NOTICE OF FINAL EXEMPT RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM - ARIZONA LONG-TERM CARE SYSTEM

PREAMBLE

1. **Permission to proceed with this final rulemaking was granted under A.R.S. § 41-1039 by the governor on:**

   November 25, 2026

2. **Article, Part, or Section Affected (as applicable)** — **Rulemaking Action**

Article 12	New Article
R9-28-1201	New Section
R9-28-1202	New Section
R9-28-1203	New Section
R9-28-1204	New Section
R9-28-1205	New Section
R9-28-1206	New Section
R9-28-1207	New Section
R9-28-1208	New Section
R9-28-1209	New Section
R9-28-1210	New Section
R9-28-1211	New Section

3. **Citations to the agency's statutory rulemaking authority to include the authorizing statute (general) and the implementing statute (specific):**

   Authorizing statute: A.R.S. § 36-2970.01(D)

   Implementing statute: A.R.S. § 36-2970.01(D)

   Statute or session law authorizing the exemption: Laws, 2026, Ch. 132, § 19

4. **The effective date of the rule:**

   December 1, 2026. An effective date sooner than the standard 60-day time frame will benefit stakeholders because it will establish requirements for provision of the HNT assessment and services and for the ECR process, provide members with access to HNT services and better align with the AHCCCS contract year to promote uniformity and ease of administration by health plans.

5. **Citations to all related notices published in the *Register* as specified in R1-1-409(A) that pertain to the current record of the proposed exempt rule:**

   Notice of Emergency Rulemaking: 31 A.A.R. 4227; Issue date: October 31, 2025; Issue Number: 44; File Number: R25-

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Notice of Emergency Rulemaking - Renewal: 32 A.A.R. 932; Issue Date: April 24, 2026; Issue Number: 17; File Number: R26-53

Notice of Rulemaking Docket Opening: 32 A.A.R. 893; Issue Date: April 17, 2026; Issue Number: 16; File Number: R26-49

Notice of Proposed Rulemaking: 32 A.A.R. 867; Issue Date: April 17, 2026; Issue Number: 16; File Number: R26-46

Notice of Termination of Rulemaking 32 A.A.R. 1862, Issue Date: August 21, 2026; Issue Number: 34; File Number: R26-139

Notice of Exempt Rulemaking Docket Opening: 32 A.A.R. 2424, Issue Date: October 2, 2026; Issue Number: 40, File Number: R26-171

Notice of Proposed Exempt Rulemaking: 32 A.A.R. 2409, Issue Date: October 2, 2026, Issue Number: 40; File Number: R26-170

6. The agency's contact person who can answer questions about the rulemaking:

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7. An agency's justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:

The Arizona Long Term Care System (ALTCS) is Arizona's Medicaid program administered by the AHCCCS Administration pursuant to A.R.S. Title 36, Chapter 29, Article 2 for individuals who are elderly or have physical or developmental disabilities. Individuals eligible for ALTCS are determined to be at risk of institutionalization. A.R.S. § 36-2970.01(D) directed that AHCCCS, "On or before October 1, 2025," adopt "a strengthened standardized assessment tool to determine the need for extraordinary care for minor children."

In addition, ALTCS children under the age of 18 who are assessed for Home and Community Based Services (HCBS) using the HCBS Needs Tool (HNT) may benefit from an Extraordinary Care Review (ECR) in instances when the member and the member's health care decision maker disagree with the assessed hours for direct care services and/or habili-

tation services based on HNT age limitations. The HNT is a standardized assessment instrument to assess a member's need for direct care services and habilitation services to determine if a member may benefit from receiving HCBS to support activities of daily living or instrumental activities of daily living.

This exempt rulemaking will describe with greater specificity the strengthened assessment tool for direct care and habilitation services for ALTCS members as well as the overall HNT and ECR processes. The exempt rulemaking will incorporate substantial clarifications to, and support for, the assessment and review processes, the HNT tool, the ECR process, and the standards imposed on contractors and others such as case managers and clinicians. AHCCCS includes the following in the exempt rulemaking:

- Enhanced descriptions of each task/service that are a part of the HNT
- Description of the ECR process Description of Managed Care Organization obligations both prior to, and upon implementation, of the ECR process
- Comprehensive listing of allowable clinician types for the ECR
- Required training for ECR clinicians, including annual training requirements for the person-centered service planning process
- Expansive description of the post implementation oversight process

This rulemaking supports the refined implementation of the strengthened assessment tool, consistent with Arizona statute, improves care delivery for ALTCS members, promotes uniformity in the assessment process and consistency in the administration of the HNT/ECR, and fosters the long-term sustainability of the ALTCS program. In addition, the exempt rules incorporate stakeholder input. A description of changes made from the proposed rulemaking to the final rulemaking in response to public comments is detailed below.

8. **A reference to any study relevant to the rule that the agency reviewed and proposes either to rely on or not to rely on in its evaluation of or justification for the rule, where the public may obtain or review each study, all data underlying each study, and any analysis of each study and other supporting material:**

   Not applicable

9. **A showing of good cause why the rulemaking is necessary to promote a statewide interest if the rulemaking will diminish a previous grant of authority of a political subdivision of this state:**

   Not applicable

10. **A summary of the economic, small business, and consumer impact, if applicable to the exemption:**

    The exempt rules are estimated to have an annualized average fiscal impact of $90 million total funds in medical expenditure savings for the program, with an 80% confidence that the annualized savings will range from approximately $54 million to $141 million statewide. On average, an estimated expected reduction of $90.2 million on an annualized basis for direct care and habilitation services is projected as compared to the most recent complete contract year. The

estimated projected savings are anticipated to be partially offset by a first-year increase in administrative costs of approximately $17 million, with long-term administrative costs currently estimated to be under $1 million per year.

11. A description of any change between the proposed exempt rulemaking, to include supplemental notices, and the final exempt rulemaking:

AHCCCS has determined that the final exempt rules are not substantially different from the published proposed exempt rules. AHCCCS carefully considered each comment received before finalizing the rulemaking. Between the Notice of Proposed Exempt Rulemaking and this Notice of Final Exempt Rulemaking, and in response to stakeholder feedback, AHCCCS made targeted changes to rule text to clarify regulatory intent and provide operational flexibility based on stakeholder feedback. As detailed below, these changes do not alter the substantive effects of the proposed rules, but adjust and clarify the final rule text to achieve intended outcomes. The specific changes incorporated in the final rule are detailed below:

R9-28-1201 Definitions:

AHCCCS removed the defined terms “ASD Module” and “PEDI-CAT” and replaced the terms throughout the rules with “evidence-based assessment tool specified by the Administration” based on a concern from stakeholders that AHCCCS should use a more generalized term for these assessments in the event the specific tools are later replaced. This resulted in an adjustment to R9-28-1207(A)(7), R9-28-1207(I), and R9-28-1208(G)(3). AHCCCS modified the definition of “change in condition” from “means a major decline or improvement in a member's health status that does not normally resolve without further intervention” to “means a decline or improvement in a member's health status that necessitates a new assessment and resulting adjustment in intervention” based on stakeholder requests that AHCCCS clarify the term “change in condition.” AHCCCS also added a new defined term “ECR decision” based on stakeholder feedback pointing out that AHCCCS uses the terms “decision” and “determination” interchangeably throughout the proposed rule text. Adding this defined term resulted in an adjustment to R9-28-1208(H)(11), R9-28-(H)(13), R9-28-1209(B) through (E), R9-28-1209(K), R9-28-1210(B) and (C). Stakeholders requested clarification of the term “hourly service cap” as used in the rule text. AHCCCS revised R9-28-1201(9), the definition of “extraordinary care review” or “ECR” to reflect that the “hourly service cap” refers to habilitation services. Stakeholders commented that the definition of the “HCBS needs tool” or “HNT” was not clear as it included references to HCBS, ADLs and IADLs. AHCCCS revised the definition to eliminate the references and revised the language to “means a tool used by ALTCS case managers to assess ALTCS member’s specific needs related to direct care services and habilitation services.” Stakeholders requested that AHCCCS clarify that “informal supports” means that services are unpaid and voluntarily provided, rather than “non-billable services.” Stakeholders also pointed out that the examples given in the definitions appeared to be limiting. AHCCCS revised the definition and removed the examples based on this feedback. Multiple commenters suggested that AHCCCS define the term “medically necessary” as used throughout Article 12. Based on the feedback, AHCCCS added a new defined term “med-

ically necessary services" as "means covered services provided by a qualified service provider within the scope of the service provider's practice to prevent disease, disability and other adverse health conditions, progression of adverse health conditions, or to prolong life." This resulted in adjustments to R9-28-1203(F), R9-28-1204(A) and (B), R9-28-1206(Q)(10), R9-28-1207(G), and R9-28-1207(G)(3). AHCCCS substituted defined acronyms in the rule text when indicated to align acronym usage throughout the Chapter. AHCCCS renumbered subsections (18) and (19) to align numbering.

R9-28-1202. Person-Centered Service Plan:

AHCCCS revised the language in subsection (C) from "...member's strengths and preferences that meet" to "...member's strengths and preferences for services that meet" based on a request by stakeholders. AHCCCS also removed subsection (D)(5) because the language was redundant and unclear, and revised subsection (E) to clarify that neither the Administration nor the contractor shall differentiate or discriminate in the type or frequency of a service authorized based on a member's status as a family member or caregiver or the caregiver's residence.

