Guiding an Improved Dementia Experience (GUIDE) Overview Webinar

8/10/2023

>>TJ Smith, SEA: Good afternoon, and thank you for joining today's GUIDE Model Overview Webinar. Before we begin, there are a few housekeeping items to discuss. Next slide, please.

Thank you. 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 continue to reach out to our help desk at GUIDEmodelteam@cms.hhs.gov.

We also would like you to know that today's presentation is being recorded. If you have any objections, please hang up at this time. As a reminder, 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 content, let me give a brief overview of the agenda for today's webinar. We will begin with a welcome from Liz Fowler and an introduction of today's speakers. Then the model team will share a basic overview of the GUIDE Model. Following that, we will share more information on the model's payment methodology and then the model team will talk more about data reporting. We will then share more information about the application timeline process and additional resources.

We will then move into a few minutes for a Q&A session, where our team will answer questions submitted by audience members. Again, as a reminder, you can continue to submit questions using the Q&A function at the bottom right-hand corner of your screen. Again, thank you so much for joining us today. We have a wonderful presentation planned for you. And with that, I'm going to pass it over to Liz Fowler, the Deputy Administrator and Director for the CMS Innovation Center to formally welcome you to today's event. Next slide please, and over to you Liz.

>> Liz Fowler, CMS: Thanks so much TJ. Good afternoon, everyone. My name is Liz Fowler, and as TJ said, I am the Director of the CMS Innovation Center, and I am really excited to welcome you to the GUIDE Model Overview Webinar.

Thanks to those of you attending today who are health care clinicians, practitioners, and advocates who have been working tirelessly for years to improve care for people living with dementia. You have our utmost respect and gratitude for all of your work. Dementia is a devastating diagnosis for a person and their loved ones. People with dementia can be robbed of their autonomy and agency, and dementia can stress families emotionally, physically, mentally and financially.

This model was developed to encourage and support healthcare practitioners to deliver the comprehensive care and support services that people living with dementia and their caregivers have said they are most in need of. We're very proud of this model, and CMS Administrator Brooks-LaSure, who headlined the announcement of this model a couple of weeks ago, is similarly excited. What struck the Administrator about this model in particular, is that she felt like GUIDE took into account the feedback and input that we've been hearing from patient and beneficiary voices and their providers, and we reflected those priorities in the model design.

As we all know, the GUIDE Model will not cure dementia, but the model, if it is successful, will facilitate a better quality of life for people living with this devastating condition, help them remain in their homes

and communities, where we know that they want to be, for longer, while also reducing strain on families and caregivers.

So thank you for being here today. And I'm now pleased to pass the virtual mic over to my colleagues, who will present today's webinar.

>>Tonya Saffer, CMS: Hello, and thank you for joining us today. My name is Tonya Saffer, and I am the Director of the Division of Health Care Payment Models. Today's speakers include myself, and the GUIDE Model lead, Emily Johnson, followed by members of the GUIDE team Sage Hart, Jennifer Brown, and Sarena Ho. These speakers, and many of our colleagues, who are behind the scenes today, have been working tirelessly and passionately over the past several months to develop this model and continue to do so as there is still much work to be done. Thank you to the entire GUIDE team, and our CMS colleagues for their work. Together, we present this opportunity to support practitioners in delivering and testing the impact that a comprehensive dementia care program can have on the lives of people living with dementia and their caregivers. Next slide.

In this section of today's webinar, we will walk you through some of the core elements of the GUIDE Model. If you'd like additional resources to share, you may also find some of these details about the model in the Model Overview Fact Sheet, which is located on the model website. Next slide, please.

We want to take every opportunity to make today's session an engaging one. We are using a platform that will allow you to participate in poll questions to share your feedback, thoughts, and insights using your phone or computer browser. Your responses to the poll will be, poll questions will be anonymous.

You should be able to see a link in the chat right now to the poll. So please, join our Poll Everywhere activity by scanning the QR code on the screen or clicking the link in the chat. I'll give you a few more moments to join the poll before moving on.

Okay, we'd love to see where you all are joining us from today. Please choose the corresponding state or territory on the map. And I'll wait a minute here so that everyone can complete that activity. I see lots and lots of colors populating on the map, it is exciting. Alright, I'll give it a few more seconds here, still seeing a lot of dots appearing on the map. Alright, they are starting to slow down. Thanks so much for participating. It's really exciting to see where everyone is joining us from today, and we've got great national representation. So thanks again for taking the time out of your day to be here for this event. Next slide please.

To set the stage for today's event, I will walk us through a bit of background information related to the GUIDE Model. Dementia is a major public health issue and is increasingly affecting the American population. About 6.7 million Americans currently live with Alzheimer's Disease or another form of dementia, a number that is projected to grow by nearly 14 million by 2060.

