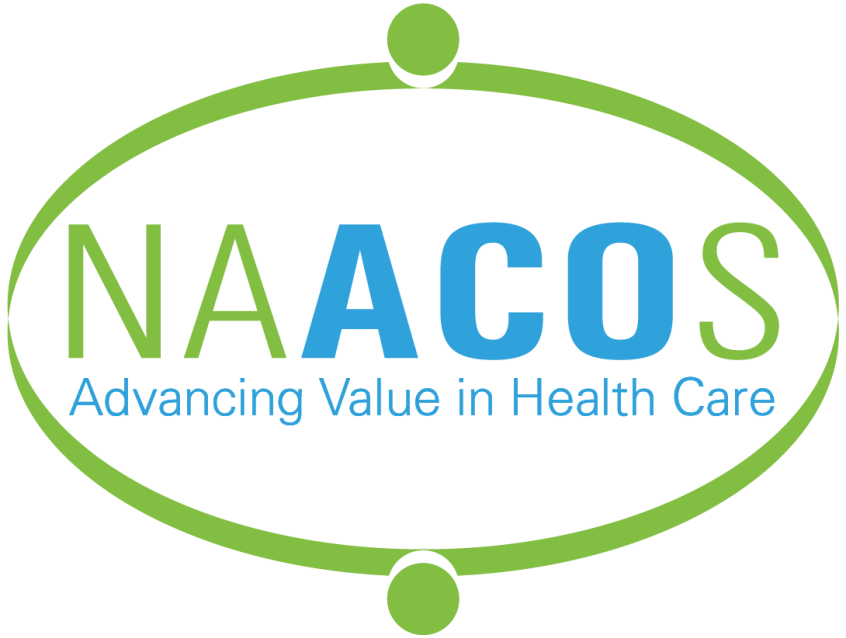
Navigating the Dementia Care Landscape: Insights from CMMI GUIDE for ACO Success



Chair: Jennifer Houlihan, Advocate Health

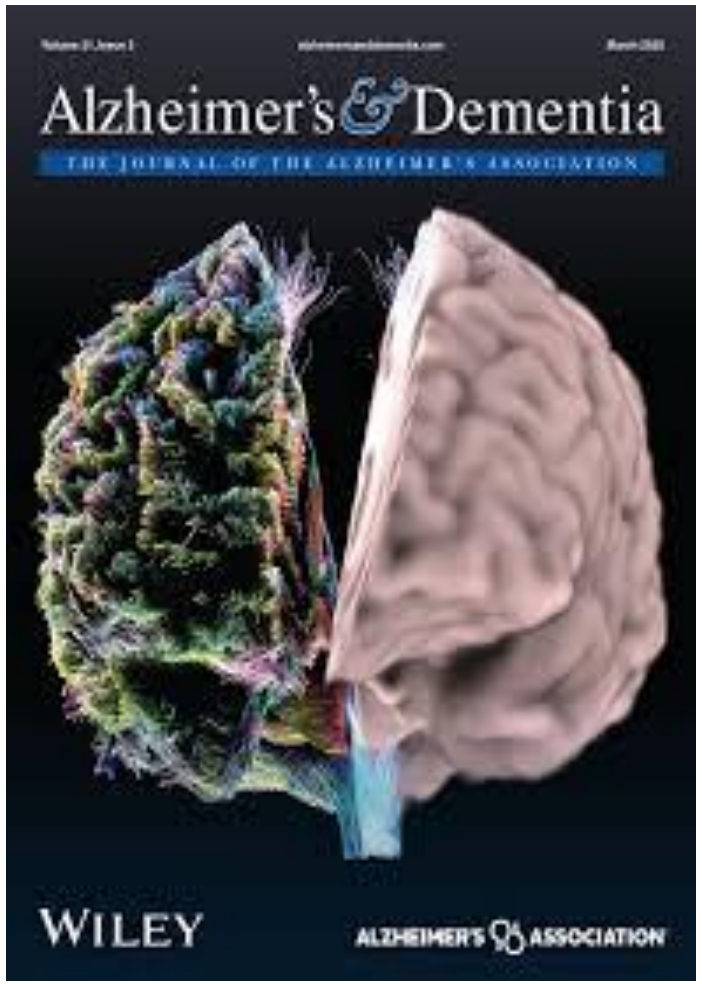
Speakers: Edo Banach, Foley Hoag

Susan Herbert, Advent Health

Nate Hunkins, Blue Stone MD

Agenda

1. Framing the Dementia Care Challenge for ACOs and GUIDE Model Introduction/Refresher
2. Session Learning Objectives
3. Perspectives on GUIDE Structures, Operations & ACO Engagement
4. Financial, Policy, and Legal Considerations
5. Scaling GUIDE Beyond Medicare
6. Q&A and Closing Reflections



Key Dementia Stats:

139 million people will have dementia worldwide by 2050

A study of Medicare data showed that **roughly 9% of beneficiaries — 5.3 million people** — may have Alzheimer's disease or a related dementia

>10% of ACO Attributed Patients have Dementia

Government spending:

- Medical and long-term care costs for dementia will amount to **$232 billion** in the U.S. in 2025 and are projected to rise to nearly **$1 trillion** by 2050In the U.S., Medicare will spend **$106 billion** and Medicaid **$58 billion** in 2025.

