ADMINISTRATIVE RULES AND REGULATIONS SUBCOMMITTEE
OF THE
ARKANSAS LEGISLATIVE COUNCIL

Room A, MAC
Little Rock, Arkansas

Monday, October 15, 2018
1:00 p.m.

A. Call to Order.

B. Reports of the Executive Subcommittee Concerning Emergency Rules.

C. Reports on Administrative Directives for the Quarter ending September 30, 2018 Pursuant to Act 1258 of 2015.

1. Department of Community Correction (Dina Tyler)

D. Rules Filed Pursuant to Ark. Code Ann. § 10-3-309.

1. <u>DEPARTMENT OF EDUCATION</u> (Lori Freno, item a; Jennifer Dedman, item b; and Mary Claire Hyatt, items c, d, and e)

a. <u>SUBJECT</u>: Educator Licensure

<u>DESCRIPTION</u>: The Rules Governing Educator Licensure regulate licensure for Arkansas teachers and administrators. The proposed rules reflect changes to implement the Educator Career Continuum and make technical corrections to certain other provisions.

Changes concerning the Educator Career Continuum:

A. Chapter 1, Section 1-2.0 Definitions, is amended to add the following definitions related to Educator Career Continuum requirements:

"ADE-recognized external micro-credential"
"Licensed teaching experience"
"Stacked micro-credential"

B. Sections 2-4.02.3 and 2-4.02.4, concerning the Educator Career Continuum designations of Lead Professional Educator and Master Professional Educator are amended to reference the new Section 4-11, which provides the requirements for those designations.

C. Chapter 4, Section 4-2.0 Application for a Standard License – In-State Applicants, is amended to provide that after January 1, 2019, a first-time license will be issued as an Early Career Professional Educator License, unless the applicant qualifies for a standard license for the Career Professional Educator License under new Section 4-11.01.

D. Chapter 4, Section 4-3.0 Application for a Standard License – Out-of-State Applicants (Reciprocity), is amended to provide that after January 1, 2019, a first-time Arkansas license issued by reciprocity will carry the Educator Career Continuum designation for which the applicant is qualified, under new Section 4-2.11.0.

E. Chapter 4, Applications for Licensure, is amended to add Section 4-2.11.0, which contains the requirements for the licensure designations under the Educator Career Continuum for:

Career Professional Educator
Lead Professional Educator License – In-State or By Reciprocity
Master Professional Educator License – In-State or By Reciprocity

F. Section 5.0, License Renewal, is amended to provide that after January 1, 2019, a standard license issued before January 1, 2019, will be renewed with an Educator Career Continuum designation for which the applicant qualifies under new Section 4-11.0.

Changes concerning Education Leader Preparation Programs:

Section 3-4.02.2 is amended to clarify the requirement for site-based, in-person interaction, and internship experiences for candidates in a program for licensure as an administrator.

Changes concerning adding an area by reciprocity to an existing Arkansas Standard License:

Section 4-10.07.2 is amended to allow an applicant holding an existing Arkansas license to add an area through reciprocity by testing out when the applicant taught the area sought to be added for at least three (3) years under the out-of-state license.

Changes concerning the Effective Teacher Licensure Exception:

Section 7-3.01 is amended to clarify an example given for the licensure exception, and to provide that the licensure exception is not available for teaching in special education.

PUBLIC COMMENT: A public hearing was held on July 27, 2018. The public comment period expired on August 15, 2018. The Department provided the following summary of the public comments that it received and its responses thereto:

Name: Jenni Phomsithi, Director of Instruction, Danville Public Schools
Date Received: July 17, 2018
Comment: Concerning proposed rules governing educator licensure, should Ed.S. degrees be included in this? I ask as a curriculum director who's Ed.S. is in curriculum, but masters is in teaching (MAT) with a BA in English (former secondary English teacher). Those who have pursued administrative degrees through an Ed.S. should not be penalized nor have to pursue another degree to obtain a master professional educator license, in my opinion.

"4-11.02.3.3 Successful completion of: 4-11.02.3.3.1 A master's degree or doctoral degree in the teacher's content area; and 4-11.02.3.3.2 An ADE-recognized external micro-credential or stacked microcredentials aligned with standards adopted by the State Board for the Master Professional Educator License."
Agency Response: Both the Lead Professional Educator and the Master Professional Educator designation have performance-based components. This requirement for a performance-based component was established as the result of input from teachers and leaders around the state. The purpose of requiring the micro-credential is so that the candidate can demonstrate that they have mastered the application of their knowledge to student learning and growth. The micro-credential contains a performance component.

Name: Lucas Harder, Arkansas School Boards Association
Date Received: July 13, 2018
Comment: (Section) 1-2.37: There is an "a" missing from between "under" and "licensure."
Agency Response: This has been corrected.

Name: Jennifer Wells, Arkansas Public Schools Resource Center
Date received: August 15, 2018
Comment: 1-2.08 & 1-2.49 Consider using the term "Stackable micro-credential" instead of stacked; a micro-credential may be earned but not yet stacked; stackable indicates those that are designated as part of series that may be stacked. For instance, the initial micro-credential in a series may be earned but not yet part of a stack.
Agency Response: The word "stacked" is intentional as the entire "stack" would need to be completed.

Comment: 2-4.02.3—are these additional roles built in to the Lead/Master licenses also required to be tied to stipends for additional work performed or are they compensated more than a Career Educator license holder as part of the district salary schedule?
Agency Response: There is no requirement, but school districts are encouraged to incorporate the licensure structure into their salary schedules, as permitted by Ark. Code Ann. § 6-20-2403.

Comment: Also consider changing the reference here [2-4.03] and in 2-4.02.4 to Section 4-11.0 to the Section title or chapter instead, which would make future revisions to rules easier.
Agency Response: The reference is to the correct section.

Comment: Section 7-3.01.i: the proposed rule indicating that you can only teach one grade level above or below seems unreasonable since a certified 7-12 licensed math teacher could certainly teach 5th grade math.
Agency Response: The rule allows one grade level above or below, not a licensure level above or below. A teacher would have to be teaching 7th grade math in order to teach a 6th grade math class, and could not teach a 5th grade math class under this exception.

Comment: General: how are fees determined? Who determines?
Agency Response: Licensure fees are determined by the Professional Licensure Standards Board under Ark. Code Ann. § 6-17-422.

Comment: Consider allowing at least one year of teaching under a waiver to count towards three years' experience. If every other standard is going to apply to that licensee, they should get some credit for it, if they have also done the necessary steps to also have additional experience post-license acquisition.
Agency Response: As no rules section is referenced, this response assumes that the reference is to "licensed teaching experience." The Career Professional Educator, Lead Professional Educator, and Master Professional Educator are designations on a standard teaching license. Educators teaching under a waiver from licensure are encouraged to become licensed. Experience under a provisional license, which is typically issued to candidates who are teaching while enrolled in an alternative educator preparation program, is counted for purposes of Career Professional Educator license designation.

The proposed effective date is November 1, 2018.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: The State Board of Education ("State Board") shall issue the license of a classroom teacher, an administrator, a guidance counselor, or a library media specialist. *See* Ark. Code Ann. § 6-17-402(a). Pursuant to Arkansas Code Annotated § 6-17-402(b)(1)–(2), the State Board shall promulgate rules for the issuance, licensure, relicensure, and continuance of licensure of teachers in the public schools of this state that: (1) require at a minimum that each in-state applicant for teacher licensure completes an educator preparation program approved by the Department of Education and demonstrates licensure content area knowledge and knowledge of teaching methods and (2) require at a minimum that each in-state applicant for an administrator's license demonstrates knowledge of state-adopted competencies and standards for educational leaders. Further, the State Board may promulgate rules for a tiered system of licensure, which may include without limitation an emergency teaching permit; a technical permit; a provisional license; a novice or first-time license; a standard license; and a license with advanced requirements. *See* Ark. Code Ann. § 6-17-402(c)(1)(A)–(F). The

State Board may also authorize a teacher leader advanced license or a teacher leader endorsement to a license. *See* Ark. Code Ann. § 6-17-402(c)(1)(F)(ii).

b. SUBJECT: Instructional Materials

DESCRIPTION: This rule was amended by striking Section 6.01 and its subsections in accordance with Act 929 of 2017. Act 929 of 2017 altered Ark. Code Ann. § 6-21-406 by striking certain language concerning the definition of "person" and the requirement that a person wishing to offer instructional materials for adoption, sale, or exchange in Arkansas must first submit a certified list of all state contracts in the previous fiscal year the publisher sold in the state and instructional materials sold to each district along with the price of the material. Section 4.03 was struck at the request of the State Board of Education in light of the fact that foundation funding is set by the General Assembly rather than the State Board of Education.