Many people with dementia are not consistently receiving high quality, high value care. Some of these issues include a lack of caregiver training and recognition, unestablished healthcare pathways, limited coverage of key supportive services and lack of a sustainable payment for a comprehensive care. The GUIDE Model aims to address the existing gaps within our nation's current dementia care landscape by defining a standardized dementia care delivery program, providing an alternative payment methodology, addressing caregiver needs, and coverage of 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 beneficiaries with dementia

and their caregivers, while delaying avoidable long term, nursing home facility placement, and enabling more beneficiaries to remain at home through 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 beneficiary's 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 ongoing caregiver needs.

GUIDE will also provide payment for a defined amount of respite for certain eligible beneficiaries and their caregivers in the model. This 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.

The GUIDE Model is a voluntary eight-year national model offered in all states, US territories, and the District of Columbia. GUIDE is designed to attract a range of Medicare Part B enrolled providers and practitioners with the expertise and capabilities to establish a dementia care program and provide ongoing longitudinal care and support to people with dementia. Other Medicare enrolled providers and non-Medicare enrolled community-based organizations may partner with an eligible Part B provider or practitioner to form a dementia care program under a single Medicare Part B enrolled Tax Identification Number, commonly referred to as a TIN. Examples of eligible participants include a standalone physician practice, practices or clinics that are part of a health system or accountable care organization, and practices or clinics that have been established by a hospice or a home health agency or PACE organization, but operate as a separate Medicare Part B enrolled service line that bills under the Medicare Physician Fee Schedule.

In this slide we have outlined possible dementia care program provider and supplier arrangements for the GUIDE Model. For example, in the first arrangement, a single Medicare Part B enrolled provider practice with multiple individual clinicians may implement a GUIDE dementia care program. In the second example, several Medicare provider practices and multiple practitioners partner to implement a dementia care program under the geriatric practice's billing TIN. In the third arrangement, at the right, a Medicare enrolled home health agency establishes a new Part B enrolled TIN to form a GUIDE dementia care program. Next slide, please.

In order to support the development of new dementia care programs, GUIDE will have two model tracks; a track for Established Programs that will launch on July 1st 2024, and a track for New Programs that will launch on July 1st, 2025, after a one-year implementation period, which participants will use to establish their new programs.

To be eligible as an Established Program Track participant, the organization must already provide comprehensive dementia care and be ready to immediately implement GUIDE's care delivery requirements. The GUIDE Model will also recruit and support model participation for organizations that do not currently offer comprehensive dementia care or have prior experience with alternative payment models in order to improve access to comprehensive dementia care nationally for diverse beneficiaries.

Applicants to the New Program Track do not have to meet the model's 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.

Now, I'll hand it over to Sage Hart to share some highlights on GUIDE's care delivery approach. Next slide please.

>>Sage Hart, CMS: Thank you, Tonya. We are really grateful to all of you for making time to be here this afternoon, as we share more information on the GUIDE Model.

The priority beneficiary population for the GUIDE Model are community dwelling Medicare fee-for-service beneficiaries, including beneficiaries dually 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.

GUIDE Model beneficiaries must have dementia, as confirmed by attestation from a clinician practicing within a GUIDE dementia care program. This may be at any stage for the beneficiary of dementia, mild, moderate, or severe. Beneficiaries must be enrolled in Medicare Parts A and B as their primary payer, and not in Medicare Advantage, including special needs plans. They also must not be enrolled in the Medicare hospice benefit or PACE program, as these 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 this 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 to a model participant, beneficiaries will maintain complete freedom of choice in where to seek care. Participants will be strongly encouraged to have at least 200 aligned beneficiaries by the end of the second model performance year. Next slide, please.

CMS will assign participating beneficiaries to one of five tiers based on combination of their disease stage, functional status, whether they have a caregiver, and if applicable, their caregiver's needs. Beneficiary needs, and correspondingly care intensity and payment, will increase by tier. The table on this slide shows a description of the five tiers. To ensure consistent beneficiary assignment to tiers across model participants, participants must use a tool from a set of approved screening and measurement tools to measure dementia stage and caregiver burden. More information about these tools will be available in the Request for Applications that will be released later this year. Next slide, please.

The GUIDE Model will promote high quality dementia care by defining and requiring a comprehensive, standardized care delivery approach. The GUIDE care delivery approach includes a standardized package of care delivery services that participants must provide to beneficiaries and their caregivers, an interdisciplinary care team to deliver theses standardized care delivery services, and a standardized training requirement for care navigators, who are part of the interdisciplinary care team. Next slide, please.

Participants must maintain an interdisciplinary care team in order to meet the care delivery requirements of the GUIDE Model. At a minimum, the care team must include a care navigator and a

clinician with dementia proficiency who is eligible to bill Medicare Part B Evaluation and Management Services. At the participant's discretion, the care team may also include additional members, such as a pharmacist, social worker, and behavioral health specialist.

A clinician will qualify as having dementia proficiency if they can meet at least one of the following criteria, that is: Attest to having at least 25% of their patient panel, regardless of payer, at some time in the past five years, comprised of adults with any cognitive impairment, including dementia; Or, attest to having at least 25% of their patient panel, regardless of payer, at some time in the past five years, comprised of adults aged 65 years old or older; Or have a specialty designation of neurology, psychiatry, geriatrics, geriatric psychiatry, behavior neurology, or geriatric neurology. Next slide, please.