Higher costs per patient:

- The lifetime cost of care for a person with dementia is estimated at over **$405,000**.
- Medicaid and Medicare costs are significantly higher for people with dementia compared to other older adults.

Higher utilization:

- **Dementia is associated with higher ED and inpatient utilization.**

Fragmented care: ACO-enrolled patients with dementia experience more fragmented primary care, seeing more distinct primary care physicians and ambulatory care clinicians overall.

Teno JM, Keohane LM, Mitchell SL, Meyers DJ, Bunker JN, Belanger E, Gozalo PL, Trivedi AN. Dying with dementia in Medicare Advantage, Accountable Care Organizations, or traditional Medicare. J Am Geriatr *Soc. 2021 Oct;69(10):2802-2810. doi: 10.1111/jgs.17225. Epub 2021 May 14. PMID: 33989430; PMCID: PMC8497397.
Johnston KJ, Loux T, Joynt Maddox KE. Risk Selection and Care Fragmentation at Medicare Accountable Care Organizations for Patients With Dementia. Med Care. 2023 Aug 1;61(8):570-578. doi: 10.1097/MLR.0000000000001876. Epub 2023 Jun 13. PMID: 37411003; PMCID: PMC10328553.

GUIDE Model & Purpose

The GUIDE Model will test whether a comprehensive package of care coordination and management, caregiver support and education, and respite services can **improve quality of life for people with dementia and their caregivers** while **delaying avoidable long-term nursing home care** and **enabling more people to remain at home** through end of life.

Care Coordination & Management

Beneficiaries will receive care from an **interdisciplinary team** that will develop and implement a comprehensive, person-centered care plan for **managing the beneficiary's dementia and co-occurring conditions** and provide **ongoing monitoring and support.**

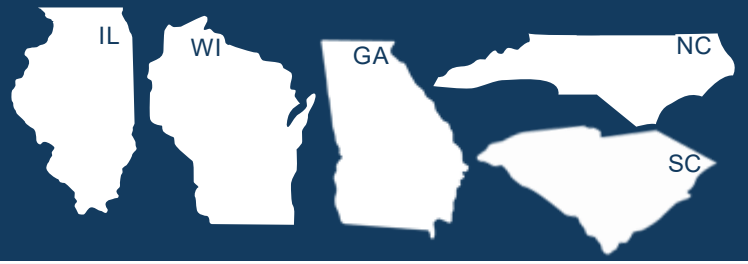
Caregiver Support & Education

GUIDE participants will provide a **caregiver support program**, which must include caregiver skills training, dementia diagnosis education, support groups, and access to a personal care navigator who can help problem solve and connect the caregiver to services and supports.

Respite Services

A subset of beneficiaries in the model will be eligible to receive payment for respite services with no cost sharing, up to a cap of **$2,500 per year**. These services may be provided to beneficiaries in a variety of settings, including **their personal home, an adult day center, and facilities that can provide 24-hour care** to give the caregiver a break from caring for the beneficiary.

Advocate Health Government Programs



1. **Shared Savings (MSSP)**
2. **Capitation (REACH)**
3. **Condition-based (GUIDE)**
4. **State-based (TMaH)**
5. **Episodic Care (TEAM)**

Nine
CMS/CMMI Models Since 2012

255K
MSSP Beneficiaries Served on Average*

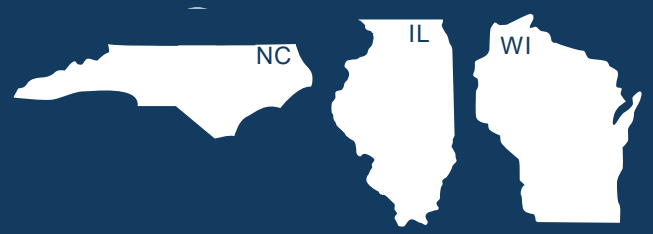
$898M
CMS/CMMI aggregate savings to Date

>95%
Average ACO Quality Score

Guiding an Improved Dementia Experience (GUIDE)

Advocate Health

1 Experienced Market: Jul 1 2024
3 New Markets: Jul 1 2025



Description: Partnership with Neuro and Geriatrics Service Lines for patient monitoring and enhanced care coordination for patients living with dementia and their caregivers, such as social work, home visits and respite care

Key Milestones	First Year Lessons Learned

GUIDE care teams configurations- starting with existing FTEs to allow for ramp up:

- .APP (service line)
- Social worker (service line)
- Outreach coordinator (service line)
- .Community Health Worker (care mngmt)

Partner Organizations for respite care and home safety assessment across 3 states- mix of national and local partners

