GUIDE Model Application Support Office Hour Session

January 11, 2024

>>Cat Fullerton, Deloitte: Good afternoon, everyone, and thank you for joining today's GUIDE Model Application Support Office Hours session. There are a few housekeeping items to discuss before we get started. During today's presentation all participants will be in listen only mode. Please feel free to submit any questions you have throughout today's presentation in the Q&A pod displayed on the right side of the meeting room window. Given time constraints, we may not get to every question, but we will collect questions for future events, and FAQs. You can also reach out to our help desk at GUIDEmodelteam@CMS.hhs.gov. We would also like you to know that today's presentation is being recorded. If you have any objections, please hang up at this time.

This slide deck, a recording of today's presentation and a transcript will be made available on the GUIDE Model website in the coming days. Next slide, please.

Before we dive into the content. Let me give a brief overview of the agenda, for today's event. We will begin with a welcome from Tonya Saffer, the Director of the Division of Healthcare Payment Models will provide an introduction to today's speakers. Then the model team will review some background information about the GUIDE Model. We will then dive into the bulk of today's presentation and share an overview of the GUIDE Model readiness. And following that, we will share more information about the application process and timeline. We will then move into our Q&A session where our team will answer questions submitted by the audience members as well as address previous, frequently asked questions. As a reminder, you can submit questions using the Q&A function at the bottom right-hand corner of your screen. Again, thank you for joining us today. We've got a great presentation plan for you.

Now I'm going to pass the mic to Tonya Saffer to formally welcome you to today's event. Next slide, please.

>>Tonya Saffer, CMS: Good afternoon, everyone, and welcome. I'm assuming, if you're here with us today, that it's because you are planning your application for the GUIDE Model, and that this isn't your first webinar with us. However, in case you're seeing us for the first time, I want to do introduce myself. I am Tonya Saffer, the Director of the Division of Healthcare Payment Models, which is the CMMI Division leading, or the CMS Innovation Center Division leading the GUIDE Model. I want to thank all of you again for your interest and commitment to improving the quality of care for people living with dementia, and for embarking on this journey with us, to test whether an alternative payment model that covers a comprehensive package of care coordination and care management, caregiver education and support and respite services will improve the quality of life for people living with dementia, reduce caregiver strain, and help people living with dementia remain in their homes and communities. If we achieve the goal set in this model which align with our requirements to reduce spending and improve quality, we will achieve success and be able to pay for this care long into the future.

The purpose of today's webinar is to help you understand how to ha submit a high quality, complete application to GUIDE.

And on that point I also want to be transparent and correct. Something we had said in our last webinar during the last webinar we had stated we would release a rubric to help applicants, and after further consideration, we decided against that as we didn't believe that it was, it would add much value to the to the conversation or to the application. There are a number of places within the application where we're very specific on what we're looking for, and so we decided not to release a separate rubric. So I just wanted to disclose that if you're waiting for some other document to come out, it won't be there, and we encourage you to go ahead and submit your application. And today's webinar will hopefully help you understand what needs to be in that application to ensure high quality and completeness. Next slide, please.

With that I wanted to introduce you to who you were. We'll hear from today, from the GUIDE Model team. We have Melissa Trible, the GUIDE Model Co-Lead; Serena Ho GUIDE Quality, Health Equity and Stakeholder Engagement Lead; and Kaleigh Ligus, GUIDE Application and Care Delivery Lead.

Next slide, please.

We are grateful for all of you joining us today, and for your interest in improving the quality of care and support for people living with dementia and their caregivers. And no, no GUIDE webinar would be complete without a poll to engage you in all of today's conversation. We are using a platform, as we have in the past that will allow you to participate in poll questions and to share your feedback, thoughts and insights using your phone or computer browser. Your responses will be anonymous, and we will have you go ahead and join the Poll Everywhere now. It looks like many of you have already started and have clicked the link that appears in the chat. I'm going to give everybody a minute to go ahead and complete that poll.

Alright, I think the dots are starting to slow. It's great to see where everybody is coming from today. If you have friends, colleagues in some of the states that are not showing on this poll, we'd love for you to reach out to them and encourage them to apply to the GUIDE Model. Alright. Next slide, please.

Great. Thank you so much for participating, and I will go ahead and pass it over to Melissa Trible who will dive into today's content. Melissa.

>>Melissa Trible, CMS: Awesome. Thanks so much, Tonya. Hello, everyone! My name is Melissa Trible. I'm the GUIDE Model co-lead, and I'm really excited that you've chosen to join us for today's event.

During this section of the webinar I will walk us through a bit of background information related to the GUIDE Model as well as participation requirements. Next slide, please.

Dementia is a major public health issue and is increasingly affecting the American population. Many people with dementia are not consistently receiving high quality, high value care. Some of the issues include a lack of caregiver training and recognition, unestablished healthcare pathways, limited coverage of key support services and lack of sustainable payment for comprehensive care. The GUIDE Model aims to address the existing gaps within our nation's current dementia landscape by defining a standardized dementia care delivery program providing an alternative payment methodology, addressing caregiver needs and paying for GUIDE respite services. Ultimately the GUIDE model will test if a comprehensive package of collaborative care, caregiver, support and education and respite services will improve quality of life for people with dementia and their caregivers while delaying avoidable long-

term nursing home facility placement, and enabling more beneficiaries to remain at home through the end of life. Beneficiaries in GUIDE will receive care from an interdisciplinary team that will identify the beneficiary's primary care provider and specialists and outline the care coordination services needed to manage the beneficiaries, dementia and co-occurring conditions. Through virtual or in person services, GUIDE participants are required to provide a Caregiver Support Program which will be based on the caregiver assessment and be responsive to the ongoing caregivers needs. The GUIDE model will also provide payment for a defined amount of respite for certain eligible beneficiaries in the model which will allow caregivers to take a temporary break from their caregiving responsibilities and attend to their own health and well-being needs. Next slide, please.

GUIDE is an 8-year voluntary model offered in all states, D.C. and U.S. territories. The model performance period will begin on July 1st, 2024, and end on June 30, 2032.

The GUIDE Model will have 2 participant tracks, one for established dementia care programs and one for new dementia care programs. We will talk more about track selection for model participants later in today's presentation. The application period for both participant tracks opened on November 15,2023, and will close January 30th, 2024. The first performance year for the established program track will begin on July 1st, 2024. The new program track will have a one year pre-implementation period that begins on July 1st, 2024, and its first performance year will begin on July 1st, 2025. Next slide please.

To be eligible as an Established Program Track participant the organization must already provide comprehensive dementia care and be ready to immediately implement GUIDEs care delivery requirements. Participants must also meet 6 out of 9 of the clinical dementia requirements of the care delivery requirements for 12 months prior to submitting the application. For the New Program Track, GUIDE will recruit and support model participation for organizations that do not currently offer comprehensive dementia care or have prior experience with alternative payment models. Through this the GUIDE Model allow aims to improve access to comprehensive dementia care nationally.

