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WYOMING DEPARTMENT OF  
DIVISION OF HEALTHCARE FINANCING

# Comprehensive & Supports Waivers

## Emergency Services and the Extraordinary Care Committee Process

Wyoming Department of Health  
Division of Healthcare Financing  
Home and Community-Based Services Section  
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Good Afternoon. My name is Kate Delgado, and I am a Benefits and Eligibility Specialist for Division of Healthcare Financing, Home and Community-Based Services Section, which we will refer to as the HCBS Section throughout this training. Thank you for joining us for today's training.



Review emergency services criteria, the Extraordinary Care Committee process, and situations that may qualify for an ECC review.

The purpose of this training is to review emergency services criteria, the Extraordinary Care Committee process, and situations that would qualify for an ECC review. We will also dive into Wyoming Medicaid rules that govern these areas.

# Training Agenda

- Review situations that are considered an emergency
- Review the ECC process outlined in rule, including situations that will and will not be reviewed by the ECC
- Review the step-by-step process for submitting a request for an ECC review



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At the end of this training, the following topics will have been introduced and explained:

- First, we will review Chapter 46, Section 14, and explain situations that are considered to be an emergency.
- Next, we will review Chapter 46, Section 15, and discuss situations that will and will not be reviewed by the ECC.
- Finally, we will take case managers through the step-by-step process for submitting a request for an ECC review, including required documentation and forms.

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# Choice



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The participant must be consulted during the ECC process, and their wishes and choices in how to address the situation must be taken into consideration.

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Choice is a basic tenet of home and community-based waiver services. You hear us say it at the beginning of every training, and we say it because we want it to be in the forefront of everyone's mind. Participants must have the freedom to choose the services they receive, who provides those services, where they live, with whom they spend time, and what they want for their future. Having choice is paramount to human dignity.

Restricting a participant's basic human rights is a really big deal, should never be taken lightly, and should never be the only response to a challenging situation. When a participant's rights are restricted on any level, some aspect of their choice has been taken from them.

This is especially important with ECC requests. Requests for an ECC review are often driven by providers or other people around them. While a participant's current situation may be a threat to their health and safety, automatically presuming that they need more supervision or support may not be the answer. The participant must be consulted during this process, and their wishes and choices in how to address the situation must be taken into consideration. More funding and supervision does not equate to quality of life, and may not be the only way to support the participant.



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## Authorities and Resources

- Chapter 46, Section 14 and 15 - Wyoming Medicaid Rules
- Comprehensive and Supports Waiver Agreements



Chapter 46 of Wyoming Medicaid Rules establishes rules related to the Comprehensive and Supports Waivers.

Section 14 of this Chapter, titled Emergency Waiver Services, establishes the criteria that a situation must meet in order to be considered an emergency. Section 15 establishes the ECC process.

In Appendix B-2 of the Comprehensive and Supports Waiver agreements, which are approved by the Centers for Medicare and Medicaid Services, the HCBS Section specifies a cost limit for each waiver. When a cost limit is established, states are required to establish safeguards to ensure that participants are not adversely affected if the participant's condition or circumstance requires them to have services that exceed the established cost limit in order to assure their health and welfare. The ECC process is one mechanism the HCBS Section has to review relevant information and allow additional supports and services when the participant has a demonstrated need, as long as the services continue to meet established service definitions.

Chapter 46 can be found on the [Public Notices, Regulatory Documents, and Reports](#) page of the HCBS website, under the *Rules* tab. The Comprehensive and Supports Waiver agreements are located on the same page, under the *Current Waivers* tab.



# Emergency Situations



Applicants and participants of DD Waiver services must follow established processes for determining and redetermining eligibility, and in many cases for determining a Level of Service score that is ultimately used to calculate the participant's individual budget amount. When applicants are initially determined eligible for waiver services, that individual is placed on a wait list until a funding opportunity becomes available. However, there are times when an **emergency** arises that requires the HCBS Section to allow these processes to be circumvented in order to assure a person's life is not in jeopardy. These **emergency** cases involve eligible individuals who require immediate action or have an urgent need for waiver services. Chapter 46, Section 14 describes these specific situations.

