Texas Association for Home Care & Hospice
Leading ★ Advancing ★ Advocating

57th Annual Meeting

Thursday, September 3, 2026

Crockett AB Room

11:15am-12:15pm

4c. GUIDE Model: Results from Claims Analysis and Translating the Model to Medicare Advantage

Presented by:

Julius Bruch, CEO and Co-Founder of Isaac Health

Thank you to our Partners:

Vesta®

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MAC LEGACY

KanTime
How better happens.

United Healthcare Community Plan

AXXESS

Isaac Health

GUIDE Model: Results from Claims Analysis and Translating the Model to Medicare Advantage

TAHC&H 57th Annual Meeting
Thursday, August September 3rd

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Introduction

Julius Bruch, MD, PhD
Founder & Chief Executive Officer of Isaac Health

- ✓ CEO of Isaac Health, a specialty provider for medical dementia and brain health services across all 50 states
- ✓ PhD in the molecular mechanisms of neurodegenerative diseases
- ✓ Trained as a medical doctor in neurology
- ✓ Previously served as a consultant in McKinsey's healthcare practice, leading initiatives in value-based care and digital health

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What we'll cover today

- The need for specialized dementia care
- Introduction to the CMS GUIDE model
- Model outcomes from claims analysis
- How home care and community organizations can partner with GUIDE entities
- How similar services can work for Medicare Advantage partners

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The need for specialized dementia care

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Why we need to act on dementia care now

30-36%

of home care recipients

have diagnosed or suspected dementia[1]

12%

Of 65+ population

have diagnosed or suspected dementia[2]

Major access challenges:

- Waiting times to see a dementia specialist average 18 months nationwide[3]
- 12 behavioral neurologists in Texas
- 40% of the U.S. is a "dementia neurology desert" (<10 neurologists available for every 10,000 people with dementia)[4]

Major underdiagnosis:

- Only 40 % of dementia cases are medically diagnosed
- Only a minor fraction is receiving specialist management

New partnership opportunity:

- New CMMI model offers dementia care and caregiver support fully covered by Medicare – not Medicaid
- New model helps delay nursing home placement by supporting individuals and their family caregiver to age in place

1: https://pmc.ncbi.nlm.nih.gov/articles/PMC12353668/ 2: Alzheimer's Disease Facts and Figures Report, 2026.
3: RAND, "The Future of Alzheimer's Care in America." https://www.rand.org/pubs/tools/TLA2643-1/tool.html. 4: Anitha Rao and Robert Eaton, "Dementia Neurology Deserts and Long-Term Care Insurance Claims Experience in the United States," published by Society of Actuaries May 2021.

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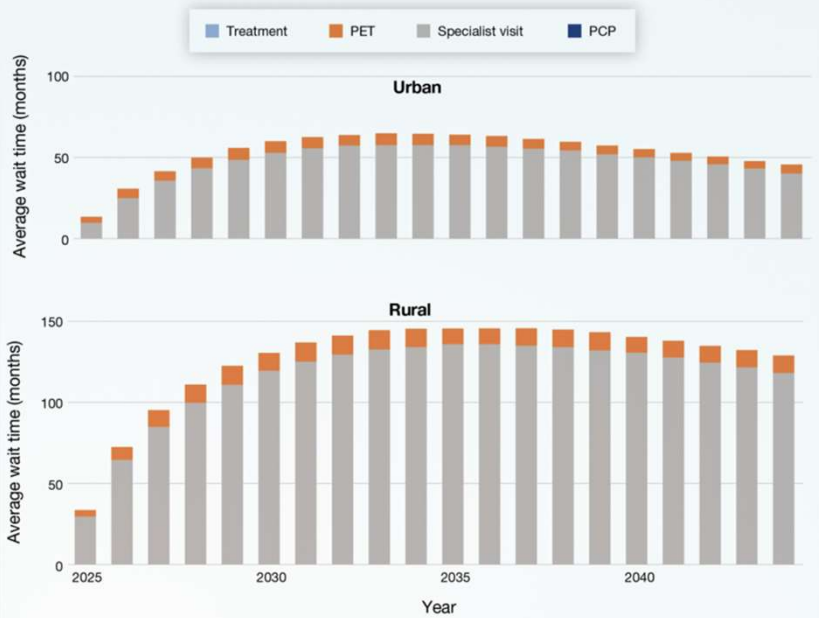
Rural areas face higher wait times for dementia care