Applicants to the New Program Track do not have to meet the Model, care delivery requirements at time of application, but must submit a plan for implementing a dementia care program that includes strategies for staffing, development of program protocols and workflows, training, and development of a referral network as well as identifying a program director who has primary accountability for implementing their dementia care program. Next slide, please.

GUIDE participants must meet the following requirements, among others specified in the participation agreement throughout their performance period of their assigned track. To be eligible, participants must be Medicare Part B enrolled providers, providers, or suppliers. The established dementia care program must be able to provide ongoing longitudinal care to people with dementia. In addition, participants must meet the care delivery requirements described in the Care Delivery section of the RFA. Participants may choose to partner with other organizations, whether they be Medicare enrolled providers and suppliers or non-Medicare enrolled entities such as community based organizations to meet these requirements. GUIDE Participants have the flexibility to provide most model services virtually or in person, in office, or in the beneficiary's home, but must conduct an initial home visit in person for line beneficiaries who have moderate to severe dementia. Participants are also required to make available for eligible beneficiaries, GUIDE Respite Services in the beneficiary's home. The GUIDE Participant has the option, but it's not required, to offer eligible beneficiaries, GUIDE Respite Services at an adult day center or at a facility that can provide 24 hour care. More details regarding GUIDE Respite Services can be found in the Respite Payment section of the RFA. The Participant must maintain an up-

to-date GUIDE Practitioner Roster and Partner Organization Roster if applicable. Lastly, the participant must also comply with all Model reporting requirements, such as care delivery, sociodemographic data and quality reporting. Next slide, please.

We have received a few questions regarding Taxpayer Identification Numbers, TINs, and National Provider Identifiers, NPIs. GUIDE Participants will be identified by a single TIN that is used to bill for GUIDE services, plus the NPIs of individual Medicare enrolled physicians and other non-physician practitioners who have reassigned their billing rights to the GUIDE Participant billing TIN.

On screen here we have provided examples of dementia care programs and highlighted the participant intended use. The first example on the left shows a multi-specialty practice where model services are billed under the practices TIN. The second example below shows a Part B enrolled primary care practice as the GUIDE Participant, and model services are billed under the primary care practices TIN. In the third example in the upper right shows how the GUIDE participant bill all model services. In this case the geriatric practices TIN, and all practitioners must reassign their billing rights to this TIN. The last example in the bottom right shows a Part B enrolled practice, which is the GUIDE Participant. So both the practice and home health agencies, model services are billed under the practices TIN. Next slide, please.

GUIDE Model Participants may contract with other Medicare providers and suppliers also known as Partner Organizations. This slide provides an example of a dementia care program with provider arrangements. In the example here the Dementia Care Program, or DCP, is established by the geriatric practice, which is the Model Participant. The geriatrics practice partners with an occupational therapy practice and a home health agency to meet the care delivery requirements of the GUIDE Model. The occupational therapy practice and the home health agency are considered Partner Organizations within the DCP. The GUIDE Participant bills all model services in this case under the geriatric practices TIN and all practitioners must reassign their billing rights to this TIN. All Participants will be expected to maintain an up-to-date list of all their Partner Organizations throughout the course of the model.

To learn more information about partner organizations we invite you all to access the GUIDE Strength in Partnership Fact Sheet which is available on the model webpage and linked here in the comments below. Next slide, please

The primary beneficiary population through the GUIDE Model are community dwelling Medicare Fee for Service beneficiaries, including beneficiaries duly eligible for Medicare and Medicaid, who often experience fragmented, uncoordinated care. The eligibility requirements for beneficiaries are outlined on the left side of this slide. The GUIDE Model beneficiaries must have dementia as confirmed by attestation from a clinician practicing within a GUIDE Dementia Care Program. Beneficiaries must be enrolled in Medicare Parts A and B as their primary payer, and not in Medicare Advantage, including special needs plans. They must also not be enrolled in the Medicare Hospice benefit or PACE program as the services overlap with those provided under GUIDE. The GUIDE Model will use a voluntary alignment process for aligning beneficiaries to Model Participants. This means that participants must inform beneficiaries about the Model and the services that they can receive through the Model and document that a beneficiary or their legal representative, if applicable, consents to receiving services from the participant. Participants will submit documentation to CMS, and CMS will confirm that the beneficiary meets the Model eligibility requirements before aligning them to the Participant. Even after a beneficiary has opted in and been aligned, co-model participant beneficiaries will maintain complete freedom of choice in where they seek care. CMS will employ several outreach strategies to supplement

GUIDE Participants beneficiary recruitment activities. For example, following a request by the GUIDE Participant, CMS will use claims data from a 3-year historical look back period to identify beneficiaries who receive Medicare services from a GUIDE Participant have claims-based ICD-10 dementia diagnosis codes and are eligible for the GUIDE Model. Using these criteria CMS will offer GUIDE participants a one-time opportunity to request prior to the GUIDE Participants first performance year a list of eligible Medicare Fee for Service beneficiaries with dementia diagnosis codes. This list would include beneficiaries to whom the GUIDE Participants provided services during the 3 year historical look back period, but who are not currently aligned to the GUIDE Participant. CMS will also send targeted outreach letters to eligible beneficiaries, informing them about the GUIDE Model, and how to voluntarily align.

I will now pass to my colleague, Serena Ho, who will cover participant readiness. Next slide, please.

>>Sarena Ho, CMS: Thanks, Melissa. Hi, everyone. My name is Sarena Ho and I am the GUIDE Quality, Health Equity, and Stakeholder Engagement Lead, and I'm excited to be here with you all today. I will now dive into participant readiness. Next slide, please.

An applicant that is accepted to participate in the GUIDE Model will become a GUIDE Participant upon execution of a Participation Agreement with CMS. The Participation Agreement will set forth the terms of the GUIDE Model, and each party's obligations under the GUIDE Model. Participants must meet the following requirements, among others, specified in the Participation Agreement throughout the performance period of their assigned track. They must meet the interdisciplinary care team, care delivery and training requirements as described in Appendix B in the RFA, use an electronic health record platform that meets CMS and Office of the National Coordinator for Health Information Technology standards for Certified Electronic Health Record Technology. The Participant has the flexibility to provide most model services virtually or in person. So in the office or in the beneficiary's home, but they must conduct an initial home visit in person for aligned beneficiaries who have moderate to severe dementia. The Participant is required to make available for eligible beneficiaries, GUIDE Respite Services in the beneficiary's home and the Model Participant has the option, but is not required to offer eligible beneficiaries, GUIDE Respite Services at an adult day center or facility that can provide 24 hour care. More details regarding GUIDE Respite Services can be found in the Respite Payment section of the RFA. Next, Participants will maintain an up-to-date GUIDE Practitioner Roster, and Partner Organization Roster. And, lastly, Participants must comply with all Model reporting requirements, including the care delivery, sociodemographic and quality reporting data requirements. Next slide, please.

