CHANGING THINKING!

Advisory 24-4

GUIDE Practitioners

BACKGROUND ON CLINICAL REQUIREMENTS

GUIDE Participants are required to operate Dementia Care Programs (DCPs) that provide *ongoing, longitudinal care and support to people living with dementia* through an interdisciplinary care team. GUIDE Participants are Medicare Part B–enrolled providers and suppliers which are eligible to bill for Medicare Physician Fee Schedule (PFS) services and agree to meet the care delivery requirements of the model. GUIDE Participants must have a detailed plan for implementing their dementia care program. GUIDE Participants must maintain an interdisciplinary care team to meet GUIDE's care delivery requirements. At a minimum, care teams must include the following:

- *Care navigator* who has received required training in dementia, assessment, and care planning.[1]
- *Clinician with dementia proficiency* as recognized by experience caring for adults with cognitive impairment; experience caring for patients 65 years or older; or specialty designation in neurology, psychiatry, geriatrics, geriatric psychiatry, behavioral neurology, or geriatric neurology.

CMMI notes that Practitioners *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.

Practitioners must be eligible to bill Medicare Part B evaluation and management services.

Although CMS has not explicitly stated this, we posit that having a patient panel of adults with intellectual disability, including Down syndrome, would qualify as "adults with any cognitive impairment."

[1] See: Changing Thinking! Project advisory #24-3 (Education/Training). August 2024.

GUIDE PRACTITIONERS

"GUIDE Practitioners" are defined as an individual who (i) is a Medicare-enrolled physician or other nonphysician practitioner identified by an individual NPI; (ii) bills under the TIN [Taxpayer Identification Number] of the Participant; (iii) is not precluded by CMS from participation in the Model; and (iv) is identified by the Participant on the GUIDE Practitioner Roster.

"GUIDE Practitioner Roster" is the list that identifies each GUIDE Practitioner that is approved by CMS for participation in the Model and which is updated from time to time.[2] "Proposed GUIDE Practitioner Roster" means the list that identifies each proposed GUIDE Practitioner and that is submitted by the Participant to CMS. Participants are responsible for identifying all GUIDE Practitioners on a GUIDE Practitioner Roster. GUIDE Practitioners identified on the GUIDE Practitioner Roster are limited to only those GUIDE Practitioners who received *prior* written approval by CMS.

GUIDE Participants are composed of the National Provider Identifiers (NPIs) of individual Medicare enrolled physicians and other nonphysician practitioners who have reassigned their billing rights to the GUIDE Participant's billing TIN. GUIDE Participants are required to maintain this list of physicians and nonphysician practitioners ("GUIDE Practitioner Roster") and keep it up to date throughout the course of the GUIDE Model, as it will be used to determine who is eligible to provide dementia attestations related to beneficiary alignment and bill for GUIDE Model payments. The GUIDE Practitioner Roster must include the name, TIN, and NPI for everyone who the Participant proposes to serve as a GUIDE Practitioner.

CMS reserves the right to review the Proposed GUIDE Practitioner Roster, conduct a Program Integrity Screening of all individuals listed on the Proposed GUIDE Practitioner Roster, and issue to the Participant a list of individuals that CMS has approved to be GUIDE Practitioners on the Participant's GUIDE Practitioner Roster. The Practitioners determine whether the Beneficiary remains in alignment with the GUIDE Participant. CMS has the authority to remove a GUIDE Beneficiary from the Participant's Beneficiary Alignment File effective on the first day of the first month after a GUIDE Practitioner attests in writing to CMS that the GUIDE Beneficiary no longer has mild, moderate, or severe dementia.

Participants may add clinicians to the GUIDE Practitioner Roster in a form and manner and by the date(s) specified by CMS. If Participants wish to add an individual(s) to their GUIDE Practitioner Roster, the Participant shall submit to CMS, in a form and manner specified by CMS, the name, TIN, and individual NPI of everyone whom the Participant wishes to add to its GUIDE Practitioner Roster. Subsequently, CMS will conduct a Program Integrity Screening of everyone identified by the Participant as a proposed GUIDE Practitioner and shall inform the Participant in writing whether the proposed GUIDE Practitioner has been added to the Participant's GUIDE Practitioner Roster following completion of the Program Integrity Screening.