Reprinted from RAND, "The Future of Alzheimer's Care in America." https://www.rand.org/pubs/tools/TLA2643-1/tool.html

Notes

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Comprehensive center of excellence care for dementia

Screening

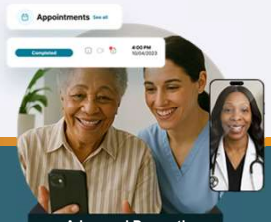
- AI-driven detection of population at-risk (>90% accuracy)
- Targeted outreach and identification

Diagnosis

- Comprehensive assessment & specialist medical consultation
- Neuropsychologist testing and lab imaging when needed

Treatment

- Comprehensive care plan, including non-drug therapies (e.g., cognitive therapy) and medication treatments
- Follow-ups with team of neurologists, geriatricians, psychiatrists, & therapists



Advanced Dementia Management

- Care navigation and 24/7 support line
- In-home facilitation of telehealth visits
- Compensatory skill training to maximize independence
- Caregiver education and psychosocial support (e.g., support groups)

\+ Clear communication with PCPs, other providers, and care managers throughout the care journey.

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A seamless, well-coordinated journey

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The CMS GUIDE Model

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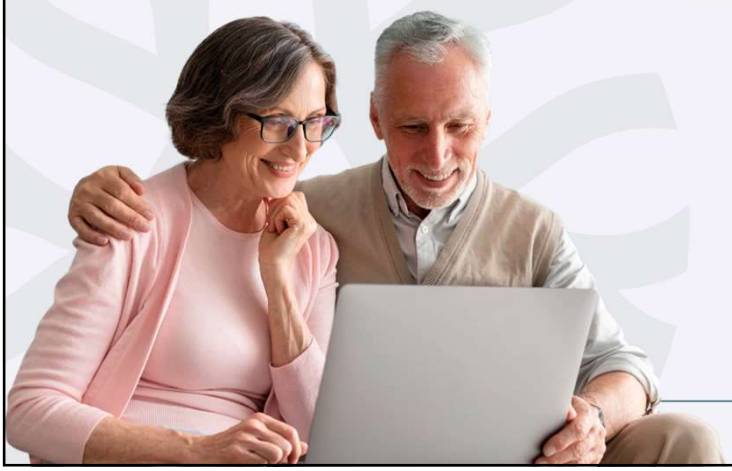
What is the CMS GUIDE Model?



- New 8-year payment model released by CMS and launched in July 2024
- Covers specialist dementia care management, caregiver support, and respite care for traditional Medicare members
- Isaac Health was selected by CMS as a GUIDE model provider

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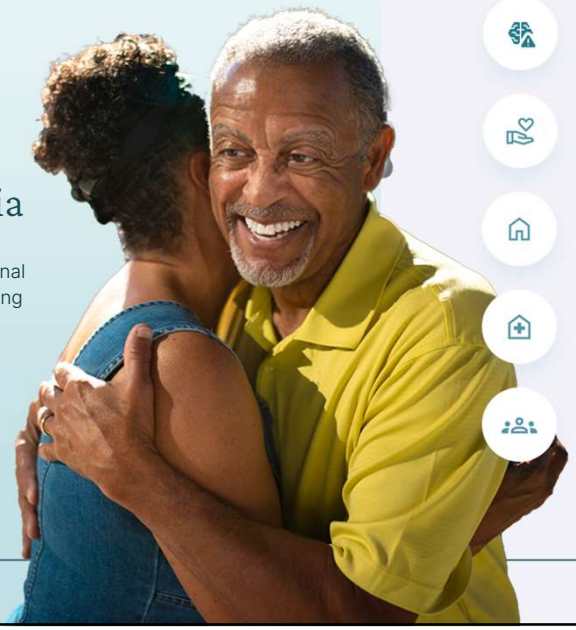
GUIDE
eligibility criteria

GUIDE is a program for traditional Medicare beneficiaries, including dually eligible beneficiaries.