CMS will allow organizations identified at the TIN level to participate in both the GUIDE Model and all other current Innovation Center models for which they meet the eligibility criteria as well as the Medicare Shared Savings Program. CMS will allow participant overlap at the TIN and NPI level with the ACO Reach Model, the Shared Savings Program and the 3 Comprehensive Kidney Care Contracting options in the Kidney Care Choices Model. Eligible beneficiaries may simultaneously be aligned to the GUIDE Model and attributed to participants in ACO Reach, the Shared Savings Program or the CKCC options in KCC. The GUIDE Model will allow participant overlap with the BPCI Advanced Model at the TIN level and eligible beneficiaries may simultaneously be aligned to a GUIDE Participant and a participant in the BPCI Advanced and CJR models.

The DCMP includes care coordination services similar to other Innovation Center models, such as Primary Care First, Making Care Primary, the Maryland Primary Care Program, the Enhancing Oncology

Care Model and Kidney Care First. GUIDE will permit participant overlap at the TIN and NPI level with these models. Eligible beneficiaries may simultaneously be aligned to a GUIDE Participant in the GUIDE Model and attributed or aligned to participants in active CMMI models, including ACO Reach, KCC, MCP, MDPCP, PCF, and the Vermont All Payer Model.

For the next portion of the session, I will hand it over to Kaleigh to cover the application process. Next slide please.

>>Kaleigh Ligus, CMS: Thank you, Serena. Hi, everyone. My name is Kaleigh, and I'm the GUIDE Application and Care Delivery lead. In the next section of the webinar I'll walk you through the process of model application and timeline. Next slide, please.

All of GUIDE applications must be submitted through the online application portal by the date that is listed here, January 30th, 2024 by 11:59. CMS may request additional information post application and deny participation based on program integrity review for GUIDE Model applicants. Applicants will be notified as to whether they have been selected for participation in the GUIDE Model in spring 2024, and the model will launch on July 1st, 2024. Questions should be directed to the GUIDE Model Team email address which will be provided in the chat. And to illustrate the ins and outs of the application, I will now do a live demonstration of the application portal and walk you through some key sections.

So now I will be going through the application portal, showing the sections, tabs, attachments, and notes. First, I'll begin by describing the landing page which has information regarding the application process under helpful links you'll see a user manual which is available as a PDF. This manual has helpful information on how to log into the system and completion of the application itself. You'll see that I have the ability to store multiple applications and perhaps even start a new one. However, for this demonstration today I'll be editing an existing application. And this is a test format, so please don't worry if you are RFA 251.

First, you'll notice that there are 3 sections of the application, complete profile, complete application, and certify and submit. In the upper right hand corner of the page there's an application checklist which will update you on the required elements of the application as you proceed.

For this existing application I have not yet filled out the organization information, or contexts, but all other fields that are required have been completed. First, I'll begin in this tab by completing the organization information. I'll be using a test organization which has prepopulated some of the answers for me. You may need to fill in the information for your organization's specific needs. If I had an organization TIN I would enter that here. New program applicants may not be able to provide this information, therefore that is why it's listed as optional. As I go through this tab, I'll answer the questions relevant to the TIN under which I'm applying. Now I'll pause here and note that open ended responses are character limited, and this limit does include spaces.

I'll stop again here at Question 8, which is where we have an application attachment. For this question we're asking that applicants first certify that they are a legal entity and then attach a copy of a certificate of incorporation or other documentation that demonstrates that the applicant is recognized as a legal entity by the state in which it is located. You will be required to upload documentation from your own computer using this icon here.

I'll scroll through the rest of the questions completing as necessary, and I'll stop here again to note another attachment is required. For this attachment we've provided a template. You may download the template by clicking on the word download here. We ask that you complete the attachment to the best of your ability keeping in mind the note that is included. Now I'll save and continue and move on to the next tab.

The next tab here is organization contacts. I'll enter the pertinent information. And please note that inclusion of organization contacts in this section specifically is for reference only. This will not add users to an application as only one User ID can access an application at any time. Therefore this information is available for reference only. You'll notice that I did not submit any information in this tab therefore the requirement is still highlighted.

Next I'll move on to the complete application section. First I'll begin by answering questions in the staffing, and interdisciplinary care team tab. Again, noting that open-ended responses are character limited. For questions. 4 and 5 there are associated templates and attachments provided. Again, you may download the template using this icon here. These attachments are optional, however, for this question, question 4 here, to be eligible for the Established Program Track or designated as a safety net provider under the New Program Track this must be provided as indicated in the note here. For Question 5, again this is not required and is listed as optional. The download option is available for the template, and you'll upload as needed.

Next, I'll go to the care delivery tab. We ask that applicants complete and respond to each of these care delivery domains as appropriate, and you'll be asked to provide additional detail on each of these services, whether you currently or plan to meet the requirement, and how. If your organization does not currently provide the service please indicate how it will be provided upon the first performance period. In addition, pay close attention to the notes in the blue text, which, as Tonya indicated, act as a sort of rubric in what additional detail reviewers are expecting to see in a good response. You'll see the remaining questions here, and I'll move on to the next tab.

For alignment I'll complete answers as requested, again paying attention to any notes and fields that are available. Again, noting that spaces are included in the character count here. Moving on to the heath equity tab responding to these questions as appropriate and again keeping in mind the notes that are provided with some of these questions.

Next, I'll move to the health information technology tab. And here you're asked to select from 3 options on your organization's ability to adopt the cert requirements. Again, I'll save and continue and move on to the final tab in this section.

Here we're asking for an applicant service area. We're asking applicants to share the service area from which your organization will accept beneficiaries. For this question please use the template that is provided here again indicated by the download word here, and then you'll upload the template once completed from your own computer.

I will continue and save and move to the final section which is, certify and submit. You'll notice that I'm unable to submit this application because there's still required fields that must be completed before moving on. Please note the application checklist will track you as you go along the application, so please do keep that in mind before moving on to submitting. After submission, you will receive an email

confirmation, and we ask that you please keep this for your records. And just a couple other key points before we move on to the Q&A section. Applicants will have the ability to revise their applications on or around the application deadline, and we ask that you please complete all attachments as best as possible, and if there is missing information you will be asked to revise the application.

That concludes the section of the Application Portal demonstration. We'll now move back to the slides. Next slide, please.

And now we'll move on to our Q&A session. Thank you to everyone who submitted questions in the chat. We look forward to addressing many of these questions in the next section. Next slide, please.

