GUIDE Model Request for Applications (RFA) Webinar

11/30/2023

>>Arbre'ya Lewis, SEA: Good afternoon, everyone, and thank you for joining today's GUIDE Model Request for Applications webinar. 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 also would like to let you 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 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 you a brief overview of the agenda for today's event. We will begin with a welcome from Ellen Lukens, the Deputy Director of the Center for Medicaid and Medicare Innovation, and an introduction of today's speakers. Then, the model team will review some background information about the GUIDE Model. They will then dive into the bulk of today's presentation and share an overview of the GUIDE Model Request for Applications. Following that we will share more information about the application process and timeline.

We will have about 20 minutes for a Q&A session where our team will answer questions submitted by audience members. 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 planned for you. Now I'm going to pass the mic to Ellen Lukens to formally welcome you to today's event. Next slide, please.

>>Ellen Lukens, CMS: Good afternoon, everyone. My name is Ellen Lukens. As mentioned before, I am the deputy director of the CMS Innovation Center. I am excited today to welcome you to the GUIDE Model Request for Applications webinar.

Dementia is a devastating diagnosis for a person and their loved ones. It can rob people living with it of their autonomy and agency, and stress families emotionally, mentally, and financially. I thank those of you attending today who are health care clinicians, practitioners, advocates, and caregivers that have been working tirelessly for years to improve care for people living with dementia. You have our utmost respect and gratitude for your work.

The GUIDE Model was developed to test if people living with dementia would experience better quality of life, less strain on their caregivers, and reduced need for long term nursing home care if CMS provided an alternative payment model to their health care practitioners. The innovative payment approach for GUIDE is intended to encourage and support health care practitioners to deliver the comprehensive care and support services that people living with dementia and their caregivers have said that they are most in need of, and we worked with many of you on the line today to develop this. If

we achieve the goals set in this model, which align with our statutory requirements to reduce spending and improve quality, we will achieve success and be able to pay for this care long into the future.

I want to emphasize that the success of the GUIDE Model relies on collaboration. We can't do this alone. We encourage diverse perspectives and partnerships that will amplify the impact of the selected participants. Your participation in this webinar today signifies your commitment to pushing the boundaries of innovation, and we are eager to see the incredible dementia care programs that will emerge from this process.

I want to express our gratitude for your dedication to advancing innovation. Together we can create a future where the GUIDE Model becomes a catalyst for positive change.

Now I'm pleased to pass over to the GUIDE Model team who will be presenting today's webinar. Next slide, please.

>>Tonya Saffer, CMS: Thank you, Ellen, and good afternoon, everyone. We're excited to have you joining us today. I'm Tonya Saffer, the Director of the Division of Healthcare Payment Models, and we're so grateful for you today and for your interest in improving quality of care and support for people living with dementia and their caregivers.

GUIDE is an innovation, and we will be asking you, for you, to try new ways to enhance care and report quality. The team here today on the screen, and the many more off screen, will be there to support you, answer your questions and collaborate with you on this journey.

For today's session we want to take every opportunity to make this engaging. 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 questions will be anonymous, and I can see everybody has started taking the poll already. There is a link in the chat, if you have not started, and please let us know where you're dialing in from today. And I'll give everybody a minute or so here to take the poll.

I think the answers are starting to come to a slow here, so thank you guys so much for participating. It's really great to see that we have so many people across the country interested in participating in GUIDE, and improving the care and support for people living with dementia. Next slide, please.

Now I'm so pleased to introduce the team that will be presenting to you today. The GUIDE Model Co-leads, Sage Hart and Melissa Trible, and Jasmine Alexis, the GUIDE learning systems and application support lead. These speakers and many of our colleagues, some who will join for the today's Q&A and others who are behind the scenes, have been working tirelessly and passionately over the past several months to develop this model and continue to do so, and there still a lot of work to be done. A huge 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. With that I will pass it over to Sage Hart. Next slide, please.

>>Sage Hart, CMS: Hello, everyone. My name is Sage Hart. I'm a 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. Next slide, please.

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 a high-quality, high-value care.

Some of these issues include a lack of caregiver training and recognition, unestablished health care pathways, limited coverage of key supportive services, and lack of sustainable payment for 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 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 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.