As mentioned earlier, there's a standard set of care delivery services that participants must provide as part of the model. The care delivery services are the minimum services that participants are required to offer beneficiaries. Participants must be able to provide the services at varying levels of intensity, depending on model tiers and the beneficiary's individual needs. The care team will deliver services by creating and maintaining a person-centered care plan which will include details on the beneficiary's goals, strengths, and needs.

The graphic on this slide summarizes these services and include, a care plan, 24/7 access to a member of the care team or a third-party representative, ongoing monitoring and support, referral and support coordination, caregiver support, medication management, care coordination and transition, and if needed, respite services. Next slide, please.

This slide shows an example of a beneficiary who was aligned to the GUIDE Model. Margaret Smith, an 82-year-old woman, who was diagnosed with Alzheimer's disease by her primary care physician two years ago. She experiences moderate dementia symptoms, and is visited daily by her daughter Kathy, who serves as her caregiver. Kathy doesn't have the capacity to give Margaret all of the attention she needs. Margaret is concerned and doesn't know how to access support, and she isn't getting guidance from her primary care provider. As a GUIDE Model beneficiary, Margaret receives a comprehensive assessment of her health and her care team develops a care plan which addresses her safety concerns about walking downstairs. She also receives ongoing monitoring and support from a care navigator who checks in with Margaret monthly. Margaret's care navigator also develops a great relationship with Kathy and helps her cope with sundowning. Margret's care navigator provides tips for Margaret to maintain her correct medication schedule, and the care navigator also refers Margaret to a community-based organization that helps her identify service providers. As illustrated in this example, the GUIDE Model aims to improve the experience of both dementia beneficiaries and caregivers through a comprehensive package of services.

With that, Emily Johnson will join us to walk us through the details of the GUIDE Model payment methodology. Next slide, please.

>>Emily Johnson, CMS: Thank you Sage. Next slide, please.

The primary model payment under GUIDE is a per-beneficiary-per-month care management payment called the Dementia Care Management Payment, or DCMP. The DCMP will replace billing for a small set of existing Physician Fee Schedule services. The DCMP gives participants more flexibility to deliver personalized dementia care than is possible under traditional fee-for-service. It covers a more comprehensive set of services than existing care management codes, is less burdensome to bill, and

allows reimbursement for members of the interdisciplinary care team who are otherwise not eligible to bill for Medicare services. The DCMP will also not be subject to beneficiary cost-sharing. The model is not a total-cost-of-care model. So, all services not included in the DCMP will continue to be billed under traditional fee-for-service.

The DCMP will have two monthly adjustments. A Performance-Based Adjustment, which can increase or decrease the DCMP depending on how well a participant performs on the model's performance metrics, which we'll discuss in a few slides. And, a Health Equity Adjustment that is based on beneficiary level health equity factors and may also increase or decrease payment. We'll discuss both of these adjustments in more detail in several slides.

In addition to the DCMP and its adjustments, participants will be able to bill for respite services that are provided to certain eligible beneficiaries in the model, up to an annual cap of $2,500 per beneficiary, per year. Beneficiaries with a caregiver and moderate to severe dementia will be eligible for this respite payment. Participants will be able to bill for respite services provided in a beneficiary's home, in an adult day health center, and in a 24-hour facility.

Finally, the model will offer a one-time, lump sum infrastructure payment for qualifying safety net providers to help with the upfront cost of establishing a dementia care program. Providers will qualify for this payment based on the share of their patient population that receives the Medicare Part D Low Income Subsidy or is dually eligible for Medicare and Medicaid. Next slide, please.

Model participants will use a set of new G-codes created for the GUIDE model in order to submit claims for the monthly DCMP. Each model tier will have a different DCMP rate to reflect the fact that covered services and care intensity will vary across the tiers. For example, for tiers that include beneficiaries without a caregiver, the DCMP does not incorporate payment for caregiver education and support. However, the DCMP rates also reflect the fact that beneficiaries without a caregiver are expected to have more intensive needs than beneficiaries in a similar disease stage who have a caregiver.

The DCMP rate will also be higher for the first six months that a beneficiary is aligned to the model to reflect the high intensity of the program activities, such as the comprehensive assessment, home visit and establishment and implementation of a new care plan. After the first six months that the beneficiary is aligned, the DCMP rate for that beneficiary will be reduced to a maintenance payment rate. Participants will be responsible for billing the correct G-code for each aligned beneficiary, each month. In order to support accurate billing, CMS will provide each participant with a monthly beneficiary alignment file that lists all of the beneficiaries aligned to that participant, their model tier assignment, and the length of their alignment to the participant.

And with that, Jennifer Brown will join us to walk us through a brief overview of the DCMP payment adjustments. Next slide, please.