PUBLIC COMMENT: A public hearing was held on July 27, 2018. The public comment period expired on August 15, 2018. The sole comment received is noted below.

Rebecca Miller-Rice, an attorney with the Bureau of Legislative Research, asked the following question:

I see in the summary the reasoning for striking Section 6.01. What was the basis for striking Section 4.03? **RESPONSE:** Section 4.03 was struck at the Board's request in light of the fact that foundation funding is set by the General Assembly.

The proposed effective date is pending legislative review and approval.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: Pursuant to Arkansas Code Annotated § 6-21-404(a)(1), the State Board of Education ("State Board") may make rules and regulations to implement the Free Textbook Act of 1975 ("Act"), codified at Ark. Code Ann. §§ 6-21-401 through 6-21-413. *See also* Ark. Code Ann. § 6-21-403(d)(2) (providing that the State Board, through the Department of Education, may promulgate rules as may be necessary to carry out the Act). Revisions to the proposed rules include those made

in light of Act 929 of 2017, sponsored by Senator Jane English, which amended or repealed obsolete laws concerning public education.

c. **SUBJECT: Public School Choice Act of 2015**

DESCRIPTION: The proposed changes include:

Renumbering where insertions/deletions made.

Section 2.01 Regulatory authority updated to include Act 1066 of 2017.

Section 4.04.5 Updated to reflect current Public School Choice Act.

Section 6.02 Clarified that instruction provided by any others than those listed must be pre-approved by ADE in order for the hours to count towards the required training hours.

Section 5.02.2 Language added by Act 1066. Adds the enrollment of a student in a private or home school to the circumstances in which a school choice transfer is voided.

Section 5.04.2 Language deleted by Act 1066. Removes the provision allowing the State Board of Education to resolve transportation disputes.

Section 6.01.1 Language added by Act 1066. Adds a ten (10) day timeline to the requirement for the nonresident district to notify the resident district of the receipt of a school choice application.

Section 7.01 Language added and deleted by Act 1066. Section 7.01, including subsections, changes the requirement for districts previously claiming a conflict with the law to submit proof to the department showing that the district has a genuine conflict that explicitly limits the transfer of students between school districts. The proof submitted must be active and enforceable, and must show the specific language that the district believes causes the conflict. The department must review the proof and notify the district within 30 days of the submission whether the district must participate in school choice. The department is required to maintain a list on its website of those schools who have received a written exemption from school choice. The district may request a

review by the State Board of Education of the department's decision.

Section 7.02.2 Language added by Act 1066. Added Ark. Code Ann. § 6-18-233 to the transfer mechanisms that do not count toward the 3% cap on transfers.

Section 8.00 Removed Data Collection from the section title as the requirement for data collection was removed by Act 1066.

Section 8.01.5 Clarified the appeal process with regard to notification by the Department to the affected parties. This section also allows the resident district the opportunity to provide additional information. This change brings the rules up-to-date with the process followed by practice.

Section 8.01.6 Added the requirement for the department to notify the affected parties of the date, time, and location of the appeal hearing before the State Board. This change brings the rules up-to-date with the process followed by practice.

Section 8.01.6 Original section deleted and incorporated into new Section 8.01.5.

Section 8.01.7 Section deleted to keep in line with current appeal practice as all parties have access to all of the documentation provided by all parties.

Sections 8.02-03 Language deleted by Act 1066. Removes the two-year data collection and reporting requirement as it has already been completed.

Section 9.03 Change allowed the resident district to have the same opportunity for participation in an appeal hearing, if desired.

Section 9.04 Change allowed the resident district to have the same opportunity for participation in an appeal hearing, if desired.

Section 9.07 Updated the nonresident district document numbering since the resident district has been given the same opportunity for participation in an appeal hearing, if desired.

Section 9.08 Addition allowed the resident district to have the same opportunity for participation in an appeal hearing, if desired.

Attachment 1 Changes reflect the updated Act year and statute references.

PUBLIC COMMENT: A public hearing was held on July 27, 2018. The public comment period expired on August 15, 2018. The Department provided the following summary of the public comments that it received and its responses thereto:

Commenter Name: Lucas Harder, Arkansas School Boards Association (3/27/2018)
Comment (1): Section 2.01: A.C.A § 6-1-106 should be added to the list of legal references as it is the location for the definition of "sibling" for school choice.
Response: Comment considered. Non-substantive change made.

Comment (2): Section 9.03: There is a stricken "s" at the end of the last "statement" that should be removed.
Response: Comment considered. No change made.

Comment (3): Section 9.04: There is a stricken "s" at the end of "case" that should be removed.
Response: Comment considered. No change made.

The proposed effective date is November 1, 2018.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: Pursuant to Arkansas Code Annotated § 6-18-1907(a), the State Board of Education may promulgate rules to implement the Public School Choice Act of 2015, codified at Ark. Code Ann. §§ 6-18-1901 through 6-18-1908. Revisions to the proposed rules were made in light of Act 988 of 2017, sponsored by Representative Andy Davis, which amended provisions of the Arkansas Code concerning school choice for foster children; Act 1066 of 2017, sponsored by Senator Alan Clark, which amended provisions of the Public School Choice Act of 2015; and Act 9 of the Second Extraordinary Session of 2018, sponsored by Representative Mark Lowery, which amended Arkansas law concerning the limit on school choice transfers under the Public School Choice Act of 2015.

d. **SUBJECT: Student Permanent Records**

DESCRIPTION: Amendments to these rules are necessary as a result of Act 936 of 2017. They also contain non-substantive edits.

Sections 1.00 and 2.00 were added to the rules to demonstrate regulatory authority and purpose of the rules.

Changes were made to allow districts to maintain student permanent records electronically as well as on paper.

Section 3.02.1.1 contains qualifying information pursuant to Ark. Code Ann. § 6-18-208. The current version of the rule requires maintenance of the student's social security number and Ark. Code Ann. § 6-18-208 provides for an exception. Similarly, Section 3.02.2 contains updated language pursuant to Ark. Code Ann. § 6-18-208(b). Section 3.02.6.1.1 also contains updated language to include the exemption from immunization requirements under Ark. Code Ann. § 6-18-702(d).

Additional requirements were added to the rule to include the information required by Ark. Code Ann. §§ 6-18-213 and 6-18-214.

Additional information regarding District responsibilities for maintenance during annexation, consolidation, and transfer was added in Sections 3.03 and 3.04 for clarity.

PUBLIC COMMENT: A public hearing was held on July 27, 2018. The public comment period expired on August 15, 2018. The Department provided the following summary of the public comments that it received and its responses thereto:

Commenter Name: Lucas Harder, Arkansas School Boards Association (7/13/2018)
Comment (1): Section 3.02.6.4: Medication is missing the "c."
Response: Comment considered. Non-substantive change made.

Comment (2): Section 3.02.8: The title for AESAA should have "Educational" instead of "Education."
Response: Comment considered. Non-substantive change made.