R9-28-1203. HCBS Needs Tool:

In subsection (A), AHCCCS added a sentence: "The case manager shall provide a copy of the completed HNT assessment to the member or HCDM," as requested by stakeholders. AHCCCS revised subsection (C)(2) from "An increase to the current services and service hours assessed on an HNT is approved" to "An increase to the current services and service hours assessed on an HNT is fully or partially approved." In subsection (D), AHCCCS replaced "HCBS" with "direct care or habilitation services" and revised subsection (D)(3) from "If the member experiences a significant change in condition that causes the member's health to improve or decline" to "If the member experiences a change in condition" because the terms removed are unnecessary and redundant as they appear in the definition of "change in condition" as suggested by stakeholders. AHCCCS revised subsection (E) from "...HCBS needs for ADL" to "...HCBS needs for assistance with ADL" based on stakeholder feedback. AHCCCS revised subsection (K) from "...consider the age of a member when assessing a task" to "...consider the age of a member and most recent ECR decision as described in R9-28-1209(B) when assessing a task"; and revised subsection (K)(4) from "Check habilitation goals against age appropriateness" to "Review habilitation goals against age-related HNT tasks to ensure only age-appropriate tasks are permitted" as requested by stakeholders. In subsection (L), AHCCCS changed the word from "note" to "document" for clarity. After considering comments received by stakeholders, AHCCCS also split subsection (N) into two sentences for clarity.

R9-28-1204. Direct Care Services:

In addition to the revisions to subsections (A) and (B) changing "medically necessary" to "medically necessary services," AHCCCS revised subsection (B) to remove the term "in nature" from the end of the sentence as unnecessary. AHCCCS revised subsection (G) from "Direct care services shall not be authorized by an ALTCS contractor or Tribal ALTCS while a member is engaging in, participating in, or receiving privately or publicly funded K-12 educational services, programs or

grants“ to “Direct care services or habilitation services shall not be authorized for an ALTCS member while the member is engaging in, participating in, or receiving privately or publicly funded K-12 educational services, programs or grants.” AHCCCS also replaced the term “attendant care” with “direct care services or habilitation services” and “parent” with “legally responsible person” in subsections (I).

R9-28-1205. Habilitation Services and Goals:

AHCCCS revised the language in subsection (A)(2) from “...shall be assessed when a case manager determines that a member has the capacity to increase the member's independence” to “...shall be assessed when an assessment indicates that a member has the capacity to increase or maintain the member's independence” based on a clarification request from stakeholders. AHCCCS revised subsection (A)(3) from “Habilitation services shall not exceed 14 hours in a 7-day period“ to “Habilitation services shall not exceed 14 hours in a 7-day period for members age 3 to 17 unless additional hours are approved through an ECR.“ AHCCCS revised subsection (A)(4) from “If a member cannot be assessed for attendant care, then the member shall not be assessed for habilitation services” to “If a member does not meet the age threshold to be assessed for an attendant care task, then the member shall not be assessed for habilitation services for that task” as requested by stakeholders. AHCCCS also removed the term “age-defined” from subsection (A)(5) as requested. After considering comments received by stakeholders on subsection (B), AHCCCS restructured the subsection and split subsection (B)(2) to form a subsection (B)(3) to clarify the rule.

R9-28-1206. HNT Criteria and Requirements:

AHCCCS corrected two typographical errors in subsection (I). AHCCCS revised subsections (Q)(9) and (R)(5) to clarify that a caregiver must be awake to be paid for general or specialty supervision as requested by multiple stakeholders. AHCCCS revised subsection (Q)(3)(d) from “Any needs not described in subsection (a) or (b)” to “Any needs not described in subsection (a) through (c).” AHCCCS revised subsection (Q)(4)(a) from “Active supervision is when a responsible adult has direct sight on a member at all times” to “Active supervision is when a responsible adult is within arm’s reach of a member at all times.” AHCCCS revised subsection (Q)(10) from “Paid general supervision is not to replace child care obligations” to “Paid general supervision is not intended to replace child care obligations.” AHCCCS revised subsection (R)(1)(c) from “trachea ventilator dependence” to “tracheostomy tube or ventilator dependence.” AHCCCS also revised subsection (R)(5) to replace “parent” with “legally responsible person” and “nonparent” with “non-legally responsible person” for clarity.

R9-28-1207. Extraordinary Care Review – ALTCS Contractor Requirements:

In subsection (J), AHCCCS clarified that services referenced are “direct care and habilitation services” as requested by stakeholders. AHCCCS added subsection (M) which states “An ALTCS contractor shall maintain previously authorized direct care and habilitation services through the ECR process when a new assessment results in a reduction of hours due to age or weekly maximum limitations” for clarity.

R9-28-1208. Extraordinary Care Review – Process:

In subsections (A)(1) and (A)(2), AHCCCS removed the phrase “regardless of any services that may or may not have been authorized” for clarity. In subsection (C), AHCCCS corrected a citation and replaced “...shall provide a member and the member's HCDM” with “...shall provide a member who is assessed for services and the member's HCDM” for clarity and removed subsection (C)(2) as redundant to subsection (C)(3). AHCCCS revised subsection (C)(3) to “That an ECR shall occur no more than once every 12 months, unless the member has a change in condition, or the member requests an ECR of a task that was not previously reviewed in an ECR” for clarity based on stakeholder feedback. In subsection (D), AHCCCS revised the language to “An ALTCS contractor shall adhere to service authorization time frames under 42 CFR 438.210 when conducting an ECR” and removed subsections (D)(1) and (D)(2) to remove redundant, confusing language and accommodate stakeholder requests. AHCCCS revised the phrase in subsection (G)(2) from “...if willing to do so” to “...if the HCDM chooses to submit supporting documentation” and the same phrase in (G)(3) “…if willing to do so” to “if the HCDM chooses to complete the assessment” to clarify that the HCDM has an option in both subsections. AHCCCS made an adjustment to the organizational structure of the subsection. AHCCCS revised the language in subsection (H)(1) from “...if necessary to better understand” to “...if determined to be necessary to better understand.” AHCCCS revised subsection (H)(13) from “Render a decision in writing” to “Render a determination in writing. The contractor's chief medical officer shall maintain final authority for the ECR decision,” and removed subsection (H)(14) as requested by stakeholders.

R9-28-1209. Extraordinary Care Review – Decisions:

AHCCCS removed subsection (A) as redundant as time frames are addressed in R9-28-1210 and renumbered the remaining subsections. AHCCCS revised subsection (B) from “...the ECR clinician decision” to “the ECR decision,” and created subsections (1) through (3) to clarify the “other requirements” referenced in R9-28-1208 as requested by stakeholders. AHCCCS revised subsection (C) to “An ECR shall result in an ECR decision that”; revised subsection (C)(2) from “...a member's HNT shall be updated by the case manager” to “...a member's HNT shall be updated by the ALTCS contractor...”; revised subsection (C)(3) to create a new subsection (D) and renumbered subsections (C)(3)(a) through (d) to (D)(1) through (4); revised the language from “Current services and service hours assessed on an HNT are appropriate, and no change is required but additional services that are not a part of the HNT assessment may be appropriate for a member's HCDM and case manager to discuss” to “An ECR decision may contain additional recommended services that are not a part of the HNT assessment that may be appropriate for a member's HCDM and case manager to discuss” based on stakeholder requests for clarification. AHCCCS also revised subsection (K) from “If a member's HCDM still has concerns” to “If an ECR decision results in reduction, denial or termination of a requested service, or if a member's HCDM still has concerns” based on stakeholder clarification requests.

R9-28-1210. Extraordinary Care Review – Time Frames:

Based on stakeholder requests, in subsection (B), AHCCCS revised the language “An ECR clinician shall have seven days from the completion of an HNT or, in instances where the ECR request is made outside of the HNT assessment process, seven days from the date of the ECR request, to complete the ECR and issue a decision, in alignment with service authorization time frames under 42 CFR 438.210, based on the completion date of the HNT” to “An ALTCS contractor shall have seven days from the date that services are requested during the HNT assessment process or, in instances where the ECR request is made outside of the HNT assessment process, seven days from the date of the ECR request, to complete the ECR and issue a decision, in alignment with service authorization time frames under 42 CFR 438.210.” AHCCCS also revised this subsection to renumber subsection (B)(1) to subsection (C) and removed subsection (B)(2) as redundant. Subsection (D) was renumbered to subsection (E) but unchanged.

R9-28-1211. Reporting and Oversight:

AHCCCS revised subsection (B)(9)(b)(iv) from “Approval of additional direct care services” to “Approval of a portion of additional direct care services” based on stakeholder clarification requests and feedback. AHCCCS adjusted punctuation throughout the Article and made minor grammatical changes where appropriate.

12. An agency’s summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments:

AHCCCS received 90 written comments from the public, and 9 letters containing rule-specific comments from stakeholders during the 30-day comment period. AHCCCS carefully reviewed and considered each comment submission before making clarifying edits to the proposed rule to create the final rule. The comments are categorized by general comments and rule-specific comments followed by AHCCCS’s corresponding response.

GENERAL COMMENTS

General Comment Summary 1: Twenty commenters using the same template raised concerns about maintaining previously authorized services during ECR and appeals, notices and appeal rights, general and specialty supervision, the role of informal supports and school time, habilitation services, assessment records, and ECR access, procedures, and decision time frames.

AHCCCS Response: AHCCCS appreciates the comments. AHCCCS carefully considered the comments and made clarifications to rule language throughout the Article. Additional details requested by commenters are contained in AHCCCS materials available on AHCCCS's website.

General Comment Summary 2: Seven commenters opposed the proposed HNT and ECR changes, expressing concerns that standardized or age-based criteria could reduce medically necessary services, overlook individual functional and safety needs, or inadequately account for supervision and caregiver circumstances. Commenters requested that AHCCCS discontinue or substantially revise AHCCCS's approach.

AHCCCS Response: AHCCCS appreciates the concerns raised. HNT and ECR determinations are intended to remain individualized and person-centered, considering each member's needs, circumstances, functional limitations, and support requirements among other factors. The ECR process provides additional consideration of extraordinary care needs, and authorized paid supports must satisfy applicable federal and state Medicaid medical necessity and extraordinary care requirements.

