Blue Cross of Idaho Health Services Inc. H1350
Dual-Eligible Medicaid Subset Zero-Cost Sharing Special Needs Plan

Model of Care Score: 88.13%
3-Year Approval **January 1, 2012 – December 31, 2014**

Target Population

Blue Cross of Idaho's (BCI) target population for this Dual-eligible Special Needs Plan (D-SNP) includes: the frail/disabled, members with multiple complex chronic illnesses, members who develop end stage renal disease after enrollment and members at the end of life. BCI ensures that the members meet the eligibility criteria prior to enrollment to tailor services to vulnerable members.

Provider Network

The Model of Care connects a full spectrum of services through a network of health providers, case managers and coordinators of community services to deliver care. The plan aims to provide medical services in the least restrictive setting for each individual member. BCI's network includes 76% of the available physicians (primary care and specialists) in its 24 county service area as well as ancillary providers, skilled nursing facilities and hospitals. As a health maintenance organization, members must select a primary care provider who acts as a key resource on the interdisciplinary care team (ICT), to meet the more diverse and complex needs of SNP members. BCI contracts with additional providers in the event that members' need further specialized services. These contracts include: diabetes centers, orthopedic programs, home health agencies, case management and medication management programs.

When a member uses the provider network, the provider delivers specialized services for care needs and reports on services delivered to each member. The case manager assures follow-up is scheduled and performed for all members. These services become part of the member's care plan, which is monitored by the ICT and through the plan's management staff.

Care Management and Coordination

Once enrolled, BCI completes an initial health risk assessment (HRA) on all members' physical, psychosocial and functional needs/limitations. The assessment ideally occurs in the member's home by clinical staff. The HRA serves as the first building block for creating an individual care plan (ICP) for all members. The meeting with the member in their home becomes the foundation for all care planning activities. During this meeting, the plan's clinical staff also complete an additional general assessment and supplemental assessment to further determine care plan activities. The results from these assessments trigger goals and objectives. BCI enters these responses into the electronic health records system to help drive the care planning process. These goals can be modified, deleted or added to create the ICP.

The ICT is unique for each member based on the ICP housed in the electronic health records system. The primary care provider acts as the medical expert and as a key member of the ICT. Other core care team members include the member or caregiver, and as needed a behavioral health and/or a social services expert. Additional specialties are added to the ICT based on the individual member's care plan.

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.truebluesnp.com.