Wyoming Department of Health
Division of Healthcare Financing, Community-Based Services Unit
Community Choices Waiver Program
Case Manager Meeting Summary

Date and Time	Conference Line	Guest Passcode
April 28, 2020, 2:30 – 4:30 PM	1-570-658-9322	8965#

Agenda Item	Summary of Discussion	Requests and Follow-Up
Welcome / Introductions	Everyone introduced themselves.	
WYhealth Health Management overview Amy Buxton	• Wyoming Medicaid's health management program (WYhealth) helps Wyoming Medicaid members coordinate and access medical care. Care managers within WYhealth communicate with CCW case managers about participant care. See the attached materials for additional information on the WYhealth program. • Referrals for WYhealth programs can come from anyone, including the participant themselves.	• Referral form and materials attached
Waiver amendment update	• The waiver amendment was submitted March 5th. Comments were posted online as well as the response. • CMS has 90 days to review and submit informal or formal request for information. CMS has submitted some informal questions. • CMS has changed their guidance on meals and will now allow for two meals a day. • The state is working with Gannett Peak on making enhancements to the EMWS to allow for our new case management tools from our pilot project. Implementation might not be by July 1 but we are working on a timeline for these changes. • We are working with consulting firms to develop training and guidance for the new case management requirements. We will be developing a new manuals and service planning materials to reflect program changes in the waiver amendment.	
COVID-19 update	• During the public health emergency, we are allowing for three meals on plans. • The Division met with the aging division and senior centers around the state. Many senior centers have closed their doors to providing a congregate meal. Aging is also working with other agencies to try to fill the gap. Flexibility to provide services and allowing more meals are a focus. Research is being done on the ability to contract with restaurants and delivery services to provide meals. • The Division has asked anyone to provide ideas and advise for what flexibilities are needed to provide care to our participants.	

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	• Other states have increased rates to allow for retention and hazard pay. We are also looking at these as possibilities and are working with our venders on so that case managers do not have to modify every service line of every plan. • We are still investigating adding additional service options. PPE and surgical gowns for direct service workers being one option. We are working to see how authorization of these services and reimbursement would look. Case managers would be able to add these as a service like to participant's plans who direct their own care. This would allow for their direct service worker to have the proper PPE to provide care. These are not guaranteed to be available due to supply issues. • We are also exploring the option of adding a homemaker service during the public health emergency so that personal care activities do not have to be conducted in order to receive the homemaker service. The homemaker service could be provided as a standalone service. • Case management activities as still allowed to be conducted over the phone. Proper documentation of the call and details will be required.	
Case Manager updates Care plan timeline (program closures)	• Care plans are required to be developed in accordance with our assurance to CMS. We will be emailing case managers to ask for updates on care plans that are taking longer to be developed. • Closures will be started for plans with no services in the 30 days. We have an assurance to CMS that our participants are people who are at risk of being institutionalized in 30 days without proper services in their home. • Renewal plans are required to be submitted the 15th of the month prior to the month they are due.	
Case Manager Updates Hearing process/involvement	• The case manager's role in the hearing process is to help the participant understand their rights to appeal. Case managers should not be acting as their representative at the scheduling conference or hearing. Case managers have a vested interest and a conflict exists. Case managers can help understand and facilitate in the participant exercising their rights.	
CCW group email	• ccw.waivers@wyo.gov • Please use the CCW email for all communications where you would email any of the CCW team. This email will help us to filter questions and provide feedback in a timely manner. • Continue to use the LTC unit email for all eligibility questions. LTCUnit@wyo.gov • Continue to use the EMWS helpdesk email for all EMWS related issues. ccw.emws.helpdesk@wyo.gov	

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EVV update	• Currently in contract negotiations and have provided and intent to award. EVV for participant direction is still waiting on ACES$ hopeful to be implemented early July. EVV for personal care through and agency will be delayed a bit behind self-direction. We are hopeful that COVID-19 will not affect the timelines in this process.	
Medicaid Handbook	• Case managers should be helping participants to find all necessary resources including resources outside of the waiver. The Medicaid handbook is a great start for other services. State plan services can help provide other services that the wavier doesn't cover. • Referrals should be made to other entities and community resources when needed.	
Q&A town hall call	• Discussion about having a call outside of our regularly scheduled case manager call where case mangers could call in and ask questions. This would not have a structure with provided agenda but be more of a place to ask questions you think others might need/want the answer too. • There will not be notes posted for this meeting and also no discussion of HIPPA information. • We hope to begin this call in May.	
Next Call	• June 23, 2020 2:30 – 4:00 PM - Please submit any agenda items you would like.	

