H6864 GuildNet Gold
Dual Eligible Subset - Medicare Zero Cost-sharing Special Needs Plan

Model of Care Score: 100.00%
3-Year Approval **January 1, 2015 to December 31, 2017**

Target Population

The GuildNet Gold target population is a subset of fully dual eligible Medicare beneficiaries who qualify for a managed long term care (MLTC) plan in New York State. Members receive Medicare and full Medicaid and require long term care services. Overall, the population is poor, frail and requires assistance to remain in the community. Members are 18 years or older, live in the approved service area and are eligible for nursing home level of care as determined by the New York State assessment tool (UAS-NY). The average age of members is 77.8 years, one-third of members are older than 86 and 71 percent of members are female.

The majority of members require caregiver and psychosocial assistance, 47.6 percent live alone, 28 percent require assistance with activities of daily living (ADLs) and 64 percent require assistance with instrumental ADLs. Members are typically hospitalized due to respiratory or cardiac problems, diabetes and GI bleeding. Many members have heart disease and severe visual impairment, co-morbidities, polypharmacy and experience declines in cognitive function. Spanish is the primary language spoken by 46 percent of GuildNet Gold members, 43 percent peak English and 5 percent speak Chinese. About 16.3 percent of members are White, 23 percent are Black and 50 percent are Hispanic.

Provider Network

GuildNet Gold contracts with EmblemHealth for the following: inpatient and outpatient facilities, psychiatric and rehabilitation hospitals, skilled nursing facilities (SNF), dialysis facilities, laboratories and radiology/imaging facilities, primary care physicians (PCP) and medical specialists. The network also includes geriatricians, internal medicine providers and family practice doctors and providers with expertise in treating HIV. The following specialty services are also available: allergy and immunology, ambulatory surgery, cardiology, chiropractors, dermatology, dentistry, ENT, endocrinology, gastroenterology, general surgery, gynecology, hematology, infectious disease, nephrology, neurology, oncology, ophthalmology, orthopedics, pain management, physical medicine and rehabilitation, podiatry, pulmonology, radiation oncology, rheumatology and vascular surgery.

EmblemHealth contracts with behavioral and mental health specialists and clinical psychologists. GuildNet also contracts with drug and alcohol counselors and physicians who specialize in diabetes and employ nurse educators. Other specialties include physical therapists, occupational

therapists, speech pathologists, certified home care agencies, radiologists, laboratory specialists and pharmacists.

Care Management and Coordination

The health risk assessment (HRA) is administered in person by a registered nurse (RN) within 30 days of enrollment and re-assessments are done every six months thereafter. The HRA is comprised of a community assessment and two supplemental tools for functional and mental health assessment. A care manager (CM), who is an RN or a social worker, reviews cases prior to the reassessment visit and identifies specific issues and needs. The CM is also the interdisciplinary care team (ICT) lead and is responsible for the member's plan of care (ICP).

CMs contact network and non-network providers, including the PCP, to obtain information about a member's status and care needs. The CM also discusses the member's draft ICP with each provider and contacts the member or caregiver to discuss the ICP. Revisions to the ICP are updated in the electronic health record (EHR) system and mailed to the PCP and the member. The ICP specifies the care and services needed to meet the member's known and anticipated medical, functional, social and cognitive needs identified in the initial comprehensive assessment. Other providers who contribute to the member's ICP are physical therapy, social day care, skilled nursing, the personal care attendant and medical specialties.

For all members, the ICT includes an RN or social worker, one of whom will be designated as CM, and a member service representative (MSR). The CM is also the primary contact for the member. The ICT may include certified occupational therapy assistants (COTA), physical therapists (PT), a mental health liaison (MHL) specialty medical providers and community based providers such as a home health aide (HHA).

The ICT/CM prioritize the needs and concerns of the member, identifies attainable goals and measurable outcomes, interventions and services to be implemented. The ICT/CM evaluates the effectiveness of the ICP through regular contact with the member and member's representative; reviews assessments from rehabilitation personnel, reassessment nurse, family and community based medical providers included in the ICT.

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 beneficiary needs.

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