- Dementia diagnosis
- Enrolled in Medicare Parts A and B
- Not residing in a long-term nursing home
- Not in a hospice
- Not enrolled in PACE

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GUIDE provides vital support to patients and family caregivers

Comprehensive Assessment
- Identify needs and review medications
- Home safety visit

Personalized care planning
- Address goals, preferences, and needs of the member

Medication management
- Medication reconciliation and management

Care Navigator

Patient & caregiver

Caregiver support
- Caregiver training and support (individual and group sessions)
- Resource library

Respite care
- Relieve the burden of caregiving duties

24/7 Access
- 24/7 support line
- Community resources

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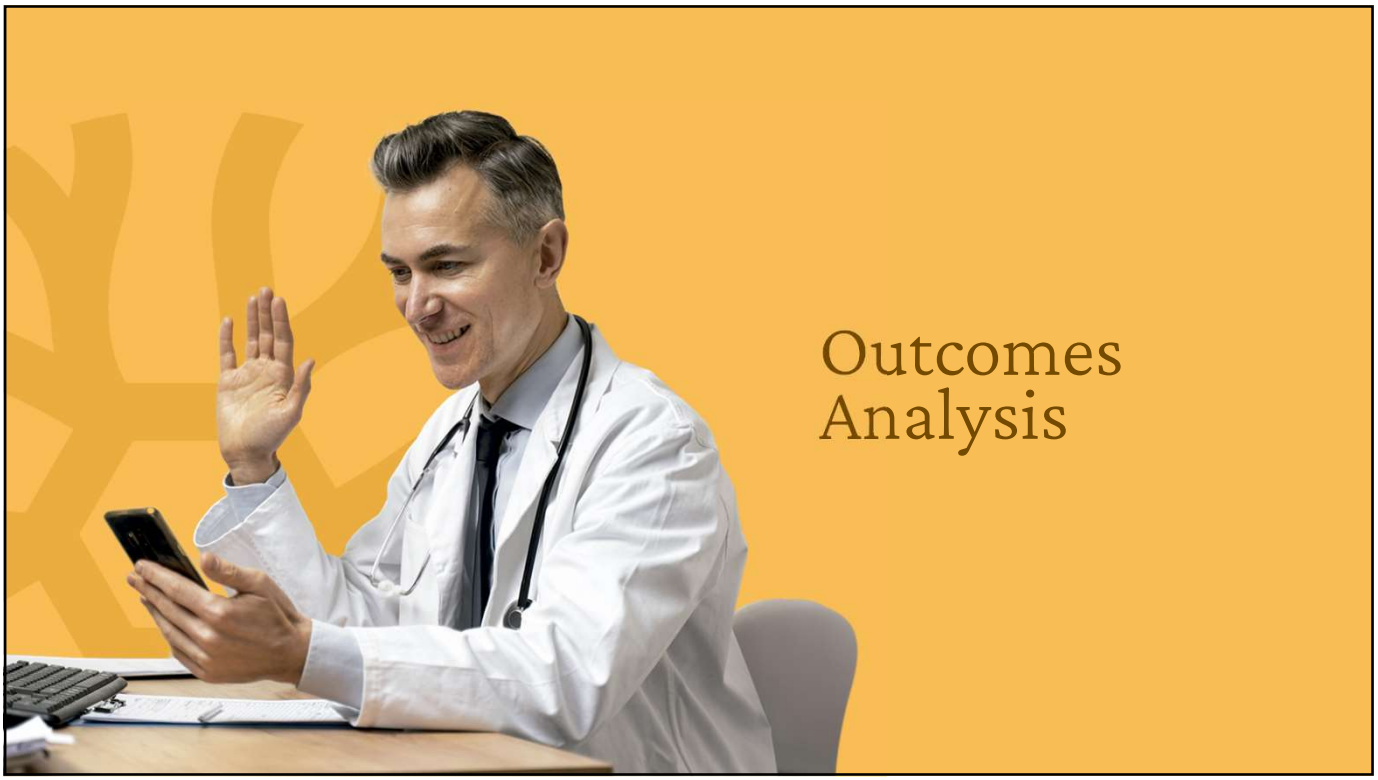