- Completed Epic Compass Rose application builds
- Development of best practices/billing playbook
- Coordination with Primary Care/order set
- Proactive Outreach with ACO rosters
- Coordination with broader BrainHealth strategy- MCI screening initiative

- **Respite Benefit is Key Driver of Patient/Caregiver Engagement**
- **ACO Overlap <25%**
- **Scheduling Optimization and Availability Adjusted to Caregiver Needs/Schedules**
- **Referral Source Impact to Successful Outreach**
  - Difference in conversion success rate for established memory care patients vs. primary care patients
- **Availability of Respite Partners in Outlying/Rural Areas**
- **Billing Complexity & Timeliness of Payment**

Learning Objectives & Panelist Introductions

- Provide perspectives on various CMMI GUIDE Model's structures
- Identify common operational challenges and key pain points in GUIDE program implementation
- Share ACO Synergies
- Discuss strategies and considerations for extending the principles

AdventHealth Overview

AdventHealth

AdventHealth Overview

1973 AdventHealth was established

9 million+ Patients served annually

100,000+ Team members

4,500+ Employed providers

55 Hospital campuses operated in nine states

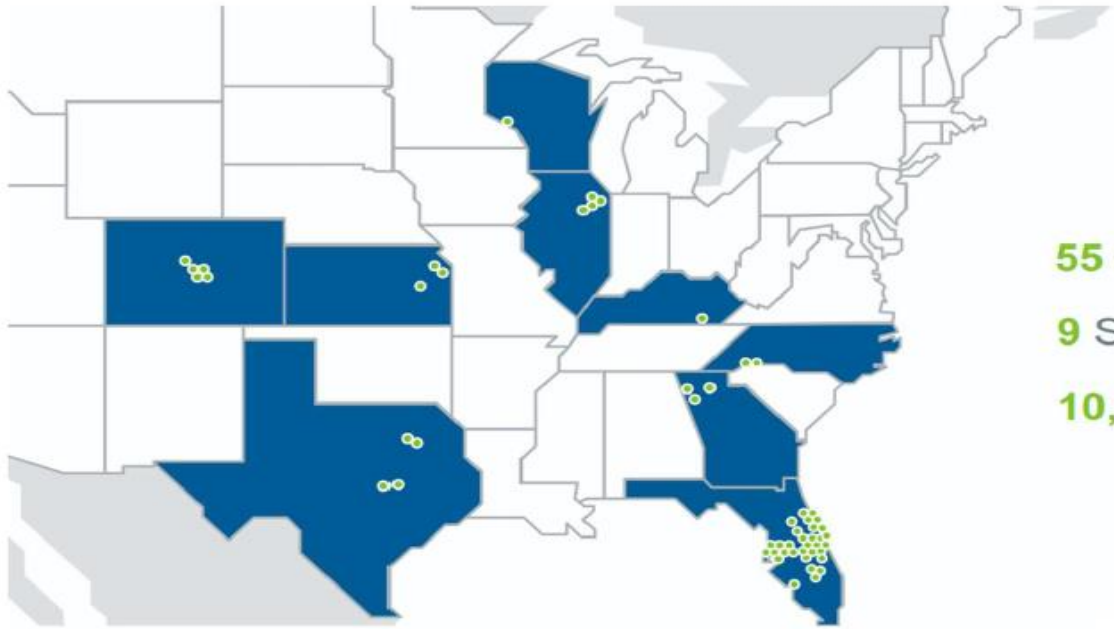
17 Home health and hospice agencies

58 Urgent care facilities

27 Offsite EDs

AdventHealth

AdventHealth Hospitals



55 Campuses

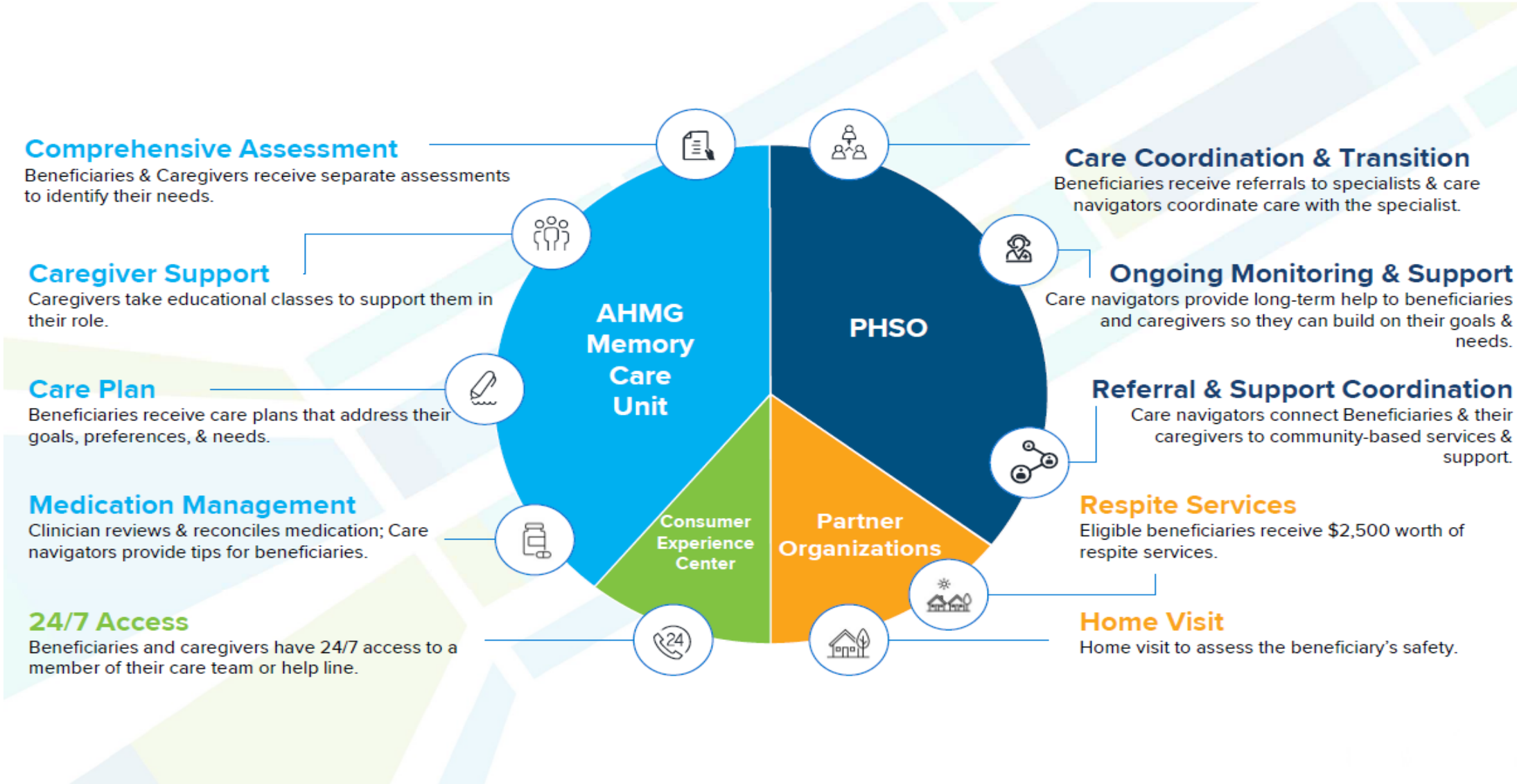
9 States

10,900+ Licensed beds

AdventHealth

AdventHealth GUIDE Program

AdventHealth


Comprehensive Assessment
Beneficiaries & Caregivers receive separate assessments to identify their needs.
Caregiver Support
Caregivers take educational classes to support them in their role.
Care Plan
Beneficiaries receive care plans that address their goals, preferences, & needs.
Medication Management
Clinician reviews & reconciles medication; Care navigators provide tips for beneficiaries.
24/7 Access
Beneficiaries and caregivers have 24/7 access to a member of their care team or help line.
AHMG Memory Care Unit
PHSO
Consumer Experience Center
Partner Organizations
Care Coordination & Transition
Beneficiaries receive referrals to specialists & care navigators coordinate care with the specialist.
Ongoing Monitoring & Support