In the following slides, we will refer to eligible individuals rather than just participants. There are times when eligible individuals who are waiting for funding can experience an emergency situation. The HCBS Section has set aside funding slots, known as reserved capacity, on the Comprehensive Waiver to allow individuals who meet the emergency criteria to receive immediate funding for Comprehensive Waiver Services.



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# emergency

 [ ih-mur-juhn-see ]

*noun, plural e·mer·gen·cies*

1. **immediate threat** or high probability of immediate danger to the life, health, property, or environment of the eligible person or another individual.
2. **immediate threat** due to the eligible individual's medical, mental health, or behavioral condition.

An emergency situation is one in which there is an immediate threat, or a high probability of immediate danger, to an eligible individual's life, health, property, or environment, or the life, health, property, or environment of another person because of the eligible individual's medical, mental health, or behavioral condition.



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## Loss of Primary Caregiver

- Due to the death, incapacitation, critical medical condition, or inability to provide continuous care.
- Situations in which the caregiver decides they no longer want to be the caregiver do not apply.

If an eligible individual loses their primary caregiver due to the caregiver's death, this would be considered an emergency situation. If the eligible individual's primary caregiver is no longer able to care for the individual due to the caregiver's critical medical condition or other incapacity, this would also qualify as an emergency situation.

It is important to note that, for a primary caregiver to be deemed incapable or unable to provide care, there must be a legitimate reason such as medical or physical disability. A caregiver cannot decide that they no longer want to care for the eligible individual and request an ECC review. If a primary caregiver has an obligation to provide care and support for an individual, and fails to do so, this could be considered abandonment or dereliction of duty, and could result in a referral to the Department of Family Services or other authorities.



## Caregiver Definition

- Family relationship
- Voluntary assumption of care
- Court ordered placement
- Residential programs
- Institution or HCBS program
- Acceptance of legal obligation or responsibility of care



A caregiver is defined as the person, agency, or other entity responsible for the physical care and supervision of an individual. This responsibility may be due to:

- A family relationship;
- The voluntary assumption of responsibility for care;
- A court ordered responsibility or placement;
- The obligations of a residential program that is providing services;
- The obligations of an institution or HCBS program to provide services; or
- The acceptance of an entity to be legally responsible to care for an individual.

# Homelessness

- For a period of thirty (30) days, lacks access to an adequate residence with appropriate resources to meet their support and supervision needs.



Homelessness is considered an emergency situation. Homelessness is defined as a situation in which, for a period of thirty days, an individual lacks access to an adequate place to live, and does not have the resources they need to have their support and supervision needs met. This lack of access puts the individual's life or health at risk of serious harm. Case managers should work closely with the assigned Benefits and Eligibility Specialist, or BES, to determine if a situation meets the criteria for homelessness.

To reiterate, an eligible individual must be homeless for a period of thirty days before the situation is considered an emergency. While the risk of homelessness may put the individual in a tenuous situation, the individual is not homeless. The risk of homelessness is different than the reality of homelessness, and the distinction is very important when discussing emergency situations.

The HCBS Section does not have the ability or authority to solve homelessness, nor can we require a provider to accept an eligible individual into services. If an ECC request is submitted on the grounds of homelessness, the HCBS Section presumes that the individual does not have a physical location where services can be delivered. The individual must be without such a location for thirty days in order for the homelessness to be considered an emergency situation. It is important for plan of care teams to explore other community options and resources to ensure that the individual has a place to live.

The HCBS Section has received questions about homeless shelters being considered an adequate residence. The short answer to this question is no. While homeless shelters may

provide a temporary roof over an individual's head, the shelter will not provide the supervision and other support needs the individual may require.