The proposed effective date is November 1, 2018.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: Pursuant to Arkansas Code Annotated § 6-18-901(a), the Department of Education, at the direction of the State Board of Education and in cooperation with any other appropriate state agencies, shall develop and publish an itemized listing of all information to be maintained in a student's permanent record during enrollment in a school district in this state. Revisions to the proposed rules were also made in light of Act 936 of 2017, § 50, sponsored by Senator Jane English, which amended provisions of the Arkansas Code concerning public school education.

e. SUBJECT: Class Size and Teaching Load

DESCRIPTION: This proposed new rule defines the maximum number of students allowed per classroom teacher, outlines the exceptions to the maximum student-teacher ratio, and sets forth how students are to be counted.

The maximum number of students allowed per classroom was previously included in the Standards for Accreditation. The maximum student-teacher ratios have been unchanged, however, the average ratio was removed.

The rules also include the student-teacher ratio exception for large group instruction which was allowed by Act 243 of 2018.

Additionally, the rule outlines how students in Grades 5 and 6 are to be counted for purposes of the maximum number of students a teacher may teach per day.

Changes as a result of the first public comment period:

Sections 3.01.2, 3.01.3, 3.01.3, and 3.01.4: At the recommendation and concern of BLR, the current class averages were added back into the class size limitations.

Section 4.02: Clarification on how to count students in grades 5-6 for those teachers who teach in a self-contained elementary model

Changes as a result of the second public comment period:

Section 2.01.4: “study hall” is removed as duplicative due to changes in Section 2.01.5

Section 2.01.5: (now 2.01.4) is changed to include specific examples

Section 2.01.6: (new 2.01.5) is changed to clarify how the courses are identified in the Course Management System

Section 4.03.1: Added to incorporate the requirements of Act 243 previously omitted

Section 4.04: Added to create the exception for virtual schools, as required by Act 243 that was previously omitted

PUBLIC COMMENT: A public hearing was held on April 19, 2018. The public comment period expired on May 15, 2018. Revisions to the proposed rules were made, and a second public hearing was held on June 6, 2018. The second public comment period ended on June 25, 2018. Additional revisions were made, and a third public hearing was held on August 6, 2018, with a third public comment period expiring on August 27, 2018. The Department provided the following summary of the public comments that it received and its responses thereto:

FIRST PUBLIC COMMENT PERIOD

Commenter Name: David Woolly, Alma School District
(4/5/18)
Comment: Section 4.02 reads in part, “...the teaching load shall be calculated by counting the number of students in each course or section.” This is very unclear as to how to count a child that has the same teacher for more than one “class.” On its face it would appear to mean to count each student in each class, which would result in counting a single child more than one time. Alternatively, it can be interpreted to mean that “student” is a single individual child, and is to be counted only one time. If the first interpretation is applied, then this rule will result in the State being in the same situation as with Act 1113 of 2017 when applied to grades five and six in an elementary school, which was the principal problem with this legislation. Hopefully the second interpretation is what is intended. If this is the case, then clarifying language would be very helpful. However, this should only be applied to grades five and six and only when housed in an elementary school. It is entirely

appropriate to count an individual child more than once in a high school or middle school when, for instance, having the same teacher for both English and speech.
Response: Comment considered. Section 4.02 is changed to add "except for those teachers in Grades 5-6 who are teaching all or most subjects in a self-contained elementary model."

Commenter Name: Amanda Heinbockel, Little Rock Central High School (4/19/18)
Comment: I implore you to limit 7-12 grade class sizes to 22 students. From my years of experience teaching, having 23 or more students in class makes it: more difficult to physically fit students into a classroom, increases student tensions and the likelihood of arguments because everyone is in each other's personal space, makes it much more difficult to give English Language Learners and students with Individualized Education Plans the one-on-one attention they need.
Response: Comment considered. No change made.

Commenter Name: Cindy Brevik, Mena School District (4/19/18)
Comment: In my opinion our class sizes are too large now. The best years I taught was when I only had about 15 students and could sit down with them at a table and work with them as a small group. I understand that it's not possible to have that small of a class size anymore. However, 25 is doable but any more than that is too many, if for no other reason our rooms would be too crowded causing a fire hazard. It is hard to reach those kids that need individualized learning now but with increased class sizes it will be impossible.
Response: Comment considered. No change made.

Commenter Name: Michele Linch, Arkansas State Teachers Association (5/1/18)
Comment: This current proposal includes rules we compromised on after the 2018 special language bill passed. However, there is one issue of concern with the rules I'm afraid will be taken advantage of, to the disadvantage of core (math, science, social studies, reading, English) teachers. Rule 4.01 states, "Except when a teacher teaches a course that lends itself to large group instruction, the maximum number of students in Grades five through twelve (5-12) is permitted to teach without receiving additional compensation shall not exceed one hundred fifty (150) student per day." The "per day" language is concerning as it is

antiquated to a time where students were assigned to 6-7 classes that met each day. With the prevalence of block and flex scheduling, the "per day" language is outdated. Fortunately, when block and flex scheduling came on the scene, districts honored the one hundred fifty (150) students "per day" rule in a manner that reflected a "total student load" as opposed to a "per day" load.

The concern is that there will be districts who use the "per day" language to assign core teachers more than 150 total student load. Given the current state of education affairs and workload of teachers, it is not in the best interests of students for their teachers to be overburdened with excess students, unless they are able to volunteer. An increase in 10 students in districts where 3-4 grades are required to be entered each week, can add hours to work week. Given that personal planning time is increasingly being moved to team planning, we just can't afford to start making decisions that would add time to a teacher's workload. I ask that the Board consider changing language now to prevent future issues.
Response: Comment considered. No change made. The proposed change would require a legislative change. Act 243 of 2018 reads, "Except when a teacher teaches a course that lends itself to large group instruction, as defined by the Arkansas Department of Education, the maximum number of students a teacher in grades five through twelve (5-12) is permitted to teach without receiving additional compensation under this section shall not exceed one hundred fifty (150) students per day."

Commenter Name: Lucas Harder, Arkansas School Boards Association (5/2/18)
Comment (1): Section 1.01: "Load" is missing.
Response: Comment considered. Non-substantive change made.

Comment (2): Section 2.01: Is art going to be one of the classes that will be eligible to be taught in large group instruction? If so, it would be nice for it to be expressly listed as I've received several phone calls from those trying to set up their schedules and not sure how they're going to handle art since they have previously been having a k-12 art teacher. In addition, art is currently the only PAM category that is not expressly listed.
Response: Comment considered. No changes made. Art is considered a visual art class. It is not considered a performing arts class that benefits from having a large number of students participating, and, therefore, is not eligible to be considered for large group instruction.

Commenter Name: Bob Chism, West Fork Elementary (5/3/18)
Comment: I am a career teacher in Arkansas. I've been teaching since the fall of 1992. I was a high school English teacher for eleven years, and since 2000, I've been a fourth-grade teacher. I have seen the struggle teachers endure when class sizes have been large. Frankly, the current rule allows too many students per teacher. Each child gets a fraction of the teacher's time, and with such current large numbers, it is difficult to have the one-on-one time necessary especially for the struggling learner. I'm aware that Arkansas currently ranks low in education when compared nationally . . . Arkansas earned a C-minus on the state report card and ranked 43rd in the nation. This is a shame, and one especially in the light that class size is critical for a quality education. Student achievement and teacher/student ratio is directly linked.... Please reject the proposed rule change and, furthermore, reduce the numbers currently allowed. This rule is not good for our children. Having twenty-five students in a 1-3 class has a negative impact on the quality of education the students gets. Having a maximum of 28 in a fourth-grade class definitely will. Research proves that a smaller teacher/student ratio helps students. Looking at our report card, I'd say we need to make the numbers smaller.
Response: Comment considered. No change made.

