H1350 Blue Cross of Idaho Health Service, Inc.
Dual Eligible (Dual Eligible Subset - Medicare Zero Cost-sharing) Special Needs Plan

Model of Care Score: 80.00%
2-Year Approval **January 1, 2015 – December 31, 2016**

Target Population

The Blue Cross of Idaho Health Service, Inc. (Blue Cross of Idaho) Dual Eligible Special Needs Plan (D-SNP) serves approximately 1000 dual eligible members. To enroll in the plan, individuals must be: entitled to Medicare Part A benefits, enrolled in Part B, eligible for Idaho's Medicaid program and more than 21 years of age. They must also reside in one of the following counties: Ada, Adams, Bannock, Benewah, Bingham, Blaine, Boise, Bonner, Bonneville, Boundary, Canyon, Caribou, Cassia, Clark, Elmore, Fremont, Gem, Gooding, Jefferson, Jerome, Kootenai, Latah, Madison, Minidoka, Nez Perce, Oneida, Owyhee, Payette, Power, Shoshone, Twin Falls, Valley and Washington.

Provider Network

Blue Cross of Idaho's network includes over 76 percent of the available physicians and over 80 percent of hospitals in Idaho, as well as additional providers in the contiguous border counties of Washington and Oregon. Its primary and specialty provider network includes: social workers, registered nurses, nurse managers, health coaches, pharmacists, physical therapists, occupational therapists, speech therapists, mental health specialists, drug counselors, clinical psychologists, audiologists and other allied health professionals. Members can access the following services and facilities: inpatient, outpatient, rehabilitative, surgery centers, infusion centers, dialysis, audiology, home and community-based services and supports, home health care, skilled-nursing care, long-term care, psychiatric, laboratory, radiology and imaging centers.

Upon enrollment, Blue Cross of Idaho assigns each member to a care manager (CM) who is a social worker, a registered nurse, a licensed practical nurse or a physician assistant. Members can choose their primary care physician (PCP) and may see any specialist within the network without a referral; some services, however, may require prior authorization. When the contracted network does not meet a member's needs as determined by his or her individualized care plan (ICP), Blue Cross of Idaho can authorize out-of-network services.

Care Management and Coordination

Within 90 days of enrollment, the CM conducts a comprehensive health assessment with each member, utilizing the State of Idaho Universal Assessment Tool for members receiving home care services or home and community-based waiver services (HCBS.) For members not

receiving HCBS the CM uses an extended assessment that includes questions to identify medical, behavioral, social, and functional barriers. The CM conducts a reassessment annually or more often if there is any significant change in medical condition, mental health status and/or living arrangement.

Following the comprehensive health assessment and within 120 days of enrollment, each member, in collaboration with the CM, develops an individual care plan (ICP) which may include referrals and facilitation for: community based social services, waivered program assessments, specialty care, chronic care improvement/disease management programs, therapy programs and self-management programs. At least annually and at the time of any significant change in the member's health status and/or living arrangement, the CM works with the member to update the ICP.

The members' unique needs drives the composition of the Interdisciplinary Care Team (ICT), which is evaluated annually. The frequency of the meetings at minimum are monthly and more frequently, if needed. The ICT is comprised of: the member and/or family member, skilled nursing facility (SNF) staff, assisted living staff or certified family home staff, primary care physician (nurse practitioner, physician's assistant), care coordinator, health plan case management, occupational, physical or speech therapist, pharmacist, dietitian, habilitation specialists, home care, mental health professionals (psychiatric, psychological, chemical dependency), and other specialties as appropriate. The Care Coordinator is the central point person ensuring communication between all enrollees of 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.truebluesnp.com.