Care navigators provide long-term help to beneficiaries and caregivers so they can build on their goals & needs.
Referral & Support Coordination
Care navigators connect Beneficiaries & their caregivers to community-based services & support.
Respite Services
Eligible beneficiaries receive $2,500 worth of respite services.
Home Visit
Home visit to assess the beneficiary's safety.

Fully Integrated & Collaborative Program Structure

AdventHealth Medical Group (AHMG)

- Clinicians
- Referral Coordinator
- Practice Administration
- Billing
- Coordinate with Consumer Experience Center for wrap around

AdventHealth Neuroscience Institute

- Social workers provide
  - Dementia care support
  - Care giver education and support

Population Health Services Organization (PHSO)

- Government Programs
  - Model administration
- Care Management
  - Assessment
  - Touch points

Early Successes

- Initially targeted currently diagnosed and aligned patients
- Developed a Cross-Departmental Workflow Design
- Integrated Care Navigation Team
- Partner Organization Engagement
- Epic Compass Rose Build

AdventHealth

Lessons Learned

- Early cross-functional involvement is critical
- Clear ownership and accountability drive progress
- Flexibility is essential when CMS requirements change mid-stream
- EHR tools need tailored development and validation
- Internal ownership of care navigation enhances integration

AdventHealth

Pain Points & Challenges

Operational Challenges

- Clinician & support staff bandwidth is a challenge in high-volume settings
- Sustained engagement needed beyond leadership level

Complex Billing Requirements

- GUIDE billing rules differ from standard Medicare processes
- PBPM payment must be manually billed (not auto-paid like other CMS models)
- Anticipate future challenges with denials and payment reconciliation

AdventHealth

Looking Ahead

- Strengthen operational ownership across practice teams
- Expand care navigator capacity and support systems
- Enhance EHR workflows for billing and documentation
- Improve caregiver engagement and education
- Monitor CMS updates and adapt workflows as needed

AdventHealth

Bluestone at-a-glance

Unique care model designed to meet geriatric patient needs

In-person, in-home care delivery that brings comprehensive care to patients living with multiple complex chronic conditions.