General Comment Summary 3: Thirty parents and caregiver commenters described family experiences with disability-related care, including safety and supervision, limitations in daily functioning, maintaining adequate support hours, age-related needs, parent caregiver roles, and the ability to meet individual care needs at home. Commenters raised concerns about the effect of service changes on family stability and requested additional hours.

AHCCCS Response: AHCCCS appreciates commenters expressing personal experiences. The HNT and ECR processes are intended to be member-centered and to account for member-specific needs. Extraordinary care needs and medical necessity may support consideration of additional hours through the ECR process. The rules do not change who may provide authorized services. Additional details requested by commenters are contained in AHCCCS materials available on AHCCCS's website.

General Comment Summary 4: Thirty commenters requested clarifications or changes concerning habilitation goals and hours, applicability to adults, general and specialty supervision including the age 10 transition and overnight needs, HNT reviews and assessment guidance, ECR requests and time frames, contractor coverage responsibilities, notices, member materials, appeals, and related implementation procedures.

AHCCCS Response: AHCCCS appreciates the comments. Habilitation goals are individualized, additional hours for qualifying extraordinary care needs may be considered through ECR. Adult HNT changes are limited and do not have the same considerations as minor children. Supervision considerations include member-specific needs. Additional clarification requested by commenters is contained in AHCCCS materials available on AHCCCS's website.

General Comment Summary 5: Three commenters raised broader issues involving parent caregiver compensation and respite services, whether time-of-day restrictions apply to adult members, and requests for clearer information for families about the HNT and ECR processes.

AHCCCS Response: AHCCCS appreciates the comments. Provider rate setting and respite service design are outside the scope of this rulemaking. Hour and time frame limits generally apply to minor children rather than adult members. Additional detailed information for families on the HNT and ECR processes is contained in AHCCCS materials available on AHCCCS's website.

RULE-SPECIFIC COMMENTS

R9-28-1201. Definitions:

Comment Summary: Commenters requested AHCCCS revise the definitions of “ADLs,” “ASD Module,” “change in condition,” “direct care services,” “extraordinary care,” “ECR,” “habilitation services,” “HCBS needs tool,” “HCBS,” “informal supports,” “IADL,” “legally responsible person,” and “PEDI-CAT.” Commenters also requested the addition of new defined terms.

AHCCCS Response: AHCCCS appreciates the comments on the definitions. After considering each comment, AHCCCS modified the definitions of “change in condition,” “HCBS,” and “informal supports” for clarity. AHCCCS removed the terms “ASD Module” and “PEDI-CAT” as specific evidence-based assessment tools and replaced the terms in the rules with a broader reference. AHCCCS also added definitions for “ECR decision” and “medically necessary services.”

R9-28-1202. Person-Centered Service Plan:

Comment Summary: Commenters requested AHCCCS add a high level of detail, specific documentation, and operational considerations throughout this rule. Commenters requested AHCCCS include requirements for contractor forms and processes. Commenters requested AHCCCS include provisions on respecting a member’s dignity, privacy, and preference for services. Commenters requested that AHCCCS specify that case managers should “strive to meet in person” when PCSPs are created or revised. Commenters requested clarification on the provisions regarding residence of the member when assessed for services. Commenters also requested that AHCCCS include in the rule an anti-discrimination provision and member rights protections.

AHCCCS Response: AHCCCS appreciates the comments on the PCSP. After considering each comment, AHCCCS elected not to include the level of detail and operational considerations requested for multiple reasons. Each contractor has discretion in preparing the contractor's plan, which contains operational processes, templates, and forms. The contractor's plan is reviewed and approved by AHCCCS and the detailed specifics vary from contractor to contractor while staying within the requirements of rule, policy and guidance. AHCCCS clarified the requirement to consider a member's preferences for services in subsection (C), and AHCCCS removed subsection (D)(5) as unnecessary and to clarify documentation requirements. Anti-discrimination and member protections are federally mandated and overarching and are not specifically called out in this rule. Further details on PCSPs are in AHCCCS materials available on AHCCCS's website.

R9-28-1203. HCBS Needs Tool:

Comment Summary: Commenters requested AHCCCS add a high level of detail to this rule, including meal-related requirements, task and time-specific sequencing, documentation, time frames, and notice and appeal provisions, and explicit prohibitions. Commenters expressed concern that the HNT assessment and ECR be completed by a person, rather than solely through software tools. Commenters also requested that AHCCCS require that case managers “strive to meet in person” for the HNT assessment. Commenters requested AHCCCS distinguish routine quarterly reviews from assessments. Commenters requested AHCCCS to extend time-assessment protections, add clinical review protections

for adults, and require that a copy of the HNT be provided to each member. Commenters also generally objected to the use of age-based limitations throughout Article 12.

AHCCCS Response: AHCCCS appreciates the comments on the HNT. After careful consideration, AHCCCS elected not to include the level of detail and explicit prohibitions requested because, among other reasons, much of the detail requested is contained in statutes and regulations, or guidance and policy available on AHCCCS's website. Contractor time frames are available in R9-28-1210. The HNT assessment and ECR are completed by a person, rather than solely through software tools, and AHCCCS added language to subsection (A) to ensure that each member receives a copy of the HNT as requested. Developmental standards support the use of age-based restrictions, and AHCCCS may impose reasonable requirements as a condition of payment.

R9-28-1204. Direct Care Services:

Comment Summary: Commenters requested definitions for terms including educational services, programs, and grants. Commenters requested the addition of a high level of detail regarding assessment and authorization of services in educational settings, and the distinction between ordinary parental care and extraordinary care. Commenters sought additional detail in the rule language regarding supervision need assessment and documentation, ADL tasks, attendant care, supervision in the context of overnight monitoring, and the billing of services in educational settings. Commenters requested clarification to language regarding assessment, authorization and provision of certain services, including overnight care services. Commenters expressed concern with exhaustion of member family members in providing care in an arrangement where overnight services have been assessed. Commenters requested a statewide service setting matrix that identifies HCBS service setting requirements, exceptions, exclusions and variances and the authority that supports each. Commenters emphasized respecting a member's dignity, sensory needs, and bodily boundaries.

AHCCCS Response: AHCCCS appreciates the comments on direct care services. After considering each comment, AHCCCS created a definition for “medically necessary services” and replaced “direct care services” with “medically necessary services” in subsection (B) to provide clarity. Services provided in educational settings are assessed on a case-by-case basis and further detail is contained in materials available on the AHCCCS website. The federal prohibition on billing two Medicaid services simultaneously applies in all settings, including educational settings. AHCCCS revised language to clarify the services that may be authorized for overnight care with appropriate supporting documentation. Additional detail requested by commenters is contained in other sections in this Article and materials available on AHCCCS's website, including the AHCCCS billing procedure code book, guidance, and policy. Respecting the dignity, preferences and needs of members is an AHCCCS foundational principle of providing care and is built into the language throughout AHCCCS's rules, guidance, and policy.

R9-28-1205. Habilitation Services and Goals:

Comment Summary: Commenters requested AHCCCS add detailed information to this section, including HCBS standards, consideration of needs, assessment routes, learning conditions, purposes of proposed services and benefit pathways. Commenters also requested that detail be added that skill maintenance, reinforcement, generalization, and prevention of regression are legitimate habilitation purposes, and that a functional skill does not become categorically educational solely because the skill is also taught at school. Commenters recommended treating the 14 habilitation hours provision as a general assessment guideline rather than an automatic authorization ceiling requiring a separate review, and asked for additional detail on when additional habilitation hours may be authorized beyond the cap. A commenter again expressed that the rules require that assessments be performed "by a person." Commenters requested revisions to subsections (A)(2) through (6) to clarify and requested a more detailed version of subsection (B).

AHCCCS Response: AHCCCS appreciates the comments on habilitation goals and services. The level of detail requested by commenters on habilitation services is contained in AHCCCS guidance and habilitation policy. The 14-hour habilitation hour cap is subject to the ECR process. Additional details on provisions for authorization of additional hours beyond the 14-hour habilitation cap are contained within this Article as well as in AHCCCS guidance and policy. AHCCCS reiterates that assessments are required to be performed by a person and not solely through the use of software tools. AHCCCS revised subsections (A)(2) through (6) to provide clarity, as requested. AHCCCS also restructured subsection (B) to provide clarity.

R9-28-1206. HNT Criteria and Requirements:

Comment Summary: Commenters requested AHCCCS add a high level of detail to clarify documentation sources and ECR process applicability, provision of direct care services by direct support professionals, mobility assessment, nutrition and meal assessment and authorization, medication pick up, environmental safety measures, and eligibility for services when a parent works from home. Commenters requested AHCCCS include a note to Table 1. Commenters requested that AHCCCS create a process for determining who may provide specialty feeding services and clarify who may conduct training and competency verification. Commenters requested additional language to clarify the definition of "active supervision" and to clarify who can provide active supervision. Commenters requested an expansion to the timeline for assessment for active supervision to continue after age 10 without reassessment. Commenters requested clarification regarding environmental modifications, overnight caregiving, the difference between assessed needs and services authorized, eligibility for services when a parent or caregiver works from home, the use of the term "arm's reach," and environmental modifications and technology. Commenters requested the language be modified to clarify that the assessment of supervision need remains member-specific and separate from who may bill for the service. Commenters emphasized the importance of fairness and requested language to ensure that a member or HCDM can correct errors.

AHCCCS Response: AHCCCS appreciates the comments on HNT criteria and requirements. The information requested by commenters to be added as a table note is already contained in the Article. The term "arm's reach" is literal in the con-

text of subsection (R). AHCCCS modified the language in subsections (Q) and (R) to clarify requirements for overnight caregiving, services when a parent is working from home, and requirements for active general and specialty supervision. Mobility assessments conform to federal Medicaid standards. AHCCCS is required to consider reasonable, cost-effective alternatives when assessing services, and supervision is considered on a case-by-case basis. Providers have the flexibility to decide provisions for competency checks within the parameters of statute, rules and policy. Assessment and authorization are dealt with separately within the rule and the distinction is clear. Further details requested on habilitation goals and services are available in materials published on AHCCCS's website.