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Our CMS reported outcomes show reductions in total cost of care & nursing home utilization

Matched case-control study of Isaac's proprietary care model (2023)

- **28%** reduction in inpatient days
- **38%** reduction in ED visits
- **20%** Reduction in total cost of care*

Financial outcomes independently validated by the Validation Institute.

Our GUIDE Model program outcomes (2024-2025)

- Total cost of care **20 percentage** points lower than actuarial expectations
- Admissions to long-term nursing homes limited to **15% of the expected rate**

Early performance results verified by CMS. Data published in February 2026.

* Insufficiently powered

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Clinical Outcomes Analysis Setup

We have conducted an internal study of our clinical outcomes data, comparing initial assessment results vs. annual reassessment results across 9 measures

ENROLLMENT

3,798 Members enrolled since program launch

1,404 completed annual reassessment — the analysis cohort

Enrollment is ongoing — the cohort grows as members reach the 12-month mark.

WHAT WE MEASURE

Nine measures at initial and repeat assessment

Cognition & Function	CDR · Katz ADL · FAQ	3 measures
Mood & Caregiver	PHQ-9 · GAD-7 · ZBI-4	3 measures
Safety & Utilization	Falls · ER visits · Hospital admissions	3 measures

Why measure counts differ by patient

- Functional measures (Katz ADL, FAQ) — assessed only when a functional concern is present.
- Caregiver measure (ZBI) — assessed only when a family caregiver is available and consents.

Source: Isaac Health data. Analysis cohort = members with a completed annual reassessment as of August 2026.

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Clinical Outcomes at One Year

Across cognition, function, mood, and caregiver strain, the Isaac Health cohort held stable or improved — where dementia's natural course predicts worsening.

1,404 Patients in cohort
9 measures

Cognition & Function

CDR (global)	▲ 0.1	0.9 → 1.0 · N=1,404 · Expected trajectory
Katz ADL	▼ 0.3	4.9 → 4.6 · N=140 · Less decline than expected
FAQ	▼ 0.5	5.5 → 5.0 · N=142 · Significant improvement in function

Mood & Caregiver

PHQ-9	▼ 0.2	5.2 → 5.0 · N=99 · Depression improved (ns)
GAD-7	▼ 0.4	3.8 → 3.4 · N=66 · Anxiety improved (ns)
ZBI, % with burden	▼ 24pp	65% → 41% · N=523 · Reduced burden (ns)

Safety & Utilization

Falls (12 mo)	▼ 0.4	4.0 → 3.6 · N=22 · Fewer falls (ns)
ER visits (12 mo)	▼ 0.4	1.8 → 1.4 · Slight decrease
Hosp. adm. (12 mo)	▼ 50%	-0.27, statistically significant reduction of 50% differences in differences

Not every measure is significant yet — but the pattern is: stable or improving where decline is expected.

● Favorable / better than expected ● Expected change or low volume

Initial vs. latest follow-up; change compared with published natural-history benchmarks.
Source: Isaac Health / Molina outcomes analysis.

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Deep-Dive: Care Partner Burden

Behind the 24-point drop in care partner burden: strain shifted down the severity scale, while patients' care needs held steady — the same load, carried with more support.

ZBI SEVERITY DISTRIBUTION · N=523 CARE PARTNERS

PATIENT NEEDS HELD STEADY

No recent fall
73% → 76%
Members reporting no fall held steady

No self-reported ER need
80% → 82%
Slight improvement at follow-up

Requiring 24-hour care
13% → 13%
Care intensity unchanged — burden fell anyway

Moderate-to-severe or worse burden: 36% → 17% — cut by more than half.