## Removed from the Home

→ Cases involving a person being removed from their home by an appropriate agency due to abuse, neglect, abandonment, exploitation, or self-neglect.

- ◆ Law enforcement
- ◆ Medical professionals
- ◆ Court System



The HCBS Section has experienced situations in which an eligible individual lives in a home where abuse, neglect, or exploitation are occurring. If law enforcement, a medical professional, or a judge removes an eligible individual from their home for their health and safety, this would be considered an emergency situation. However, emergency placement in waiver services shall not be made as an alternative to incarceration or jail (waiver services are never provided to those that are ineligible for Medicaid.) Also, please keep in mind that, in situations involving minors, the Department of Family Services or local school district will most likely be responsible for funding emergency services. Medicaid is always the payer of last resort.

# Requests for 24-Hour Support

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- Limited to eligible individuals whose health or safety is at **significant risk** due to **extraordinary needs** that cannot be met in current living arrangement due to:
  - ◆ Substantial threat to life or health
  - ◆ Medical or behavioral conditions that pose a threat or require ongoing twenty-four hour support and supervision
  - ◆ Loss of caregiver due to death, incapacitation, critical medical condition, or inability to provide care.

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If an eligible individual is in a living situation that cannot support their health or safety needs, and their life or health is at at significant risk, this may be a reason for emergency 24-hour support. These situations must be corroborated by the Department of Family Services, Protection and Advocacy, or law enforcement. Emergency 24-hour support may also be warranted if the individual has a health condition that poses a substantial threat, or they demonstrate challenging behavior that poses a substantial threat to the individual's life or health, or the life or health of other people in their home. If an eligible individual loses their primary caregiver and meets the criteria in Section 14, they may qualify for 24-hour support.



## Demonstrating an Emergency

- Recent documentation to support the claim
  - ◆ Incident reports
  - ◆ Reports from law enforcement
  - ◆ Medical documentation
- Situation reflected in individualized plan of care
- Documentation that other community options have been researched



In order to demonstrate that an emergency situation exists, the case manager must collect and submit documentation that supports the claim. These situations are not taken lightly, and the HCBS Section requires the case manager to submit comprehensive and up-to-date information in order to make the determination that a situation qualifies as an emergency. Ideally, all supporting documentation should be dated within the last 30-60 days and must demonstrate that the individual is actively being followed by a physician or other medical professional.

If the emergency situation is based on a medical concern, information on the severity of the condition, how it contributes to the eligible individual's disability, and the increased support that the individual will need because of the medical condition will need to be explained. Documentation of the individual's diagnosis and prognosis, signed and dated by the licensed medical professional, must be included. Additionally, if the medical condition is chronic, a summary of the individual's medical appointments for the last three months and any protocols that are currently in place must be submitted to demonstrate the treatment the individual has received and how the medical condition has progressed over time.

If the emergency situation is based on a behavioral concern, the case manager will be required to submit documentation that demonstrates how the eligible individual's behavior is a threat to the life, health, or environment of themselves or others. This may include positive behavior support plans, a summary of the individual's psychiatric appointments, a letter from the appropriate medical or mental health professional, a functional behavioral analysis, a summary of incident reports, or a summary of interventions performed by law enforcement agencies.

Again, we want to stress the importance of having up-to-date supporting documentation, dated within the last 30-60 days and demonstrating the individual's recent interactions with their medical care professionals.

If the eligible individual in the emergency situation is already a participant on a DD Waiver, ongoing medical or behavioral concerns must already be reflected in their individualized plan of care, or IPC. For example, Rhonda is a participant who lives with her mother and is receiving services on the Supports Waiver. Her mother is 75 years old and suffers from Rheumatoid Arthritis. Rhonda's health has been declining, and she now needs physical assistance to bathe, dress, and use the restroom. Rhonda's mother is physically unable to support her any longer, and both of them fell last week when she was helping Rhonda out of the shower. Documentation of Rhonda's medical decline, the support she needs, and how Rhonda's providers and mother currently provide support to Rhonda, should be documented throughout Rhonda's IPC. It may be noted in several sections of the IPC such as the Mealtime, Self Care, and Supervision portions of the *Needs and Risks* Section, the *Medical* Section, and in the Case Management Monthly Review documentation. Incidents should be reported, and the incidents should be summarized when the case manager completes the Case Management Monthly Review form. If this information isn't reflected in the IPC, it will be difficult to prove that Rhonda's medical decline and current living situation rise to the level of an emergency situation.