R9-28-1207. Extraordinary Care Review - ALTCS Contractor Requirements:

Comment Summary: Commenters requested AHCCCS add a high level of detail to this rule regarding the ECR process, training, documentation, reviewer qualifications, conflict of interest, specific autistic characteristics, and standard forms. Commenters requested statewide standards for the ECR process and corrective actions for when inconsistencies between ECR clinicians are identified. Commenters requested clarification language to make clear that the PEDI-CAT is optional. Commenters requested clarification of the terms "medically necessary" and "extraordinary care." Commenters requested AHCCCS clarify the responsibilities of the ECR clinician versus the ALTCS contractor. Commenters also requested a high level of detail be added regarding the ECR clinician's qualifications, experience and review requirements. Commenters requested AHCCCS clarify the provision of notice of the ECR to provider agencies. Commenters expressed concern about incentives for ECR clinician reviewers to authorize reduced hours.

AHCCCS Response: AHCCCS appreciates the comments on ALTCS contractor requirements. Training and competency verification is managed by the individual contractor. Contractor standard forms, training, authorization and ECR processes are submitted to AHCCCS for review and approval and vary from contractor to contactor. Interrater reliability processes are a core contractor function; minimums are established in rule and policy. AHCCCS added a definition for "medically necessary services," and added clarifying language to clearly delineate responsibilities during the ECR process. Incentives or targets related to case manager service reductions are not permitted. This rule read as a whole addresses many of the comments, and further details are available in materials published on AHCCCS's website.

R9-28-1208. Extraordinary Care Review - Process:

Comment Summary: Commenters requested AHCCCS add detailed information in this section, including provisions for the role of support coordinators, skill maintenance and regression, preventative benefits, stability, NABDs, and appeals. Commenters requested a high level of detail on the 14-hour habilitation cap provisions, eligibility determinations, the HCDM's legal role, and optional provisions for submission of requests and documents. Commenters requested provisions include operational contractor requirements, a requirement for contractors to assist providers in submitting requests for additional hours, contractors permit a case manager or support coordinator to submit the ECR request on behalf of the HCDM, the HCDM be permitted to submit verbal requests for an ECR, and contractors provide detailed clini-

cian qualifications. Commenters requested provisions on clinician decisions such as clarification on when an ECR clinician is expected to obtain input from member of the care team, an ECR clinician consider co-occurring services where clinically appropriate, and a clinician consider provider agency records, direct care worker service notes, and supervisory documentation as evidence. Commenters suggested AHCCCS include additional oversight provisions on reduction in HCBS spending in this section. Commenters also requested AHCCCS clarify subsections (A)(2)(c) through (d), (C), and (D). Multiple commenters requested clarification on subsection (H)(14).

AHCCCS Response: AHCCCS appreciates the comments on the ECR process. The level of detail requested in many of the comments is outside the scope of the information intended to be covered in this rule. Much of the detail requested is provided in the contractor's plan processes, and AHCCCS guidance and policy. Appeal rights for adverse actions are contained in Articles 4, 5, Chapter 34, and in federal Medicaid regulation and are not repeated in this section. Contractor plans are reviewed and approved by AHCCCS but are prepared by individual contractors and vary from contractor to contractor. ECR clinicians determine the need for an ECR and consider a variety of information on a case-by-case basis. For this reason among others, AHCCCS elected not to provide detailed information on clinician determinations in this rule. Reporting and oversight are covered in R9-28-1211 and not included in this rule. AHCCCS revised subsection (C) and removed subsection (C)(2) as redundant to promote clarity. AHCCCS revised subsection (G)(2) to clarify that submitting supporting documentation is optional. AHCCCS removed subsection (H)(14) as the information is addressed in R9-28-1209.

R9-28-1209. Extraordinary Care Review – Decisions:

Comment Summary: Commenters requested AHCCCS add a high level of detail to this section, including detailed information on reduction in services, denial or partial denial of requested services or service hours, repeat ECRs, skill maintenance and regression, meaningful participation, and notice and appeal rights. Commenters requested AHCCCS require specific details be added to contractor ECR templates, clarify additional recommended services, and include additional provisions on cost-effectiveness evaluations and outcomes. Commenters requested additional information on the “carry forward” provisions in subsection (C), and AHCCCS to define the meaning of “other requirements” subsection (C) in the cross-reference to R9-28-1208. A commenter repeated its request that AHCCCS distinguish between references in the rules to “determination” and “decision,” and requested AHCCCS to define the term “outcomes.”

AHCCCS Response: AHCCCS appreciates the comments on ECR decisions. The level of detail requested by many commenters is outside the scope of the information intended to be covered by this rule, and much of the language commenters requested be added to this rule reflects case-by-case considerations. The components of a contractor's template are determined by the contractor and reviewed by AHCCCS. In response to the comments, AHCCCS revised subsection (C) to clarify “other requirements,” removed the cross-reference and clarified the ECR decision “carry forward” provisions. AHCCCS also reorganized subsection (D) to clarify additional recommended services provisions, and revised

subsection (K) to include a provision that if an ECR decision results in reduction, denial or termination of a requested service, an NABD is issued. As referenced in R9-28-1201, AHCCCS provided a definition of "ECR decision" and revised the rules to indicate the difference between the clinician's determination and the contractor's ECR decision throughout the Article. AHCCCS removed the term "outcomes" and replaced the term with "ECR" or "ECR decision" where appropriate.

R9-28-1210. Extraordinary Care Review - Time Frames:

Comment Summary: Commenters requested AHCCCS clarify ECR time frames, federal authorization requirements, and detailed information on appeal rights, timely implementation protection of continuity of services, and accountability for delays.

AHCCCS Response: AHCCCS appreciates the comments on ECR time frames. After considering each comment, AHCCCS revised the rule to reflect that an "ALTCS contractor has seven days from the date that services are requested during the HNT assessment process or, in instances where the ECR request is made outside of the HNT assessment process, seven days from the date of the ECR request, to complete the ECR and issue a decision, in alignment with service authorization time frames under 42 CFR 438.210." AHCCCS also removed redundancies and unnecessary language from the rule to improve clarity. Detailed information requested by commenters is available in materials published on AHCCCS's website.

R9-28-1211. Reporting and Oversight:

Comment Summary: Commenters requested AHCCCS add detailed provisions including standardized quarterly reporting and reporting requirements, corrective action and follow-up monitoring oversight, and publication of data reported and audit findings. Commenters also requested AHCCCS measure gaps between authorization and service delivery, whether services actually reach the member, and service quality.

AHCCCS Response: AHCCCS appreciates the comments on reporting and oversight. After considering each comment, AHCCCS determined that the level of detail requested by commenters such as monitoring gaps, service quality and whether services reach the member is outside the scope of the information intended to be covered in this rule. Quality improvement after an audit is not covered in this rulemaking but can be found in AHCCCS guidance and policy. Information obtained by AHCCCS under this section can be obtained by submitting a public information request.

13. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:

There are no other matters prescribed. This rulemaking is exempt from the Administrative Procedures Act, Arizona Revised Statutes, Title 41, Chapter 6, and not subject to Council review.

a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general

permit is not used:

Not applicable

b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:

Not applicable

c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:

Not applicable

14. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rules:

Not applicable

15. Whether the rule was previously made, amended or repealed as an emergency rule. If so, cite the notice published in the *Register* as specified in R1-1-409(A). Also, the agency shall state where the text was changed between the emergency and the exempt rulemaking packages:

Notice of Emergency Rulemaking: 31 A.A.R. 4227; Issue date: October 31, 2025; Issue Number: 44; File Number: R25-247

Notice of Emergency Rulemaking - Renewal: 32 A.A.R. 932; Issue Date: April 24, 2026; Issue Number: 17; File Number: R26-53

The rules established under the emergency rulemaking expired on October 10, 2026.

16. The full text of the rules follows:

Rule text begins on the next page.

TITLE 9. HEALTH SERVICES

CHAPTER 28. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM - ARIZONA LONG-TERM CARE SYSTEM

ARTICLE 12. ~~REPEALED~~ HCBS NEEDS TOOL AND EXTRAORDINARY CARE REVIEW

Section

R9-28-1201. Definitions

R9-28-1202. Person-Centered Service Plan

R9-28-1203. HCBS Needs Tool

R9-28-1204. Direct Care Services

R9-28-1205. Habilitation Services and Goals

R9-28-1206. HNT Criteria and Requirements

Table 1. Direct Care Services for Members Under Age 18

Table 2. Habilitation Service for Members Under Age 18

R9-28-1207. Extraordinary Care Review - ALTCS Contractor Requirements

R9-28-1208. Extraordinary Care Review - Process

R9-28-1209. Extraordinary Care Review – Decisions

R9-28-1210. Extraordinary Care Review - Time Frames

R9-28-1211. Reporting and Oversight

ARTICLE 12. ~~REPEALED~~ HCBS NEEDS TOOL AND EXTRAORDINARY CARE REVIEW

R9-28-1201. Definitions

The following words and phrases apply to Article 12, in addition to definitions contained in A.R.S. §§ 36-2901 and 36-2931, and 9 A.A.C. 22, Article 1, unless the context explicitly requires another meaning:

1. "Activities of daily living" or "ADLs" means activities a member performs daily for the member's regular day-to-day necessities, including mobility, transferring, bathing, dressing, grooming, eating, and toileting.
2. "Case manager" means a person responsible for locating, accessing, and monitoring the provision of services to a member in conjunction with a clinical team.
3. "Change in condition" means a decline or improvement in a member's health status that necessitates a new assessment and resulting adjustment in intervention by staff or by implementing a standard disability-related clinical or behavioral intervention, or by which current services are no longer effective due to the change of the member's health status. A change in condition has an impact on one or more areas and requires review or revision of the PCSP or HNT.
4. "Clinician" means a person who is licensed, certified, registered, or otherwise authorized under applicable federal or state law to provide health care services and who practices within the scope of the clinician's professional credentials. A clinician is the person respon-

sible for reviewing documentation and making extraordinary care determinations for a member who chooses to engage in the ECR process.