WYhealth

Wyoming Department of Health

WYhealth
Clinical Health Management (HM) Program

What is the WYhealth HM Program? The goal of Health Management is to work with individuals to help them take steps needed to manage their condition(s), remove barriers to care, and get them actively involved in their health. There are multiple components:

> ***General Population Health Management*** aims to address health concerns within the general Medicaid population through educational materials, education, preventive services, and general wellness initiatives in coordination with Agency and State health priorities.
>
> ***Catastrophic Care*** provides shorter-term care for unexpected health conditions requiring longer stretches of hospitalization or recovery periods resulting from situations such as: a car wreck, heart attack, and cancer.
>
> ***Disease Management*** includes clients with chronic disease states or other targeted conditions, such as diabetes or asthma, for outreach and prevention initiatives. While the Agency has identified certain conditions of significant interest (including diabetes, asthma, COPD…) outreach will be prioritized by the acuity of individuals, inpatient utilization, and not limited by a specific condition.
>
> ***Care Transitions*** is coordination and communication with facility discharge planners, provides training, and refers clients to Care Management (WYhealth) to ensure the discharge plan meets the client's needs, there is timely follow-up services in place, and that the transition to the community or lower level of care is safe and effective.
>
> ***Complex Care Management*** is the most extensive health management method available to Wyoming Medicaid clients determined to be at "high risk" for greater medical costs, and/or have the highest cost of service utilization. It includes the coordination of services, appointments, follow up with community resources, and coordination of other unmet needs/barriers faced by the client. These are individuals who are at risk of demonstrating poor health outcomes and/or experiencing fragmented health care delivery, and would benefit from Care Management services.

What does WYhealth Care Management look like? WYhealth HM uses an interdisciplinary care team approach that includes Medical Directors, Registered Nurses, Behavioral Health Advocates (BHAs), Community Health Workers (CHWs), and non-clinical support staff.

Each enrolled client is assigned a primary Care Manager. The Care Manager will assess the client using a clinical health assessment, which also asks social determinants of health questions (if positive, will result in referrals for community support or hotlines being provided to the client on the spot). The Care Manager will also engage the client to discuss their chronic condition(s), medication(s), establish goals and a plan of care. Each subsequent call will address aspects of their goals in the POC, as well as "meeting the client where they are at." Social Determinants of Health are gauged during each engagement and support provided, if necessary.

A plan of care usually lasts from 3-6 months but could be longer depending on the condition and how quickly the client learns to appropriately manage it. At intervals, the clinical health assessment is done again with the client to monitor their needs, progress, and possible SDOH needs.

How do you refer someone to Care Management? If you have a Medicaid client who you believe would benefit from being enrolled in CM, you can complete the referral form and submit it by fax: 1-888-245-1928 or via email: optumhmwy@optum.com. (Referral form is the last page.)

Applicable Health Incentives, Tools, and Resources:

Choice Rewards: This is an incentive program for Wyoming Medicaid clients who are enrolled in Care Management. The purpose of Choice Rewards is to call attention to a client's diabetes condition, support them to actively manage their diabetes, and engage clients in their health.

- Clients participating in the program can earn a $25 gift card each quarter for up to four (4) quarters - $100!
- Client tracks and shares their A1C Test Results and weight each month and reports these to their RN Care Manager
- The client is eligible if he/she has an A1C at or above seven (7). (If the client is unsure or does not know their current A1C, the RN Care Manager encourages the client to contact their PCP.

24/7 Nurseline: 1-888-545-1710. Medicaid clients can have access to registered nurses 24/7/365.

Wiser Together: Everyone has access to the Wiser Together tool. Is a decision support tool, which has 300 conditions to search on, and will give you treatment options based on condition. There is no need to create a profile either, which is nice. It can be found through the WYhealth website: https://www2.mywiserhealth.com/

My 307 Wellness: Is an interactive app with reliable, credible health information for individuals and Wyoming families. You can track health milestones and immunizations, and find information about important screenings and resources available in Wyoming communities. You can find it on Google Play, the App Store, or by texting 'FAMILY' to 307-317-0819.