Before we get to the Q&A session we'd like to engage you all in more poll questions. Please join our Poll Everywhere activity by scanning the QR code on the screen with your phone or mobile device. The link to the poll has been included in the chat so you can easily participate using your computer browser, if you prefer that method. I'll give you all a few minutes before moving on.

After the portal demonstration. I'm hoping that you're feeling more comfortable in completing the application portal. Of course, if you have any questions on any of the application questions you may get. You may direct those to the GUIDE Model Team in the email that's provided in the chat. I'm glad to see that most people are feeling at least somewhat comfortable. That's great.

Alright. Looks like responses have slowed down. I'll move on to the next slide, please. thank you for participating.

And now we have a second poll question which we would appreciate for your participation. If you participated in the previous polls this should load automatically, and again the link has been included in the chat, so you can easily participate if you prefer that method. I'll give you a few minutes before moving up.

Okay, looks like responses have slowed down. Looks like close to 70% of the participants in today's webinar are planning to submit an application to the GUIDE Model. So thank you so much for your participation in this poll, and we hope the next section of Q&A's will help you better understand the GUIDE Model and answer any lingering questions that you may have if you're in the unsure category. Next slide, please.

Okay, so before we move on to the live Q&A, we'd like to address some frequently asked questions that have been submitted to us since the release of the RFA. And after we present these frequently asked questions we'll collectively address additional questions that have come in for us. Next slide, please.

So, this first question, I'm happy to take on. This first question, is asking, is an applicant assigned to an Established Program Track expected to provide only 6 of the 9 Care Delivery domains during the performance period? I think this is a great question and a great clarifying one, so I'm happy to take this.

To be eligible for the Established Program Track applicants must have an interdisciplinary team that has provided at least 6 of the 9 care delivery domains to people living with dementia for the past 12 months prior to the application deadline of January 30th. During the performance period, GUIDE Participants in both the New and Established Program Tracks must provide all 9 care delivery domains, either alone or

by contracting with one or more Partner Organization. So hope that clarifies the question on when the transition from 6 to 9 occurs and again established, and new will both be performing all 9 Care Delivery domains in the performance period. Next slide please.

Alright. I think I'll send this to Melissa. If you could please answer this question. Can a healthcare organization with multiple TINs submit multiple applications? Is there any limit to how many applications can be associated with one organization?

>>Melissa Trible, CMS: Yeah, thanks, Kayleigh. And this is definitely a question we've gotten quite a bit. So there can only be one TIN per application. So for every TIN you have to submit a new application. That said, if an organization has multiple TINs, there is no limit to how many applications that organization can submit. Again one application per TIN now. Back to you, Kaleigh.

>>Kaleigh Ligus, CMS: Great. Thank you so much, Melissa. And next slide, please.

All right for this next question. Applicants are required to provide CMS a list of service areas by zip code which was indicated in the application portal demonstration. Is this list of service areas by zip code limited, or can participants expand the list over the course of the Model? And, Melissa, I think you could answer this one as well. Thanks.

>>Melissa Trible, CMS: Yeah, for sure. So participants can absolutely expand or reduce the number of zip codes on that list that we'll be doing the mailings, to over the course of the model. There will be a regular cadence described further in the PA and the Payment Methodology Paper, I believe as well, explaining exactly what this cadence is, but they can, practices can expand or reduce the number of zip codes. I also just want to mention here this service area zip code list is used for mailings by CMS like we were talking about earlier to let potential GUIDE beneficiaries or GUIDE eligible beneficiaries know about the Model, and know that there is a provider in their area participating in the Model. We do not require that the beneficiaries come from the zip codes you initially list. Your attributed beneficiaries could be beneficiaries that are already within your practice, or referred to you from another provider. But this is just one way that CMS hopes to assist with getting word about the GUIDE model out there. Back to you, Kaleigh.

>>Kaleigh Ligus, CMS: Thank you so much, Melissa, I know that question has come up a lot, so I really hope that that has clarified for those who are wondering. And now I will ask the next question if we could see the next slide. Thank you. I think Tonya can answer this question. What is the difference between model tracks, and how is an applicant assigned to a track?

>>Tonya Saffer, CMS: Thanks, Kaleigh, I can definitely answer that question. And, Kaleigh, you answered part of it already, but I will say, CMS will assign participants to one of 2 Model Tracks, either the Established Program Track or the New Program Track, and, as Kaleigh stated just a minute ago in making this decision, we will primarily consider whether providers have an established track record of providing comprehensive dementia care. So over the past 12 months, we want to know if you have been providing 6 out of the 9 care delivery requirements. So other, you know other responses, how else will we determine and who's goes into the tracks? Other responses to the application questions may also inform our decision on this point. The differences between the tracks include the year in which they can start receiving the Model payments. That is, the Dementia Care Management Payments known as the DCMP, and the GUIDE Respite Services Payment. The Established Track will be able to

start billing and receive payments, starting as soon as July 1, 2024, while the New Program Track will have a one year pre-implementation period, that begins on that same date and ends on June 30th, 2025. During this period the New Program Track participants will have time, have additional time, to more fully develop their program, create partnerships as necessary, hire their workforce and create their workflow processes. They will also receive technical support from CMS during this pre implementation period. New Program participants may also receive an infrastructure payment during this time, if they meet the GUIDE safety net participant definition. Participants in the New Program Track will be eligible and receive GUIDE Model payments beginning July 1, 2025. I'll turn it back to you, Kaleigh.

>>Kaleigh Ligus, CMS: Thank you so much, Tonya, for that thorough response there. And I think we'll turn it to the final question if we could please see the next slide. Oh, there it is, so, what credentials or certifications are needed to complete the Home Visit Assessment for beneficiaries? And I'm happy to take this question. Any member of the interdisciplinary care team can perform the home visit assessments for beneficiaries. The GUIDE Model is not requiring any specific credentials and or certifications needed to complete the home visit assessment and participants will have discretion on how they operationalize the Home Visit Assessment beyond what's described in the RFA. All right next slide, please.

Now our team will respond to questions submitted before and during today's event, as a reminder due to the high volume of attendance, we may not be able to get every question, and will certainly be taking note of each question and try to ensure that future materials help address any common themes. And you're also welcome to submit additional questions to the GUIDE Model Helpdesk, which is again GUIDEmodelteam@CMS.HHS.gov, which has also been included in the chat.

So to begin, I'm going to script Sarena, the FAQs reference a framework that will be provided for creating a Health Equity Plan. Where can this framework be found?

>>Sarena Ho, CMS: Yeah, thanks, Kaleigh. So in the coming months CMS will provide technical assistance to participants on a variety of topics, including health equity data reporting which will encompass guidance on completing health equity plans. The template for Health Equity Plans will be part of the annual care delivery reporting survey, and it will be in the form of questions and considerations CMS hopes participants are taking when they're developing their health equity plans. So in other words, the template will include questions that guide participants in structuring their health equity plans and strategies, and in thinking about how to identify and address disparities in their populations.