5. "Cost effectiveness study" or "CES" means a method of evaluation to determine if a member's needed HCBS exceed 100% of the net cost of institutional care for that member and to determine appropriate allowable HCBS within the member's CES or alternate care options.
6. "Direct care services" means the services provided by a person employed or contracted by a provider agency to provide attendant care, personal care or homemaker services to a member. Direct care services include tasks described in R9-28-1206(A) through (R).
7. "ECR decision" means an ALTCS contractor's review of a clinician's extraordinary care determination and issuance of the determination. A contractor shall adopt a clinician's extraordinary care determination except when concerns of the clinical integrity of that clinician's extraordinary care determination are identified. In such instances, the contractor's chief medical officer shall maintain final authority for the extraordinary care determination.
8. "Extraordinary care" means care that exceeds the range of activities that a legally responsible person of a minor child would ordinarily perform in a household on behalf of a member if the member did not have a disability or chronic illness, and that is necessary to ensure the health and welfare of the member.
9. "Extraordinary care review" or "ECR" means a review process available to an ALTCS member under the age of 18 or the member's HCDM who disagrees with the number of assessed hours for direct care services or habilitation services as a result of an HNT age limitation or habilitation hourly service cap.
10. "Habilitation services" means services provided to a member as described in A.R.S. § 36-2939.
11. "HCBS needs tool" or "HNT" means a tool used by ALTCS case managers to assess an ALTCS member's specific needs related to direct care services and habilitation services.
12. "Health care decision maker" or "HCDM" means a person who is authorized to make health care treatment decisions for a member, including a legally responsible person of an unemancipated minor or person lawfully authorized to make health care treatment decisions as specified in A.R.S. Title 14, Chapter 5 and A.R.S. §§ 8-514.05, 36-3221, 36-3231 and 36-3281.
13. "Home and community based services" or "HCBS" means services provided to a member as described in A.R.S. § 36-2939.
14. "Informal supports" means unpaid services voluntarily provided to a member by a family member, friend, or volunteer to assist or perform ADLs or IADLs.
15. "Instrumental activities of daily living" or "IADL" means activities a member performs that are more complex in nature and necessary for independent living and community participation, including managing money, preparing meals, shopping, doing laundry, and using transportation.
16. "Legally responsible person" means a parent or legal guardian with formal physical or legal custody.
17. "Licensed health aide services" means services provided to a member as described in A.R.S. § 36-2939.

18. "Medically necessary services" means covered services provided by a qualified service provider within the scope of the service provider's practice to prevent disease, disability and other adverse health conditions, progression of adverse health conditions, or to prolong life.

19. "Parents as a paid caregiver" or "PPCG" means a service delivery model that permits a legally responsible person to receive compensation for providing paid direct care and habilitation services to a minor child who is an ALTCS member.

20. "Person-centered service plan" or "PCSP" means a written plan developed through an assessment of functional needs that reflects paid and unpaid services and supports that are important for a member in meeting the identified needs, goals, and preferences for the delivery of services and supports.

R9-28-1202. Person-Centered Service Plan

A. An ALTCS contractor case manager shall conduct a PCSP at least annually, with direct involvement from a member, and an HCDM when appropriate.

B. An ALTCS contractor case manager shall conduct and document a PCSP in each instance prescribed by 42 CFR 441.725. A member's HNT may be updated without a full PCSP revision being required.

C. A PCSP shall reflect a member's strengths and preferences for services that meet the member's social, cultural, and linguistic needs, individually identified and prioritized goals and desired outcomes, and reflect risk factors, including risks to member rights and measures in place to minimize the risks, including individualized back-up plans and other strategies.

D. When a PCSP is created or revised, a case manager shall:

1. Schedule a PCSP meeting with a member and HCDM, and any other person included in the planning;
2. Determine if a member resides at home, whether the member or HCDM is interested in receiving HCBS, and if the care team has determined that HCBS services are appropriate;
3. Assess a member for direct care services and habilitation services using an HNT when the member or HCDM indicates interest in direct care services or habilitation services; and
4. Provide documentation to support the assessment and hours authorized.

E. Neither the Administration nor an ALTCS contractor shall differentiate or discriminate in the type or frequency of a service authorized based on a member's status as a family member or caregiver or the caregiver's residence.

R9-28-1203. HCBS Needs Tool

A. An ALTCS contractor case manager shall conduct an HNT assessment for an ALTCS member before authorizing direct care services or habilitation services. The case manager shall provide a copy of the completed HNT assessment to the member or HCDM.

B. An HNT may be updated outside of the annual PCSP process. An ALTCS contractor case manager shall determine if a full PCSP process is required at the time of each HNT assessment.

C. Before authorizing approved services, an ALTCS contractor case manager shall:

1. Determine a member's living situation;

2. Discuss informal supports with a member and HCDM to determine the member's preference for caregivers and whether care will be given by formal paid caregivers or informal supports or a combination of formal and informal supports;

3. Determine and document if a member is receiving care from another source, such as Medicare home health or hospice;

4. Review the current HNT if a member has one;

5. Complete a new HNT, or an updated HNT, when appropriate; and

6. Verify that a member's PCSP and HNT both accurately reflect the member's functional abilities and service needs.

D. An ALTCS contractor case manager shall complete an HNT, with direct involvement from a member, and an HCDM when appropriate, if the member or HCDM is interested in receiving direct care or habilitation services:

1. At least annually if the member is currently receiving a direct care or habilitation service;

2. If any discussion with the member or HCDM indicates a potential need for a service;

3. If the member experiences a change in condition;

4. At any time the member or HCDM requests to receive an updated assessment; and

5. When the member or HCDM requests to be evaluated for HCBS in place of institutional care.

E. An HNT shall assess a member's specific HCBS needs for assistance with ADL or IADLs specific to direct care services and habilitation services.

F. An ALTCS contractor case manager shall determine through the use of an HNT if direct care services or habilitation services are medically necessary services and appropriate for a member's unique needs and circumstances. The HNT shall:

a. Be reviewed during each quarterly case management review meeting;

b. Be completed in collaboration with the member, HCDM or any person requested by the member or HCDM to participate;

c. Include the member's or HCDM's description of the need for each task assessed;

d. Identify each direct care or habilitation service needed regardless of cost-effectiveness or service delivery method; and

e. Be incorporated by reference into the member's PCSP.

G. An ALTCS contractor case manager may directly engage a member who is a minor in the assessment process, if appropriate for the member's age and developmental stage.

H. An ALTCS contractor case manager and a member or HCDM shall discuss the care needed for the member, and the amount of time it may take to complete the care.

I. After the HNT is completed, an ALTCS contractor case manager shall discuss with a member or HCDM the availability of informal supports and community services to meet the member's needs, including stressors informal supports may experience in providing care and available supports through community resources.

J. Service time on an HNT is a guideline that reflects the time it may take a member to complete a task based on general and reasonable expectations in home care. Member-specific care needs for a direct care task may exceed the service time guidelines shown on the HNT. An ALTCS case manager shall:

1. Base the time assessed for each category on the evaluation of the member's individual needs.

2. Document comments on the HNT to support the time allotment when services are authorized.

3. If time for a direct care task beyond the HNT guideline in a category is assessed, include in the comments section of the HNT:

   a. An explanation for assessing time beyond the HNT guideline;

   b. A reason for any change in assessing the task, including the number of tasks per day and minutes each task takes, to reflect the member's current condition; and

   c. Any comments or concerns raised by the member or HCDM.

K. An ALTCS contractor case manager shall consider the age of a member and most recent ECR decision as described in R9-28-1209(B) when assessing a task. An ALTCS contractor case manager shall:

1. Not assess the task if the member does not meet the age threshold established in the HNT for the task;

2. Provide clear documentation regarding the member's age as rationale for not assessing the task;

3. Document concerns from the member's HCDM regarding the assessment limit; and

4. Review habilitation goals against age-related HNT tasks to ensure only age-appropriate tasks are permitted.

L. An ALTCS contractor case manager shall document an HCDM's concerns on a member's HNT and provide written communication and education materials about the ALTCS contractor's ECR process for a member under age 18.

M. If a member or HCDM decides not to pursue the ECR process, an ALTCS contractor case manager shall:

1. Document the member and HCDM's decision not to pursue an ECR;

2. Inform the member and HCDM that electing not to pursue the ECR process does not prevent the member or HCDM from pursuing the ECR at a later date; and

3. Meet the time frames for authorization or discontinuation of HNT services.

N. A member or HCDM may request an ECR at a later date if time is needed to review an HNT document and determine if there is interest in pursuing an ECR. If the member has a change in condition, or the member's care needs change, a new HNT assessment may be conducted.

O. An ALTCS contractor shall conduct a CES to determine services that may be provided within ALTCS cost effectiveness standards after a member's needs are assessed and documented. Services with total costs that are at or below 100 percent of the cost of institutionalized care or those that are predicted to be at or below 100 percent within six months may be authorized.

R9-28-1204. Direct Care Services

A. An ALTCS contractor case manager shall authorize only direct care services determined to be medically necessary services and based on an assessment of a member's unique needs documented in the member's PCSP or HNT.

B. For a member under 18 years, an ALTCS contractor case manager shall authorize only medically necessary services determined to be extraordinary care.