>>Jennifer Brown, CMS: Thank you, Emily. Hello everyone, my name is Jennifer Brown, and I'm a Social Science Research Analyst on the GUIDE team.

As Emily mentioned, participant's DCMPs will be adjusted by a Performance-Based Adjustment as well as a Health Equity Adjustment. The Health Equity Adjustment, or the HEA, is designed to decrease the resource gaps in serving historically disadvantaged communities. The HEA will be calculated based on certain social risk factors. Potential social risk factors that may be used include the National Area

Deprivation Index, or National ADI, associated with the beneficiary's place of residence, the State Area Deprivation Index, or whether a beneficiary receives the Part D Low Income Subsidy or LIS, and whether the beneficiary is dually eligible for Medicare and Medicaid.

The HEA will be based on each individual beneficiary's social risk factors, meaning that within a single participant's beneficiary population, different beneficiaries will have different HEAs. CMS is continuing to explore other measures that may improve the ability of the HEA to appropriately compensate the participants for care provided in historically underserved communities. More information about the HEA methodology will be available in the Request for Applications.

The Performance-Based Adjustment, or PBA, will increase or decrease participants' monthly DCMPs, depending on how they perform on the model's five performance metrics. These metrics include, the use of high-risk medications in older adults, quality of life outcomes for people with neurological conditions, Zarit Burden Interview, which is measuring caregiver burden, total per capita costs, long-term nursing home rate. The high-risk medications, quality of life and Zarit Burden Interview measures will be reported by participants to CMS on an annual basis. The total per capita cost and long-term nursing home metrics will be calculated by CMS based on claims and administrative data. Two of these measures, the Zarit Burden Interview measure and the long-term nursing home measure, are being created specifically for the GUIDE model, and may not be available until later years of the model.

The PBA will be applied as an ongoing percentage adjustment to the model's monthly DCMP rather than a separate annual performance payment. Once all of the quality measures are fully phased in, participants can increase their DCMP amount by up to 10% through high performance, or decrease their DCMP by as much as negative 3.5% for poor performance. The PBA will be applied to the DCMP beginning in quarter three of the second model performance year based on performance during the first model performance year.

With that, I will pass the mic over to Sarena Ho. Next slide, please.

>> Sarena Ho, CMS: Thanks, Jennifer. As Tonya mentioned at the top of the call, my name is Sarena Ho, and I am a Health Insurance Specialist on the GUIDE team. We're so excited to be here to share information about the GUIDE Model. During this section of the webinar, I will talk about the data reporting requirements of the model. Next slide, please.

This slide offers an explanation of data reporting in the model. GUIDE will require participants to collect data that is necessary to monitor and evaluate the model which could include protected health information. As Jennifer mentioned, participants will be required to report quality data for the non-claims-based performance metrics annually. Those metrics are high-risk medication use, beneficiary quality of life, and caregiver burden.

Participants will complete care delivery reporting at least once per year, which will consist of a series of questions about how they're implementing the care delivery requirements of the model, including how frequently they are interacting with enrolled beneficiaries and their caregivers, and what care modalities they are using. Care delivery reporting will also include a Health Equity Plan section which I'll discuss in more detail in a moment.

Participants will conduct an initial assessment of potentially eligible beneficiaries and their caregivers and submit a patient assessment and alignment form to CMS that includes data on the beneficiary's

dementia stage, whether they have a caregiver, and the level of burden that the caregiver is experiencing. Participants will also be required to reassess beneficiaries and their caregivers, at least annually, and submit the reassessment results to CMS using the Patient Assessment and Alignment Form. This data will be used to assign beneficiaries to model tiers as well as in the evaluation to establish baseline beneficiary and caregiver characteristics and track change over time. Finally, GUIDE participants will be required to collect and report a core set of sociodemographic measures on an annual basis from GUIDE beneficiaries willing to share this information. I'll speak to this more on the next slide. Next slide, please.

As I mentioned before, GUIDE participants will be required to collect and report data on aligned beneficiary sociodemographic characteristics and health-related social needs, though beneficiaries will have the option to opt out of data sharing if they prefer. The data elements in this core set will be consistent with the sociodemographic elements being collected in other Innovation Center models, and they include measures like race, ethnicity, sex assigned at birth, disability status, and preferred language.

Health-Related Social Needs, or HRSN, are used to describe individual-level social needs and are individual-level adverse social conditions that negatively impact a person's health or health care. HRSN collection and referrals will be part of the model's broader care delivery requirements for comprehensive assessment and referral for social services and supports. Participants will annually report aggregated, domain-level data from HRSN screening domains such as food insecurity, housing instability, transportation needs, utility difficulty, and interpersonal safety, starting after the first model performance year.

GUIDE model participants will be encouraged to use one of two preferred HRSN screening tools, the Accountable Health Communities, or AHC HRSN screening tool, or the Protocol for Responding to and Assessing Patient Risk, or PRAPARE tool. Collecting and reporting beneficiary reported sociodemographic data and health-related social needs data will help participants identify and address disparities within their patient population and track their progress towards health equity goals over time. Next slide please.