Commenter Name: Bob Chism, West Fork Elementary (5/8/18)
Comment: Please consider reducing the maximum number of children in elementary classes. I am a teacher with thirty years of experience and I know first-hand that class size impacts the education children receive. A small class size means more one-on-one time. A small class size means that I get to know my students better, and that classroom management is easier—all which translates to more achievement. The current maximums have harmed our children at our district. During teacher time where I can speak with colleagues, we are always talking about the overcrowding of our classes. I understand the need to be frugal with money and get the best deal we can, but Arkansas was ranked in Education Week at the beginning of 2018 as 43rd out of 50 states. That figure is embarrassing because it can be fixed, and one of the best ways is to reduce class size maximums. I am a current fourth grade teacher, and I can tell you that even twenty-four is too many. Please do not choose saving money over the education of our children. They deserve better. Reduce the maximums. [Agency Note: This comment was received twice, but due to it being the same statement, it was not included twice in this list.]

Response: Comment considered. No change made.

Commenter Name: Mike Mertens, Arkansas Association of Educational Administrators (5/15/18)
Comment (1): Section 3.01.2: Add the following statement after (1-3), "the average student/teacher ratio in a school district shall be no more than twenty-three (23) students per teacher in a classroom and . . . ."
Response: Comment considered. Suggested change has been made.

Comment (2): Section 3.01.3: Add the following statement after (4), "the average student/teacher ratio in a school district shall be no more than twenty-five students per teacher in a classroom and . . . ."
Response: Comment considered. Suggested change has been made.

Comment (3): Section 3.01.4: Add the following statement after "large group instruction," "the average student/teacher ratio in a school district shall be no more than twenty-five (25) students per teacher in a classroom and . . . ."
Response: Comment considered. Suggested change has been made.

Comment (4): Section 4.01 and 4.02: Eliminate section 4.02 in its entirety since the intent of the law (150 students per day) is covered in 4.01.
Response: Comment considered. No change made.

Comment (5): Counting the number of students in grades 5-6 in each "course and section" can't work since it is possible that multiple grades can be given by one teacher to one student in the same time period. Counting students in each course and section could artificially inflate the number of students a teacher has during a school day.
Response: Comment considered. Section 4.02 is changed to add "except for those teachers in Grades 5-6 who are teaching all or most subjects in a self-contained elementary model."

Commenter Name: Jennifer Wells, Arkansas Public School Resource Center (5/15/18)
Comment (1): Title: "2018" should be added to the title.

Response: Comment considered. The effective date will be added once the rule completes the promulgation process. The line under the title represents the place where the effective date will be added.

Comment (2): Sections 3.0 & 4.0: There needs to be an exception for virtual schools to match that laid out in Act 243. See Sec. 33, p. 21, I. 20-21 of Act 243 of 2018.
Response: Comment considered. The rules are changed to include the exception for virtual schools in Section 4.04.

Comment (3): Section 4.01: "five" and "twelve" should be capitalized, in order to match style throughout.
Response: Comment considered. Non-substantive change made.

SECOND PUBLIC COMMENT PERIOD

Commenter Name: Penny McGraw, Parent (5/24/18)
Comment: If you really want to improve student performance, lower class size in K-3 to 15 max and enforce it! You go try to teach 22 kindergarteners for a week and if you don't have problems, let me know.
Response: Comment considered. No change made.

Commenter Name: Melissa Williams, Teacher (5/24/18)
Comment: I teach K-5 art with 9 years' experience and I can contest that first grade is THE very worst grade to fill to the max with 25 students. The previous wording said that the district average must be 23 per class, but that has been scratched. Honestly, there should never be more than 23 in a first grade class. They are still immature babies coming from a K class of 20. Throwing in 5 more kids, five more personalities is hard enough. Please consider limiting first grade to 23. Also, studies show that test scores do increase slightly when class sizes are smaller in grades K-2. But mostly, my concern is for the overall classroom environment.
Response: Comment considered. No change made.

Commenter Name: Debbie Dunigan (5/24/18)
Comment: There are a growing number of students enrolling in public schools that are ADHD, ADD, Dyslexic, and autistic. Smaller class sizes at the elementary level would allow teachers to address the needs of this population of students. Perhaps with K-3 with no more than 16 students and 4-6 with 22.
Response: Comment considered. No change made.

Commenter Name: Doug Vann, Bryant High School (5/24/18)
Comment: Are there any exceptions for an advisory period not counting toward the total 150 students per day in grades 6-12? In the past, administration has told teachers that the additional 20-30 minute period for advisory and other purposes over the years did not count toward the total 150 students even when it required an additional lesson plan, etc. Sometimes the same students were in this period as another period, but many years this was totally different students. It would be nice if this was clarified, so there are no loop-holes within the intent of the proposed rule. Administration did not always translate this "advisory" period as another course and said it was an extension of another class which already counted toward the 150 total. This has varied from year to year, so I'm sure it would be nice to address it in the plan.
Response: Comment considered. Section 2.01.5: The definition for "large group instruction," is changed to include advisory periods, student activity periods, and study hall as "non-academic activities," which are large group instruction courses.

Commenter Name: Jennifer White, Teacher (5/24/18)
Comment (1): As a teacher completing my 12th year, I don't see much change in these proposed rules. I was getting excited thinking maybe ADE finally was going to listen to teachers and reduce class sizes because the way it is now is too much. I work at a school with 98% free and reduced lunch with children coming from every horrible life experience you can imagine. To say there are behavior issues and emotional issues, is an understatement. We also don't have security and only one full time counselor to serve 600 children. How does the state max class sizes serve these children? Then there is the gall to label these schools as F schools.
Response: Comment considered. No change made.

Comment (2): What about lowering class sizes in high poverty schools at least? That could also help attract more teachers to those types of schools. The state did right by investing in the NBCT increase by working at high poverty school. There was even a number attached to that qualifying increase which I believe is 75% or higher. Why not the same thing for class size? It needs to be 20 or less to be truly effective. 15 for kindergarten. Look at other high performing states such as North Dakota, Vermont, and Nebraska. All have lower class sizes than Arkansas. If the state would lower class sizes for schools that are 75% or higher free and reduced

lunch, then the remaining schools would adhere to the current standards.
Response: Comment considered. No change made.

Commenter Name: Christy Henry, Teacher (5/25/18)
Comment: I have been a fourth grade teacher for almost a decade now. I have 15 years of experience in teaching. I have seen a change in students over time that is not a positive one. I remember seeing a post from ADE last year about truly getting to know all of your students and being an advocate for them. With today's challenges of single parenting, grandparents raising their children, the huge amounts of children staying indoors in front of tv's or video games comes a new strain of children. Behavior problems are definitely on the rise. When you pack my classroom with 25-27 students and in that mix I have 4 dyslexic students who have a 504 that says everything must be read to them, 1 student with anxiety who just turns in a paper half blank, 2 ADD students who don't turn in work at all, and a huge behavior problem whines if a certain student looks at him or if he's asked to write (or he throws an all-out 2 year old fit because he has developmental delays); it is a wonder I get any teaching done at all. I want to advocate for the students who come every day expecting to learn, too. The malpractice of them not learning because of all of the other behavior problems being dealt with is huge, not only in my classroom, but many others. I would LOVE to see class sizes drop to 20 for 4th grade and for there to be a requirement for ALE classrooms even at an upper elementary level for students who constantly require attention because of behavior. It doesn't have to be a life sentence (ALE), just an alternative until they pull their act together.
Response: Comment considered. No change made.

Commenter Name: Rachel Pfenenger, Sheridan School District (5/25/18)
Comment: 30 may seem like a reasonable number until you have to keep up with that many students in laboratory. I am deeply concerned about the safety of my students when more than 24 are placed in a period class. I am also concerned about elementary and intermediate teachers being able to lay a solid foundation for students that will eventually come to me if they have more than 22 students. Test scores go up and student achievement as well when you have a lower student to teacher ratio. Teachers are more able to provide extra support for struggling students and have more time for enrichment for high achieving students if they have less

students to teach. 6th grade is when the number should go up to 24, and I don't believe that any class should have more than 24 (grades 6-12). If we want our children to succeed and our best and brightest teachers to keep teaching, lessen the class size and allow them more time to plan great lessons that last a lifetime.
Response: Comment considered. No change made.