C. An ALTCS contractor case manager shall evaluate extraordinary care for each task independently based on a member's age, developmental milestones, and the type of support the member requires.

D. If a member's age indicates the member may be assessed for a task under the age range specified in R9-28-1206, an ALTCS contractor case manager shall base the direct care services determination on the member's ability to complete the task, the time it takes to complete the task, and the level of support needed to complete the task.

E. If a member's age does not indicate the member may be assessed for a task under the age range specified in R9-28-1206, an ALTCS contractor case manager shall document any needs, comments or concerns from the member's HCDM specific to a task to support the ECR should the HCDM request an ECR after completion of the assessment.

F. Direct care services and habilitation services shall not be provided at the same time.

G. Direct care services or habilitation services shall not be authorized for an ALTCS member while the member is engaging in, participating in, or receiving privately or publicly funded K-12 educational services, programs or grants.

H. Direct care services, including supervision, shall be discussed as appropriate based on a member's needs as part of the assessment process.

I. A legally responsible person for a member under 18 years may be paid to provide care for a member between the hours of 6:00 a.m. and 10:00 p.m. Paid overnight direct care services or habilitation services between the hours of 10:00 p.m. and 6:00 a.m. may be authorized only if:

1. An HNT indicates that direct care services or habilitation services between the hours of 10:00 p.m. and 6:00 a.m. are necessary;
2. An ALTCS contractor case manager documents the specific need that requires paid overnight direct care services or habilitation services; and
3. The legally responsible person being paid for care is awake and actively engaged in caring for and supporting the member during the documented time of care.

R9-28-1205. Habilitation Services and Goals

A. Habilitation services facilitate the learning of new skills and foster greater independence for a member and may be provided in the home or in the community, based upon where the skill is most likely to be used, according to the following:

1. Habilitation services shall not be assessed for a member under age 3;
2. Habilitation services shall be assessed when an assessment indicates that a member has the capacity to increase or maintain the member's independence in the completion of a task with instruction and assistance;
3. Habilitation services shall not exceed 14 hours in a 7-day period for members age 3 to 17 unless additional hours are approved through an ECR;
4. If a member does not meet the age threshold to be assessed for an attendant care task, then the member shall not be assessed for habilitation services for that task. A member shall not receive attendant care during the same day and time that habilitation services are delivered;

5. Assessed time for habilitation services shall consider a member's capacity to absorb, learn, practice, and retain information; and

6. Ongoing assessment and monitoring of a member's progress shall occur for each habilitation goal to ensure it remains appropriate.

B. Habilitation goals shall not:

1. Be limited to ADLs and may include IADLs;

2. Be considered for age-appropriate learning; or

3. Include education that is part of a school or home school curriculum.

R9-28-1206. HNT Criteria and Requirements

A. Housekeeping and cleaning. Housekeeping and cleaning shall not be assessed for a member under age 18. Housekeeping and cleaning tasks include performing an activity necessary to attain and maintain sanitary living conditions. Housekeeping and cleaning are appropriate habilitation goals for a member age 13 or older to support skill building and preparation for transition to adulthood.

B. Laundry. Laundry tasks shall not be assessed for a member under age 18. Laundry tasks include preparing clothing or linens for washing, placing laundry in a washer, placing laundry in a dryer or on a clothesline, and folding and putting away laundry, with a goal of maintaining a member's laundry in a clean and neat appearance. Laundry is an appropriate habilitation goal for a member age 16 or older to support skill building and preparation for transition to adulthood.

C. Incontinence laundry. Incontinence laundry needs shall not be assessed for a member under age 4. Incontinence laundry is specific to extraordinary care when a member age 4 or older needs laundry support due to incontinence episodes. Laundry tasks include preparing clothing or linens for washing, placing laundry in a washer, placing laundry in a dryer or on a clothesline, and folding and putting away laundry, with a goal of maintaining a member's laundry in a clean and neat appearance. Incontinence laundry tasks apply only to the member's clothing and linens and do not include bathing, re-dressing, or other tasks specific to the member's cleanliness.

D. Shopping. Shopping tasks shall not be assessed for a member under age 18. Shopping tasks include grocery shopping, obtaining household items, travel time and putting away groceries. Shopping is an appropriate habilitation goal for a member age 16 or older to support skill building and preparation for transition to adulthood.

E. Medication pick up. There is no age requirement for assessment of medication pick up. Medication pick up is specific to obtaining medications for a member's chronic conditions when home delivery of medication is not an option. Medication pick up for a one-time prescription for an acute illness shall not be assessed.

F. Meal preparation and meal clean up. Meal preparation and meal clean up shall not be assessed for a member under age 12.

1. Meal preparation includes meal planning, preparing food for cooking or preparing uncooked food, and cooking and serving food for a member who is:

   a. Able to be home alone for short periods of time but is unable to prepare food due to physical, behavioral, or safety limitations;

   b. Safely home with a sibling who cannot support the member's specific needs related to food preparation; or

   c. Home with a caregiver during a mealtime and a family member is not available to prepare a meal.

2. Meal clean up includes storing food and leftover food, and cleaning dishes involved in preparing and presenting food.

G. Specialty meal preparation and clean up. There is no age requirement for assessment of specialty meal preparation and clean up.

1. Specialty meal preparation includes meal planning, preparing food for cooking or preparing uncooked food, and cooking and serving food, and food modifications to safely consume food, such as blending, pureeing and thickening, for a member who:

   a. Is unable to eat the same meal as the family due to a prescribed specialty diet or if the meal requires special preparation due to documented medical, physical, or behavioral limitations; or

   b. Has restrictive dietary needs, with documented food aversions or inability to eat certain textures, or specific nutritional requirements including low carb, gluten free, lactose free, and food allergies.

2. Specialty meal clean up includes storing food and leftover food, and cleaning dishes involved in preparing and presenting food.

3. Alternative meal schedule. Alternative meal schedule is for a member with diabetes or other medical condition that requires a specific meal or nutrition to maintain proper nutritional intake for medical reasons. Alternative meal schedule includes small meals throughout the day to help regulate the body outside of regular meals with family members.

H. Eating and feeding. Eating and feeding shall not be assessed for a member under age 5. Eating and feeding is the process of transferring oral nourishment from a vessel to a member after it is cooked or prepared for eating, and includes simple meal set up, cutting up food, or cueing the member to eat.

I. Specialty eating and feeding. There is no age requirement for assessment of specialty eating and feeding. Specialty eating and feeding is for a member with a documented need for specialty assistance related to a medical, physical, or behavioral condition impacting the member's ability to consume food, including a gastrostomy tube, chewing or swallowing impairments, choking risks, and other conditions that impact the member's ability to eat safely or effectively.

J. Bathing. Bathing shall not be assessed for a member under age 5. Bathing is the process of washing, rinsing, and toweling the body or body parts and transferring a member in and out of a bathtub or shower. Bathing includes preparing the bath water or equipment ready for bathing in a bathtub, shower, sink or bedside and using assistive devices such as a bathtub or shower chair, pedal or knee-controlled faucets, or long-handled brushes.

K. Dressing. Dressing shall not be assessed for a member under age 5. Dressing includes laying out, taking off, putting on, and fastening clothing and footwear.

L. Grooming. Grooming shall not be assessed for a member under age 5. Grooming includes oral hygiene, nail care, face cleaning, shaving, and arranging hair.

M. Toileting. Toileting shall not be assessed for a member under age 4. Toileting tasks include providing reminders, removing clothing and redressing, diapering, post-toilet hygiene, and use of toileting equipment.

N. Specialty toileting. There is no age requirement for specialty toileting. Specialty toileting includes care needed when a member has a catheter or ostomy bag, demonstrates digging or smearing behaviors that require personal or environmental cleaning, demonstrates

chronic constipation or holding behaviors, or follows a prescribed formal toileting schedule developed by a physician, occupational therapist, or behavioral therapist.

O. Mobility. Mobility shall not be assessed for a member under age 2. Mobility is the extent of a member's purposeful movement within the member's residence, independently or using assistive devices including a wheelchair, walker, or quad cane.

P. Transferring. Transferring shall not be assessed for a member under age 2. Transferring is a member's ability to move horizontally or vertically between furnishings or movables, including a bed, chair, wheelchair, or commode.

Q. General supervision.

1. General supervision shall not be assessed for a member under age 10. Members under the age of 10 shall be assessed for specialty supervision needs.
2. Supervision shall be assessed according to established age requirements and guidelines related to each type of supervision. Time assessed encompasses the time between a specific task a caregiver is performing and the time a member is engaged in other activities or programs where supervision is provided.
3. A member's need for supervision shall be based on safety concerns related to the member's specific medical or behavioral needs and limitations and shall be clearly documented. Supervision shall not be authorized solely for the purpose of adult presence without a member-specific need present. A member's needs include:
    a. Complex medical conditions requiring consistent monitoring for safety, including frequent seizure activity, high risk for choking, and ventilator dependence;
    b. Behavioral needs including elopement, placing inappropriate items in the mouth and eating non-food items, self-injurious behaviors, and aggressive behaviors;
    c. If a member has a physical limitation that prevents the member from safely leaving the home in the event of an emergency; or
    d. Any needs not described in subsection (a) through (c) but that are outlined in subsection (R).
4. Types of general supervision include:
    a. Active supervision. Active supervision is when a responsible adult is within arm's reach of a member at all times. A member age 0 to 9, with or without a medical condition requires active supervision and shall not be assessed for general supervision.
    b. Direct supervision. Direct supervision is when a responsible adult is readily and easily accessible in the home.
5. A member may be supervised through the night if the member has sleep issues due to a documented medical or behavioral condition that makes it unsafe for the member to be left unattended.
6. Environmental modifications such as specialty locks, life/safety alert systems, and assistive technology shall be considered to lessen the need for paid supervision.
7. Paid general supervision shall not be authorized for the administration of medications to a member.