Since 2006

we have cared for over

250K patients

with Dementia or cognitive impairment.

20K active patients in over 575 senior living communities

currently in Bluestone's care across Minnesota, Wisconsin and Florida.

2020 Joined the MSSP ACO program

Our Multi-Disciplinary Care Team	Physicians Nurse Practitioners Physician Assistants Psychiatric Nurse Practitioners	Clinical Support Team Dementia-Certified Care Managers Behavioral Health Care Managers Medical Home Coordinators

Bluestone patients

Bringing care to 20K patients across Minnesota, Florida and Wisconsin

Population focus:

- Assisted Living
- Memory Care
- Independent Living
- Group Home
- Community Dwelling

Patient volume

- Over 20,000 patients on service
- Over 6,500 patients in our ACO
- Over 575 senior living community partnerships in more than 200 cities

Patient demographics

82 Average Age

7 Average number of chronic conditions

65% have a form of dementia

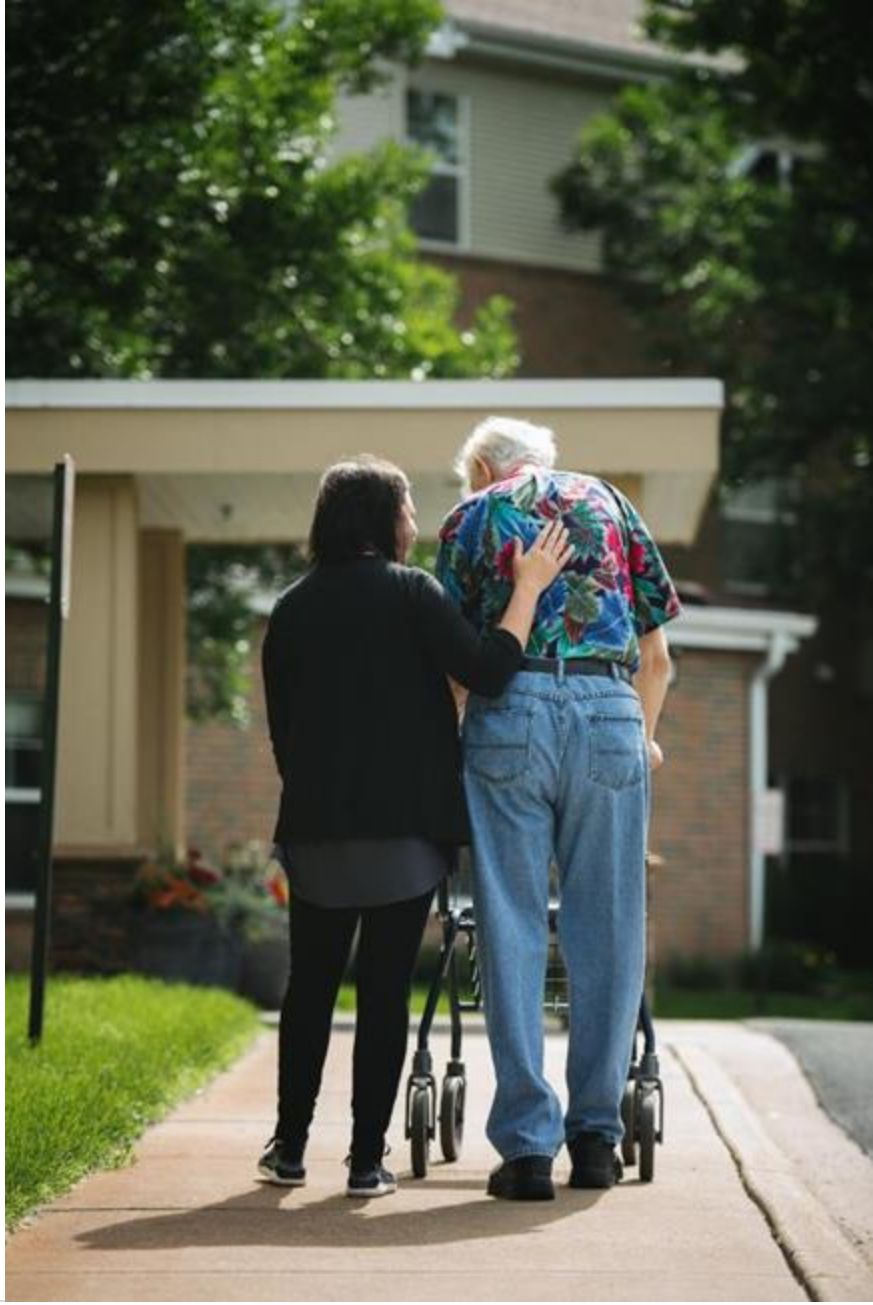
39% suffer from depression

2.2 Average HCC score

30% are Medicaid/Dual Eligible

Dementia Care Programs

- Enhanced MSSP Track in 2024
- GUIDE Model Launch 7/1/2025
- C-SNP Dementia Care Partner