The Innovation Center believes that equitable care is a key component of achieving high quality care for beneficiaries, and is therefore critical to GUIDE success. GUIDE is focused on improving quality of care for all beneficiaries with dementia, with an emphasis on closing the gaps in care in underserved populations. Along with the Health Equity Adjustment to payments, the new program track and infrastructure payment for safety net providers, and the referral and coordination of social services and supports domain in care delivery, GUIDE participants will develop and implement a Health Equity Plan based on the CMS disparities impact statement so they can identify disparities and outcomes in their patient populations and implement initiatives to measure and reduce these disparities over the course of the model.

The first Health Equity Plans will be due after participants have signed Participation Agreements, but before model launch. They will focus specifically on beneficiary outreach and engagement as a precursor to more comprehensive annual Health Equity Plans which will begin at the start of the second performance year. The goal of the first Health Equity Plan is to encourage participants to develop and implement health equity recruitment strategies from the model's onset.

With that, I will pass the mic back over to Emily to discuss model application timeline and processes. Next slide, please.

>>Emily Johnson: CMS: Thank you, Sarena. In the next section of the webinar, I will walk you through the model application timeline, process, and resources available. Next slide, please.

Right now, we are in the pre-application period for GUIDE. Prospective applicants, who are strongly encouraged to submit a non-binding Letter of Intent, or LOI, by September 15th ,2023. We are sharing a link in the chat, so you may easily access the site.

The model application period will take place from fall 2023 through winter 2024, and applicants will be notified of selection decisions in spring 2024. The model performance period will begin on July 1st, 2024, and end on June 30th, 2032, and will include at least two participant tracks, one for established dementia care programs and one for new dementia care programs. The Established Program Track will begin model implementation on July 1st, 2024, and continue through June 30th, 2032. The New Program Track will have a one-year pre-implementation period from July 1st, 2024 through June 30th, 2025, and we'll begin model implementation on July 1st, 2025. Next slide, please.

The model team has created a number of resources that are aimed to help support applicant throughout this process. The GUIDE Model's Letter of Intent will help us better assess your interest in the model, and learn more about your organization's goals and challenges in applying. We strongly encourage you to submit an LOI, if you are considering applying, by the deadline of September 15th, 2023.

A number of factsheets, infographics, and FAQ resources are available on the model website to help you understand the model and share information about it with your organization. We also have a model inbox where you can submit questions to CMS in case you have questions that we aren't able to get to in our Q&A session today. In the coming weeks and throughout the application process, we will be posting additional resources. The recording of today's event will be available in about a week. And then, in fall 2023, we'll be releasing the Request for Applications which will have even more details about model policies.

Now, I will pass it back to Tonya to kick off our question and answer session. Next slide, please.

>>Tonya Saffer, CMS: Thank you Emily, and thank you guys, all of our, thank you to all of our panelists and also to our Center Director, Liz Fowler, for her open opening, welcoming remarks. I failed to thank her at the beginning there, but really appreciate her time and welcoming of everybody here, so thank you.

Before we get to the live Q&A portion of today's event, we would like to take some time to understand more about what elements of the model you all are interested in. So, we're going to do another poll here. So please join our Poll Everywhere activity by scanning the QR code again on the screen with your phone or mobile device. The link to the poll has also been included in the chat so you can easily participate using your computer browser if you prefer that method. I'll give you a few moments to join before moving on.

Okay, it looks like participation has slowed here a bit, so we'll go ahead and close that out. Thank you for your participation. It looks like we've got almost like a quarter split here on beneficiary eligibility,

attribution, and caregiver support. High interest in learning more about care delivery, and then, of course, the interest in payment methodology, with quality strategy following. So great, we will work to address all of your questions as we do a round-robin here with Q&A with our panelists. Alright, next slide, please.

Nope, you are already on top of it, great. During this section of the event, we will answer a few questions which were collected from the event's registration and take the time to answer live Q&A which have been submitted during the event. As Emily mentioned, we've had robust participation and quite a few questions, so we may not get to every one. But we'll do our best to get through as many live as we can. Alright, so thank you again for your time and attention here.

Let's go ahead and start with the first, I'll take the first question. So, given that the model can be delivered through contracted partner organizations, what are the supervision requirements for services delivered by vendors outside of the employees of the part biller of record?

So, just to clarify here, partner organizations must be Medicare enrolled organizations and they must meet the same requirements and program integrity requirements that they have today. We will provide more, very specific and more details in the Request for Applications. And model participants, I just want to highlight here as well, that model participants may contract with non-Medicare enrolled programs who deliver home and community-based services in order to deliver respite and as well as to support other care delivery requirements in the model.

I will turn it over now to Sage for the next question.

>>Sage Hart, CMS: Thank you, Tonya, and thank you for everybody for participating today. It's been really encouraging to see the number of questions rolling in. We have received a number of questions about the care delivery requirement for 24/7 access, and there will be additional details about 24/7 access in the Request for Applications.

