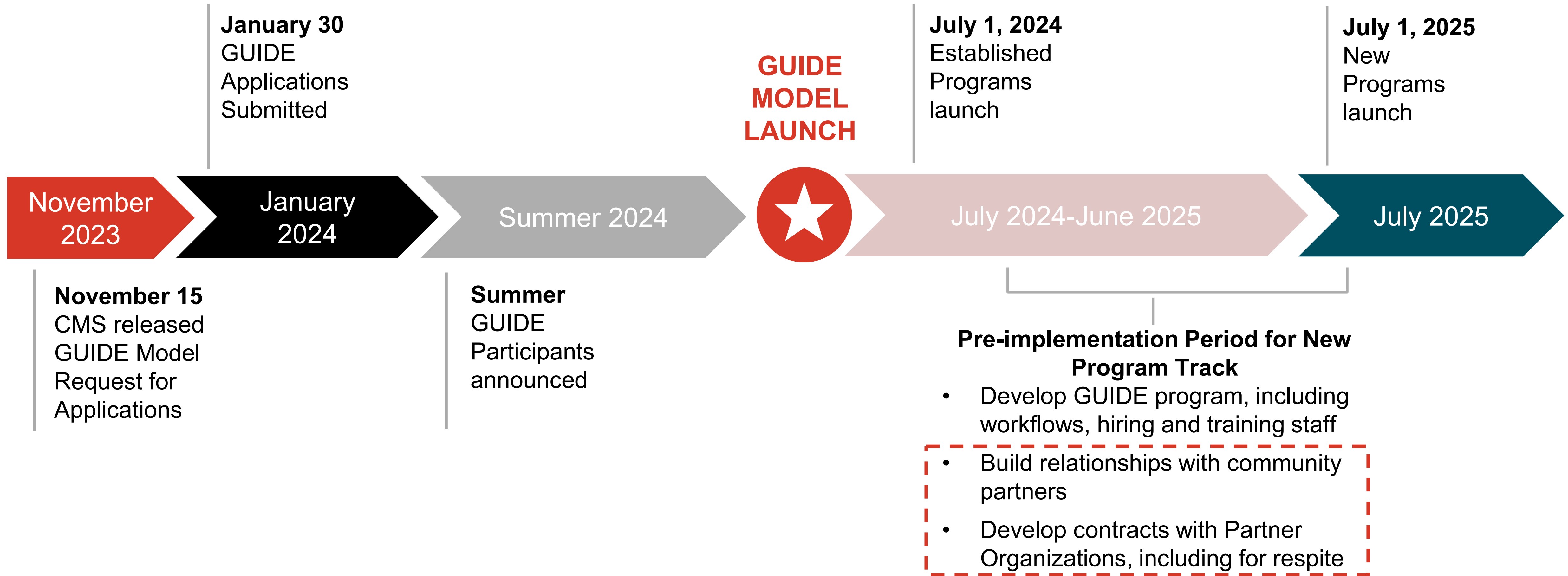
**Respite** services

GUIDE Participants may contract with downstream **"Partner Organizations"** to meet the GUIDE care delivery requirements. Partner Organizations can providers, suppliers, or organizations, including both Medicare-enrolled and non-Medicare enrolled entities. Payments for services provided would be negotiated and flow to the GUIDE Participant and then to any Partner Organizations.



Source: GUIDE Request for Applications, November 2023

# MUCH OPPORTUNITY REMAINS TO PARTNER



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# GUIDE

# TRANSFORMING THE SENIOR LIVING APPROACH TO DEMENTIA

# AT HOME HARMONY ("AHH")

***About Us:*** At Home Harmony, based in Richmond, VA, delivers an innovative healthcare model through which seniors with complex medical needs experience the highest quality coordinated geriatric medical and pharmacy care at home.

***Who We Serve:*** We deliver our innovative home-based care model in the following settings:

- Private Homes
  - Unique transitional Care Management program for seniors discharged from the hospital or SNF
- Senior Living Communities
- Care Homes

At Home Harmony

Source: At Home Harmony

# AGENDA

- **CMS GUIDE Model**
- **AHH GUIDE Model**
- **AHH Medical Model**
- **Questions**

Dear Mr. Smith

You qualify…

- …$2,500 Yearly
- …Caregiver relief
- ...Training/Education
- …24/7 support
- …Personal Care
- …Respite Care

Contact these GUIDE Providers…

# MEDICARE'S GUIDE PROGRAM

**COMPREHENSIVE ASSESSMENT**
Beneficiaries and caregivers receive separate assessments to identify their needs and a home visit to assess the beneficiary's safety.

**CARE PLAN**
Beneficiaries receive care plans that address their goals, preferences, and needs, which helps them feel certain about next steps.