Practitioners perform several functions within the Participants DCP. **One is to be the clinician who functions as part of the interdisciplinary treatment team.** The other is **the clinician who attests to the presence of dementia and the stage of dementia in the Beneficiar**y. GUIDE Practitioners are

[2] Guiding an Improved Dementia Experience (GUIDE) Model Participation Agreement.

responsible for submitting a Patient Assessment and Alignment form to CMS for the Eligible Beneficiary and billing HCPCS G-codes for the Eligible Beneficiary.

GUIDE Practitioners are responsible for having taken the following actions before furnishing services for which GUIDE Payments are made under the Participant Agreement:

1. Agree to accept assignment of all Medicare claims, as evidenced by the submission of a Medicare Participating Physician or Supplier Agreement (Form CMS-460) to CMS.

2. Reassign their right to receive Medicare payment under the Model to the Participant.

3. Agree to bill Medicare for services provided under the Model using the TIN of the Participant.

4. Agree to comply with the applicable terms of the Participant Agreement.

Practitioners play a role in validating alignment and eligibility of Beneficiaries, who must meet the following criteria, **that the Beneficiary has mild, moderate, or severe dementia**, as confirmed by the GUIDE Practitioner's attestation on a Patient Assessment and Alignment form and that:

- The Beneficiary meets the National Institute on Aging-Alzheimer's Association diagnostic guidelines for dementia based on the Beneficiary's Comprehensive Assessment.[3]
- The Beneficiary meets the DSM-5 diagnostic guidelines for major neurocognitive disorder based on the Beneficiary's Comprehensive Assessment[4,5,6]; or
- The GUIDE Practitioner has received and concurs with a written report of a documented dementia diagnosis for the Beneficiary from another Medicare-enrolled practitioner.

An updated version of the National Institute on Aging-Alzheimer's Association diagnostic guidelines for dementia was introduced in 2024 by the Alzheimer's Association[7] is based on defining a disease

[3] McKhann GM, Knopman DS, Chertkow H, Hyman BT, Jack CR Jr, Kawas CH, Klunk WE, Koroshetz WJ, Manly JJ, Mayeux R, Mohs RC, Morris JC, Rossor MN, Scheltens P, Carrillo MC, Thies B, Weintraub S, Phelps CH. 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. *Alzheimers Dement*. 2011 May;7(3):263-9. doi: 10.1016/j.jalz.2011.03.005. Epub 2011 Apr 21. PMID: 21514250; PMCID: PMC3312024.

[4] American Psychiatric Association . Diagnostic and Statistical Manual of Mental Disorders. ed 5. Arlington: American Psychiatric Publishing; 2013. https://www.psychiatryonline.org/dsm

[5] The American Psychiatric Association's 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; 2013) introduced the term "neurocognitive disorders" (NCDs) to replace the DSM-IV category "delirium, dementia, amnestic and other geriatric cognitive disorders." In the DSM-5 criteria for NCDs, impairment in any cognitive domain, including executive function, is sufficient for the diagnosis, and the memory domain is no longer the key factor. The DSM-5 criteria provide for a distinction between "mild" and "major" NCDs, with the first term being closely aligned with MCI. The DSM-5 notes that mild and major NCDs exist along a continuum, and that precise thresholds are difficult to determine, but they recommend evaluating an individual's performance with respect prior administrations of the same test.