The GUIDE Model will also provide payment for a defined amount of respite services 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 eight-year voluntary model offered in all states, Washington D.C., and U.S. territories. The model performance period will begin on July 1st, 2024, and end on June 30th, 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 opens on November 15, 2023, and will close on 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.

In this next section of the webinar, I will introduce you to the GUIDE Model Request for Applications. Next slide, please.

This slide walks you through information you'll need to understand the GUIDE Model application materials, registration process, and application due dates. All application materials information can be found on the Model web page.

If you have questions about those materials or any resources that may be available, please reach out to the model team directly at GUIDEmodelteam@cms.hhs.gov. For your convenience we've dropped that email in the chat for you.

Appendix A of the RFA includes all application questions, deadlines, and contact information. Sections of the application include organization information, ownership interest, organization contacts, staffing and interdisciplinary care team, care delivery, alignment, health equity, health information technology and applicant service area. All required information must be included in GUIDE Model applications. The application may be accessed via the online portal linked in the chat.

CMS strongly recommends that you do not wait until the application due date, January 30th, 2024 to begin the application submission process. GUIDE Model applicants may begin the application now and then save and return to the application before the deadline on January 30th, 2024. Not all applicants are guaranteed participation in the model. In selecting participants CMS will consider factors critical to ensuring a robust evaluation of the model. CMS may also deny individual clinicians, or any other individual or entity, participation in the GUIDE Model based on the results of a program integrity review. CMS will issue a rubric that will be used during its selection process to help evaluate the quality of applications. Next slide, please.

I will cover the participant eligibility requirements now. Next slide, please.

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, or TIN. Examples of eligible participants include a standalone physician practice, practices that are part of a health system or ACO, and practices that have been established by a hospice agency, 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. Applicants may apply from all 50 states, Washington D.C., and U.S. territories.

During the model, GUIDE Participants must meet the care delivery requirements described in the care delivery section of the RFA who may choose to partner with other organizations, including both Medicare enrolled providers and suppliers and non-Medicare enrolled entities, such as community-based organizations, to meet these requirements. These organizations do not need to share a TIN. Next slide, please.

GUIDE Participants must meet the following requirements, among others specified in the participation agreement throughout the performance period of their assigned track. That is, they must meet the interdisciplinary care team, care delivery, and training requirements, as described in the Participation Agreement. See the Care Delivery section in Appendix B of the RFA.

They must use an electronic health record platform that meets CMS and Office in the National Coordinator for Health Information Technology Standards for Certified Electronic Health Record Technology.

The GUIDE Participant has the flexibility to provide most model services virtually or in-person, at an 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 GUIDE Participant is required to make available for eligible beneficiaries GUIDE respite services in the beneficiary's home. The GUIDE Participant has the option, but is not required to offer eligible beneficiaries GUIDE respite services at an adult day center or 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, and comply with all model reporting requirements, including care delivery, sociodemographic data, and quality reporting. Next slide, please.

As briefly mentioned earlier in our presentation, the GUIDE Model will have 2 participant tracks. To support the development of new dementia care programs, GUIDE will have a track for established programs that will launch on July 1st, 2024, and a track for new programs that will include a one-year pre-implementation period and start the performance period on July 1st, 2025. 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.

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 aims to improve access to comprehensive dementia care nationally. 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 work flows, training and development of a referral network, as well as identifying a program director who has primary accountability for implementing their dementia care program. In summary, track assignment will depend on whether, at the time of application, the applicant has an interdisciplinary team that has provided comprehensive dementia care to people living with dementia for at least the past 12 months. 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's 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 5 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 sometime in the past 5 years comprised of adults aged 65 years or older, or have a specialty designation of neurology, psychiatry, geriatrics, geriatric psychiatry, behavior neurology, or geriatric neurology. Next slide, please.

The GUIDE Participant will be required to maintain a list of physicians and non-physician practitioners in the list of partner organizations if applicable. The GUIDE Participant will be required to maintain this list of physicians and non-physician practitioners, called the GUIDE practitioner roster, and keep it up to date throughout the course of the model. This roster will be used to determine who is eligible to bill for GUIDE Model payments. Additionally, this list must include at least one clinician with dementia proficiency.