It is also important to remind case managers and plan of care team members that Medicaid is always the payer of last resort. Plan of care teams should research and consider other community resources that are available to support the individual. If these resources are not adequate, the case manager must be able to explain what was considered and why the resources won't work for the individual. If other resources have not been considered, the HCBS Section may not review the case for emergency services.

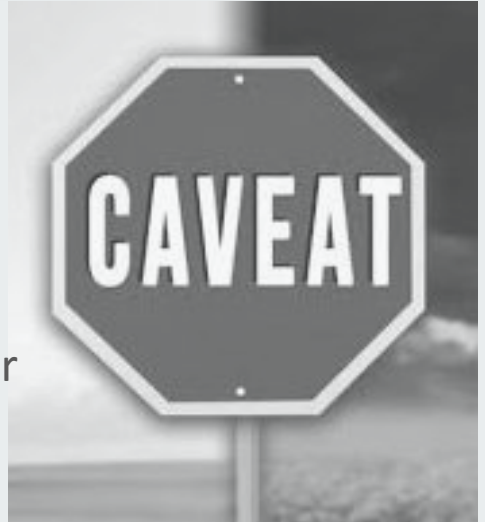


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## Emergency Services Caveats

- Emergency cases must be referred to the ECC for review.
- Individual must be determined eligible for waiver services, regardless of the emergency.
- Emergency placement in waiver services shall not be made as an alternative to incarceration.



When considering emergency situations, there are a few caveats that case managers need to remember.

Once a situation has been established as an emergency, the case manager must submit a request for a review by the Extraordinary Care Committee (ECC) in order to be considered for additional funding or emergency placement on the Comprehensive Waiver. We will discuss the ECC process in the next section.

Individuals must be determined eligible before they can receive DD Waiver services. Eligibility criteria, which are covered in Chapter 46, Section 4, include citizenship, residency, financial, institutional level of care, and clinical eligibility diagnosis requirements.

In rare circumstances, individuals who could be determined eligible for DD Waiver services are sentenced to jail. Although these situations are not ideal, these individuals cannot be placed in waiver services as an alternative to incarceration.





# Extraordinary Care Committee

As we mentioned earlier in this training, Appendix B-2 of the DD Waiver agreements, which are approved by CMS, specifies a cost limit for each waiver. Because cost limits are established in these waivers, the HCBS Section is required to establish safeguards to ensure that participants are not adversely affected if a participant's condition or circumstance requires them to have services that exceed the established cost limit in order to assure their health and welfare. The ECC process is one mechanism the HCBS Section has to review relevant information and allow additional supports and services when the participant has a demonstrated need, as long as the services continue to meet established service definitions. Chapter 46, Section 15 establishes the rules for the ECC.

Let's talk a little bit more about the ECC, including its makeup, purpose, and the process for the ECC review.

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## Committee Members



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- Medicaid Manager
- Division (HCBS Section) Managers
- Department of Health Fiscal Representative
- Ad hoc Membership, as needed

*All of which have full-time jobs separate and outside of this role*

The Benefits and Eligibility Specialist presents the case to the committee members as established in Medicaid Rules. The Benefits and Eligibility Specialist does not have voting authority, however. The voting members of the ECC include a manager from Medicaid, managers from the HCBS Section, and a representative from the Department of Health's fiscal unit. Depending on the cases being reviewed, the ECC may include the Division's licensed psychiatrist, the Medicaid Medical Director, the Division's registered nurse, or other behavioral specialists. The ECC may consult other specialists as they deem appropriate.