Source: Isaac Health / Molina outcomes analysis. ZBI-4 distribution, initial vs. annual reassessment; percentages approximate.

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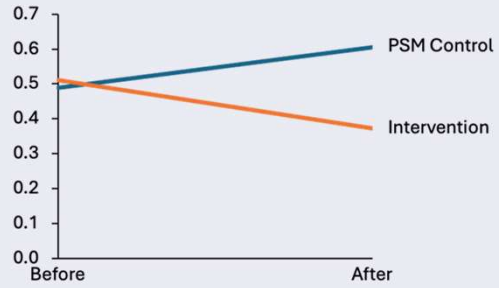
Deep-Dive: Hospital Utilization

Inpatient admissions over 6 month period before and after enrollment for intervention and propensity score–matched (PSM) control groups*



Effect of Enrollment on Hospital Utilization (6-month window)

Outcome	Post-index window	Effect estimate (β)	p-value
Hospital utilization (admissions)	6 months	-0.27 (50% reduction)	<0.05

Enrollment in the program was associated with a reduction in hospital utilization over the 6-month post-index period compared with matched controls, corresponding to an absolute reduction in admissions.

*Values represent the mean number of inpatient admissions per patient in the 6-month periods before and after the index date. The intervention group demonstrates a decline in admissions over time, whereas admissions increased in the matched control group, consistent with the difference-in-differences estimate. Statistical significance defined as two-sided p<0.05.

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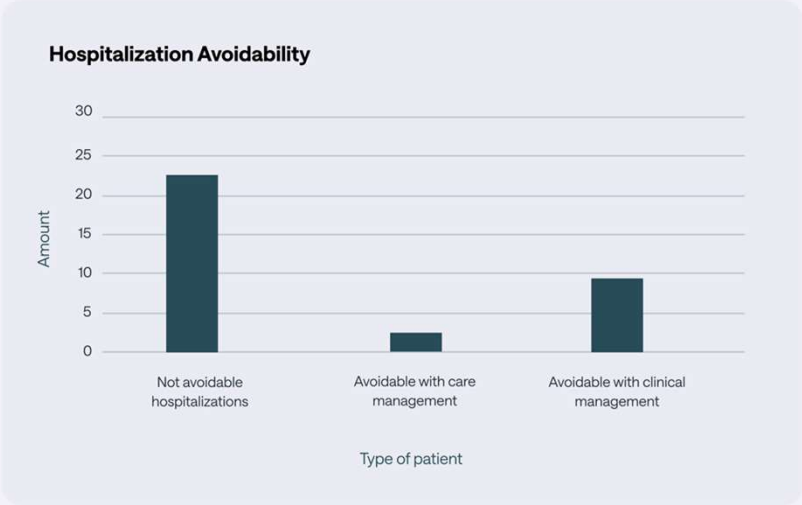
Deep-Dive: Hospital Utilization - Most admissions that occurred were unavoidable



Complete records and sufficient clinical detail were available for 44 admissions across 36 unique individuals. Admissions were categorized and summarized using descriptive statistics.

Note: Data includes one overlapping patient – non avoidable and avoiable with clinical care.

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Deep-Dive: Hospital Utilization - Proactive clinical intervention can potentially further reduce avoidable hospitalizations

- ✓Among admissions classified as potentially avoidable (13/37, 35%), the majority (10/13, 77%)were judged to be preventable through **proactive clinical intervention**: improved management of falls in the setting of polypharmacy (4/10, 40%), better control of common ambulatory medical issues like diabetes (3/10, 30%), and stronger preventive management of stroke risk (2/10, 20%) and neuropsychiatric symptoms (1/10, 10%).
- ✓A smaller but still meaningful share (3/13, 23%) appeared potentially preventable through enhanced care navigation and caregiver support, specifically respite needs and therapy coordination.
- ✓These findings suggest that the program's impact likely arise not from a single intervention, but from a specialist-led model that systematically identifies and mitigates multiple pathways to hospitalization.