**24/7 ACCESS**
Beneficiaries and caregivers can call a member of their care team or a third-party representative using a 24/7 helpline.

**ONGOING MONITORING & SUPPORT**
Care navigators provide long-term help to beneficiaries and caregivers so they can revisit their goals and needs at any time and are not left alone in the process.

**REFERRAL & SUPPORT COORDINATION**
Beneficiaries' care navigator connects them and their caregivers to community-based services and supports, such as home-delivered meals and transportation.

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

**MEDICATION MANAGEMENT**
Clinician reviews and reconciles medication as needed; care navigators provide tips for beneficiaries to maintain the correct medication schedule.

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

**Launches nationwide to approved sites July 1st**

**Caregiver support for those living with dementia**

**Managed through medical practices**

**AHH accepted as GUIDE provider in 9 states**

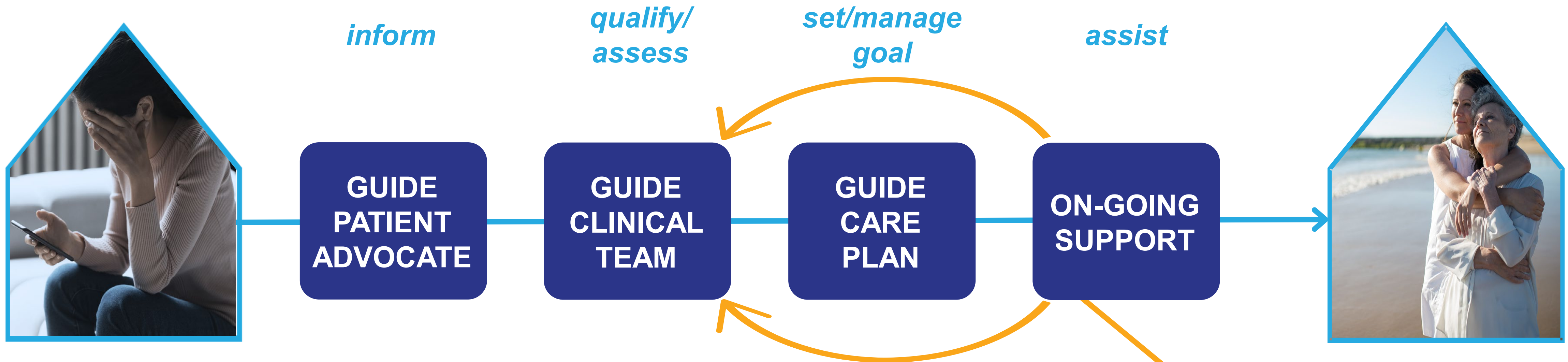
**$2,500**
**Annual Respite Benefit**
Personal Care, Overnight, Day Support

At Home Harmony

Source: At Home Harmony

# AT HOME HARMONY – GUIDE PROGRAM PROCESS

## *CAREGIVER-FOCUSED / PATIENT CENTERED*




# PURPOSE

- Improve quality of life of persons living with dementia
- Reduce caregiver strain
- Prevent/delay need for long-term nursing care

- **Caregiver Education** with 24/7 Dementia Care Navigation Support
- **Respite Service** with Voucher
- **Care Coordination** with Clinical Team

# AT HOME HARMONY – GUIDE PROGRAM PROCESS

## *SENIOR LIVING*

- Offers a turnkey, stand-alone dementia support program
- Integrates with your existing care teams
- Provides clinical staffing at no cost to your community
- Reduces staff burdens while caring for families and high-need residents
- Improves outcomes for residents with memory impairments
- Enhances communication with families, residents

At Home Harmony

Source: At Home Harmony

# AT HOME HARMONY – GUIDE PROGRAM

## AHH Capability

- At Home Harmony is approved by CMS for GUIDE payment/clinical model
- GUIDE must be administered by a medical practice