>>Kaleigh Ligus, CMS: Great. Thank you, Sarena. And Melissa, the question came in, how do we pay for home respite if we can't find a contract for $104 per 4 hours?

>>Melissa Trible, CMS: Yeah, thanks, Kaleigh. So before I answer this question, I just wanted to highlight that the GUIDE team just uploaded a new round of FAQs onto their website, and one of them, I think is payment methodology, question 19 does address this question, I think a little bit further. But just to expand on the GUIDE payment, right now in the RFA we state that it's $26 per hour for home based respite. That does not include that we do intend to put the geographic adjustment factor on top of that, or the GAF will be included. It also doesn't, the $26 an hour figure also does not include that we intend to make an adjustment for the home health agency market basket. It's the home health agency market basket, less the productivity adjustment. Again, under the FAQs there is a link to some of the

numbers underlying that, but we do intend to adjust by that, and the $26 an hour number is the 2021 number, so for 2024-2025, we intend to adjust that each year by that home health agency market basket adjustment. Thanks, Kaleigh.

>>Kaleigh Ligus, CMS: Thank you for answering that question again. I know another one that's frequently asked. And I'll take this next question, we've also received this many times. Is email an acceptable method for the monthly check in with beneficiaries and or caregivers? And this is a really great question, and just to clarify email and electronic health record messaging may not be used to satisfy the minimum contact frequency, but we do anticipate individuals being able to meet in person by phone, or using a platform such as Zoom for those conversations. The modalities, such as email or EHR messaging can certainly be used for other communications.

And now I think I'll move to another question for Sage. What other services are we allowed to bill while the beneficiary is under a GUIDE program?

>>Sage Hart, CMS: Thank you, Kaleigh. So to first answer this question, I just want to first take a step back and explain that the Dementia Care Management Payment will replace Fee for Service payment for some existing Medicare Fee Physician Scheduled Services, and there's a table in the RFA under the DCMP Payment section, listing the Physician Fee Schedule Services that are included within the DCMP. So, therefore, the GUIDE Participant will not be able to bill separately for these services that are on the list for line beneficiaries, and to answer the question, the inverse is true as well. The person may be able to bill for other services that are not on the list that are provided to to beneficiaries. Thank you, Kaleigh.

>>Kaleigh Ligus, CMS: Thank you, Sage. Sarena, I'm going to go back to you. What do you consider to be a key components of a successful Health Equity Plan under the GUIDE Model?

>>Sarena Ho, CMS: Yeah, thanks, Kaleigh. So the purpose of the Health Equity Plans really is for each GUIDE Participant to identify disparities and outcomes in their patient populations, and to implement initiatives to measure and reduce these disparities over the course of the model. So the focus of health equity planning really will be on improving quality of care for underserved beneficiaries and addressing health disparities. And GUIDE Participants will be required to set goals and monitor progress over time, identifying and selecting evidence-based interventions for addressing health disparities and achieving equitable health outcomes. And, as I mentioned, previously, additional technical assistance for health equity data reporting, including Health Equity Plan guidance will be provided in the coming months to accepted applicants.

>>Kaleigh Ligus, CMS: Thank you very much. Sarena. Melissa, another question on payment. Is the funding for respite care a separate financial accounting than the funding for monthly management of services?

>>Melissa Trible, CMS: Great, yeah, thanks, Kaleigh. So funding for monthly management of services, I'm going to assume means the Dementia Care Management payment for the DCMP. Yes, respite is a separate $2,500 capped kind of set of funding that is totally outside of the DCMP. So respite is not expected to be funded through the DCMP. That is for some of the other care delivery requirements. Thanks, Kayleigh.

>>Kaleigh Ligus, CMS: Alright, and I think I'll take this next question given my experience with the application and doing the demonstration a minute ago. Do applicants need to include all vendor or technology partners on their Partner Organization Roster? This is a really great question on the scope of the roster. What to include on the roster and perhaps what not to include. So GUIDE Participants are only required to identify by the organizations that will help them meet the care delivery requirements. So any additional relationships that are formed in your healthcare system, or as a provider do not have to be identified in this in this Partner Organization Roster. So I hope that clarifies that question as well. Sage, I'm going to ask you a question. Would an on-call service staffed by physicians after hours satisfy the 24 / 7 access requirement?

>>Sage Hart, CMS: Thanks, Kaleigh. Without any more specific information, it sounds like it would. But I would like to emphasize that our overarching goal for the 24 / 7 access to the care team was to ensure that beneficiaries and caregivers have access to their to the care team or care navigator in order to provide general support in in times of emergency, or for example, in the evening, should the beneficiary or the caregiver need some additional assistance or direction. So it's not necessary to have a medical provider available on that the 24 / 7 access line, and to bring it back to an even more basic level, just to review the requirements specifically in the RFA, we have stated that either the participant can make available their care team 24 / 7 via a phone line, or they can create a helpline through which the care team would be available during business hours, and then, after business hours is when they can, may contract with a third party to provide that support. And we also have focused on and ensuring that if a participant contracts with a third party, just as was asked in the question, that there's a system in place that the third party will share information about any communications back to the participant to close that communication loop. Thanks, Kaleigh.

>>Kaleigh Ligus, CMS: Thank you, Sage. Another question for Sarena. How can applicants effectively demonstrate their commitment to addressing health disparities in their application?

>>Sarena Ho, CMS: Yeah, that's a great question. So the application includes a couple of questions that relate to health equity. One question asks applicants to describe their organization's role in improving health equity among their beneficiary population. And here applicants should demonstrate an understanding of health equity, and how to improve health equity among their service area. Another question asks applicants to describe the organization's historical or planned processes in engaging underserved populations. And here, CMS is seeking to understand applicant experiences with providing care to underserved populations, including, for instance, any engagement with community based organizations that they've previously engaged in to address health equity.

>>Kaleigh Ligus, CMS: Thank you, Sarena. Another question on program structure for Melissa. Do we have to include participant TIN and NPIs as part of the application, or will be, will there be a chance to do so ahead of the participation agreement being signed?

>>Melissa Trible, CMS: So, certainly you will need to participate in GUIDE under the TIN in which you apply with. That said, you're welcome to add and remove clinicians at the NPI level throughout the life of the GUIDE Model. Again, that will be at a regular cadence that we will describe further in the PA, but you are able to add and remove NPI's so long as you're still practicing under that same TIN.