The GUIDE Participant will be identified by a single TIN that's used to bill for GUIDE Model services plus the National Provider Identifiers of individual Medicare enrolled physicians and other non-physician practitioners who have reassigned their billing rights to the GUIDE Participant's billing TIN. If a GUIDE Participant contracts with another Medicare enrolled or non-Medicare enrolled entities, these contracted providers and suppliers will be known as partner organizations. Both Medicare enrolled and non-Medicare enrolled entities may contract with more than one GUIDE Participant. Next slide, please.

The primary beneficiary population for the GUIDE Model are community dwelling Medicare Fee-for-Service beneficiaries, including beneficiaries dually eligible for Medicare/Medicaid, who often experience fragmented, uncoordinated care. The eligibility requirements for beneficiaries are outlined on the left side of the slide. 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 also must not be enrolled in 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 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 to a model participant, beneficiaries will maintain complete freedom of choice and where to seek care. CMS will employ several outreach strategies to supplement GUIDE Participant's beneficiary recruitment activities.

For example, following a request by the GUIDE Participant CMS will use claims data from a three-year historical look-back period to identify beneficiaries who received Medicare services from a GUIDE Participant, have claim-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 Participant's first performance year, a list of eligible Medicare Fee-for-Service beneficiaries with dementia diagnosis codes. The list would include beneficiaries to whom the GUIDE Participant provided services during the three-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. Next slide, please.

I will now turn it over to my colleague Melissa, for the payment methodology slides.

>>Melissa Trible, CMS: Thank you, Sage. Hello, everyone, I'm Melissa Trible, one of the GUIDE Model co-leads. I will cover the GUIDE alternate payment methodology now. Next slide, please.

The primary 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 2 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, and a health equity adjustment that is based on beneficiary-level health equity factors, and may also increase or decrease payment. We will discuss both of these adjustments in more detail later.

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 respite services. Participants will be able to bill for respite services provided in a beneficiary's home, in an Adult Day Center, and in a 24-hour facility. Next slide, please.

The performance-based adjustment will be calculated annually and applied monthly to participants' DCMPs. The performance-based adjustment can either decrease or increase the monthly payment depending on the participant's performance on the five GUIDE quality metrics. Each measure has an associated performance-based adjustment potential, which can be seen in the table here, and once all five measures are phased in, a participant's total performance-based adjustment potential can range from minus 3.5% to plus 10%.

The timeline on this slide indicates when each performance-based adjustment will be applied for each program track. Since the performance-based adjustment is based on participant performance, and quality data will be reported annually, the first performance-based adjustment will not be applied until each track's second performance year. Next slide, please.

New program track participants classified as safety net providers can receive a $75,000 Infrastructure Payment to offset upfront costs for launching a dementia care program. This one-time payment, starting in July 2024, aims to support safety net providers in hiring, training, program development, community outreach and electronic health record technology adaptations. The payment will be geographically adjusted, based on the Physician Fee Schedule factor used for the DCMP.

To qualify, applicants need a Medicare Fee for Service beneficiary population meeting specific criteria reflecting CMMI's safety net definition. 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%

beneficiaries receiving the Part D low-income subsidy, or 33.7% of beneficiaries who are dually eligible for both Medicare and Medicaid. Next slide, please.

The DCMP rates above represent base payment rates and will be adjusted for geographic variation in cost, as well as cost growth over time. To account for geographic variation costs, CMS will adjust the DCMP base rates by the Medicare Geographic Adjustment Factor for each DCMP claim submitted by the GUIDE Participant. The geographic adjustment factor applied to the DCMP is a weighted geographic adjustment based on all services in the Medicare Physician Fee Schedule. It summarizes the combined impact of the geographic practice cost index expense categories such as work, practice expense, and malpractice on a locality's physician reimbursement level. To account for cost growth over time, CMS will annually update the DCMP base rates by the Medicare Economic Index, a measure of physician practice cost growth calculated by the CMS Office of the Actuary. Next slide, please.

The GUIDE Health Equity Adjustment is designed to provide additional resources to GUIDE Participants to deliver care to beneficiaries from underserved communities. CMS will calculate a health equity adjustment for each beneficiary that is aligned to a GUIDE Participant based on the beneficiary's health equity score. The Health Equity Adjustment will be calculated annually and then applied to the DCMP for each beneficiary as a monthly adjustment. The Health Equity Adjustment is intended to be budget neutral, to minimize the financial impact of the overall model. The Health Equity Adjustment will be calculated using a composite methodology that includes both area level and beneficiary level measures of deprivation. Specifically, the Health Equity Adjustment will be comprised of four measures: state and national comparison Area Deprivation Index, which are measured at the census block group level, and low-income subsidy status and dual eligibility which are beneficiary-level measurements. Next slide, please.