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How to Partner

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How Home Care and Community Organizations Can Partner with GUIDE Entities

Community Organization

- ✓Refers patients with known cognitive concerns
- ✓Can provide data for screening of members with likely undiagnosed dementia

Patient referrals →

← **Payment for services**

GUIDE Participant

- ✓Bills CMS directly (includingfor respite care)
- ✓Can integrate and pay for any covered services (e.g., caregiver support or respite)
- ✓Can reach out to members directly or act only on referral

Get fully implemented in **<8 weeks**, with minimal work on your end.

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Types of partnerships for GUIDE

Example partnership archetypes

❄ Provided by GUIDE Entity ◯ Provided by Partner

GUIDE Components	Referrals only	Caregiver support only	Care navigation and caregiver support	Complete model except medical
Comprehensive assessment	❄	❄	❄	❄
Care planning	❄	❄	❄	❄
24/7 access	❄	❄	❄	◯
Ongoing monitoring and support	❄	❄	◯	◯
Care coordination	❄	❄	◯	◯
Referral coordination	❄	❄	◯	◯
Medication management	❄	❄	❄	❄
Caregiver education and support*	❄	◯	◯	◯
Respite care*	❄	◯	◯	◯

* May be provided by partner organizations (e.g., Trualta, TCARE, Caregiving.com etc.)

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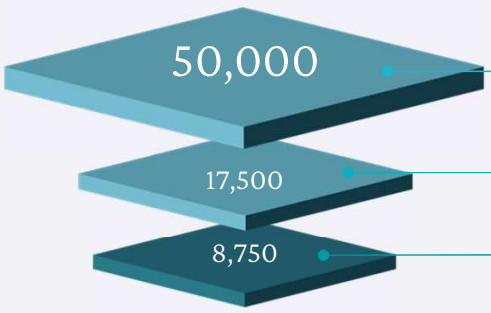
Example financial impact for Respite and Caregiver Support

Assuming population of 50,000 dually eligible lives



- 50,000 — Estimated members enrolled in LTSS plan
- 17,500 — Members with Dementia (~35%)
- 8,750 — Members eligible for GUIDE Model (50%)*

Revenue PMPY** x $2,600

PMPY paid by Isaac to Partner

Respite	***$2,500***
Caregiver Support	***>$100***

(supports 100% Community Health Worker Model)

* Based on estimate of proportion of members eligible for GUIDE. Most significant eligibility criterion is Medicare Parts A and B coverage
** Assumes average complexity - please see attached SOW Exhibit D for detailed breakdown by dementia complexity; respite is paid at CMS rates up to a cap of $2,500 PMPY

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Benefits of partnering for GUIDE

No cost to your organization

- ✓The cost of the GUIDE program is covered by CMS

Revenue opportunity

- ✓Get paid for respite care, caregiver support, or care navigation

Better care

- ✓Offer a well-coordinated experience for patients, families, and caregivers
- ✓Provide improved access to specialist medical care

* Thus far, we only have Medicare Advantage outcome data for our model; however, the MIND at Home and ADC are comparable, such that we expect similar outcomes for LTC costs.

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Adapting the CMS GUIDE model to Medicare Advantage

Broad service coverage

Most CMS GUIDE services can be delivered to Medicare Advantage members — respite care is the exception.

Broad MA membership

Isaac Health already holds broad Medicare Advantage membership across its markets and can make these available to its partner organizations.

Comparable economics

Reimbursement is on par with or slightly below GUIDE rates, and is often time-based.

Code families that can cover community-partner services

Chronic Care Management **(CCM)**	Principal Care Management **(PCM)**
Principal Illness Navigation **(PIN)**	Community Health Integration **(CHI)**
Caregiver Training Services **(CTS)**	Behavior Management Caregiver Training
Transitional Care Management **(TCM)**	Care Plan Oversight **(CPO)**

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Q & A

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Isaac Health

Let's discuss

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