8. Paid general supervision shall not be authorized for a member requiring active or direct supervision whose legally responsible person works from the home, unless supervision is provided by a non-legally responsible person or by a legally responsible person not working during the hours requiring supervision.

9. A caregiver shall be awake to be paid for general supervision.

10. Paid general supervision is not intended to replace child care obligations. Supervision shall be a medically necessary service and based on a member's unique care needs to maintain the member's health and safety.

R. Specialty supervision.

1. Specialty supervision for a member under age 10 shall only be assessed when the member requires a caregiver within arm's reach at all times due to documented medical or behavioral risks, including:

   a. Environmental risk-taking, including eating of non-food objects, unsafe climbing, property destruction, mouthing electrical cords, unsafe interaction with electrical outlets despite use of reasonable safety precautions including outlet covers, and elopement risk despite use of reasonable safety precautions;

   b. Frequent and severe self-injurious behavior, including head banging, self-biting, or other forms of self-harm, and physical aggression towards others; or

   c. Uncontrolled seizures that require a caregiver to physically intervene to prevent harm, including airway risk due to tracheostomy tube e or ventilator dependence, and risk of choking.

2. A member's need for supervision shall be based on safety concerns related to the member's specific medical or behavioral needs and limitations and shall be clearly documented. Supervision shall not be authorized solely for the purpose of adult presence without a member-specific need present.

3. A member may be supervised through the night if the member has sleep issues due to a documented medical or behavioral condition that makes it unsafe for the member to be left unattended.

4. Environmental modifications shall be considered to lessen the need for paid supervision.

5. Paid specialty supervision shall not be authorized for a member requiring active or direct supervision whose legally responsible person works from the home, unless supervision is provided by a non-legally responsible person or by a legally responsible person not working during the hours requiring supervision.

6. A caregiver shall be awake to be paid for specialty supervision.

7. Paid specialty supervision is not intended to replace child care obligations. Supervision shall be a medically necessary service and based on a member's unique care needs to maintain the member's health and safety.

S. Habilitation services shall be conducted as outlined in R9-28-1205.

Table 1. Direct Care Services for Members Under Age 18

Direct Care Services Task	Age Limitation
Housekeeping	Shall not be assessed for children under age 18

Laundry	Shall not be assessed for children under age 18
Incontinence-Based Laundry	Shall not be assessed for children under age 4
Food Shopping	Shall not be assessed for children under age 18
Medication Pick Up	No age limitation
Meal Preparation and Clean Up	Shall not be assessed for children under age 12
Specialty Meal Preparation	No age limitation
Eating and Feeding	Shall not be assessed for children under age 5
Specialty Eating and Feeding	No age limitation
Bathing	Shall not be assessed for children under age 5
Dressing	Shall not be assessed for children under age 5
Grooming	Shall not be assessed for children under age 5
Toileting	Shall not be assessed for children under age 4
Specialty Toileting Needs	No age limitation
Mobility	Shall not be assessed for children under age 2
Transferring	Shall not be assessed for children under age 2
General Supervision	Shall not be assessed for children under age 10
Specialty Supervision	No age limitation

Table 2. Habilitation Services for Members Under Age 18

Member Ages	Weekly Service Limits
Members under age 3	Habilitation Service shall not be assessed
Members aged 3-17	Not to exceed 14 hours in a 7-day period

R9-28-1207. Extraordinary Care Review - ALTCS Contractor Requirements

A. Each ALTCS contractor shall develop and implement a process to administer an ECR and submit the process to the Administration for review and approval prior to implementation. The process shall include all of the following:

1. A purpose statement.
2. The contractor's methodology for the ECR process, including a description of:
   a. How determinations will be made regarding the appropriate clinician to be assigned to each review;
   b. How the clinician will receive the documentation including all information submitted by a member's HCDM and all information outlined in R9-28-1208(H);
   c. How the clinician will conduct the review and account for the available documentation;
   d. The criteria that the clinician will use to determine if there is a need to connect with a member's HCDM to complete the review;
   e. How the clinician will evaluate the holistic needs of a member, ensuring child-specific considerations; and
   f. How the clinician will document the outcome of the ECR.
3. The contractor's description of the contractor's notification and education processes to inform a member of the ECR including:

a. The plan for methods of member education including proactive notification of the ECR process ahead of an HNT assessment;

b. Contractor website content;

c. Contact information for ECR questions or support; and

d. How to obtain additional information.

4. When and how an ECR may be requested, including time frames, and information regarding how to request reasonable accommodations and language access requests.

5. Information required to be documented and submitted by an HCDM when requesting an ECR, and how to submit the information.

6. Information that may be submitted by an HCDM for review during the ECR process, and how to submit the information.

7. The contractor's process to administer the evidence-based assessment tool specified by the Administration to a member when appropriate, if the member's HCDM chooses to participate in the assessment, and if completed, how the results of the assessment shall be shared with an ECR clinician.

8. The type of clinician used to conduct an ECR, including how the contractor determines the selection of a clinician to conduct an ECR for specific members.

9. Training an ECR clinician is required to receive prior to conducting an ECR, and the continued training required for a clinician that conducts ECRs.

10. The method of notifying a member's HCDM of:

a. The contractor's time frame extension to engage a member's care team or specialty clinicians in an ECR;

b. The date and time for a meeting with an ECR clinician when clinically appropriate; and

c. The outcome of the ECR.

11. The time frame for completing an ECR and notifying a member's HCDM of the outcome.

12. Template forms for providing information or notifying a member's HCDM about the ECR, including the standardized form to document an ECR decision.

13. The plan and time frame for training all staff involved in an ECR.

14. A description of how ECR records are maintained.

15. A description of how ECR data required by the Administration is collected.

16. A workflow and timeline of the proposed ECR process that clearly describes the review from beginning to end.

B. The ECR process shall be conducted by a clinician with relevant professional experience, and current licensure or certification. The following clinician types meet this requirement:

1. Developmental pediatricians;

2. Child and adolescent psychiatrists;

3. Registered nurses with additional training in behavioral health or complex medical conditions;

4. Licensed psychologists;

5. Board-certified physical medicine and rehabilitative physicians;

6. Board-certified internal medicine physicians;

7. Board-certified family medicine physicians;

8. Licensed occupational or physical therapists;

9. Speech/language pathologists;

10. Board-certified behavior analysts; or

11. Other appropriately licensed clinicians as approved by the Administration.

C. An ALTCS contractor shall verify that an ECR clinician, regardless of background, is trained on person-centered service planning at the beginning of the ECR process and annually thereafter. An ALTCS contractor may also require additional training for the ECR clinician as appropriate for the scope of the role.

D. An ALTCS contractor shall authorize an ECR clinician to consult with other ECR-approved clinicians in instances where a member's specific case has complex, multi-factorial considerations. An ALTCS contractor shall provide an ECR clinician access to the following when necessary:

1. A person who can provide a whole person care perspective in addition to bringing awareness of available community supports;

2. A person who holds a nationally recognized certification such as a qualified intellectual disability professional, a NAQ-certified intellectual/developmental disability specialist, a National Association for the Dually Diagnosed dual diagnosis specialist, or a licensed master social worker for a review involving a member with an intellectual or developmental disability; and

3. A member's case manager.

E. An ALTCS contractor shall only use a clinician that is either an employee or contracted by the contractor to participate in the ECR process. The contractor shall take measures to mitigate conflict of interest by verifying that a clinician or expert has no direct benefit as a result of the outcome of an ECR. A case manager that meets the requirements for an ECR-approved clinician may not serve as the ECR clinician conducting the review for a child on the case manager's assigned caseload.

F. If an ALTCS contractor uses multiple clinicians for the contractor's ECR process, the contractor shall outline and implement procedures for each clinician ensuring interrater reliability, including the process for implementing interrater reliability standards and the frequency of interrater reliability activities as well as steps to remediate inconsistencies if any are discovered during an interrater reliability exercise.

G. An ALTCS contractor shall verify that any service provided to a member under age 18 is extraordinary in nature as determined by the use of the HNT and a medically necessary service. Requested services that are not assessed due to age-based limitations or habilitation hourly limitations shall be evaluated to determine if:

1. The services are an ordinary requirement of a legally responsible person, versus services that are extraordinary and would not be needed in absence of a disability or other medical condition;
2. The member may benefit from the services; and
3. The services are medically necessary services.

H. An ALTCS contractor shall provide a clinician conducting an ECR with full access to all relevant portions of a member's record. If an ECR clinician has additional questions or requests information available to the contractor, the contractor shall have a process to provide the clinician with the information in a timely manner.

I. An ALTCS contractor shall establish a process to administer an evidence-based assessment tool specified by the Administration to a member as part of the ECR process as well as a process to make the results available to the ECR clinician when the member's HCDM chooses to complete the assessment.

J. An ALTCS contractor shall verify and document that direct care and habilitation services are not:

1. Co-occurring unless clinically appropriate; or
2. Billed during the time a member is sleeping unless there is a present medical or behavioral condition that requires awake, one-to-one care or frequent or continuous monitoring by a caregiver during sleeping hours.

K. An ALTCS contractor shall adhere to time frames outlined in R9-28-1210 regarding decision making and notification of the outcome to a member and the member's HCDM.

L. An ALTCS contractor shall provide reasonable accommodations and language access to a member or the member's HCDM who needs assistance, in whole or part, with the ECR process.

M. An ALTCS contractor shall maintain previously authorized direct care and habilitation services through the ECR process when a new assessment results in a reduction of hours due to age or weekly maximum limitations.

R9-28-1208. Extraordinary Care Review - Process

A. A member under age 18 may be eligible for the ECR process if the member's HCDM disagrees with the hours in the HNT when:

1. The member was not assessed for one or more direct care service tasks due to an age limitation; or
2. The member was not assessed for habilitation services due to age limitations or was assessed and received limited habilitation hours due to weekly hourly limits on the HNT.