The first 2 payment examples below show how total GUIDE Model payments will be calculated for an individual aligned beneficiary over the course of a full performance year. In the first example, the beneficiary is in a tier that is eligible for GUIDE respite services, and the example assumes that she reaches the respite cap for the year. In the second example, the beneficiary is in a tier that is not eligible for GUIDE respite services. Each of these examples are rounded to the nearest dollar, and assume that all beneficiaries are newly aligned in the first month of the performance year, and therefore are eligible for the new patient DCMP rate for the first six months of the year and the established patient DCMP rate for the next six months. Next slide, please.

In the next section of today's webinar. I will cover the care delivery requirements of the model. Next slide, please. As mentioned earlier, there is a standard minimum set of care delivery services that participants must provide as part of the model. Participants must be able to provide the services at varying levels of intensity, depending on model tier 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 includes nine care delivery domains. They are: comprehensive assessment, 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. GUIDE Model Participants have the option to contract with a partner organization to make certain services available to their beneficiaries, including 24/7 access to a

member of the care team or helpline, referral and support coordination, respite services, if needed, and caregiver education and support. Next slide, please.

During the comprehensive assessment, the interdisciplinary care team will assess the beneficiary and their caregiver across a number of required domains, including cognitive function, functional status, clinical needs, behavioral and psychosocial needs, and caregiver burden, with the goal of confirming a dementia diagnosis and creating a comprehensive care plan. As part of the comprehensive assessment, The GUIDE participant will administer approved screening tools and submit the resulting scoring data on the patient assessment and alignment form. CMS will use this data to assign beneficiaries to a model tier. The table on this slide shows how the screening tools scoring corresponds to the GUIDE Model tiers. CMS GUIDE Model Participants must use a tool from a set of approved screening tools to measure dementia stage and caregiver burden. Approved measurement tool sets include two tools to report dementia stage. One, the Clinical Dementia Rating, and two, the Functional Assessment Screening Tool. There is also one to report caregiver strain, the Zarit Burden Interview. Alternatively, the GUIDE participant will have the option to seek CMS approval to use an alternative tool by submitting the proposed tool along with published evidence and a crosswalk for how it corresponds to the GUIDE Model's tiering thresholds. Next slide, please.

In the next section of today's webinar, I will walk you through some of the quality measures and reporting criteria for the GUIDE Model. Next slide, please.

CMS plans to measure GUIDE Participant performance on five performance measures including quality, patient experience, utilization, and cost metrics. These include use of high-risk medications in older adults, quality of life outcome for people with neurological conditions, caregiver burden, total per capita cost, and long-term nursing home stay rate. The caregiver burden and long-term nursing home stay rate are new metrics that will be developed for use in the GUIDE Model. The five measures in the performance measure set will be used to adjust GUIDE Participants' monthly payments. CMS plans to phase in the use of these measures over time.

Next slide, please. I will now pass it to Jasmine for the data reporting requirements section.

>>Jasmine Alexis, CMS: Thank you, Melissa. Hello, everyone. My name is Jasmine Alexis, and I am the GUIDE Model learning systems and applicant support lead. As mentioned earlier, GUIDE Participants will complete care delivery reporting at least once per year, which will consist of a series of questions about how they are implementing the care delivery requirements of the GUIDE Model, including how frequently they are interacting with the aligned beneficiaries and their caregivers, and what care modalities they are using. CMS will require all GUIDE Participants to collect and report certain beneficiary reported social demographic data and health-related social needs data from their aligned beneficiaries willing to share this information. GUIDE Participants are not required to report this data to CMS for any beneficiary who chooses not to disclose them. GUIDE Participants will be encouraged to use one of two preferred health-related social needs screening tools: the Accountable Health Community's Health-related Social Needs Screening tool or the Protocol for Responding to and Assessing Patient's Assets, Risk, and Experience tool. GUIDE Participants will be required to annually report health-related social needs data that is aggregated across aligned beneficiaries and includes domains such as food insecurity, housing instability, transportation needs, utility difficulty, and interpersonal safety. This data collection will allow CMS and GUIDE Participants to evaluate health inequities and disparities in GUIDE communities. 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 Realizing Equity Access and Community Health Model, the Shared Savings Program, and the three Comprehensive Kidney Care Contracting Options in the Kidney Care Choices Model. Eligible beneficiaries may simultaneously be aligned to the GUIDE Model and attribute to participants in the ACO REACH, the Shared Savings Program, or the Comprehensive Kidney Care Contracting Options in the Kidney Care Choices Model. The GUIDE Model will allow participant overlap with the BPCI Advanced Model at the TIN level. 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 attribute or align to participants in active CMMI models including ACO REACH, Kidney Care First, Making Care Primary, the Maryland Primary Care Program, and Primary Care First, as well as the Vermont All-Payer Model. Next slide.