Commenter Name: Karen Burnett, Sheridan School District (5/25/18)
Comment: As a science teacher at the high school level 9-12 I think that a class size of 30 students is too large to keep the students safe during lab activities. I think that a class size for lab science should be limited to 24 students, this is easier to keep an eye on all students during lab activities.
Response: Comment considered. No change made.

Commenter Name: Christy Wheeler, Teacher (5/25/18)
Comment: I just recently finished teaching the school year in a first grade classroom. I have had 25 students on my roster up until spring break when I lost one student. First grade is a major year for students academically because they have to make the largest gains in reading while they continue learning new skills in every subject. First grade is a critical year where we are seeing signs of dyslexia and reading disabilities. These students are requiring more intense instruction to help them make gains. When I look at best practices for first and second graders, 23-25 students in a room is too many. Students have trouble focusing in a large room. It is also difficult to give each one of the students my focus and attention. I give each and every one of my students my best every day, but they deserve more.
Response: Comment considered. No change made.

Commenter Name: Kathy Medford, Ouachita River School District (5/25/18)
Comment: The proposed rule changes from the first public comment period helped clean up and clarify the grade level student-teacher ratios. As a small district, we occasionally have a larger group of students pass through a grade level that may be one or two students over the allowable ratio. This causes the district to hire a teacher that will not be needed the next school year. The proposed rule changes, out for comment now, go back to the same problems as before. Ouachita River School District prefers the first proposed changes to the rule, not the current proposal.
Response: Comment considered. No change made.

Commenter Name: Sara M. (5/25/18)
Comment: Section 3.01.5: Where is the statement that 7-12 teachers can have no more than 150 students per day? Some schools have 8 periods a day and, if a teacher has 30 students in each class, that is 240 students a day. That is not acceptable.
Response: Comment considered. No change made. In Section 4.01, the rule states that except when a teacher teaches a course that lends itself to large group instruction, the maximum number of students a teacher in Grades Five through Twelve (5-12) is permitted to teach without receiving additional compensation shall not exceed one hundred fifty (150) students per day.

Commenter Name: Shannon Miller, Mena School District (5/25/18)
Comment: As an elementary teacher for 16 years I have seen the improvement my students can make when they are in a smaller class. Increasing the class size only benefits administration who are only worried about money. The department of education should be more worried about our students and their education than dollar signs. I have taught both sizes of classes. One year I had 25 students with an aide. I have to say I did a very poor job of helping my lower kids make progress. A few years later I had a much smaller class. When test scores came back every one of my students were advanced or proficient. The reason why was because I had more time to work with them individually. I could spend more time bringing my low kids up and challenging my highest. I ask that you please add my name to the list of those educators who oppose this change and urge the department of education to put children first.
Response: Comment considered. No change made.

Commenter Name: Sarah Grinnell, Lonoke School District (5/26/18)
Comment: 23-25 students in a 1st grade classroom is too many even with an aide. Classrooms are not equipped to handle that many students with supplies nor space. Kindergarten classes are difficult with 20 much less as many as 22 even with help. A major difference in the ability to provide differentiated instruction to students that require RTI is much more successful in classes with 17-18 students. Especially in kindergarten when you have students that have not attended any type of preschool program. The last few years it seems that my classes have gotten more and more students in this category including a heavier Hispanic population.

Response: Comment considered. No change made.

Commenter Name: Rebecca Vinzant, Prairie Grove School District (5/26/18)
Comment: I am a fourth grade teacher at Prairie Grove Elementary and I know smaller class sizes makes a huge difference in my ability to serve every student's needs. Please consider lowering class sizes for fourth grade from 28 to 25. I know the students in Arkansas would really benefit from this decision.
Response: Comment considered. No change made.

Commenter Name: Darryl Dean, Sheridan School District (5/29/18)
Comment: When looking at the proposal of JROTC to be listed as large group instruction. I am wondering what they are basing this on. If a normal class can be 30 to 1. What would the class size for a large group instruction be? Fifty, sixty or a hundred? Seventy percent of the classes that are taught to the freshmen (Let 1) JROTC cadets are small group instruction, sitting at a desk, with a book, paper, pencil and presentation giving by the instructor. The percentage of classroom instruction gets higher as you move up to sophomore, junior, and senior (Let 2, Let 3, and Let 4). The JROTC classroom curriculum includes coursework on leadership, civics, geography, global awareness, health and wellness, language arts, life skills, and U.S. history. The curriculum is based on the principles of performance based, learner centered education and promotes development of core abilities: capacity for life-long learning, communication, responsibility for actions and choices, good citizenship, respectful treatment of others, and critical thinking techniques. In the past JROTC spent more time outside marching or doing physical training. Now more of these events are done as Co-curricular activities after school just as JROTC Leadership Challenge and Academic Bowl that is a competitive program that imparts values of leadership and citizenship while preparing for higher education milestones like college entrance exams. STEM Camps that are a week long college residential program that takes place at STEM labs. During this event the students get to interact with college-level professors and students. The cadets also have the opportunity to compete in Raider, Drill, and Air Rifle Competitions. All of these co-curricular activities take place after school. So this leads me back to the original question what are they basking the proposed label for large group instruction for JROTC? If a JROTC class was larger than 30 to 1 based on the curriculum that is required to be taught having larger

than 30 students in class would lead to the inability to meet the desired teaching outcomes. My recommendation would be for JROTC to be considered in the 30 to 1 classroom size.
Response: Comment considered. No change made.

Commenter Name: Michelle Mayo, Newport School District (5/29/18)
Comment: As a teacher in an elementary school, I believe that the class sizes are too large. My input would be the following: Kindergarten 16; [grades] 1-3, 4-20; [grades] 5-6, 22.
Response: Comment considered. No change made.

Commenter Name: Darryl Dean, Sheridan School District (5/30/18)
Comment: The U.S. Army has contracts with all the schools that have Army JRTOC. In Sheridan HS, JROTC the max class size by the contract is 40 students. I feel this is too many students and the contract is from 2002 was the last time it was renewed. A lot has changed in the curriculum and the programs in 16 years.
Response: Comment considered. No change made.

Commenter Name: Magan Duffel, Teacher (5/31/18)
Comment: We have full inclusion in our classrooms and have students that are several grades below grade level. I feel that these classes need smaller numbers than 28 in a room. I am thankful that the max number of students is reduced to 150, but it is still excessive especially if you teach writing. Most of your personal life is spent grading essays. I wish these factors would be taken into consideration. Classrooms with several 504 & IEP students must have fewer numbers or our average students won't get the direction they need.
Response: Comment considered. No change made. Additional class size requirements for special education students can be found in the Arkansas Department of Education Special Education and Related Services Rules, Section 17.00 Program Standards.

Commenter Name: Robin English, Riverview High School (6/6/18)
Comment: I am in agreement with the propositions concerning 7-12 course load. For years, the 30 per class and no more than 150 per day was the standard. I am glad to see that this is being proposed. I could list many more reasons why this is a good idea, but I'm guessing the committee already knows them all. I simply wanted to voice my opinion in support of this class load standard.

Response: Comment considered. No change made.

Commenter Name: Bob Chism, West Fork Elementary
(6/11/18)
Comment (1): I am a career teacher who has been teaching in Arkansas since 1992. I am concerned, first of all, with the language of the pending rule concerning class size. The numbers in the teacher/student ratios are too high. Allowing a class size of 25 and 28 in grades 1-4 puts students at a disadvantage because the teacher will have extreme difficulty in addressing individual student needs in a school day. I would propose no more than 18 for grades 1 and 2, and I would propose no more than 25 for grades 3 and 4.
Response: Comment considered. No change made.

Comment (2): I believe it is important to include in the rules that these are regular classes and do not include special education classes. That is, that a special education teacher cannot be considered one of the grade level teachers because they could conceivably considered a teacher at every grade level depending on the students they see. It seems to me that a school might be able to work around the average language by identifying a special education teacher as a grade level teacher and then allow the average language to be circumvented. I propose that you include language in the rule that excludes special education teachers from being considered a separate classroom at each level.
Response: Comment considered. No change made. Additional class size requirements for special education students can be found in the Arkansas Department of Education Special Education and Related Services Rules, Section 17.00 Program Standards.