B. An ALTCS contractor case manager shall note a member's or HCDM's areas of concern on the HNT, specific to each task reviewed to support an ECR review if one is requested.

C. An ALTCS contractor case manager shall provide a member who is assessed for services and the member's HCDM with additional documentation and resources on the ECR process, including:

1. That requesting an ECR does not mean that the member is automatically eligible for an ECR; and
2. That an ECR shall occur no more than once every 12 months, unless the member has a change in condition, or the member or HCDM requests an ECR of a task that was not previously reviewed in an ECR.

D. An ALTCS contractor shall adhere to service authorization time frames under 42 CFR 438.210 when conducting an ECR.

E. A member's HCDM shall request an ECR in writing to the member's contractor.

F. If a member's HCDM has a concern that does not meet the ECR criteria in subsection (A), or when the HCDM has a concern about the assessment but does not want to pursue an ECR, an ALTCS contractor shall issue a Notice of Adverse Benefit Determination under the requirements and time frames outlined in 42 CFR 438.404.

G. If a member's HCDM elects to pursue the ECR process, the HCDM shall:

1. Submit to the member's contractor a formal request in writing for an ECR that includes:
    a. Whether the member is seeking additional direct care services, habilitation services, or both;
    b. The reason the member is requesting additional time and details that make the care need extraordinary;
    c. The number of additional hours requested for each service type; and
    d. A task-specific rationale describing the need for additional direct care services.
2. Submit supporting documentation for the ECR within the required time frame, if the HCDM chooses to submit supporting documentation.
3. Complete an assessment using an evidence-based assessment tool specified by the Administration, if the HCDM chooses to complete the assessment.

H. If a member's HCDM decides to pursue the ECR process, an ECR clinician shall:

1. Meet with the member and HCDM in-person, by phone, or virtually, if determined to be necessary to better understand member-specific needs.
2. Review the results of the HNT and hours assessed by a case manager as well as any comments or documentation regarding the HCDM or care team's concerns about the assessment and assessed hours.
3. Consider the member's PCSP including unique diagnoses, needs and personal goals, the time and effort it takes to support the member with ADLs, IADLs, or skill building that supports the member in obtaining or maintaining age-appropriate skills, exceeding what a parent or caregiver of a member without disability needs for assessed tasks including circumstances when the member might need multiple caregivers to support a particular task, need or skill.
4. Consider the member's daily schedule to determine the hours in the day the member may be available to receive services including:
    a. Other services the member receives in addition to direct care or habilitation services; or
    b. The member's time spent in educational activities.
5. Consider the risk of institutionalization or out-of-home placement if the member does not receive the services.
6. Determine the availability of other services that may be more appropriate to address the member's needs.
7. Consider other services or supports that were authorized but did not benefit the member.
8. Determine the member's ability to benefit from the services or hours of service received.

9. Determine the member's risk of functional ability or skills regression.

10. Review the member's use of other services, including:

    a. Inpatient hospitalization;

    b. Emergency department visits;

    c. Crisis observation visits;

    d. Out-of-home placements;

    e. Incident reports; and

    f. Other services covered by an ALTCS contractor.

11. Document a consultation between clinicians or a clinician and a subject matter expert as part of th ECR record. A consultation serves as informational only, with the extraordinary care determination to be the sole responsibility of the assigned ECR clinician.

12. Complete an ECR for direct care services, habilitation services, or both consistent with the request.

13. Render a determination in writing. The contractor's chief medical officer shall maintain final authority for the ECR decision.

R9-28-1209. Extraordinary Care Review - Decisions

A. An ECR clinician shall document the clinician's findings, rationale, and determination for an ECR on a standardized template developed by the ALTCS contractor. When the outcome of the ECR results in approved changes to the assessed hours or services, the ECR clinician shall work with the ALTCS contractor to update the HNT as part of the ECR decision documentation process.

B. A revised HNT, with hours documented as determined appropriate by an ECR clinician, shall become the basis for a member's next HNT and PCSP update. If the member's needs have not changed during the time of reassessment, the ECR decision shall be carried forward:

1. Until such time the member's needs have changed;

2. Another ECR is requested and a new ECR decision is issued; or

3. The age requirement for a task not previously assessed has been reached.

C. An ECR shall result in an ECR decision that:

1. Current services and service hours assessed on an HNT are appropriate and no change to the HNT is required; or

2. An increase to the current services and service hours assessed on an HNT is fully or partially approved, and a member's HNT shall be updated by an ALTCS contractor with direction from an ECR clinician to include the additional services or service hours.

D. An ECR decision may contain additional recommended services that are not a part of the HNT assessment that may be appropriate for a member's HCDM and case manager to discuss, including:

1. Home health or licensed health aide services;

2. Therapies;

3. Applied behavior analysis; or

4. Other services as determined by an ECR clinician.

E. An ECR decision resulting in additional services or service hours shall be evaluated for cost effectiveness and shall not exceed the member's allowable CES.

F. Rationale for approving an ECR request shall specify at least one of the following:

1. Evidence and supporting documentation that a member's unique needs and circumstances are extraordinary in nature and receipt of additional services or service hours may alleviate the member's complex care needs or improve the member's safety, health, and well-being;
2. The presence of an immediate threat, or a high probability of immediate danger to the life, health, property, or environment of a member or another person due to the member's medical or mental health diagnosis, or behavioral condition;
3. A risk of removal from the family home by an authorized agency due to concerns regarding a member's care related to the member's complex condition;
4. Evidence that an out-of-home placement is not as cost effective as increasing services to support a member in remaining safe at home; or
5. Other evidence-based clinical rationale that justifies additional services or the increase in service hours.

G. Rationale for denying an ECR request shall specify at least one of the following:

1. Evidence that a member's unique needs and circumstances are not extraordinary in nature and do not require additional services or service hours;
2. Evidence that the services or service hours determined on an HNT are appropriate due to a member's needs and abilities;
3. Evidence that additional services or service hours are not medically necessary services;
4. Evidence that a member cannot benefit from additional services or service hours; or
5. Other clinical rationale specific to a member's unique condition and circumstances as determined and documented by the reviewer.

H. An ECR decision shall be provided to a member's HCDM in writing and specify:

1. The decision rendered for the ECR;
2. Evidence-based documentation and rationale that supports the review decision and outcomes; and
3. Relevant ECR clinician notes and considerations based on professional expertise.

I. ECR findings and decision shall be entered into a member's HNT and incorporated into the member's PCSP.

J. An ECR decision shall be provided to a member's HCDM in writing by email and mail. If the HCDM does not have access to email, a mailed decision shall be sufficient.

K. If an ECR decision results in reduction, denial or termination of a requested service, or if a member's HCDM still has concerns with the outcome of an HNT or the ECR process, the contractor shall issue a Notice of Adverse Benefit Determination under the requirements and time frames outlined in 42 CFR 438.404. Concerns regarding the outcome of the ECR must be documented in the member's PCSP and HNT.

R9-28-1210. Extraordinary Care Review - Time Frames

A. An ALTCS contractor's ECR process shall adhere to the service authorization time frames under 42 CFR 438.210.

B. An ALTCS contractor shall have seven days from the date that services are requested during the HNT assessment process or, in instances where the ECR request is made outside of the HNT assessment process, seven days from the date of the ECR request, to complete the ECR and issue a decision, in alignment with service authorization time frames under 42 CFR 438.210.

C. An ALTCS contractor may request an extension of up to an additional 14 days in instances when the extra time will be of benefit to a member to engage the member's care team or specialty clinicians in the ECR.

D. If an ECR decision includes other services that may more effectively meet the needs of a member, an ALTCS contractor's case manager shall schedule a follow-up discussion with the member and HCDM within 14 days of the ECR decision.

E. An ALTCS contractor shall implement the actions determined by the ECR process within the time frames under 42 CFR 438.210.

R9-28-1211. Reporting and Oversight

A. An ALTCS contractor shall maintain a complete record of all ECR requests and outcomes.

B. An ALTCS contractor's records shall include:

1. Member demographic information including name, AHCCCS ID number, and age at the date of request.
2. Date of the HNT, date of the ECR request, date of the ECR, date of the ECR decision, and date a member or HCDM is made aware of the ECR decision.
3. All information and documentation submitted as part of the ECR request including the written request and supporting documentation provided by a member, HCDM, the member's care team, or the member's providers.
4. Specific clinicians assigned to the ECR as well as the clinicians' professional qualifications.
5. Documentation or evidence referenced in the ECR.
6. The outcome of the ECR.
7. Communications regarding the ECR and the ECR's outcome.
8. The date that communication and follow-up activities were completed.
9. Data related to the following:
    a. The number of reviews completed.
    b. The number of decisions made by category type, including:
        i. Requests approved;
        ii. Requests where no services or service hours were added to the HNT but where other services outside of those covered on the HNT were recommended, including capturing data when a member's HCDM declined recommended services;
        iii. Requests denied;
        iv. Approval of a portion of additional direct care services and total additional number of hours associated with each task where additional time was approved; and

v. Approval of the total additional habilitation service hours during the reporting period.

c. The total and average increases in service hours by service as well as other services recommended outside of those covered on the HNT.

d. The average time to conduct an ECR, data specific to each phase of the ECR process, and overall average time frame for the ECR process.

e. Analysis of any trends that support review and oversight of the ECR process.

C. An ALTCS contractor shall report requested information and data to the Administration at periodic intervals.

D. The Administration shall conduct a periodic audit to ensure compliance and evaluate the effectiveness of an ALTCS contractor's ECR process.

E. An ALTCS contractor shall provide additional information requested by the Administration to support periodic audits of the contractor's ECR process.