In the next section of the webinar, I will walk you through the model application process and timeline. Next slide, please.

All GUIDE applications must be submitted through the online application portal by 11:59 PM Eastern Daylight Time, on January 30th, 2024. 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 GUIDE Model will launch on July 1st, 2024. Now, I'll pass the mic back to Sage to lead our question and answer session. Next slide, please.

>>Sage Hart, CMS: Great. Thank you, Jasmine, for wrapping up the overview of the model and application process. Next slide, please. 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're interested in. 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 also 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 moments to join before moving on.

Seems like care delivery may be the winner with payment methodology catching up. With that, we thank you for participating. Your input on this poll will help inform future model events and resources. Next slide, please.

And we also ask that you please participate in the survey for today's event by clicking the link in the chat window. You may send an additional input on today's session or concepts to GUIDEmodelteam@cms.hhs.gov. Thank you in advance for your participation in the survey. Next slide, please.

So, during the next 15 minutes our team will collectively 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 to every question. We will take note of each question and try to ensure that future materials help address any common themes. Also, you're welcome to submit additional questions after today's event to the GUIDE Model helpdesk at GUIDEmodelteam@cms.hhs.gov. And to begin, Charlotte, I'm going to point the first question to you. We had a question that came in asking, does participation in an APM prevent participation in the GUIDE Model? If you could please come off mute and respond. We'd appreciate it.

>>Charlotte Kaye, CMS: Sure. Thank you. CMS will allow organizations which are identified at the TIN level to participate in other APM models. Eligible beneficiaries may simultaneously be aligned to a GUIDE Participant in the GUIDE Model and attributed, or aligned, to participants in another APM. I will pass it back to you now Sage.

>>Sage Hart, CMS: Great. Thank you, Charlotte. And Sarena, I'm hoping that you can answer this question, and it asks, will there be recommendations or benchmarking from institutes on how they are able to achieve some of the larger financial benefits?

>>Sarena Ho, CMS: Yeah, thanks, Sage. So, in terms of performance metrics, as shared previously, a performance-based adjustment will be applied to the DCMP depending on performance on the five GUIDE measures. The GUIDE Model will calculate benchmarks for each quality measure that result in the different adjustments, and model participants will receive benchmarking details before each performance period. As far as general recommendations for achieving success in the model, in addition to providing benchmarks for quality performance, the model will have a learning system to encourage knowledge sharing across Model Participants.

>>Sage Hart, CMS: Great. Thank you, Sarena. And Kaleigh, I have a long question for you, so so please bear with me. But the question came in, it's a three-part question, could you share more details about the requirements for caregiver skills training? And are there any particular expectations about the kinds of training materials and resources that must be provided to caregivers? And then, lastly, how do you consider skills training to be different from a support group?

>>Kaleigh Ligus, CMS: Thank you so much for that question, Sage. CMS will require GUIDE Participants to provide GUIDE care delivery services to align beneficiaries as applicable and appropriate to each individual beneficiary's needs. Participants will have discretion in how they operationalize these requirements, such as the caregiver education and support, beyond what is described in the RFA and the GUIDE Participant shall provide caregiver, caregivers with the option to participate in a group setting where the facilitator, trained in dementia and caregiving, shall work with caregivers on self-care, home safety, caregiver skills, personal care, and other elements, and training shall include the following topics for caregiver skills. Examples include emergency services, safety in the home, or assistance with activities of daily living. Additional information on these services can be found starting on page 72 of the RFA.