[6] Such determinations are independent of the etiology of dementia, which could be attributed to Alzheimer's disease, or vascular, Lewy body, fronto-temporal forms, or either a mixture of etiologies or of idiopathic origin. See, for example, the work of Salvadori et al. and the VMCI-Tuscany Study Group (2018). Application of the DSM-5 criteria for major neurocognitive disorder to vascular MCI patients. *Dementia and Geriatric Cognitive Disorders Extra*, 8(1), 104–116. https://doi.org/10.1159/000487130

[7] Jack, C.R. Jr, Andrews, J.S., Beach, T.G., Buracchio, T., Dunn, B., Graf, A., Hansson, O., Ho, C., Jagust, W., McDade, E., Molinuevo, J.L., Okonkwo, O.C., Pani, L., Rafii, M.S., Scheltens, P., Siemers, E., Snyder, H.M., Sperling, R.,

biologically, rather than based on syndromic presentation, and uses a biomarker framework for determining the presence and staging of Alzheimer's disease based on the amyloid load. The new guidelines also recognize the intrinsic presence of potential Alzheimer's disease in adults with Down syndrome due to early build-up of amyloid using resulting in the expression of Down syndrome associated Alzheimer's disease (DS-AD) by the early 50s. The original 2011 guidelines cited as a basis for determining the presence of dementia were also specifically designed as 'criteria for all-cause dementia and for AD dementia.'

Practitioners can also deliver services via a Telehealth Benefit Enhancement. An "Eligible Telehealth Provider" is an individual who is a physician or non-physician practitioner listed at 42 CFR § 410.78(b)(2) who is a GUIDE Practitioner.

With respect to enhancing the skills of Navigators, it is probable that Practitioners will aid in orienting Navigators employed or contracted by the Participants in undertaking comprehensive assessments of beneficiaries and caregivers at initiation of contacts and in subsequent visits. Such consultations may include advising on noting secondary conditions as well as coincident neuroatypical or neurodivergent conditions (such as autism or intellectual disabilities), physical impairments and limitations, speech and comprehension communication skills, and 'behavioral and psychological symptoms of dementia'.

PRACTITIONERS AND DEMENTIA DETERMINATION

According to the GUIDE model, the approved initial measurement tools include two instrument that gauge dementia stage, the Clinical Dementia Rating (CDR)[8] and the Functional Assessment Screening Tool (FAST)[9], as well as one tool to report caregiver strain, the Zarit Burden Interview (ZBI).[10] For dementia staging (the CDR and the FAST) pick up on the capacities in cognitive functioning and activities of daily living (ADL) and/or instrumental activities of daily living (IADL). Both the CDR and FAST can apply to adults with mild to moderate intellectual disability (including Down syndrome), but in most case they may show significant impairment due to floor effects related to innate cognitive impairments (particularly among adults with severe or profound intellectual disability).

CMS notes that during the initial Comprehensive Assessment, the Participant must administer screening tools that measure dementia stage and caregiver burden by either:

> 1. Using the Zarit Burden Interview to measure caregiver burden and either the Clinical Dementia Rating (CDR) or the Functional Assessment Screening Tool (FAST) to measure dementia stage. CMS may, in its sole discretion, modify the approved screening tools and/or

Teunissen, C.E., & Carrillo, M.C. Revised criteria for diagnosis and staging of Alzheimer's disease: Alzheimer's Association Workgroup. *Alzheimers Dement*. 2024 Aug;20(8):5143-5169. doi: 10.1002/alz.13859. Epub 2024 Jun 27.

[8] Morris, J.C. Clinical Dementia Rating: A Reliable and Valid Diagnostic and Staging Measure for Dementia of the Alzheimer Type. *International Psychogeriatrics*. 10 January 2005.

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

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

the criteria for the corresponding assessment tool scores outlined in Appendix F, Table 1,[11] upon 30 Days written notice to the Participant.

2. Receiving advance approval from CMS to use an alternative screening tool(s) by submitting to CMS, in a form and manner specified by CMS, the proposed tool(s), published evidence that the tool(s) is valid and reliable, and a crosswalk for how the tool(s) corresponds to the Model's tiering thresholds outlined in Appendix F, Table 1.[12] After the Comprehensive Assessment, the Participant must submit the Patient Assessment and Alignment form and the individual responses from the Zarit Burden Interview, if applicable, to CMS in a form and manner specified by CMS. If the Participant submits to CMS an alternative screening tool, CMS will approve or reject the alternative screening tool(s) within 90 Days of CMS receiving the Participant's submission. The Participant may not submit scoring data on the Patient Assessment and Alignment Form for a proposed alternative screening tool(s) until the Participant receives written approval to use the alternative scoring tool from CMS.