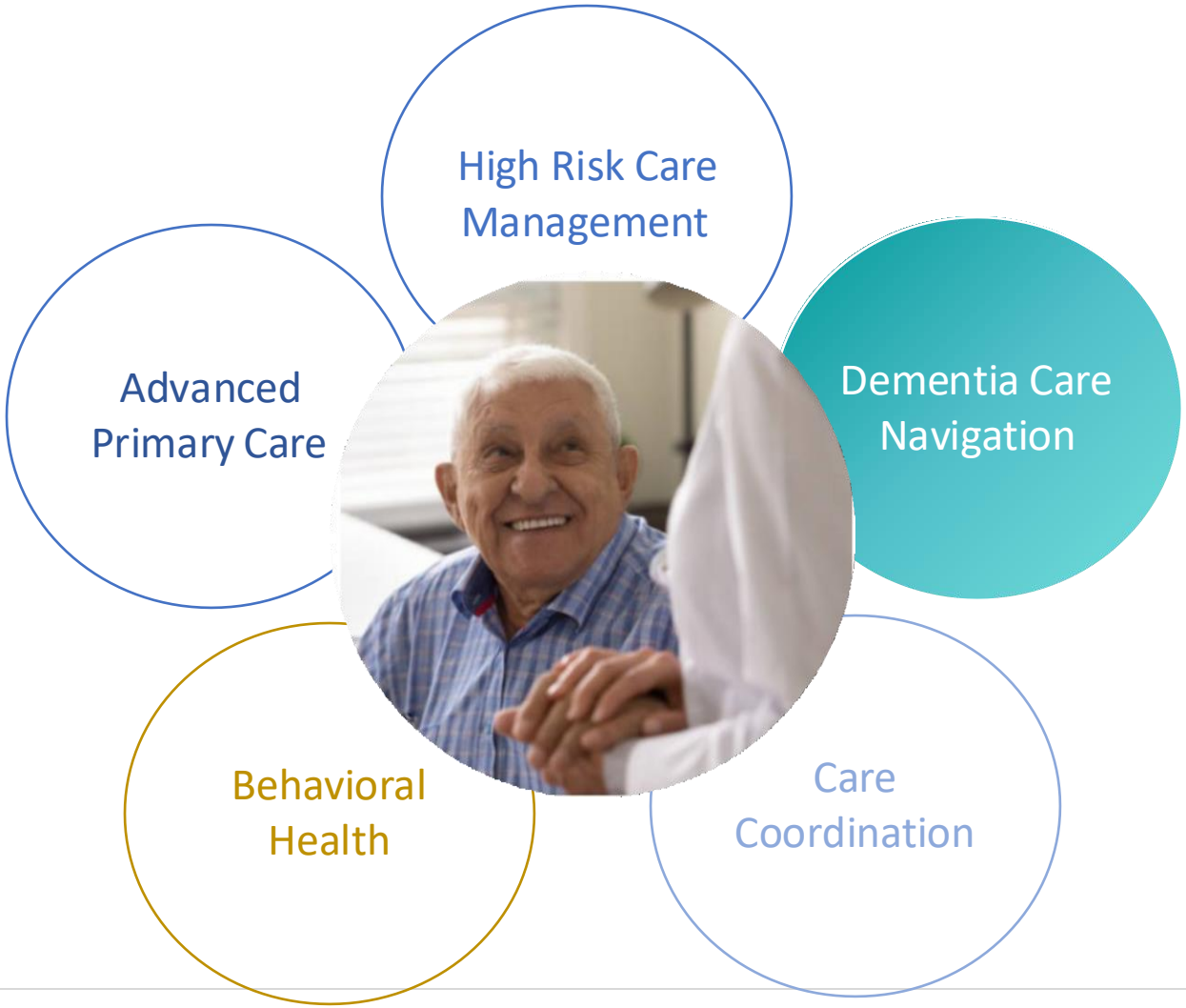
Bluestone ACO Performance Summary

Bluestone MSSP Performance Summary	2020	2021	2022	2023	2024
Attribution (Person Years)	5,559	6,533	5,992	5,426	5,409
Updated Benchmark (PMPY)	$28,666	$30,808	$31,509	$34,269	$36,597
Total Cost of Care (PMPY)	$27,303	$28,018	$27,066	$28,015	$30,385
Gross Savings (Total)	$7,421,581	$18,227,480	$26,620,895	$33,935,219	$33,602,217
Gross Savings (PMPY)	$1,363	$2,790	$4,443	$6,254	$6,212
Gross Savings Rate (%)	5%	9%	14%	18%	17%
MSSP Track / Share Rate	40%	40%	50%	50%	75%
Quality Score	100%	80%	71%	91%	83%

ACO Performance Highlights

- Significant Increase in Gross Savings and Savings Rate
- Fluctuating Attribution but Controlled Costs
- Submitting eCQMs since 2022

Bluestone ACO - Intentional Focus on Upstream Services



To deliver on mission, Bluestone added **dementia care navigation** through CMS GUIDE to the comprehensive upstream services we provide

What is the CMS GUIDE Program?