For now, just note that the GUIDE Model requires, for this requirement that either one, the participant provides beneficiaries with after-hours access directly to member of the care team, and it could be any member, doesn't have to the specific care navigator. Or two, the participant may satisfy this requirement by maintaining an after-hours helpline that the beneficiary or their caregiver may call to speak with either a member of the care team or a third party engaged by the participant to provide after-hours communication. Referring the beneficiary to a publicly available 24/7 helpline is not sufficient to satisfy this care delivery requirement.

And with that, I will pass it on to Emily.

>>Emily Johnson, CMS: Thank you, Sage, and thank you all for your questions. I just wanted to reiterate we probably won't be able to get to all questions that we're receiving today. But, we will be following up with a Frequently Asked Question resource and also our model help desk is a great resource for specific questions that you have.

So with that, we've gotten a couple of questions about what costs are covered in the model's capitated rate and what services and billing codes are outside of that capitated rate. So, the GUIDE Model is not meant to be a total-cost-of-care model. So those monthly payment rates are just meant to cover the required care delivery activities under the model, so the things like comprehensive assessment, and care

planning, care coordination and management, caregiver education and support. Those are the types of activities that are covered under the model's monthly payment. And then all other costs and services, including services from specialists related to unrelated conditions, hospital services, post-acute therapy, labs and imaging, all of those costs would be outside of the model's monthly payment and continue to be billed as normal under fee-for-service.

And I am going to pass it to Jennifer for the next question.

>>Jennifer Brown, CMS: Thanks, Emily. So we've had a few questions on some quality measures, specifically the use of high-risk medications in older adults.

So just to clarify, this will be the NQF-endorsed measure, number 0022, that we use in the CMS MIPS Program. And yes, the measure will have an inverse relationship, meaning that the lower the score means higher performance. Additional details on this measure will be available in the Request for Applications, so we ask that you review that document.

And I'll pass this on to Sarena.

>>Sarena Ho, CMS: Thank you, Jennifer, and thanks again to you all for joining us to learn more about the GUIDE Model. The next question that I'll be answering concerns telehealth, and more specifically, whether the model will support the use of digital health or telehealth for expanding access to care for underserved populations.

The GUIDE care delivery requirements provide beneficiaries and caregivers with flexibility when receiving care. And we anticipate that nearly all model components could be delivered virtually, which will allow for model access for beneficiaries and caregivers in rural areas and other communities without access to specialized dementia care. So one example of this, is the comprehensive assessment care delivery requirement that was mentioned earlier. And this is an assessment that can be performed via telehealth, or in person, based on the preference of the beneficiary or caregiver. Caregiver education and support are also components of the model that can be delivered virtually. And the only in-person visit requirement is the in-home visit for certain beneficiaries when they first join the model.

Tonya, I will pass it back to you.

>>Tonya Saffer, CMS: Thanks, Sarena. Another question I received, this is a great question: How can home and how can community-based organizations participate in the GUIDE Model if you need to be a Part B provider to bill?

So through the development of GUIDE, of the GUIDE Model, we have learned how important home and community-based organizations are to supporting and caring for people living with dementia. We do require a Medicare Part B enrolled provider or practitioner who is eligible to bill for Physician Fee Schedule Services, to be a model participant, and that is, in order to integrate clinical services with support services. However, we strongly encourage home and community-based organizations to partner with an eligible provider or clinician in order to participate in the model.

And I will turn it back to Sage.

>>Sage Hart, CMS: Thank you, Tonya. One of the next questions I'll answer is: What credentials are required for the person that is the care navigator? And I'll also touch base on the training that we will require for care navigators, as there were a few questions about that as well.

The GUIDE Model will not require that the care navigator has certain credentials or professional accreditation. A variety of professions, such as a community health worker, physician assistant, social worker, just as examples, could fill this role. The model is requiring, however, that the individual who works as a care navigator receives training on a variety of certain topics related to dementia model, which will be listed in the in the RFA. And some examples of these topics are ensuring that the care navigator receives an overview of dementia as a medical condition, learning what a care plan is, learning about person-centered planning, and the participant will be responsible for arranging that their care navigators receive this training. And participants have options to either create and use their own training, or they can look to other training materials that are already available through other organizations to ensure that their care navigators receive training on GUIDE's required training topics.

And with that, I'll turn to Emily.

>>Emily Johnson, CMS: Thanks, Sage. We got a question about the infrastructure payment, the timing of that, and what it's expected to cover.

So this payment is meant for providers who are safety net providers and who are in the New Program Track. And remember, that New Program Track has a one-year pre-implementation period that starts on July 1st, 2024. So the infrastructure payment would be made at the beginning of this pre-implementation period, and then our expectation would be that participants who receive that payment would use it to fund program startup activities, so things like hiring and training staff, building out your referral networks, developing workflows and processes. All of those costs related to program setup are expected to be covered by that upfront payment.

And I will pass it to Jennifer.

>>Jennifer Brown, CMS: Thanks, Emily. So we did get a couple of questions on how to administer the survey-based measures.