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## Allowable ECC Requests

- Emergency situations defined in Chapter 46, Section 14
- Significant changes in service need due to the onset of behavioral or medical condition or injury - (ie. CLS Level 3+)
- Other supplemental requests



Requests for an ECC review should only be submitted for situations that meet the emergency criteria established in Section 14. These include significant changes in a participant's needs due to the onset of a behavioral or medical condition or injury, temporary changes to a participant's circumstances that will require a higher level of service or support, or other identified supplemental requests. For example, all plan modifications requesting Community Living Services at a level three or above, must be reviewed and approved by the ECC. Temporary circumstances may include situations in which a participant breaks their leg or is recovering from surgery, and need additional help for an identified but temporary amount of time.

## Things to Consider Prior to Submitting an ECC Request

- What other community resources have been explored?
- Have all other available waiver services been considered?
- Is the current IBA being utilized in the most efficient manner?

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Before pursuing a request with the Extraordinary Care Committee, it is important for case managers to lead the team in considering alternative solutions. What other community resources have been explored? Look into other services and supports available through other federal, state, or local public programs in the area. Have all other available waiver services been considered? Adjusting the current plan to include different services might be a good solution. Consider the menu of options available like Child Habilitation, Homemaker, Companion Group, or a lower level of Adult Day Services. Would creating a Positive Behavior Support Plan (PBSP) help the current providers better support the participant? Would redirecting plan funds from one service to another better serve the participant? Is the current IBA being utilized in the most efficient manner to meet the participants needs? Instead of having 365 days of level 5 Community Living Services (CLS) on the plan, perhaps the participant could be supported with a combination of both CLS level 4 and 5?

# The ECC Review



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- The ECC will **only** review requests that meet criteria and have compelling, documented evidence.
- The ECC may request additional assessments, referrals, or outside consultation.
- The ECC may approve, partially approve, or deny any request.

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The HCBS Section will conduct a preliminary review of all ECC requests to determine if they meet one of the established criteria. Although all of the situations submitted for review are compelling, the ECC will only review cases that meet the established criteria, so case managers must submit **documentation** that sufficiently demonstrates that one of these situations exist. Supporting letters must be signed and dated within the last 90 days.

The ECC may request additional assessments, referrals, or outside consultation. As an example, a participant may be required to obtain a new Inventory for Client and Agency Planning, or ICAP assessment, or may be referred to the Partnership Access Line (PAL) for a medication review. These activities must be completed before the ECC will review additional requests from the participant, and they may delay or deny a decision until the additional activities are conducted. The ECC may approve a request for a short period of time in order to allow the individual's plan of care team to complete the additional assessments or consultations.

Once the ECC reviews the case, they may approve, partially approve, or deny the request. So, what does a partial approval look like? Let's go back to Rhonda. Rhonda currently has an IBA of \$26,000 based on a her participation on the Supports Waiver. Rhonda's medical condition has declined significantly over the past year, and her team has determined that she needs 24-hour support and an IBA of \$100,000 in order to get her needs met. Rhonda's case manager submits the necessary paperwork and the HCBS Section approves an ICAP for Rhonda so her Level of Service score can be calculated. The calculation of her Level of Service score, based on the ICAP, allocates \$75,000 for her IBA. The ECC will only approve funding up to a participant's calculated Level of Service score; therefore, the ECC can only approve

\$75,000 of her request.

## ECC Decisions

- Decisions will be by majority vote, and issued in writing within twenty (20) business days.
  - ◆ *In the event of a tie, the Section Administrator will issue the final vote*
- The Section Administrator may approve time limited funding while a decision is pending.
- The ECC will only approve requests if funding is available in the waiver budget.