>>Tonya Saffer, CMS: I wanted, sorry, Melissa, I wanted to jump in here, because I think this is a little different for the New Program Track that may not have a Medicare Part B enrolled TIN at the type of time of application. And so, if you are eligible for the New Program Track, and you apply under a

different TIN that's not Medicare Part B enrolled, and at the time of participation you use a Medicare Part B enrolled TIN, that would be acceptable. But what you'll want to do is list your intent, or somehow indicate that intent in some of the open answered responses in the application, so that we know that the TIN that applied is now going to be a partner versus the actual participant.

>>Kaleigh Ligus, CMS: Thank you, Tonya and Melissa, for answering that question that was great. Thank you. And so the next question I can answer, we get many of these questions, and I think it's really important to see the level of enthusiasm from Partner Organizations. So, how can community based organizations who work with diverse communities and trusted community workers become involved in the model? And we certainly see a large role for community based organizations to participate as a partner organization. Again, Partner Organizations will help GUIDE Participants to meet the Care Delivery Requirements. So we asked that interested community based organizations or partner organizations work with their GUIDE Participant, the applicants, those who are interested in applying those have already started an application, in order to form those partnerships. Again, there's not an option to apply to be a Partner Organization in the GUIDE Model, but there's also no limit to the number of Partner Organization or Participants that a Partner Organization can support. CMS will also be releasing a list of all participants in the model in summer of 2024 so we're hoping at that time Partner Organizations can certainly become connected with any GUIDE Participant in their area. Sage, I have a question for you on the Comprehensive Assessment and the Home Visit Assessment. Can the Comprehensive Assessment and the Home Visit Assessment be done at the same time?

>>Sage Hart, CMS: Thanks. Kaleigh, and the Home Visit Assessment can be done at the same time as the Comprehensive Assessment should the Participant wish to structure their care delivery services in that manner. I just saw a question live that was submitted today, asking whether the Home Visit Assessments is a one-time visit, or must it be done annually, and as you may mentioned earlier, the Home Visit Assessment is just a one-time assessment that must happen within 2 months of the initial appointment. I also want to note just more generally in looking at the questions that we have been coming in, the GUIDE Care Delivery Services are a framework and generally requirements for services that participants must provide. But other than what we've provided in the requirements, Participants are free to structure their program as they best see fit, both for their own circumstances, as a program, and best to meet their beneficiary needs. Back to you, Kaleigh.

>>Kaleigh Ligus, CMS: Thank you. That's a great clarification. I really appreciate you bringing that up. Sarena, another question for you this time for quality. Does CMS recommend any particular process or benchmark for quality improvement in delivering the GUIDE Model?

>>Sarena Ho, CMS: Yeah. Great question. So to ensure that CMS is setting accurate and meaningful benchmarks for GUIDE Participants, the GUIDE Model will have a pay for reporting approach for performance year one for the non-claim space measures. And then, based on the data that is reported during performance year one CMS will set benchmarks for both measures and keep them constant for the second and third performance years. For the claims-based measures benchmarks for performance year one will be calculated, based on claims, data from prior years. Benchmarks will then be updated for performance year 2 based on the models performance year one data and, like the non-claims, based measures, the benchmarks will be kept constant for performance years 2 and 3, after which time CMS may decide whether to update the benchmarks in order to ensure continuous improvement. On an annual basis CMS will also be publishing a paper that will show the technical specifications and benchmarks for the performance measures.

>>Kaleigh Ligus, CMS: Thank you, Sarena. I'll take this next question. Will GUIDE participants need to use both the CDR and FAST, or just one of these tools for model tiering? Just to clarify the GUIDE Participant may use either the CDR or FAST during the Comprehensive Assessment which then will be submitted through the Patient Assessment and Alignment form. So to clarify both tools are not needed to be completed simultaneously. Only the results of one of those tools will be completed and submitted through the Alignment form. I think I will ask Sage this next question. How much information should applicants include about Respite Care Partners as contracts if they don't have that figured out at the time of application?

>>Sage Hart, CMS: Thanks, Kaleigh. We just asked that in terms of the information provided in the application if there isn't a Care Delivery Service that the Participant is currently providing, including, for example, partnerships with a respite provider, that they just provide as much detail as possible about what their intentions are. For providers in the New Program Track in addition to some support that will be provided during that pre implementation period, we're going to ask that they resubmit their partner organization rosters and their practitioner rosters, I think it's about 2 months prior to when the first performance year starts in July of 2025 for the New Program Track. So we do expect that they may there may be some of evolution of the partner organizations on that roster during that time, and we'll ask that they again resubmit any information that they have prior to just starting the performance year. Thanks, Kaleigh.

>>Kaleigh Ligus, CMS: Thank you, Sage. I'll answer this next question then I will tee up a question for Sarena. Are - as an Established Program Track applicant are these program track participants going to be eligible for coaching or training through the GUIDE Model Learning System? And the answer is, yes, we do anticipate a peer to peer learning system for all Participants, both in the new and established program track in which you'll participate again, peer to peer with dementia care programs across the nation, in order to learn more about their processes, learn more about the ups and downs of their program. And again, as a collaborative learning system in order to improve the dementia care program that you have initiated or will be initiating in the future.

So, Sarena, I'm going to ask you a question. Are FQHCs eligible to participate as Participants or Partner Organizations?

>>Sarena Ho, CMS: Yeah. So, per the eligibility requirements providers that are eligible to be GUIDE Participants must be Medicare Part B enrolled providers and suppliers who are eligible to bill under the Medicare Physician Fee Schedule and while this excludes FQHCs from directly billing for GUIDE Model services, as you all know, Participants can and are encouraged to contract with other Medicare providers and suppliers like FQHCs in order to meet the Care Delivery Requirements. So in this case the contracted FQHC would be a Partner Organization.

>>Kaleigh Ligus, CMS: Excellent. Thank you so much. And Sage, I'm going to ask a question to you. Our partnership contracts due in conjunction with the application submission. Is there anywhere to submit the contract? Is it necessary? How would that process work?

>>Sage Hart, CMS: Thanks, Kaleigh. We're not going to ask that Participants submit their contracts with Partner Organizations. I'm just I'm laughing, so that would be a lot of information to submit so please don't. But we do encourage that you have those contracts in place, you know, before you, you provide services with a Partner Organization. And again, we just ask that you do provide details on that partnership itself, but not the actual contract. And then, in terms of how quickly a Participant will need

to have the 200 beneficiaries that they're providing services to. We did state that we're encouraging participants to meet a minimum threshold of 200 aligned beneficiaries. And that's by the end of their second performance year, and we asked that they maintain this throughout the course of the model. But I would like to know this is this is not a requirement, so a Participant would not be asked to leave the Model should that number drop below the 200 threshold. Thanks, Kaleigh.