So CMS, we do expect the model participants to administer these surveys for the beneficiaries and caregivers. Thank you for this question, for these two questions, they were great.

And I will pass that along to Sarena.

>>Sarena Ho, CMS: Thanks, Jennifer. So we received a few questions about what the data reporting requirements will be for participants. And then in the second poll that was completed, there was some interest in hearing more about data reporting.

More information about specifics of the data submissions will be available later this fall with the release of the RFA. But at a high-level, participants in GUIDE will be collecting and reporting information that will allow us to monitor and evaluate the model. And this will include, one, quality data, so participants will be annually reporting quality data for the non-claims-based performance metrics. Two is care delivery data, and this will consist of a series of questions about how we're implementing the model and specifically, the care delivery requirements of the model. Third is beneficiary and caregiver assessment data, so participants will conduct an initial assessment of potentially eligible beneficiaries, and

caregivers as applicable, and submit data to CMS that includes beneficiary dementia stage, whether they have a caregiver, and level of burden. And then, lastly, sociodemographic and health-related social needs data.

Back to you, Tonya.

>>Tonya Saffer, CMS: Thank you, Sarena. We received several questions about overlaps in existing value-based programs like ACO REACH, the Medicare Shared Savings Program, and you know, the patient PCF Model, and other total-cost-of-care models. So is there ability, will the program be able to overlap?

So yes, GUIDE, if you are participating in a, in a model already, within the Innovation Center, we will allow for overlap and participation in GUIDE. So, you can participate in both simultaneously. So, the CMS Innovation Center has a 10-year goal of all beneficiaries receiving care in an accountable care arrangement, and so the model was designed to overlap with those other total-cost-of-care models, and therefore providers and practitioners that participate in ACOs, in MSSP, or other total-cost-of-care models can participate in GUIDE under a single Medicare Part B enrolled TIN. If members are in another CMS model like MSSP, or ACO REACH, they will be able to bill under that single TIN as well. And so that would be the only difference here, is rather than an ACO being the participant, a provider or a single entity must be the actual participant for the model.

And I will turn it back over to Sage.

>>Sage Hart, CMS: Thanks, Tonya. We received, a question that asked, if we could please clarify the requirements for types of respite services, for example, does the model require adult day services.

As some background, as Emily discussed earlier, the GUIDE Model provides coverage for three types of respite services, up to an annual cap of $2,500 per beneficiary, per year. The three types of respite covered by GUIDE are respite services provided in the beneficiary's home, in an adult day center, which includes both medical and social programs, and in a 24-hour facility. And while the model provides coverage for these various settings, participants will have some flexibility in the type of respite services that they make available to their beneficiaries. The model provides that all participants are required to make available in-home respite services, either directly or by contracting with a provider of in-home respite. However, participants have the option, but are not required, to make available respite through an adult day center or a 24-hour facility.

And with that, I'll pass it to Emily.

>>Emily Johnson, CMS: So we've gotten a couple of questions about how the payment would flow to partner organizations, community-based organizations that were partnering with model participants.

So again, the model participant entity is a Part B Medicare enrolled provider or supplier and then they could partner with either other Medicare enrolled providers or community-based organizations that are not enrolled in Medicare in order to participate. But that Part B entity, that is the participant entity, would be the one billing for all model services. They'd be billing for the DCMP and they'd be billing for the respite services, and then they'd be responsible for having financial arrangements in place with their partner organizations, in order to reimburse for any services that those partner organizations are providing to their aligned beneficiaries.

And with that, I will pass it to Jennifer.

>>Jennifer Brown, CMS: Thanks again, Emily. So I did receive this great question on the Performance-Based Adjustment. So the person asked: Is the PBA metric performance dependent upon percent completion or a percent quality threshold regardless of attempts?

So, at a high-level, each performance measure will have its own benchmark to denote if it's an upward or downward adjustment. More specifics, though, will be provided at a later date.

And with that, I'll pass it along to Sarena.

>>Sarena Ho, CMS: Thanks, Jennifer. So we've received a few questions about what kinds of data the GUIDE Model will be sharing back with participants and how this data will be shared.

The primary platform that GUIDE will use to share data with participants will be through a data dashboard, which will provide participants with an interactive and user-friendly interface for viewing data for their enrolled beneficiaries and this will be updated periodically. As far as the types of data being shared, data will be available on a variety of topics, including utilization, quality data, sociodemographic data, and other domains.

Back to you, Tonya.

>>Tonya Saffer, CMS: Okay, and I'm actually searching to see what other questions we have here. Okay, so we have, this is an interesting one, and we have a question here that says: Can practices in the Established Track transfer existing patients with dementia and Medicare into the GUIDE model?

So we would expect that patients that are in an existing program would be, continue to receive care under that existing program. But they would have the option to choose another program if there was a new one that was more in their, just in their preference, or in their local community, they'd have the ability to opt to choose and select a new program. So, that that would be completely voluntary on the part of the beneficiary.

