	DEPARTMENT:	Case Management
	SUBJECT:	Health Home Management Program
	PRODUCT LINE:	All
	POLICY NUMBER:	HM107
	ORIGINAL POLICY EFFECTIVE DATE:	08/17/2021
	LAST REVISED DATE:	N/A
	LAST REVIEWED DATE:	8/14/2025

POLICY:

Group Health Cooperative (GHC) of Eau Claire's Health Home Management Program is designed to coordinate services with all members enrolled in a specialized Hub and Spoke Integrated Recovery Support Services Health Home for Substance Use Disorder (SUD) treatment.

A significant component of a health home is the focus around engaging community partners to ensure successful linkages to community and social supports.

GHC will coordinate access to appropriate specialists and Medicaid-covered services for members enrolled in a health home program. As part of coordinating access, GHC will enter into a Memorandum of Understanding with each DHS contracted hub and spoke pilot site to coordinate services in the pilot program service areas.

Member enrollment into a health home is voluntary. Members who chose not to enroll into a health home will continue to receive services in GHC's benefit package.

Purpose:

The purpose of the GHC Health Home Management Program is to coordinate care across all settings.

Covered health home activities include the following:
- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up
- Patient and family support, including authorized representatives
- Referral to community and social support services

PROCEDURE:

When arranging direct care services, the health home provider must follow GHC's requirements regarding prior authorization for HMO-covered services, referrals to in-network providers, and claim submission.

Eligible members may be identified and referred by GHC case management services, utilization management, or by our providers. Members may also be identified by the Vivent Health home or Hub and Spoke pilot sites, who must then inform GHC to ensure care is coordinated.

Pilot Hub sites will determine eligibility and enroll members in Hub and Spoke services.

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<u>Enrollment criteria:</u>

GHC may refer members with SUD who have access to a Hub and Spoke pilot site to the pilot site with the member's consent.

1. <u>Hub & Spoke Integrated Recovery Support Services</u>. Members must have a diagnosis of SUD and at least one other chronic condition or be at risk of developing another chronic condition.

To avoid duplication of care coordination activities, HMOs are encouraged to work with the health home to develop a MOU or contract that clearly delineates the respective roles. At a minimum, the HMO should address the following with the health home provider:

Communication with Health Home Hubs and Spokes includes:

1. The GHC Case Management Manager will be the single point of contact to work with each Hub's single point of contact.
2. Response to critical events (emergency room visit, hospitalization, detox/mental health crisis).
3. GHC will ensure expanded access to health care occurs where appropriate.
4. GHC will notify the appropriate Hub if a member opts out of the health home.
5. The Hub will notify GHC if a member opts out of the health home.
6. Mode and frequency of contact between GHC and each hub will be determined by the points of contact.

Member engagement (in accordance with state and federal confidentiality requirements)

1. Identification
2. Outreach
3. Obtaining member consent (to participate and for information sharing)
4. Re-engagement if lost to follow-up (for example, member identified in an emergency room)

GHC Case Management engagement in care plan development and implementation related to the health home will include but not be limited to:

1. Identification and engagement of member's PCP and other health care providers
2. Access to needed health care
3. Identifying gaps in care, needed referrals, and referral follow-up
4. Addressing missed appointments
5. GHC resources

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Reporting and data sharing:

GHC and the health homes will determine the level of reporting and data sharing necessary to ensure that the goals of health home services are accomplished. Some examples include:

1. Health home utilization (member count, average number of contacts per month)
2. ER use
3. Hospitalization
4. Referrals
5. Adherence to prescribed therapy
6. Results of member satisfaction surveys (conducted by the health home)
7. Sharing clinical and care plan information

APPROVED: _Michele Bauer MD._ DATE: 8/14/2025

REVISION HISTORY:

Rev. Date	Revised By/Title	Summary of Revision
8/18/2022	Michele Bauer, MD, CMO	Reviewed. No changes.
8/23/2023	Michele Bauer, MD, CMO	Reviewed. No changes.
8/14/2024	Michele Bauer, MD, CMO	Reviewed. No changes.
8/14/2025	Michele Bauer, MD, CMO	Reviewed. No changes.