Commenter Name: Bob Chism, West Fork Elementary
(6/11/18)
Comment: Please consider lowering the teacher/student ratios for another reason. The pending rules for Accreditation allow up to 90 days for a school district to correct a violation of the student/teacher class size ratio. That would mean that a school district could have very large class sizes in excess of the maximum for up to a third of a school year. This matter is too important to allow a district to violate this rule for this length of time. Research shows that student/teacher ratios are very important for student achievement.
Response: Comment considered. No change made.

THIRD PUBLIC COMMENT PERIOD

Commenter Name: Phyllis Norris (7/25/18)
Comment: I do not understand the wording on class size because it states no more than 23 students per teacher then the next sentence it says no more than 25 students per teacher. How can it be both? Have I missed something?
Response: Comment considered. No change made. Section 3.01.2 states that the *average* student/teacher ratio in a school district for grades 1-3 shall be no more than twenty-three (23) students per teacher in a classroom and that there shall be no more than twenty-five (25) students per teacher in any classroom. No one class may have more than 25 students, but the overall average cannot exceed 23 students per teacher.

Commenter Name: Bob Chism, West Fork Elementary (8/6/18)
Comment (1): The numbers are currently too high. The kindergarten and first grade limits should be less than twenty. Allowing up to twenty-eight students in a fourth grade class is untenable in light of the statewide test scores. Class size has a very important impact on the effectiveness of a teacher. Reducing it to twenty-five would make more sense.
Response: Comment considered. No change made.

Comment (2): There should be a clear and swift consequence for schools which do not comply. Schools should not be allowed more than two weeks to make a change before consequences follow. Put some teeth into the consequences. Giving schools months to rectify the problem only harms the students and gives no real incentive to make sure of being in compliance with the rule. It should be spelled out in the rule itself. I could not find it.
Response: Comment considered. No change made.

Comment (3): The rule should address the situation where students are assigned to a special needs teacher, but who are in a regular classroom for most of the day.
Response: Comment considered. No change made. Additional class size requirements for special education students can be found in the Arkansas Department of Education Special Education and Related Services Rules, Section 17.00 Program Standards.

Commenter Name: Bob Chism, West Fork Elementary
(8/19/18)
Comment (1): It is evident that the rule committee is working to more clearly spell out the number of students a teacher can have in a class, but I don't see that clarity in the consequences of not abiding by the rules. I believe that the rule would be better if it plainly identified the steps schools must take if they find themselves afoul of the rule. Furthermore, the consequences need to be such that it gives incentives for the school to rectify the problem with alacrity. If the school is allowed to take weeks or months to fix the problem, that would mean that students would not be getting the quality education we are tasked to give them.
Response: Comment considered. No change made.

Comment (2): This year, I have been assigned twenty-six students (the most I have ever had). This is six more than I had last year. Of course, it is two less than the current rule would allow, but I am fearful that the West Fork Schools will really have no real incentive to hire additional staff should the number exceed the limit. There are two other fourth grade teachers who each have 24, so none of us has the maximum, nor does our average for the grade exceed the limit of 25– but we are hovering there, and it doesn't seem that the admin are the least bit concerned. I believe they will do as they have before and merely assign students to another teacher but have the in-class teacher/student ratio exceed the limit.
Response: Comment considered. No change made.

Comment (3): Please put consequences in the rules that have some force. I believe the numbers are too high, but if you are going to keep the numbers, please consider putting some teeth into the consequences. Every additional child in a classroom means that each child gets a smaller fraction of the teacher's one-on-one interaction. Spell out the consequences. I know that the school board association and the superintendents have a greater lobbying ability than teachers, but I believe their concern is simply the bottom line on a spread sheet and not the solid education of students. Let us be a leader in reducing the teacher/student ratio by making schools act quickly and decisively when the number triggers a violation of the class size rule.
Response: Comment considered. No change made.

Commenter Name: Jennifer Wells, Arkansas Public School Resource Center (8/27/18)
Comment: ADE Rules Governing Distance and Digital Learning 7.07 defines certain courses as "large group instruction." APSRC would like to add that cross reference into these rules as well.
Response: Comment considered. No change made. The rule as written includes in the definition of "large group instruction," other courses identified as large group instruction in the Course Code Management System.

Rebecca Miller-Rice, an attorney with the Bureau of Legislative Research, asked the following questions during the first public comment period:

Is the Department comfortable with the establishment of these new rules pertaining to class size where Arkansas Code Annotated § 6-17-812, as amended by Act 243 of 2018, § 33, provides that the Department "shall include in the Standards for Accreditation of Arkansas Public Schools and School Districts the maximum number of students to be taught per day and the exception under subdivision (a)(4)(A)"? **RESPONSE:** Because we did receive rule making authority in Act 243 of 2018, we decided to pull the class sizes out of standards and instead incorporate them by reference into the standards (Standard 1-A.6 – must comply with the laws of the state and rules of the department regarding class size and teaching load).

I'm not seeing included in these new rules the "manner in which students in grades five (5) and six (6) are to be counted for the purposes" of § 6-17-812, as required by Ark. Code Ann. § 6-17-812(e)(2), as amended by Act 243 of 2018, § 33. Was there a reason the manner was not provided therein or is the Department planning to include that in another set of rules? **RESPONSE:** Section 4.02 of the proposed rules do provide a mechanism for counting students in grades 5-6. The updated draft provides a little more clarification on that mechanism.

The proposed effective date is pending legislative review and approval.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: Act 243 of 2018 became effective on and after July 1, 2018, and served to make an appropriation for

grants and aid to local school districts and special programs for the Department of Education ("Department") for the fiscal year ending June 30, 2019. Pursuant to Arkansas Code Annotated § 6-17-812(e)(1), as amended by Act 243, § 33, the Department shall promulgate rules to implement the statute, which concerns compensation for teaching more than the maximum number of students permitted. The rules promulgated by the Department shall include without limitation the manner in which students in grades five (5) and six (6) are to be counted for the purposes of this section. *See* Ark. Code Ann. § 6-17-812(e)(2), as amended by Act 243, § 33.

2. <u>DEPARTMENT OF ENVIRONMENTAL QUALITY, OFFICE OF LAW AND POLICY</u> (Michael Grappe)

a. <u>SUBJECT</u>: Regulation No. 1: Prevention of Pollution by Oil Field Waste

<u>DESCRIPTION</u>: The purposes of the amendments to this regulation are to:

1. Simplify the name of the program to Prevention of Pollution by Oil Field Wastes;

2. Eliminate a duplicative permitting process for disposal wells that are not commercial disposal wells or high volume disposal systems by establishing permit by rule for disposal wells permitted by the Arkansas Oil and Gas Commission (AOGC);

3. Update definitions; and

4. Make minor revisions to include correcting typographical, grammatical errors, and updating formatting to conform with current stylistic guidance throughout the regulation.

<u>PUBLIC COMMENT</u>: A public hearing was held on July 26, 2018. The public comment period expired on August 16, 2018. The Department provided the following summary of the sole public comment received and its response thereto:

Charles Moulton, Administrative Law Judge to the APC&EC Comment: Recommended the title of Chapter 1 be changed to "General Provisions."

Response: The Department agrees with the recommended change and has made the change in the revised markup draft.

The proposed effective date is December 31, 2018.

FINANCIAL IMPACT: There is no financial impact on the regulated entities. The entities subject to the proposed amendment operate disposal systems for oil field waste. The proposed amendment will not impose an additional cost on any entity operating a disposal system. Implementation of the amended regulation is estimated to decrease the cost because it eliminates duplicative permitting and most entities will save approximately $250 per year in permit fees.

The proposed amendment will not impose an additional cost or regulatory burden on ADEQ. The program is supported by permit fees.

