

GuildNet

JEWISH GUILD

HEALTHCARE

Vision + Health

Do All Roads Lead to Rome?

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New York State

Office for People With Developmental Disabilities

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Jewish Guild Healthcare

- Nonsectarian
- Not-for-profit
- Health care organization serving visually impaired, blind and multi-handicapped persons
- Widest range of services offered anywhere in the world
- Many services are unique
- Includes a full range of health services
- Addresses the special needs of people with vision loss



Programs and Services

- Low Vision Rehabilitation Clinic
- Diagnostic & Treatment Clinic
- Diabetes Care & Self Management Education
- Psychiatric Clinic
- Mental Health Day Treatment
- Developmental Disabilities Day Treatment
- Crisis Counseling
- SightCare
- Bressler Prize in Vision Science
- GuildScholar Award
- GuildCare – Adult Day Healthcare
- Guild Institute for Vision and Aging
- Workplace Technology
- Independent Living Skills
- Employment Development
- Guild School
- Children’s Vision Health
 - Parent tele-support
 - Teen tele-support
- **GuildNet – Managed Long Term Care**

Facts about Vision Loss

- Decline in vision status is associated with lower emotional, physical and social functioning. Branch et al. (1989). The implications for everyday life of incident self-reported visual decline among people over age 65 living in the community. *Gerontologist*, 29, 359-365.
- 39% of legally blind individuals experience ADL limitations, compared to 7% of those with better vision. Salive et al. (1994). Association of visual impairment with mobility and physical function. *Journal of the American Geriatrics Society*, 42, 287-292.
- Onset of legal blindness results in a 78% increase in the likelihood of ADL limitation. Sloan, et al. (2005). Effects of changes in self-reported vision on cognitive, affective, and functional status and living arrangements. *American Journal of Ophthalmology*, 140, 4, 618e1-618e12.

Facts about Vision Loss

- Overall, visually impaired patients are less satisfied with their healthcare Iezzoni, et al. (2003). Quality dimensions that most concern people with physical and sensory disabilities. Archives of Internal Medicine, 163, 2085-2092.
- Visually impaired patients experience more problems after discharge Boteret al. (1998). The problems of elderly patients at home after ophthalmic treatment. Journal of Ophthalmic Nursing Technology, 17(2), 59-65.
- Vision impairment contributes significantly to excess hospital length of stay, with patients four times more likely to have rehabilitative care prescribed on discharge Morse et al., (1999). Acute care hospital utilization by patients with visual impairment. Archives of Ophthalmology, 117, 943-949.

Vision Impairment & healthcare utilization

- Vision loss adds to the complexity of healthcare service delivery whether
 - occurring alone
 - as a comorbidity
 - as a consequence of an illness such as diabetes...
 - Vision loss impacts significantly on healthcare utilization and is generally overlooked as a contributor to excess health care cost

New York's Medicaid Program

- NY ranks first nationwide on per capita spending, almost twice the national average.
- 15 percent of Medicaid beneficiaries are dual eligible (approximately 700,000) comprising 45 percent of Medicaid spending and an estimated 41 percent of Medicare.
- New York spends far more each year on long term care than any other state.

SAAM Predictors

- **Socio-demographic**
 - Female/Age 80+ interaction
- **Disease Conditions**
 - Dementia
 - Cerebrovascular
 - Chronic renal failure
 - Diabetes with complications
 - Hx of hip fracture >64 years
 - Chronic joint/musculoskeletal
 - Chronic neuromuscular
 - Chronic neurodegenerative
 - Other paralysis
 - Quadriplegia and PVS
- **Functional**
 - Ambulation/locomotion
 - Bathing
 - Bowel incontinence
 - CPAP
 - Dressing
 - Lower body limitation
 - Upper body limitation
 - Feeding/eating
 - Grooming limitation
 - Medication management
 - Disruptive behaviors
 - Impaired behaviors