After CMS receives the completed Patient Assessment and Alignment form from the Participant, it will analyze the data on the Patient Assessment and Alignment form to confirm whether the Beneficiary is an Eligible Beneficiary. If CMS determines that the Beneficiary meets the criteria to be an Eligible Beneficiary, CMS will complete the following steps within 15 business days of CMS receiving a Patient Assessment and Alignment form from the Participant (1) Align the Eligible Beneficiary to the Participant by adding the Eligible Beneficiary to the Participant's Beneficiary Alignment File, at which time the Eligible Beneficiary becomes a GUIDE Beneficiary; (2) Assign the GUIDE Beneficiary to one of five Model Tiers in accordance with the tiering criteria, and (3) Notify the Participant of the GUIDE Beneficiary's Model Tier assignment and their alignment to the Participant in a form and manner specified by CMS.

Beneficiaries must have dementia to be eligible for alignment to a GUIDE Participant but may be at any stage of dementia—mild, moderate, or severe (note that *mild cognitive impairment is not a dementia diagnosis* and is not sufficient to meet this eligibility criterion). To confirm that beneficiaries have dementia that makes them eligible for the GUIDE Model, CMS will rely on clinician attestation rather than prior claims-based ICD-10 dementia diagnosis.

To be eligible, a Practitioner on the GUIDE Participant's GUIDE Practitioner Roster must attest that, based on their comprehensive assessment, beneficiaries meet the National Institute on Aging Alzheimer's Association diagnostic guidelines for dementia and/or the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM5) diagnostic guidelines for major neurocognitive disorder. *Alternatively*, they may attest that they have received a written report of a documented dementia diagnosis from another Medicare enrolled practitioner. This attestation occurs at the time the Patient Assessment and Alignment Form is submitted to the CMS.gov Enterprise Portal (ePortal).

CAVEATS RE: PRACTITIONERS AND INTELLECTUAL DISABILITY

At issue is to what extent clinicians on the Practitioner Roster have the expertise and experience to assess whether an adult with an intellectual disability meets the criteria for dementia or major neurocognitive disorder. It has been noted that many instruments currently in use for assessing for the

[11] Guiding an Improved Dementia Experience (GUIDE) Model Participation Agreement
[12] Guiding an Improved Dementia Experience (GUIDE) Model Participation Agreement

presence of dementia may fail to be sensitive to discerning dementia among patients with intellectual disability and that often Practitioners may have to use accepted measures designed specifically for adults with intellectual disability.[13]

A challenge is to determine the extent of knowledge about neuroatypical adults among clinicians on the Practitioner Roster, as criteria for placement on the Roster does not include a requirement for this extent of knowledge. Whether this will be an impediment to ascertaining eligibility is a question currently absent an answer. One strategy, to determine whether this is a barrier, would be to survey Practitioners on the Roster and query their self-perceived experience and knowledge related to determining dementia among adults with intellectual disability and to what extent they use the various measures used with the public-at-large to make this determination – given the limitations of most general measures with adults with concurrent cognitive impairments. Reports have noted the limitations present in the CDR and its use with persons with pre-existing cognitive limitations and have recommended use of adapted versions.[14]

For dementia staging (the CDR and the FAST) pick up on the capacities in cognitive functioning and activities of daily living (ADL) and/or instrumental activities of daily living (IADL). Both the CDR and FAST can apply to adults with intellectual disability (including Down syndrome), but in most case they show significant impairment due to floor effects related to lifelong cognitive impairments. The use of these instruments will confirm deficits, but if GUIDE Participants are seeking precision with respect to dementia impairment and staging, tools more specialized for use with adults with intellectual disability would be more appropriate. An exception to this caveat would be the Zarit Burden Interview which has widespread application and has been used in the intellectual disability field to assess caregiver burden with reasonable reliability.