CMS launched the **Guiding an Improved Dementia Care Experience (GUIDE) program** with the goals of:

- Improving quality of life for people living with dementia
- Enhancing support for caregivers
- Helping people with dementia stay in their communities for longer

Bluestone GUIDE Services

A **dedicated Care Navigator** for every eligible resident

Comprehensive Assessment to fully understand condition

Advanced Care Plans tailored to resident's unique needs

Caregiver support and resources to ease burden

24/7 Access to clinical team to meet needs around the clock

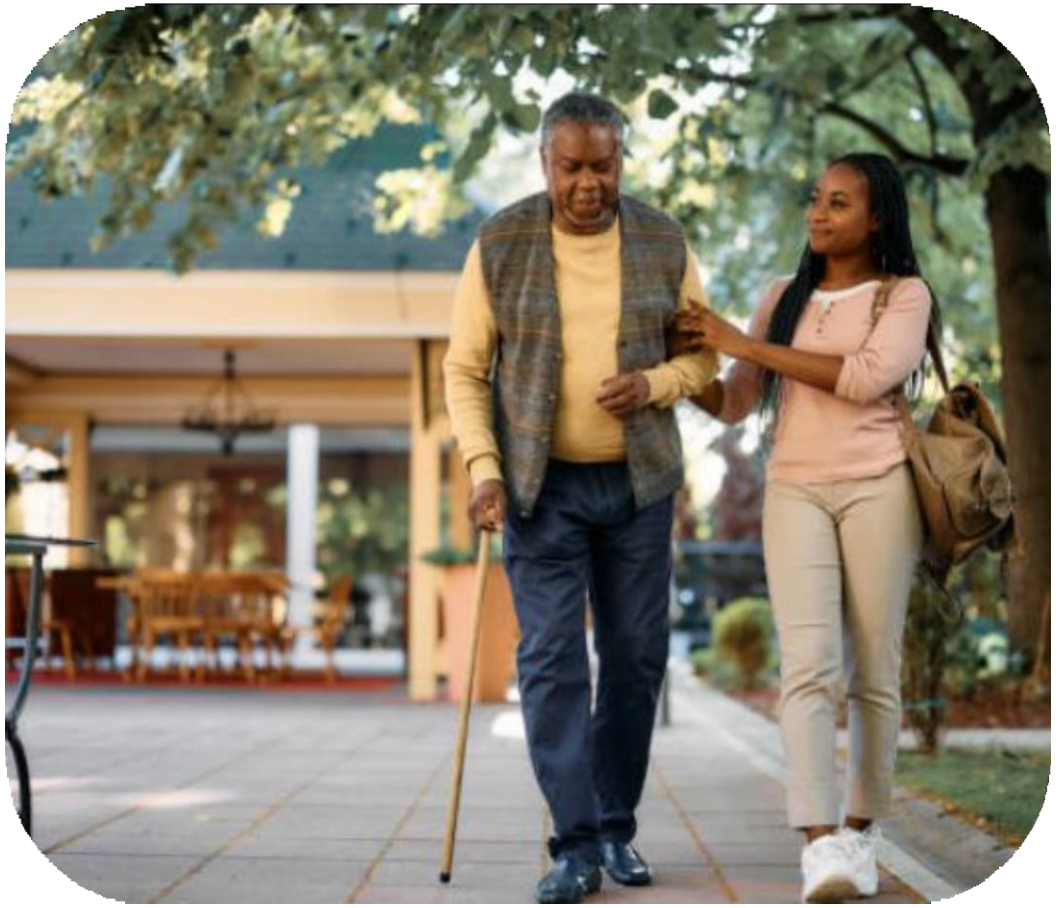
Support with **Change of Conditions** to reduce disruption

GUIDE is a VBC Lever for ACO Improvement

- **Dementia Complicates Care:** 40% of Medicare beneficiaries w/ dementia have 6+ chronic conditions. High complexity with unique care needs requires a specialized approach.

- **Cost Impact:** Average cost is 2.8x higher, Inpatient services is 2.7x higher, 30% greater risk of having a preventable hospitalization. As an ACO, GUIDE is a lever to offsets these costs.

- **Experience Matters:** 100% of our primary care providers and Navigators are Dementia Certified.