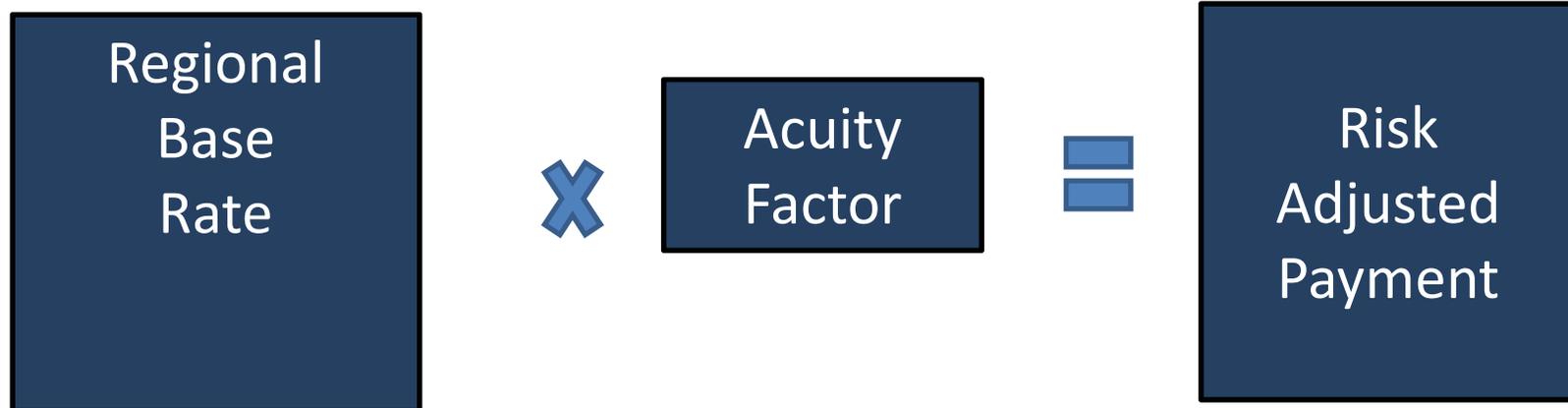
MLTC Benefit Package

- Assessment & Care Planning
- Home Health Care:
 - Nursing
 - Home Health Aide
 - Physical Therapy
 - Occupational Therapy
 - Speech Therapy
 - Medical Social Services
- Personal Emergency Response System
- Respiratory therapy
- Nutritional counseling
- DME
- Adult Day Health Care
- Personal Care
- Nursing Home
- Non-emergent transportation
- Home delivered meals
- Social Day Care
- Social and environmental supports
- Podiatry
- Dentistry
- Optometry/Eyeglasses
- Audiology/Hearing Aids
- Outpatient therapies
- Coordination of non-covered services

Capitation premium includes all covered services

	Units PMPM	Unit Cost	Net PMPM	% of Revenue
REVENUE			\$3,950.	100%
EXPENSES				
Personal Care	150.0	\$17.00	\$2,550.	
Home Health Nursing	2.0	\$110.00	\$220.	
Skilled Nursing Facility	0.7	\$270.00	\$189.	
Transportation /Non- Emergent	3.7	\$36	\$133.	
Other Expenses			\$200.	
TOTAL EXPENSES			\$3,292.	83%
Care Management			\$315.	8%
Administrative Expenses	(Capped)		\$215.	5%
NET PROFIT			\$128.	3%

MLTC Risk Rate Methodology



An acuity factor (“risk score”) is applied to the MLTC services and care management components of the premium rate.

GuildNet has two distinct delivery models

GuildNet

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- A partially capitated Medicaid-only plan
- A fully integrated dual-eligible Medicare Advantage Special Needs Plan (MAP). The

GuildNet Demographics

- 83% of GuildNet members are duals
- ~11,600 are in MLTC
- ~400 in Medicare Advantage Special Needs Plan (dual cap)
- Age range 18+
- Average age 76
- 70% Female
- 46% live alone

Organizational Structure & Function

- Intake Nurses
- Case Managers – RNs & MSWs
- Reassessment Nurses
- Member Service Representatives
- Specialized Teams
 - Diabetes
 - Mental Health
 - Palliative Care
 - Intensive CM
 - Others, as needed

MLTC Care Management

- Goals:
 - Maintain optimal level of functioning to avoid or delay nursing home placement
 - Manage appropriate utilization of services
- MLTC care management rationalizes use of services not maximizing services
- Requires insurance-type approach and assumption of risk:
 - Managing care versus providing care
 - Care coordination