>>Sage Hart, CMS: Thank you, Kaleigh, for your, for your detailed response. Ameila, we had a question that came in that asked, what happens if a participant is unable to attribute, or in our case align, or maintain 200 beneficiaries by the second performance year?

>>Ameila Citerone, CMS: So, participants will be encouraged, but not required to have at least 200 aligned beneficiaries. We would like them to have 200 aligned beneficiaries throughout the model, but it is not required. Back to you, Sage.

>>Sage Hart, CMS: Great thanks, Ameila. Charlotte, I'm gonna loop a question back to you. We were asked the rates for in-home respite and facility-based respite are low in current market, most are looking at $29 an hour versus the $26 an hour through the GUIDE Model, and facility-based respite is at $275 versus the $260 in the GUIDE Model. And the question is, will these reimbursements have geographic adjustments and be adjusted over time?

>>Charlotte Kaye, CMS: Thanks, Sage. Yes, the respite payments will be adjusted for the geographic adjustment factor, or also known as the GAF payments, will just will be adjusted upward or downward, based on inflation, fees by physicians, general wage levels, and geographic variation. As we continue to build on the model, CMS will continue to evaluate and adjust reimbursement rates to allow for the provision of the best care along with maximum flexibility. Send it back to you.

>>Sage Hart, CMS: Thanks, Charlotte. And Sarena, how does CMS envision FQHCs participating? Will there be a chance for FQHCs to join later?

>>Sarena Ho, CMS: Yeah, great question. So, providers that are eligible to be the primary GUIDE Participant must be able to bill Medicare part B services under the Medicare Physician Fee Schedule and, while this excludes FQHCs from directly billing for GUIDE Model services, participants can and are encouraged to contract with other Medicare providers and suppliers as partner organizations, like FQHCs, in order to meet the care delivery requirements.

>>Sage Hart, CMS: Thank you, Sarena. Kaleigh, we had a few questions related to the one I'm about to ask now and it's, if the applicant will have delivered comprehensive dementia care for 12 months by July of 2024, can they apply as an established program?

>>Kaleigh Ligus, CMS: Thank you again for your question, Sage. We ask that applicants care delivery requirements are assessed at the time of the application deadline, which is January 30th. Back to you.

>>Sage Hart, CMS: Ameila. I have a short and sweet question for you. We were asked, how is attribution made and lost?

>>Ameila Citerone, CMS: So, the GUIDE Model will use voluntary alignment for aligning beneficiaries to Model Participants. Participants will inform beneficiaries about the model and the services they can receive through the model, and the participants will then submit the consent to CMS and will confirm the beneficiary's eligibility. Beneficiaries will remain in the model and align to the GUIDE Participant until they become ineligible. And they can become ineligible for reasons like joining, enrolling in Medicare Advantage, becoming a long-term nursing home resident, or if the beneficiary stops receiving care delivery services from the GUIDE Participant, or they move out of the service area.

>>Sage Hart, CMS: Okay, thank you, Ameila. Charlotte, if you could please address this question, it asks as a larger health care organization, we have providers in multiple TINs. It sounds like we would need to submit one application per TIN, are we allowed to submit more than one application for the organization? And is there any limit to how many TINs we can apply for under the same organization?

>>Charlotte Kaye, CMS: Great question, and we're excited that you are interested in applying. We encourage you to submit as many applications as you would like, but we please keep it for one per TIN. Thanks.

>>Sage Hart, CMS: Thank you, Charlotte. We've also received a handful of questions related to the next one. I'm going to ask, ask you, Sarena, and that relates to the health-related social needs screening tool requirements. Can you share what those are?

>>Sarena Ho, CMS: Yes, absolutely. So, GUIDE Participants will be encouraged, but not required, to use one of two preferred HRSN screening tools, and those are the Accountable Health Communities (AHC) Tool or the Protocol for Responding to and Assessing Patient's Assets, Risks and Experiences, or PRAPARE tool. For GUIDE, participants will be able to use other HRSN screening tools, provided that they cover the domains that are outlined in the RFA, which include food insecurity, housing instability, and transportation needs.