>>Kaleigh Ligus, CMS: Thank you, Sage. We received a question about completing Baseline Care Delivery Reporting, and that's a great question, and I'm happy to take that. Additional information on the requirements, including the Baseline Care Delivery, completion will be shared with GUIDE participants at the beginning of the model. So at this time there would be no expectation of completion of any baseline information until accepted into the model as a participant.

Sarena, I'm going to ask you another question. Does the $75,000 infrastructure payment intended for Safety Net providers have to be repaid?

>>Sarena Ho, CMS: Yeah, good question. So GUIDE Participants may be required to pay the infrastructure payment back to CMS if they withdraw or are terminated from the GUIDE Model. So Participants that withdraw or are terminated before the start of the second performance year will be required to repay the whole infrastructure payment to CMS and GUIDE Participants that withdraw from the GUIDE Model or are terminated during the second performance year, will be required to repay half of the infrastructure payment.

>>Kaleigh Ligus, CMS: Great clarification. Thank you. Melissa, we got a question asking how many providers will the GUIDE Model be accepting in one geographic area? Would you be able to answer that for us?

>>Melissa Trible, CMS: Yeah, sure, Kaleigh, so GUIDE does not have any specific targets, or specific numbers set aside. I see that we're getting a lot of questions about exactly how many providers we're going to accept, and we do not have a specific number in mind. GUIDE is aiming to have a lot of variety in geographies and types of clinics that we include in the model. But again, we do not have any specific limit or numbers that we are aiming for. Thanks, Kaleigh.

>>Kaleigh Ligus, CMS: Wonderful! Thank you so much. For Sage, I have another question related to a care delivery requirement. A clinician with prescribing authority must review beneficiaries, medications, how often does that need to be completed?

>>Sage Hart, CMS: Thank you for asking Kaleigh. As with some of the other Care Delivery Requirements, and what I had mentioned a few questions before, we have not specified in the Care Delivery Services how often a prescriber clinic would have to review a beneficiary's prescriptions. So that falls within the bucket of services that we're leaving to the Participant’s discretion on, on how often to complete. Thanks, Kaleigh

>>Kaleigh Ligus, CMS: Thank you Sage. And I'm going to take this next question. Are there any specific qualifications or training requirements for Care Navigators to be used in the GUIDE Model? And this is a really great question. And there's actually a section in the RFA specifically for the Care Navigator training. So we expect that GUIDE Participants will develop and administer Care Navigator training that covers certain required topics. Which, again, are outlined in the RFA, and will be described in the

Participation Agreement. To the extent possible, GUIDE Participants can use a combination of training programs that are already in existence in order to meet this requirement. Some examples of topics include background on dementia, overview of assessments, person-centered planning, supporting a caregiver and additional domains.

And I believe I'm going to ask the next question for Tonya. Can a GUIDE Participant limit a beneficiary enrollment into the model? For example, if a nursing home wanted to participate and could meet all other requirements, would they restrict participation in the model to individuals living in their facility? Part 2 really related to link participation, can a participant limit participation to individuals who have a caregiver?

>>Tonya Saffer, CMS: So let me start with the overarching broad question which is, can GUIDE Participants limit the beneficiary pool that they are serving by severity, caregiver status, or other factors, and we have required that GUIDE Participants will offer all model services to all eligible beneficiaries, clearly recognizing that you know that doesn't require all, meaning, everyone that comes in your doors, that you're you have to have the capacity to be able to serve them, but we do not allow for there to be any sort of limiting of services, or any like criteria limitations, for who can be served by GUIDE. We're expecting that all GUIDE Participants will provide, you know, services to their their beneficiaries that are diagnosed with that, with dementia. With that said, in terms of nursing homes, we do not, anybody that is living permanently in a nursing home is not a beneficiary eligible for GUIDE. So there's an eligibility issue with that question. One of our model goals is to actually delay placement in a long term, nursing home and to help beneficiaries remain in their homes and communities for as long as possible. So in that scenario, a GUIDE Participant, and that beneficiary population would not be able to be aligned to the, to the Model. Did I get the second one relating to - so then, I think just to reiterate on caregiver status, no, we expect that GUIDE Participants to serve beneficiaries with or without a caregiver, so provide services to all model tiers within the within the dementia care program that's participating in GUIDE.

>>Kaleigh Ligus, CMS: Thank you so much. I am going to ask Sage another question. Will CMS be releasing information on the number of applications received?

>>Sage Hart, CMS: Thanks, Kaleigh, for asking this question, and I think this this could relate to many questions I've seen come through about whether we're going to release the regions of where we received applications or just data generally, that we've we may have from applications. And I just wanted, as with most CMS innovation Center models, will not be providing information about the applications that we receive and that includes the collective data that could be pulled from those applications. But, as previously mentioned, once we've selected the participants, we will release the list of the Participants participating in the model in the spring or summer of 2024. Thanks, Kaleigh.

>>Kaleigh Ligus, CMS: Thank you. Sage. We received a question, we assumed our EMR met CMS guidelines, but just found out they have not completed the process, does CMS have a list of approved EMR companies? And I'll just say that for the GUIDE Model there's no specific EMR requirement or company or vendor that would be endorsed in using. Participants will have discretion, and whichever their preferred vendor may be. And I think I will ask Sarena another question. Do the telehealth flexibilities outlined in the program extend for the FAST or CDR or the any other tools that may be used for the Model?

>>Sarena Ho, CMS: Yeah, thanks, Kaleigh. So we anticipate that nearly all of the Model components, including the Comprehensive Assessment with that could be delivered virtually and this includes these initial assessments. The only in-person visit requirement is the in home visit for beneficiaries with the caregiver and moderate or high complexity, dyad tiers, or beneficiaries, without a caregiver and moderate to high complexity individual tiers.

>>Kaleigh Ligus, CMS: Thank you so much. I'm going to ask Melissa a question. Will letters be sent to beneficiaries on an ongoing basis as they're identified through CMS claims, or are letters only being sent to the initial launch of the model?

>>Melissa Trible, CMS: Yeah, great thanks, Kaleigh. So letters will be sent throughout the course of the Model. We are not sending letters only at the start. It won't be on an ad hoc basis we'll have a regular time annually throughout the model that we will send out those letters. I also wanted to clarify, so the letters are based on the zip code level service areas that GUIDE Participants provide to CMS. So if a beneficiary does reside in a zip code where multiple GUIDE Participants are listing as a service area, they will see on their letter all available GUIDE Participants for their area it won't just be one. Additionally, if a GUIDE Participant does drop out of the model, then that beneficiary will be eligible to receive those letters at the next time that CMS is sending them out. The only part that is just once prior to the start of the model, is something we had discussed a little bit earlier in the slide, which is that CMS will provide, at the request of GUIDE Participants, a list of beneficiaries that may be eligible for GUIDE just that may be eligible for attribution to GUIDE just once at the very start prior to the first performance year, so that one's just one. The letters are throughout the course of the model. Thanks, Kaleigh.