GUIDE - Early Lessons Learned

Lesson Learned
Hiring and onboarding care navigators has been more challenging compared to other care management roles
Encountered **more patient-level resistance** than expected.
Need more **proactive engagement** with to generate buy-in from residential care communities
Population churn, **5% of eligible population turns over every month**.
GUIDE Billing and systems integration (new software, restrictive billing codes, Medicare portals)

Bluestone's Core Values

Dedication

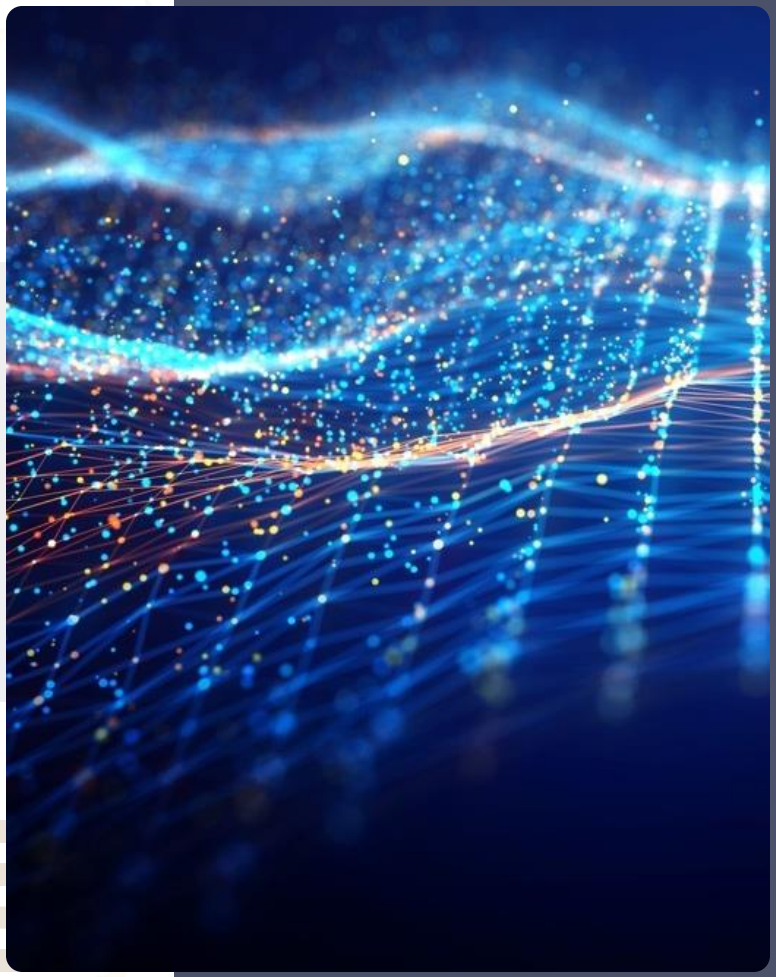
Excellence

Collaboration

Compassion

Our purpose is to achieve great outcomes as we focus on bringing exceptional care to patients living with complex chronic conditions.

FOLEY HOAG



October 2025

GUIDE Model: Policy and Beyond

National Association of ACOs

Edo Banach

GUIDE Model Parameters

- Prime participants must be Medicare providers. This includes technology companies, senior housing providers, and many other that had not previously enrolled in Medicare.
- GUIDE Participants may participate in multiple CMS Innovation Center models (ACO Reach) or Medicare value-based care initiatives (MSSP) to accelerate innovation in care delivery, reduce the cost of care, and improve population health.
- Participants may NOT be a hospice but may be a group affiliated with a hospice, and Medicare Advantage enrollees are not eligible to participate in GUIDE.

The GUIDE Model: Risks and Considerations

- Enrolling as any Medicare provider carries some risk of audit and recoupment. This includes compliance with the False Claims Act. Remember: ‘I didn’t know’ is not an excuse.
- Participants may undertake care coordination, respite and other elements themselves, or through partner organizations.
  - Risk-sharing with any partner can create incentives to provide better care (good) or more care (bad). Therefore, any partnership agreement must be structured so as not to implicate anti-kickback, physician self-referral (Stark) and similar statutes.

What is Being Tested? What does it mean for the future?

- Any CMS model must show savings (or cost-neutrality) and an improvement in quality. The first-year evaluation is expected soon.
- This model is not only about dementia. It's about a theory that non-medical supports and services, stacked on top of fee-for-service Medicare, result in lower overall costs and improved outcomes.
- Rather than a post-acute model, this is a toolkit that is can be used to prevent declines.
- Massive implications for the future of Medicare itself.

Edo Banach

Co-Chair
Health Care

Washington, D.C.

202.261.7316

ebanach@foleyhoag.com

- GUIDE Coalition Facilitator
- Former President and CEO, National Hospice and Palliative Care Organization
- Former Deputy Director, CMS Medicare-Medicaid Coordination Office
- Operating at the intersection of law, policy and politics