## GUIDE Respite Services

- In-Home (4-hour increments): $120
- Facility-Based (24 hours): $260

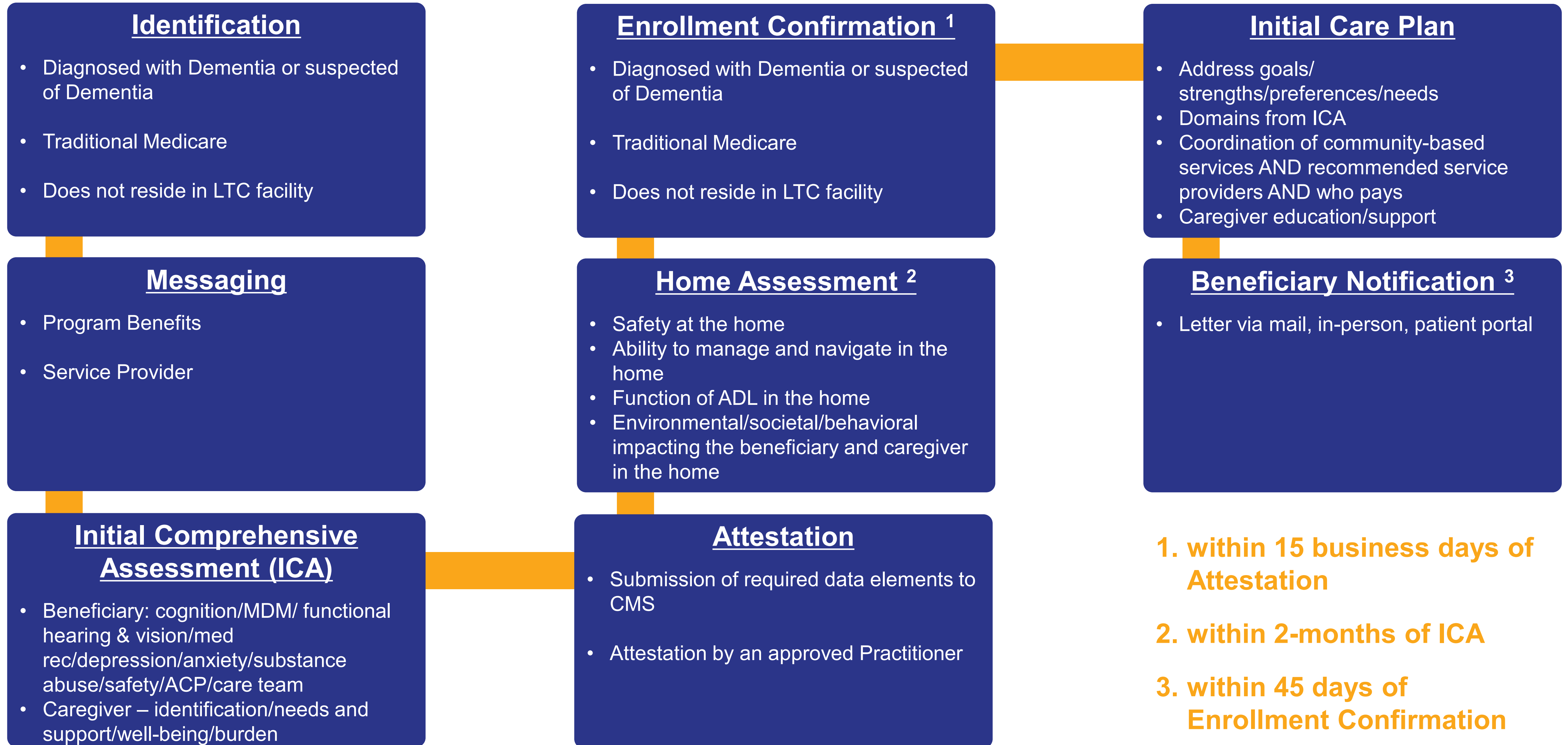
## Further Requirements

- Patient must be formally cognitively assessed by the care provider
- Patient & Caregiver must consent
- Services must adhere to provider’s care plan

## Additional Elements

- Caregiver Training & Support
- Must serve patients with both moderate & severe complexity
- Patients must be Medicare FFS

# ENROLLMENT PROGRAM FLOW AND TIMELINE




At Home Harmony

Source: At Home Harmony

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# BENEFICIARY ALIGNMENT FILE

| | Beneficiary type | Tier | | FAST | ZBI | Respite? |
|---|---|---|---|---|---|---|
| BCL | Beneficiaries with caregiver | Low complexity dyad tier | Mild dementia | 4 | | |
| BCM | Beneficiaries with caregiver | Moderate complexity dyad tier | Moderate or severe dementia AND low to moderate caregiver strain | 5-7 | 0-60 | yes |
| BCH | Beneficiaries with caregiver | High complexity dyad tier | Moderate or severe dementia AND high caregiver strain | 5-7 | 61-88 | yes |
| BL | Beneficiaries without caregiver | Low complexity individual tier | Mild dementia | 4 | | |
| BMH | Beneficiaries without caregiver | Moderate to high complexity individual tier | Moderate or severe dementia | 5-7 | | |