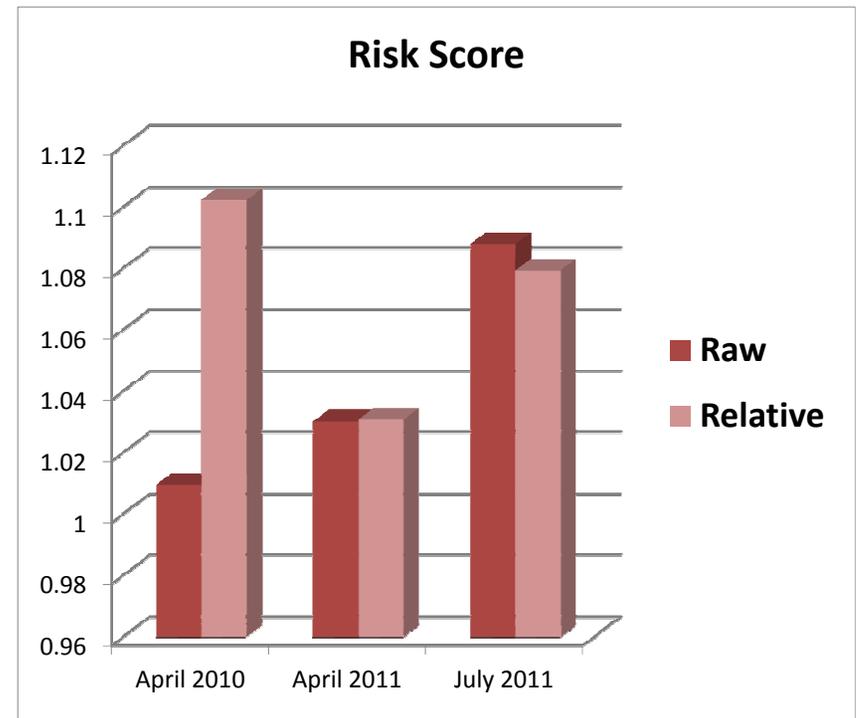
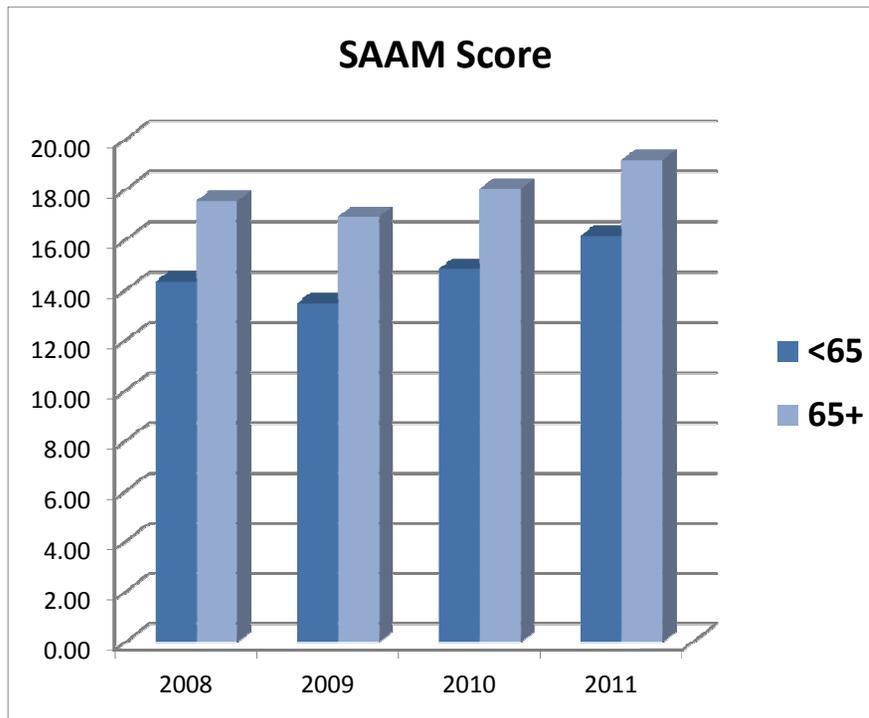
Care Coordination

- Consistent with Olmstead, care planning must:
 - include the member in decision-making
 - address quality of life
 - actively support member preferences
- Coordinate care among primary, acute, behavioral and other services including those not in the benefit package to promote continuity of care:
 - assure that transitions between service settings are made smoothly
 - New orders require action
 - Referrals and coordination of non-benefit package services

Monitoring Utilization

- Utilization management is key
- Requires IT systems to report, track and monitor
- Budget utilization as well as cost
- Monitor experience vs. budget on at least a monthly basis
- If off budget, take steps immediately to remedy

GuildNet SAAM & Risk Scores



Opportunities

- Coordinated & integrated care
- Ability to address specialized needs
- Marketplace differentiation and specialization
- Financial control for State through capitation
- Financial gain for plans through effective care management

Challenges

- Mandatory enrollment and auto-assignment
- Assessment of needs
- Consumer rights & entitlements
- Home Care vs. Managed Care
- The fair hearing process
- Administrative issues
 - Electronic enrollment
 - Mandated contractual relationships
 - Living wage
 - Alignment of incentives between Medicare and Medicaid
 - Conflicting Medicare and Medicaid rules and procedures
- Understanding market incentives is key

A Final Caveat:

- Without a controlled, capitated marketplace, care costs will continue to skyrocket.
- **So...Yes, all roads do lead to Rome.**

Questions?

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