As a strategy, it will be functional to pair the recommendation to use of the GSA ID Companion[15] as an assessment resource and recommend use of the NTG-EDSD[16] for collecting relevant function and behavior information, as well as for use in formulating the dementia plan of care[17].

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[13] Janicki, M.P., Hendrix, J., & McCallion, P., (2022). Examining older adults with neuroatypical conditions for mci/dementia: barriers and recommendations of the neuroatypical conditions expert consultative panel. Alzheimer's & Dementia: Diagnosis, Assessment & Disease Monitoring, 14(1), e12335. Doi: 10.1002/dad2/12335.

[14] Lessov-Schlaggar, C. N., Del Rosario, O. L., Morris, J. C., Ances, B. M., Schlaggar, B. L., & Constantino, J. N. (2019). Adaptation of the Clinical Dementia Rating Scale for adults with Down syndrome. Journal of neurodevelopmental disorders, 11(1), 39. https://doi.org/10.1186/s11689-019-9300-2

[15] Gerontological Society of America. (2024). Addressing Brain Health in Adults with Intellectual Disabilities and Developmental Disabilities: A Companion to the KAER Toolkit for Primary Care Providers. GSA: Washington, DC USA. https://gsaenrich.geron.org/kaer-toolkit-for-brain-health

[16] National Task Group. (2013). NTG - Early Detection and Screen for Dementia (NTG-EDSD). https://www.the-ntg.org/ntg-edsd

[17] The GSA 'ID Companion's function is to (i) raise awareness of unique needs of adults living with intellectual disability; (ii) equip and encourage caregivers and health care teams to engage in appropriate brain health conversations with adults with intellectual disability; (iii) promote brain health conversations and early detection of changes in cognitive and adaptive function for adults with intellectual disability and aid with screening and diagnostic processes; and (iv) assist with the identification of community supports and resource networks aimed at enhancing function and quality of life for adults with dementia and intellectual disability.

As CMS has noted, additional tools may be added to the approved measurement tool set throughout the course of the GUIDE Model. While these are the only specified assessment tools that CMS requires for model tiering and quality measure development, participants may use other assessment tools necessary to meet the care delivery requirements and developing dementia care plans. As a critical mass of GUIDE Participants and partners evolve and broaden their beneficiaries, including eligibles with intellectual disability or Down syndrome, an agreed-upon set of measures tailored to this population could be adopted. Such standardization of equivalencies would contribute to agreement that the data set being used for the GUIDE program evaluation would reflect the inclusion of the assessment of services to families/caregivers of adults with intellectual disability.

A PLAN FOR ENGAGING PRACTITIONERS

Within the Changing Thinking! Project it is proposed to undertake several initiatives to enhance Practitioners skills and abilities to accurately attest to the presence of dementia and its staging among Beneficiaries with intellectual disability. This would involve:

1. Determining which clinicians are on the Practitioner Roster and via a simple survey determine to what extent they are aware of the nuances of diagnosing dementia and staging in adults with intellectual disability and can accurately attest from a Comprehensive Assessment to the presence of dementia in beneficiaries with intellectual disability.
2. Construct multi-media education programs for Practitioners to enhance knowledge of diagnosing dementia in adults with intellectual disability.
3. Organize a contract with a CEU provider to provide certification credits for Practitioners taking education program in diagnosis and staging of dementia and intellectual disability.
4. Offer webinars for Practitioners for broadening general knowledge on diagnosing dementia in adults with intellectual disabilities, as well as the use of pharmacological interventions.
5. Introduce Practitioners to the “Addressing Brain Health in Adults with Intellectual Disabilities and Developmental Disabilities: A Companion to the KAER Toolkit for Primary Care Providers.”
6. Construct a continuing education program for Practitioners to update skills in the diagnosis of dementia among adults with intellectual disability.

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