>>Sage Hart, CMS: Thank you, Sarena. And Kaleigh, this is an interesting question that came in, I'm going to ask, will the primary caregiver be able to identify a surrogate caregiver to promote consistency? That's a great question.

>>Kaleigh Ligus, CMS: It is a great question. GUIDE Participants are only required to identify one caregiver for evaluation and reporting data. However, GUIDE Participants are encouraged to involve other caregivers in the care delivery to best meet the needs of each individual beneficiary. If a primary caregiver, identified by the aligned beneficiary, is unable to remain engaged in the model, GUIDE Participants are permitted to complete a reassessment of the beneficiary and update the information regarding the new caregiver. Back to you.

>>Sage Hart, CMS: Thank you, Kaleigh. I'm going to take a stab at a question that I saw come in and it asks, would it - next of kin be an acceptable decision maker if a beneficiary does not have a guardian or pre-designated representative? And most likely no, a next of kin, with no other legal authority, may not make health care decisions for a beneficiary that lacks capacity to make those decisions for themselves, and that includes whether the beneficiary participates in the model. And each state has its own laws related to guardianship and medical decision making, and the model does not trump, or, in other words, the model's not an exception to to the State laws, and so providers and the beneficiary's family members must follow the laws of their state as it relates to obtaining legal authority to make decisions for someone who lacks capacity to make those medical decisions, whether that's through a medical advance directive or a guardianship. I hope that that answers that that question.

I'm next going to see, Charlotte, I have another question that I think you can answer. And it's asking, let's see, I'm hearing that the Per Beneficiary Per Month Payment replaces the E/M billing provided to the beneficiary? Is that correct, or can you provide some clarification on that question?

>>Charlotte Kaye, CMS: Absolutely. And it's a very good one. It's a, it's a confusing topic. The E/M codes are not included in the roll up to the PBPM, or Per Beneficiary Per Month Payment. That means that you may also bill these, continue to bill these for providers, I mean for beneficiaries, alongside the DCMP.

>>Sage Hart, CMS: Great, thank you, Charlotte. Thank you for my colleagues who participated in the question and answer session, and for everyone for your attention and engagement during today's session. That's all the time we have for questions and answers today. Next slide, please.

As we near the end of the webinar, I want to share that the model team has created a number of resources that are aimed to help support applicants throughout the application process. A fact sheet, infographic, and frequently asked question resources are available on the model website to help you understand the model and share information about the model with your organization. In the coming weeks, and throughout the application process we will be posting additional resources on the model website. For example, a recording of today's event will be available in about a week. And I'm now going to pass it back to Tonya. Next slide, please.

>>Tonya Saffer, CMS: Thank you, Sage, and thank you to the audience for your engagement and your questions, as well as thank you, Melissa and Jasmine, for joining Sage, for your thorough presentations, and to the rest of the team for joining the Q&A. I hope everybody can- can see just how much work and expertise has gone into building this model from the team represented here, and I thought they did a phenomenal job asking questions, or for answering questions. If you did not get your question answered, you can check the Q&A. There have been some that have been answered in writing as opposed to live. So, check that out and see if your question is in there. And if we didn't get to your question, as the team mentioned in the coming weeks, we'll look through the questions and see if we need to add some additional ones to our FAQs, which are available on our website as Sage just mentioned. So, I just with that strongly encourage you to go ahead and start those applications now, and don't wait till the deadline. We will be sending out more information in the coming weeks about opportunities for technical assistance in completing your application. And, as I said, any mean - in the meantime you can submit any additional questions you have to the help desk, and the team will respond to them as quickly as they possibly can. But please do check those FAQs on the website as we do notice that most of the time when we get questions, a lot of the answers are already there in that the FAQs. It might be a quicker way to get your response, but the team will definitely get back to you as soon as they can. As you can imagine, there, there have been receiving quite a few questions. You can see, we've gotten, received over 100 just on this webinar alone. But, as always, we look forward to working with you through the application process. We genuinely thank you for your collaboration with us as we embark on this journey together to improve the care and support for people living with dementia. So, thank you again for attending today's webinar.

And oh, I'm almost forgot the survey. There is a link in the chat to take a survey, and you, that will just help us improve content and moving forward. So please do take that survey. We appreciate your feedback, and this concludes today's webinar. Thank you for joining. I hope you have a good rest of your day.

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