Guildnet Inc., H6864
Dual Eligible (Medicaid Subset - $0 Cost Share) Special Needs Plan

Model of Care Score: 90.00%
3-Year Approval **January 1, 2012 – December 31, 2014**

Target Population

GuildNet Gold is a zero cost share plan. There is no plan premium, and members have no co-pays for medical or long term care services. All members are eligible for the low income subsidy and have no co-pays for covered prescription drugs. The plan contracts with the New York State Department of Health for a Medicaid Advantage Plus plan. This contract allows GuildNet to offer Medicaid benefits, including long term care benefits. Together, these two contracts allow GuildNet to offer a fully integrated dual eligible SNP, with a benefit package that consists of most of the services that members used to get from Original Medicare and most of the services, including long term care services, which the member used to get from Medicaid fee-for-service.

Provider Network

GuildNet contracts with EmblemHealth to provide certain Medicare related administrative functions for the plan which include utilization management, payment of claims, and processing of enrollments. GuildNet Gold has a Point of Service benefit which means that members may go to out of network providers for Medicare covered services. The provider network includes physicians, nurse practitioners, physical therapists, occupational therapists, optometrists, mental health providers, certified home care agencies, hospitals, skilled nursing facilities for Medicare covered stays, and other ancillary providers.

Care Management and Coordination

The health risk assessment (HRA) tool mandated by the state of New York is called the Uniform Assessment System - New York (UAS-NY) . The UAS-NY, which is used to determine nursing home eligibility, is administered in person during the enrollment process and every six months thereafter. The UAS-NY may be re-administered more frequently if there are significant changes in the member's condition. The UAS-NY evaluates the member's medical history, clinical issues, diagnoses, functional status, psychosocial issues and cognitive status. The UAS-NY also evaluates potential health risks that may be amenable to intervention, such as tobacco use, obesity and decreased medication adherence. The information collected using the UAS-NY is the basis for development of the plan of care (ICP), including the identification of member-specific problems and goals.

The plan of care (ICP), which is collaboratively developed by the interdisciplinary care team (ICT), includes services that address the member's health risks and needs as identified by the UAS-NY, through monthly assessment calls to the member and through other health information identified by the ICT. Once enrollment is processed, the member's assigned nurse case manager (NCM) or Social Work Case Manager (SWCM) works with the ICT to further develop the ICP.

When the member is assigned to the NCM/SWCM, the NCM/SWCM initiates an orientation phone call to the member during which the NCM/SWCM discusses, among other things, the ICP with the member. Based on the discussion with the member, which includes care preferences and the ability of family to provide support, the NCM/SWCM determines if there are any changes required to the ICP. A copy of the revised plan is mailed to the primary care physician (PCP).

The ICT includes the NCM/SWCM, the member/caregiver, along with the PCP, a social worker, a mental health liaison, and the member's home health aide or personal care aide, specialists, other providers, and staff, based on the member's health conditions and the results of the health risk assessments. The NCM/SWCM shares health risk information with members of the ICT through the electronic health record when members of the ICT are part of the organization or parent organization. In all other cases, the NCM/SWCM shares information with the ICT verbally or in writing. ICT members also provide information back to the NCM/SWCM regarding services and interventions that should be put in place to meet the member's needs.

This MOC summary is intended to provide a broad overview of the SNP's MOC. Although the full extent of any MOC cannot be conveyed in a short summary, this summary provides the reader with a general overview of how the SNP addresses member needs.

For more information about this health plan refer to the Special Needs Plan's website at: www.guildnetny.org .