LEGAL AUTHORIZATION: Pursuant to Arkansas Code Annotated § 8-4-217, it is unlawful for any person to cause pollution of any of the waters of this state or to place or cause to be placed any sewage, industrial waste, or other wastes in a location where it is likely to cause pollution of any waters of this state. *See* Ark. Code Ann. § 8-4-217(a)(1)–(2). The Arkansas Department of Environmental Quality ("Department") is charged with the power and duty to administer and enforce all laws and regulations relating to the pollution of any waters of the state, and the Arkansas Pollution Control and Ecology Commission ("Commission") is charged with the power and duty to promulgate rules and regulations implementing the substantive statutes charged to the Department for administration. *See* Ark. Code Ann. § 8-4-201(a)(1), (b)(1)(A). *See also* Ark. Code Ann. § 8-4-202(a) (charging the Commission with the power and duty to adopt, modify, or repeal, after notice and public hearings, rules and regulations implementing or effectuating the powers and duties of the Department and the Commission under Title 8, Chapter 4, of the Arkansas Code, concerning the Arkansas Water and Air Pollution Control Act).

3. DEPARTMENT OF ENVIRONMENTAL QUALITY, WATER DIVISION (Michael Grappe)

a. SUBJECT: Regulation 2, Water Quality Standards; Third Party Rulemaking by Huntsville

DESCRIPTION: The City of Huntsville ("Huntsville") operates a municipal wastewater treatment facility ("WWTP") on Highway 23 North of Huntsville in Madison County, Arkansas. Treated municipal wastewater is discharged from Outfall 001, as authorized by the Arkansas Department of Environmental Quality (ADEQ) under National Pollutant Discharge Elimination System (NPDES) Permit No. AR0022004 that was effective on June 1, 2011 ("the Permit"). Outfall 001 discharges to Town Branch, which flows into Holman Creek, which flows War Eagle Creek. The Permit requires Huntsville to monitor and report the concentration of TDS in its effluent, and includes a condition that Huntsville undertake a study to evaluate all options for achieving compliance with water quality standards for dissolved minerals; i.e. Chlorides ("Cl"), Sulfates ("SO4") and Total Dissolved Solids ("TDS").

Huntsville submitted the required work plan, which was approved by ADEQ. Huntsville implemented the work plan and issued a report, which recommended establishing site specific criteria for dissolved minerals for certain stream segments downstream of the Huntsville WWTP. Following the initial comment period and extensive discussions with ADEQ, Huntsville limited the scope of the stream segments for which site specific criteria were requested, and issued a revised report entitled *Revised City of Huntsville, Arkansas Section 2.306 Site Specific Water Quality Study: Town Branch, Holman Creek, and War Eagle Creek* ("the Study").

Based upon discussions with ADEQ and the Study, Huntsville is requesting the following modifications to APCEC Regulation No. 2 for the stream segments identified below (the "Stream Segments"):

Establish site specific Cl, SO4 and TDS criteria for Town Branch from Point of Discharge of the City of Huntsville WWTP downstream to the confluence with Holman Creek as follows: 223 mg/L Cl, 61 mg/L SO4 and 779 mg/L TDS

Establish site specific Cl, SO4 and TDS criteria for Holman Creek from the confluence with Town Branch downstream to the confluence with War Eagle Creek as follows: 180 mg/L Cl, 48 mg/L SO4 and 621 mg/L TDS

Establish site specific Cl, SO4 and TDS criteria for War Eagle Creek from the confluence with Holman Creek Downstream to Clifty Creek as follows: 39 mg/L Cl and 248 mg/L TDS

Removal of the Domestic Water Supply use for Town Branch beginning at Latitude 36.112330°, Longitude- 93.732833° and extending downstream to its confluence with Holman Creek at Latitude 36.0118158°, Longitude- 93.736039°; (OH-1, #6) and for Holman Creek beginning at its confluence with Town Branch at Latitude 36.118158°, Longitude -93.736039° and extending downstream to its confluence with War Eagle Creek at Latitude 36.140824°, Longitude -93.729594° (OH-1, #7)

Huntsville's proposed site-specific criteria and use removal are supported by the following:

- Huntsville is not seeking a change from historical water quality conditions in or removal of a designated aquatic life use or the removal of an existing or attainable domestic water supply use in the Stream Segments; rather Huntsville seeks the establishment of site specific criteria and designated but not existing or attainable uses in the Stream Segments, which allow Huntsville to be compliant with its NPDES Permit while making certain that its effluent does not limit the attainment of any of the designated aquatic life uses of the Stream Segments or any of the uses in Beaver Lake, including the domestic water supply use.

- The Study established that:

  - Setting the chloride, sulfate and total dissolved solids at the site specific levels requested will not cause acute or chronic toxicity in the Stream Segments;
  - Setting the chloride, sulfate and total dissolved solids at the site specific levels requested will not impair existing or attainable designated uses, including aquatic life in the Stream Segments; and
  - Setting the chloride, sulfate and total dissolved solids at the site specific levels requested will not impair Beaver Lake; and
  - Removing the domestic water supply use from the stream segments will not impair an existing or attainable use in the Stream

Segments and will not impair Beaver Lake.

- The fish collections for the Stream Segments were typical of Ozark Highlands Ecoregion fisheries. The habitat quality of the Stream segments is adequate to support the designated aquatic life uses. The biological assessment upstream and downstream of the Stream Segments supports the determination of full attainment of the fishery use. All sampling locations influenced by Huntsville WWTP's discharge showed the presence of ecoregion key and indicator species and species composition consistent with the attainment of a Ozark Highlands fishery designated use. The requested site specific criteria will have no adverse effect on the aquatic life communities;

- Toxicity testing on *Ceriojdaphnia dubia* and *Pimphales promelas* using Huntsville WWTP effluent showed no significant lethal or sublethal toxicity in either test organism at concentrations exceeding the site specific criteria requested herein;

- There are no current economically feasible treatment technologies for the removal of the minerals. Reverse osmosis treatment technology does exist; however, this technology is not cost effective and generates a concentrated brine which is environmentally difficult to dispose of. The technology is not required to meet the designated aquatic life uses and even if implemented would produce no significantly increased environmental protection;

- There has been no historical and there is no existing domestic water supply use on the Stream Segments and the Stream Segments are not capable of supporting a domestic water supply use;

- Establishing site specific criteria for Cl, SO4 and TDS, and removal of the domestic water supply use for the Stream Segments are necessary to accommodate important economic and social development in the Huntsville area.

- The basis for site-specific standards is provided in 40 CFR 131.10(g). Huntsville's request for the modifications to APCEC Regulation No. 2 set forth above is supported by 40 CFR 131.10(g)(6) which provides that the state may establish less stringent criteria if controls more stringent than those required by section 301(b) and 306 of the Clean Water Act would result in

substantial and widespread economic and social impact.

- 40 CFR 131.11(b)(1)(ii) provides states with the opportunity to adopt water quality standards that are "modified to reflect site-specific conditions."

PUBLIC COMMENT: The third-party proponent of the instant rule change, the City of Huntsville, initially sought to amend Regulation No. 2 in 2013, with a public hearing held on October 28, 2013, and the public comment period expiring on December 2, 2013. Revisions were made to the site specific criteria, and due to the significant level of those revisions, a second public hearing was held on November 13, 2017. The second public comment period expired on December 4, 2017. The following public comment summaries by both the Department and the City of Huntsville were provided:

PUBLIC COMMENT SUMMARY OF ADEQ

Pursuant to Minute Order 13-23 and Minute Order 17-19, the Arkansas Department of Environmental Quality (ADEQ or Department) submits the following Statement of Basis and Purpose and Responsive Summary regarding proposed changes to Arkansas Pollution Control and Ecology Commission Regulation No. 2 (Reg. 2), Regulation Establishing Water Quality Standards for Surface Waters of the State of Arkansas, as required by Arkansas Pollution Control and Ecology Commission Regulation No. 8.