WYOMING HEALTH MANAGEMENT STATEWIDE LIST

HM Operations Director: Carrie Brown 307-286-7768

Lou Ann Carmichael Statewide Manager 307-823-6876

REGION 1

RN		CHW		BHA		COUNTIES		TOWNS				
Carol Cutler	*307-823-6898*	Stacy Evelo	*307-315-1608*	Lori Day	*307-823-6881*	Weston	Washakie	Barr Nunn	Buffalo	Casper	Clearmont	Dayton
Katherine Spaay	*307-829-3270*	Chanda Snook	*307-622-2865*			Crook	Johnson	Douglas	Edgerton	Evansville	Gillette	Glenrock
Trisha Kenney	*307-941-0762*					Campbell	Sheridan	Hulette	Kaycee	Kirby	Lost Springs	Midwest
Tonya Wynne	*307-829-3278*					Converse	Hot Springs	Mills	Moorecroft	Newcastle	Pine Haven	Ranchester
						Natrona		Rollinghills	Sheridan	Sundance	Tensleep	Thermopolis
								Upton	Worland	Wright		

REGION 2

RN		CHW		BHA		COUNTIES		TOWNS				
Jennifer Coughanour	*307-212-2573*	Morgan Tajan	*307-829-3271*	Laurie Nicol	*307-349-9059*	Big Horn	Uinta	Afton	Alpine	Bairoik	Basin	Bear River
Lori Leisch	*307-212-1003*	Pamela Wayt	*307-823-6870*	Maike Tan	*307-231-0582*	Park	Sweetwater	Big Piney	Burlington	Byron	Cody	Cokeville
Karyn Jones	*307-212-2599*					Teton	Lincoln	Cowley	Deaver	Diamondville	Dubois	Evanston
Kristy Paterson	*307-823-6891*					Fremont	Sublette	Frannie	Granger	Green River	Greybull	Hudson
Susan Hayes	*307-823-6872*							Jackson	Kemmerer	La Barge	Lander	Lovell
								Kyman	Manderson	Marbleton	Meeteetse	Mountain View
								Opal	Pavillion	Pinedale	Powell	Riverton
								Rock Springs	Shoshoni	Star Valley Ranch	Superior	Thayne
								Wamsutter				

REGION 3

RN		CHW		BHA		COUNTIES		TOWNS				
Kim Coulter	*307-631-6751*	Chris Rhodes	*307-630-1579*	Lisa Hendrickson	*307-757-5428*	Carbon	Goshen	Albin	Baggs	Burns	Cheyenne	Chugwater
				Mitch Gerharter	*1-855-690-0364 ext 61831*	Albany	Laramie	Dixon	Elk Mountain	Encampment	Ft. Laramie	Glendo
						Platte	Niobrara	Guernsey	Hanna	Hartville	La Grange	Laramie
				Joanna Morris	*307-823-6873*			Lingle	Lusk	Manville	Medicine Bow	Pine Bluffs
								Rawlins	Riverside	Rock River	Saratoga	Sinclair
								Torrington	Vantassell	Wheatland	Yoder	

Statewide Employee	
Erin Clingman Business Analyst and BSL	*307-823-6899*

Wyoming Department of Health

WYhealth

WYhealth Care Management Referral Form

Client/patient information:

Name: _____ DOB: _____ Medicaid #: _____ Address: _____

City: _____, WY Zip: _____ Phone Number(s): (h)_____(c) _____

Parent/Guardian: _____ Phone Number: _____

Primary language: ☐English ☐ Spanish ☐Other: _____ Primary Diagnosis: _____

Reason for referral (check all that apply):

☐ Education RE: dx/treatment plan ☐Medication/treatment compliance ☐Smoking cessation ☐Links to community resources
☐Assist coordination of care ☐Disease management* ☐Adult weight management ☐Depression
☐Mental health/psychosocial concerns ☐High risk maternity: weeks gestation _____ ☐Recent hospitalization/readmission
☐Other: _____

Helpful documents to attach if available: current medications list, history & physical, psychosocial assessment, recent progress note

**Asthma, Diabetes, CAD, COPD or HF*

Do you want the Case Manager to contact you with patient care updates? ☐No ☐Yes, if yes, please provide name, title, phone number and/or email address to use for provider communication purposes. _____

_____

Facility/provider information: ☐PCP ☐Psychiatrist ☐RN/LPN ☐LCSW/LPC ☐Other: _____

Referring provider: _____ Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Phone: _____ Fax: _____

Additional providers for patient (if applicable):

PCP: _____ Mental health: _____

Other: _____

Fax completed form to 1-888-245-1928. For questions, please call WYhealth at 1-888-545-1710
All cases will be reviewed for determination and eligibility.