Once the ECC reviews a request, they have twenty (20) business days to make their decision. If the vote on an ECC decision results in a tie, the HCBS Section Administrator issues the tie-breaking vote. In extreme circumstances, the HCBS Section Administrator has the authority to approve limited funding while the ECC deliberates their decision.

The HCBS Section must stay within the DD Waiver budget appropriated by the Wyoming Legislature. If funding is not available in the DD Waiver budget, the ECC will not approve requests...even if they meet the established criteria.

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## Committee Denials



Eligible individuals denied funding by the ECC may request a reconsideration or administrative hearing.

If the ECC denies an eligible individual's request for funding, the individual may request a reconsideration or an administrative review of that decision as outlined in the ECC decision letter. The ECC decision letter is mailed to the participant or LAR, and uploaded to EMWS for the case manager's reference. Rules related to administrative hearings are established in Chapter 4 of Wyoming Medicaid Rules.





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# Submitting an ECC Request for Review

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As mentioned previously, requests for a review by the ECC must meet the criteria outlined in Chapter 46. The case manager must complete and submit an ECC Checklist, an ECC Request Form, supporting documentation, and an ECC Team Consensus Form before the HCBS Section will forward a request to the ECC for review. Let's walk through the process.

# Extraordinary Care Committee Checklist



<b>Participant Legal Name:</b>  <b>Participant Age:</b>	<b>Select Current Waiver:</b>  Comprehensive <input type="checkbox"/> Supports Waiver <input type="checkbox"/> Other <input type="checkbox"/> Waiver Name:  Plan of Care Start Date:	<b>Case Manager:</b>  <b>BES Name:</b>
<b>Living Situation:</b> Choose an item. <i>If receiving CLS, please indicate level:</i>  <b>Level of Service Score:</b>	<b>Date of Psychological Evaluation:</b>  <b>Full IQ Score:</b>	<b>Date of ICAP:</b>  • ICAP General Maladaptive Score • Service Score • Personal Living Score

### Required documentation for all requests:

- ECC Checklist
- ECC Request form
- ECC Team Consensus form
- Individualized Plan of Care
- List of current medications (i.e., current Medication Assistance Record, pharmacy record)
- Summary of previous ECC decisions, including dates and results
- Documentation required in Chapter 46, Section 15(f)(i) – (v) of Wyoming Medicaid Rule
- All Case Management Monthly Review forms completed and submitted in EMWS



The Extraordinary Care Committee Checklist was designed to support case managers in collecting and submitting the information that is required to demonstrate the necessity of a case to be reviewed by the ECC. It lists the specific documentation that will be required based on the reason the request is being submitted.

All ECC requests must include:

- The ECC Request form;
- The ECC Team Consensus form;
- The participant’s IPC;
- A list of the participant’s current medications, which may be demonstrated through a current Medication Assistance Record or pharmacy record; and
- A summary of previous ECC decisions, including dates and results.

Before a case manager can submit the request on behalf of a participant, they must ensure that they have completed and submitted all of the Case Management Monthly Reviews and that the plan of care reflects the participant’s current needs and circumstances.

The checklist can be found on the [HCBS Document Library](#) page of the HCBS Section website, under the *DD Forms* tab. This checklist, as well as the required supporting documentation and other documentation requested by the HCBS Section, must be submitted through the Electronic Medicaid Waiver System, referred to as EMWS, using the *Supplemental Requests* function.

# Extraordinary Care Committee Request



Participant Legal Name	Date of Request
Current Level of Service (LOS) score	Date of last ICAP Assessment
Current Individual Budget Amount (IBA)	Plan Start Date
Are you requesting 24-hour services? <input type="checkbox"/> Yes <input type="checkbox"/> No	

## Request Information:

The case manager, in conjunction with the plan of care team members, shall provide justification for the extraordinary care request. The questions below shall be completed to give background information on the person's case and provide supporting information for the request. **Please note that if the request doesn't meet criteria outlined in Chapter 46, Section 14 or 15, and a specific rule citation isn't included, the request will be automatically denied.** The Division may request more information, additional documentation, or information from other team members to support a request before it is reviewed by the Division. Completed requests are submitted in EMWS under supplemental requests, ECC request.