# CAREGIVER NAVIGATOR TRAINING

| Topic | Further Detail of Topic |
|---|---|
| **Background on Dementia** | Overview of dementia as a medical condition; Progression of disease and balancing dementia with other co-morbidities |
| **Overview of Assessments** | Assessments available related to dementia; Recommendations for a successful assessment |
| **Care Plan** | What is a care plan; Including beneficiary in the development of plan |
| **Person-Centered Planning** | What person-centered planning means; How to incorporate into planning |
| **Challenging Behaviors** | Behavioral symptom management; Common behavioral changes due to dementia and how to address |
| **Functional Needs** | What are activities of daily living (ADLs) and instrumental activities of daily living (IADLs); Evaluation of ADLs and IADLs; Common changes in ADLs and IADLs due to dementia and how to address; Medication monitoring and maintaining a medication schedule |
| **Advanced Care Planning** | What is an advance medical directive and POLST form; How to assist beneficiary in advance care planning |
| **Decision-Making Capacity** | What is capacity for medical decision-making; What it means when a beneficiary does not have capacity for medical decision-making; supported decision-making |
| **Safety** | Considerations for safety at home, in public, and driving; elder abuse, neglect, and financial exploitation; access to weapons and dangerous substances |
| **Communication** | Communication strategies for persons with dementia and their Caregivers |
| **Coordination of medical care and community services** | Communication with clinical providers; Supporting beneficiary in transitions between settings; Accessing community-based services and supports, including respite services; Working with case managers and other coordinators to address gaps and duplication in a beneficiary's community-based services and supports |
| **Supporting a Caregiver** | Caregiver strain and support (e.g.: peer -to -peer support, support group, 1:1 support); In-home caregiver training and importance of caregiver education |
| **Diversity in Dementia** | Treating dementia and communicating with diverse populations in a culturally competent way |

# INITIAL COMPREHENSIVE ASSESSMENT

| GUIDE Requirement | Domain | Actor | Standardized Instrument or Topic |
|---|---|---|---|
| **Caregiver** | Identification | Non-provider | Contacts / Caregiver / POA Demographic and assessment |
| **Beneficiary** | Clinical | Participant APP | Cognition-focused evaluation including a pertinent history and examination |
| **Beneficiary** | Clinical | Participant APP | Evaluation of medical decision-making of moderate or high complexity; CURVES if uncertain |
| **Beneficiary** | Clinical | Non-provider | Functional: ADL (KATZ), IADL, additional questions |
| **Beneficiary** | Clinical | Non-provider | Hearing and Vision |
| **Beneficiary** | Clinical | Participant APP | Dementia diagnosing (MOCA) and staging (FAST) |
| **Beneficiary** | Clinical | Non-provider | Med rec and review |
| **Beneficiary** | Behavioral Health and Psychological Needs | Non-provider | Mental health / substance abuse history and assessments (PHQ2/9, GAD, BEHAV5) |
| **Beneficiary** | Behavioral Health and Psychological Needs | Non-provider | Safety assessment |
| **Beneficiary** | Health-Related and Social Needs | Non-provider | PRAPARE |
| **Beneficiary** | Advance Care Planning | Non-provider | Advance Directive, POLST |
| **Beneficiary** | Coordination of Care | Non-provider | Documentation of care team, specialists, home health, community-based services and supports |
| **Beneficiary** | Quality of Life | Non-provider | Quality of Life Outcome for People with Neurological Conditions (PROMIS-10) |
| **Caregiver** | Assessment | Non-provider | ZARIT (22-item) |
| **Home** | In-Home for Beneficiaries with FAST = 5 – 7 | Non-provider | Home safety assessment |

At Home Harmony

Source: At Home Harmony

# PARTNERSHIP MODELS

## Care Navigator

- Delivery of non-Provider services, including components of Initial Comprehensive Assessment
- Collaboration with Harmony GUIDE Team to build, implement, monitor and update Care Plan
- Collaboration with Harmony GUIDE Team and Beneficiary's care team for ongoing care coordination and support
- 24x7 support
- PMPM

## Screenings & Instruments

- Selected non-Provider assessments (e.g. ZARIT Burden Interview) and data collection (e.g. Caregiver demographic)
- Priced per completion

# SAMPLE IMPLEMENTATION TIMELINE

**JULY 1-SEPT 30 2024**

## PHASE 1

### GUIDE PROGRAM INITIATION

- AHH APP conducts cognitive assessments for xxx clients who qualify for GUIDE program
- Work with two sites

**OCTOBER 1 2024**

## PHASE 2

### LESSONS LEARNED & EXPANSION

- Harmony and xxxx meet to define lessons learned and expansion plan across the state

**BY 2025**

## PHASE 3

### EXPANSION



Source: At Home Harmony

# ABOUT ZIEGLER

- Ziegler is a privately-held investment bank, capital markets and proprietary investments firm
- A registered broker dealer with SIPC & FINRA
- Ziegler provides its clients with capital raising, strategic advisory services, equity & fixed-income trading and research
- Founded in 1902, Ziegler specializes in the healthcare, senior living and educational sectors as well as general municipal finance

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