>>Kaleigh Ligus, CMS: Thank you, Melissa. I'm going to ask another question to Tonya. Will all applications that are responsive to the RFA ultimately be supported? Or will there be some kind of competitive application process?

>>Tonya Saffer, CMS: Thank you for that, Kaleigh. So I think I'll answer this question in 2 ways, and I think we also put a written response. So no, not necessarily. We had, we will not necessarily accept all applications for participation. But there's also not, it's not necessarily competitive meaning, if you're getting at competitive in terms of like, will we only accept one program that is serving a particular geographic area? Or make considerations like that? Not necessarily, not necessarily. We're not looking to limit competition in any way as part of this model. We are looking for high quality applications. We're also going to consider factors that will help us with a robust evaluation as is required by our statute to meet our requirements of lower cost and better quality, tests that we have as an Innovation Center. We also will be screening for program integrity, as well as other factors. So just wanted to reiterate, reiterate there's not a guarantee that all applicants will be selected.

>>Kaleigh Ligus, CMS: Thank you very much for that answer. I'm going to ask Melissa another question. Has there been any thought towards consents for beneficiary acceptance into the GUIDE?

>>Melissa Trible, CMS: Yeah, got it, good question. So beneficiaries are aligned to the GUIDE Model through a voluntary alignment process. So beneficiaries must elect to join the GUIDE Model with a GUIDE Participant. That is done through the Beneficiary Assessment and Alignment form which is discussed in the RFA. I believe there's even a copy of it in there, I mean that form includes attestation, that the beneficiary has been diagnosed by a clinical professional with dementia, includes information requesting, like, if there's a caregiver for the beneficiary, if that caregiver lives with the beneficiary and

a few other things that the GUIDE Model would just like to know. So and to summarize, yes, the beneficiary does need to consent to join the model and does need to kind of opt in, and may opt out or de-enroll from the model at any time. Thanks, Kaleigh.

>>Kaleigh Ligus, CMS: Thank you, Melissa. And another question that I'm seeing in the in the Q&A section, and has been asked frequently, that I can address here, has also been answered here in the Q&A. Are assisted living residents eligible for the GUIDE Model? And the answer is, yes, provided that they meet all other eligibility criteria. We do have a definition of community dwelling which does include assisted living. So, in addition to that, they would also need to meet all the other eligibility criteria outlined in the RFA for a Participant. Sage, I'm going to ask you another question. Is the documentation the provider completes and sends to Medicare for alignment available at this time?

>>Sage Hart, CMS: I think that what that is referring to is the Patient Assessment and Alignment form which we have provided as appendix C I believe, in the RFA, I know it's from the last pages of the RFA. And that Patient Assessment line form is an example of the information that we would be requiring. We may make changes to that form, and we are working to program the form so that the information can be electronically returned to us. Thanks, Kaleigh.

>>Kaleigh Ligus, CMS: Thank you, Sage, that's very helpful. Sarena, I'm going to ask you a question. Can you please provide more information about what a safety net provider or organization is, and do applicants indicate on the application that they are a safety net provider?

>>Sarena Ho, CMS: Yeah, thanks, Kaleigh. So the GUIDE safety net provider designation is not an attestation to qualify as a GUIDE safety net provider. A new program applicant must have a Medicare Fee-for-Service beneficiary population comprised of at least 36% of beneficiaries receiving the Part D low-income subsidy, or 33.7% of beneficiaries who are duly eligible, and these thresholds are based on the safety definition, safety net definition that the Innovation Center has developed more broadly in order to track safety net provider participation in all of its models, and CMS will be using Medicare claims to assess the composition of a beneficiary population.

>>Kaleigh Ligus, CMS: Excellent. Thank you so much. Another question for Sage, and I will note that we are running low on time, so we'll try to get in a few remaining questions. If the application is accepted by CMS, is there an ability to elect not to enter into the program if selected? Can you point to any language in the RFA to support this?

>>Sage Hart, CMS: Well, I hope that's not the case. But should that be the circumstance where, both an applicant submits an application, they want to withdraw and that I'm going to answer to 2 situations here. The first one is, if the applicant submits an application that they want to withdraw, the RFA, there's this particular paragraph in the RFA, which outlines that the applicant should email CMS, I believe it has to be a PDF letter, PDF level letter on the letterhead for the organization, as well as include information on why they're withdrawing their application. Should an applicant be notified by CMS that they have been selected them to participate, and the applicant wishes to then withdraw, the applicant is, is free to do so as well. The RFA references that this is a voluntary model for participants, so they are to free, to leave the Model should they wish to do so, and that includes, prior to signing the Participation Agreement. Thank you, Kaleigh.

>>Kaleigh Ligus, CMS: Thank you, Sage. And Sarena, I'm going to ask you another question related to quality. What are the allowable Quality of Life measures for the GUIDE Model?

>>Sarena Ho, CMS: Yeah. So the Quality of Life measure in the GUIDE measure set is the quality of life outcome for patients with neurological conditions measure, and that is based on the Promise 10 survey.

>>Kaleigh Ligus, CMS: Excellent. Thank you so much. Alright. Well, thank you, everyone for your time and attention today. For today's session that's all the time that we have for questions and answers and concludes the Q&A session. Thank you again for sharing your questions, we'll be sure to collect all of these, and perhaps answer them in a future FAQ. So now I'm going to pass it back to Tonya. Next slide, please.

>>Tonya Saffer, CMS: Thank you. I know we received a high volume of questions and really want to encourage everybody. Some of the questions were also very specific to the organization asking them, and so if you didn't get your question answered, and it was specific to your organization, please do email the help desk, and we will get you an answer as quickly and completely as we can. I also wanted to let you know that, I probably should have prompted the next slide here, that we have additional resources on our website and strongly encourage everybody to read those. I know the documents can be very thick and weedy, and we've pulled together some helpful Fact Sheets for people to reference. We also updated, as of this morning, our FAQs on the website, so please do, I think there are probably over 80 FAQs on that document. Many of those FAQs I also saw in today's Q&A so I know that your answers, many of your answers, to your questions, are actually out there and up on our website in an FAQ document. So please do go reference that document. You can find the links to our website for that here. And but again, if you still can't find the answer to your question, you are very welcome and strongly encouraged to email us at GUIDEmodelteam@cms.hhs.gov. and that's also in the chat here. Please do stay up to date with announcements about the GUIDE Model and future information by signing up for our GUIDE Listserv, and then I think we can drop that into the chat as well. And you can follow us on X, formerly known as Twitter @CMSInnovates.

And with that I will transition to the next slide, and thank you for joining us today. We've really appreciated your engagement and your questions, and look forward to continuing with you on this journey. So, this concludes today's webinar, I thank you for joining, and hope you have a great rest of your day.

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