I'll turn it back to Sage.

>>Sage Hart, CMS: The next question I will answer asks: Is this model intended for older persons living independently? May beneficiaries living in assisted living facility participate?

And yes, the beneficiary may be living independently in their own home or in a community setting such as an assisted living facility. And their caregiver does not have to live with the beneficiary to qualify to participate in the model. The caregiver may live in a different home, as an example, or even a different state, as long as they are actively participating in the beneficiary's care.

Thanks, and I'll turn it to Emily.

>>Emily Johnson, CMS: Thanks, Sage. So there was a question about whether there is a financial need requirement to receive respite services.

And there is not. So all beneficiaries who have a caregiver and are either in the moderate or severe stage of the disease, and in those associated model tiers, would be eligible for respite services, regardless of their financial situation.

And I will pass it to Jennifer.

>>Jennifer Brown, CMS: Thank you. So we did receive a question on MIPS: So will providers be required to participate in MIPS, in MIPS to report?

So we do expect the GUIDE Model will qualify as a MIPS APM for both the established and new dementia care provider tracks. However, the new provider track will not qualify during their pre-implementation period, which is the 12 months prior to their participation. However, we do want participants to understand that for MIPS measures that are outside of the model that they are actively participating in those will be tracked separately from our model.

And with that, off to you, Sarena.

>>Sarena Ho, CMS: Thanks, Jennifer. So the next question I'll be answering is: What does the Help Equity Plan requirement entail and how will it be evaluated?

So GUIDE participants will develop and implement a Health Equity Plan, and the purpose of the plan is for each participant to identify disparities and outcomes in their patient populations and implement initiatives to measure and reduce disparities over the course of the model. So, as we stated earlier, the first plans will be due before model launch, and those will focus specifically on beneficiary outreach and engagement at the start of the model. And those will be precursor to more comprehensive, annual Health Equity Plans that will continue over the course of the model. Participants will be held accountable for submitting the Health Equity Plans and reporting data, but progress on health equity goals that are outlined in the plans will be self-assessed.

Right back to you, Tonya.

>>Tonya Saffer, CMS: Thanks, Sarena. I have another question regarding overlaps with other CMMI models and the Medicare Shared Savings Program, and that was: If there are members in another CMS model, will the GUIDE Model per-beneficiary-per-month payment count as a medical expense in those models?

And the answer is, yes, it will count towards their expenses as part of that model. And there'll be more detail on timing of that, as well as whether it counts towards the benchmark when we release the RFA in November.

Alright, I'll turn it back over to you, Sage.

>>Sage Hart, CMS: Thanks. We've received a few questions about the care delivery requirement for caregiver education and training,

And I just want to note, to answer these various questions, the caregiver education under the model is not standardized by the GUIDE Model. Participants have the option to establish their own programs and provide caregiver training themselves internally, or the participant can contract with a third-party vendor to provide these services. So there's some flexibility in how the participant wishes to provide these services to the beneficiaries.

With that, I'll turn to Emily.

>>Emily Johnson, CMS: Thanks. And I know we're nearing the end of the hour. So I just wanted to address one question about participation and Letters of Intent that we've been receiving.

So I did want to clarify that, although we strongly encourage Letters of Intent, and they're very helpful for us, and understanding what questions you have about the model, what challenges you see with the model, what interests you about the model, submitting a Letter of Intent is not required to then apply for the model. So, although it's very helpful to us, they're not required, and they're also not binding. So it is possible to submit a Letter of Intent, and then choose not to apply for the model when the application becomes available.

And I think with that I'm going to pass it back to Tonya,

>>Tonya Saffer, CMS: Thank you. That is all the time we have for questions and answers, and I want to thank everybody for their engagement, we had over 400 questions in the chat live. So we're going to work through answers to those and we'll do our best to get back to you. And then I think we've also posted the link to the help box, email box for you to submit your questions there as well. So thank you guys, really appreciate all of the time and attention.

And then just building off of Emily's last comment, the Letters of Intent again, are non-binding. Strongly encouraged, they'll help us tremendously identify people that are interested, identify areas where we want to maybe even recruit more people to participate in the model. So they're helpful, and they're non-binding, so you wouldn't have to submit an application if you later chose not to. And with that, I'll ask for the next slide.

Okay. So thank you for joining the webinar again. We received a ton of great questions, and always we look forward to continuing in the future dialogue with you. We are going to ask you to take note of the following actions, to continue engagement with us, and to learn more about GUIDE. So you can visit our GUIDE webpage to find more information on the model and the announcements about future GUIDE events. You'll see that link posted in the chat as well as the help desk mailbox that's already in the post in the chat by TJ. And you can also sign up to the GUIDE listserv to receive email updates as we progress in releasing more information, including the Request for Applications, and so you could please, might want to sign up for that, that listserv. That link should be available to you as well. And you can follow us on Twitter @CMSInnovates.

Alright, this concludes today's webinar, and I want to thank you again for joining, and I hope you have a good rest of your day. Take care.

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