The Extraordinary Care Committee Request form is the document that case managers must use to explain the circumstances that the individual is experiencing.

Case managers must describe how the extraordinary care request meets the criteria specified in Chapter 46 of Wyoming's Medicaid Rules. They must cite the specific criteria being met and the reason the request is being submitted. If the request is due to the onset of the medical or behavioral condition, or injury that indicates a significant change in a participant's needs, they must describe the condition, and why the request is functionally, behaviorally, or medically necessary based upon the current assessed needs of the participant. If the request is for 24-hour support, the case manager must describe the change in the participant's living situation, and why that change requires 24-hour support.

Remember, Medicaid is the payer of last resort; therefore, case managers must describe other non-waiver services, such as natural, community, and other paid supports, that were explored and implemented prior to submitting the ECC request.

# ECC Team Consensus Form



Pursuant to Chapter 46, Section 15 of the Department of Health's Medicaid Rules, before an ECC request is submitted, the participant's plan of care team shall meet and come to a consensus that the request is necessary and other support or resource options have been explored.

The case manager and plan of care team members are required to use this form to demonstrate consensus of the need for an ECC request.

Participant Legal Name	Case Manager	Approved IBA	Plan Start Date
<b>What is the team requesting?</b>			
<b>Is the ECC request necessary?</b>			
<b>How does the request meet Wyoming Medicaid Rules Chapter 46 Sect. 14 and 15?</b>			



Before the case manager submits an ECC request, the participant's plan of care team must meet and come to a consensus that additional funding is necessary and other support or resource options have been explored. When describing the support or resource options that have been explored, the case manager should include the resources considered, such as counseling or PAL consultations, how or why these resources failed or were not a viable option, and confirm that community and natural resources have been exhausted. Remember, Medicaid is the payer of last resort, so it is imperative that all other supports have been researched and eliminated before requesting a review by the ECC.

Each member of the participant's plan of care team must indicate if they agree or disagree with the ECC request, and sign and date the form. The completed form must be submitted as part of the ECC request packet.

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# Division Review



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- BES has seven (7) calendar days to review request for completeness.
- Request will be rolled back if not complete
- Once resubmitted, the BES will review again.
- Complete request will be reviewed and scheduled by a program manager.

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After the case manager has completed the required forms and collected the necessary documentation, they must submit the ECC request in EMWS using the *Supplemental Requests* link.

EMWS will create a task for the area BES to review the request. The BES has seven calendar days to review the request. The BES will evaluate the justification, review all submitted documentation, and verify that the case manager is up-to-date with their monthly documentation. If the request is not complete, the BES will roll it back to the case manager with a request for additional information. Once the additional information is received, the BES will need time to conduct further review.

The ECC Checklist was designed to support the case manager in identifying and developing a complete ECC request. Case managers should review the ECC Checklist and ensure that all necessary and required information is submitted. Failure to submit required information will cause a delay in the case being reviewed by the ECC.

Once the BES receives and reviews a complete request, they will forward it to a program manager to verify the completeness of the ECC request and schedule the case to be reviewed by the ECC.

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# ECC Reminders



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- ECC reviews may result in a decrease to the participant's Level of Service score or IBA.
- Case managers must notify the HCBS Section about changes to the participant's living situation.
- Providers must ensure they can meet the needs of the participant.

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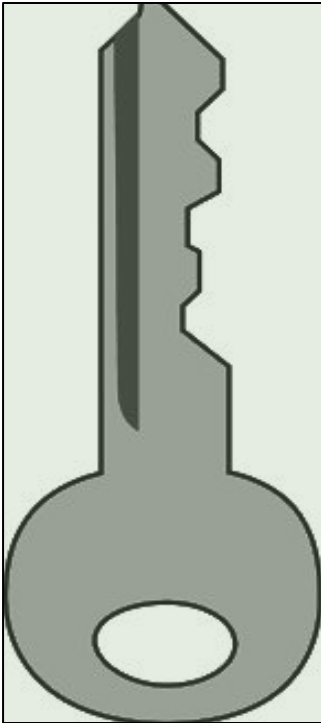
As we close today's discussion on emergency services and the ECC process, it is important that case managers are reminded of some very important facts related to the ECC process.

First, it is critical that case managers remember that the ECC will only approve funding in the amount of a participant's calculated Level of Service score for the Comprehensive Waiver. If new assessments result in a calculation of a Level of Service score that is lower than the participant's current Level of Service score, or if the calculated IBA for the Level of Service is less than the participant's current IBA, the participant's approved IBA may actually decrease.

The participant's IBA is based on their living situation. If a participant's living situation changes, the case manager must notify the HCBS Section so the participant's IBA can be recalculated to reflect their current situation. For example, the ECC approved 24-hour support for Rhonda due to her steep medical decline and her mother's inability to keep her safe. However, Rhonda's physicians were able to diagnose her condition, and she is now on medication that has alleviated her symptoms. She is able to take care of her personal needs and doesn't need support from others in this area. Rhonda and her mother decide that Rhonda should move back in with her mother. Since Rhonda's IBA is based on her receiving 24-hour support, the IBA is no longer accurate. Rhonda's case manager must notify the HCBS Section so that Rhonda's IBA can be adjusted to account for the fact that she is no longer receiving 24-hour support.

Please note that it is absolutely not acceptable to have a participant move into an independent living situation that is not appropriate to support their level of need in an attempt to get them 24-hour support as an emergency situation.

Finally, providers must ensure that they are able to meet the needs of the participant if they accept them into their services. The HCBS Section has seen several instances of providers accepting a participant when they have a temporary increase in funding, only to terminate those services once the temporary funding ends. Providers, as part of the plan of care team, must take into account temporary and ongoing funding levels, and be sure they can support the participant with their long-term funding levels before accepting them into services.



# Key Takeaways



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1. Case managers must understand what constitutes an emergency situation, and submit ECC requests accordingly.
2. Case managers must follow the ECC Checklist and submit complete ECC requests.
3. Plan of Care teams must come to a consensus that an ECC request is necessary.
4. Medicaid is the payer of last resort.

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Before we end today, we'd like to remind case managers of the key takeaways of today's training.

1. Case managers must understand what constitutes an emergency situation, and submit ECC requests accordingly. If a participant's situation does not meet the emergency criteria outlined in Chapter 46, Section 14 of Wyoming Medicaid Rules, the ECC will not consider the request.
2. Case managers must follow the ECC Checklist and submit complete ECC requests. Failure to submit the required forms and supporting documentation will result in a delay in the ECC's review of the request.
3. The entire plan of care team must come to a consensus that an ECC request is necessary. All team members must sign the ECC Team Consensus Form, indicating that other resources have been explored and they agree with the need for an ECC request.
4. Finally, everyone must remember that Medicaid is the payer of last resort. A component of the ECC Team Consensus Form is an explanation of other support or resource options that have been explored. A participant and their plan of care team should not default to the ECC and a request for additional funding. They should explore all available natural supports and community options before submitting an ECC request.





HOME AND  
COMMUNITY-  
BASED  
SERVICES

HOME AND COMMUNITY-BASED SERVICES DIVISION  
WYOMING DEPARTMENT OF HEALTH SERVICES

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# Questions?

**Contact your Benefits  
and Eligibility Specialist**

<https://health.wyo.gov/healthcarefin/hcbs/contacts-and-important-links/>

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Thank you for participating in today's training. If you have questions related to the information presented today, please contact the assigned Benefits and Eligibility Specialist. Contact information can be found by visiting the web address provided in the slide.