On July 26, 2013, the Arkansas Pollution Control and Ecology Commission (APCEC or Commission) granted City of Huntsville's (Huntsville) Petition to Initiate Rulemaking to amend APCEC Reg. 2. The third-party petition was filed pursuant to APCEC Reg. 8.809. Huntsville proposes to revise APCEC Reg. 2 by modifying the state water quality standards for Chloride, Total Dissolved Solids (TDS), and Sulfate. One public hearing was held in the City of Huntsville on October 28, 2013. The deadline for submitting written comments on the proposed changes was 4:30 pm, November 12, 2013, but the comment period was extended to December 2, 2013, by the Hearing Officer during the public hearing. The Commission received written comments from seven (7) entities during the public comment period. One (1) oral comment was received during the public hearing.

The Department advised Huntsville of its opposition to the calculation methods used to derive the proposed site-specific criteria (Attachment A). The Department's opposition to the calculation methods used in the initial petition was based on the following:

1) Use of 4 cfs as the critical background flow for Town Branch and Holman Creek is inappropriate because it does not represent actual background flow conditions.

2) The use of the effluent flow and effluent mineral concentration (Qe and Ce) in calculations for Holman Creek and War Eagle is inappropriate. Flow and minerals concentrations should reflect the entirety of the contributing waterbodies, not just the effluent.

3) The Department opposes use of ecoregion values as background concentrations for minerals when actual in-stream data exists for those stream segments.

In ADEQ's July 22, 2014 letter, ADEQ stated that it could support site-specific criteria values for chloride, sulfate, and total dissolved solids that are no higher than the 95th percentile of data submitted from the 2011 Section 2.306 Site Specific study and available ADEQ data. The Department considers these values to be largely protective of the aquatic life use. (Attachment B).

In Huntsville's second petition to initiate rulemaking, Huntsville revised the proposed site-specific criteria using the observed instream data from the 2011 Section 2.306 Site Specific study and available ADEQ data. Huntsville's proposed site-specific criteria values for chloride, sulfate, and TDS are no higher than the 95th percentile of that data.

Due to the significant level of revision to the proposed site-specific criteria in Huntsville's Petition to Initiate Rulemaking, the Commission instructed Huntsville to proceed with a second public hearing and comment period. Huntsville submitted Minute Order 17-19 on August 25, 2017, and the Third Amendment to Petition to Initiate Third-Party Rulemaking to Amend Regulation No. 2 on October 10, 2017. The second public hearing was held on November 13, 2017, with no oral comments received. Twelve written comments were received during the public comment period.

COMMENTS RECEIVED DURING THE FIRST PUBLIC COMMENT PERIOD

ORAL COMMENTS (Huntsville public hearing)
Commenter: Colene Gaston on behalf of Beaver Water District
Comment: Request extension to public comment period to give time to review the supplemental report on alternate treatment technologies.
Response: Extension for public comment period was granted by the APCEC Hearing Officer until December 2, 2013.

WRITTEN COMMENTS
Commenter: Butterball, LLC
Comment: Butterball, LLC submits these comments for the Public Record in support of the 3rd Party Rule Making effort to amend the minerals Water Quality Criteria for Town Branch, Holman, and War Eagle Creeks. Butterball, LLC also supports removal of the non-existing but designated Domestic Water Supply use for Town Branch and Holman Creeks, as recommended in the City of Huntsville, Arkansas, Site Specific Water Quality Study.

Butterball continues to support the City of Huntsville's position during this 3rd Party Rule Making effort, and the process that Arkansas has in place for amending Water Quality Criteria. We have reviewed the Site Specific Water Quality Study, which concludes that the City of Huntsville's Wastewater Treatment Plant is not adversely impacting the above named Creeks. In addition, we note that an independent study performed by the United States Geological Survey (USGS) concludes that there are no adverse mineral impacts to Beaver Lake from the City of Huntsville's discharge.

As such, Butterball respectfully requests that the 3rd Party Rule Making be accepted and that mineral concentration limits not be imposed on the City of Huntsville Wastewater Treatment Plant.
Response: The Department acknowledges the comment.

Commenter: Beaver Water District
Comment: The following comments are in regard to the City of Huntsville's third-party rulemaking that proposes changes to the Arkansas water quality standards for minerals in Arkansas Pollution Control and Ecology Commission (APCEC) Regulation No.2 (hereinafter, "Reg. 2"). The City of Huntsville (hereinafter, "Huntsville") seeks, among other things, to increase the water

quality criteria (WQC) for the minerals sulfate, chloride, and total dissolved solids (TDS) at Reg. 2.511 that apply to certain segments of Town Branch, Holman Creek, and War Eagle Creek. Huntsville discharges treated municipal wastewater into Town Branch approximately one-half mile above its confluence with Holman Creek. Holman Creek is a tributary of War Eagle Creek, a significant tributary of Beaver Lake. The comments are submitted on behalf of Beaver Water District (BWD), the largest of the four public drinking water utilities whose source of raw water is Beaver Lake and the second largest drinking water utility in Arkansas. BWD produces the drinking water for over 300,000 people and numerous businesses and industries in Northwest Arkansas.

BWD expressed concern at the June and July 2013 meetings of the APCEC when Huntsville sought to initiate its third-party rulemaking. BWD stated that, among other things, Huntsville's proposed rulemaking was premature given the ongoing uncertainty related to Arkansas Act 954 of 2013, which has since been repealed, and the changes to Reg. 2 proposed by the Arkansas Department of Environmental Quality (ADEQ) as part of its triennial review process and rulemaking. BWD recognized, however, that pursuant to provisions in Huntsville's National Pollutant Discharge Elimination System (NPDES) permit, any changes to the minerals WQC sought by Huntsville would need to be completed by the permit expiration date of May 31, 2014.

For that reason, BWD did not directly oppose Huntsville's request to initiate rulemaking at the July 2013 APCEC meeting. Nonetheless, BWD stated its belief that Huntsville's request to initiate rulemaking before the issues related to minerals were settled was inadvisable. BWD suggested that a better approach would to be to delay the third-party rulemaking under an ADEQ consent agreement or other appropriate mechanism that provided relief from the permit deadline, which BWD stated it would support.

The approach taken by Huntsville in its Section 2.306 Site Specific Water Quality Study (hereinafter, the "Study") is inconsistent with ADEQ's proposed changes to Reg. 2 and ADEQ's stated opposition to the APCEC regarding the use of four (4) cubic feet per second (cfs) as an automatic flow factor in the development and implementation of WQC for minerals. BWD, however, is not submitting detailed comments on this issue or the other variables that Huntsville utilized in its mathematical equations to derive its

proposed changes to the minerals WQC. We simply point out that any proposed rulemaking premised on values that will not be utilized by ADEQ in the future and that are unlikely to be upheld by the United States Environmental Protection Agency can only lead to further conflict and confusion.

BWD's primary concern is with the proposed changes to the WQC applicable to War Eagle Creek.

War Eagle Creek flows approximately twenty-nine (29) miles from its confluence with Holman Creek to Beaver Lake. The War Eagle Creek watershed constitutes approximately one-third of the Beaver Lake watershed upstream of BWD. Huntsville proposes one set of increases to the minerals WQC for the approximately twenty (20) mile segment of War Eagle Creek from its confluence with Holman Creek to Clifty Creek and another set of lesser increases to the minerals WQC for the approximately nine (9) mile segment of War Eagle Creek from Clifty Creek to Beaver Lake. The proposed changes represent over a six hundred percent increase in the WQC for chloride, a thirty percent increase in the WQC for sulfate, and a sixty percent increase in the WQC for TDS.

BWD believes that the proposed changes to the WQC for War Eagle Creek are unnecessary and unsupported. Instead of focusing on an analysis of the mathematical equations and projections related to War Eagle Creek in the Huntsville Study, BWD believes that a review of the twenty (20) plus years of ADEQ and United States Geological Survey ambient water quality monitoring data on minerals in War Eagle Creek is sufficient to show that the proposed changes are not needed.

Out of almost four hundred samples taken since 1993, the *current* WQC for sulfate has never been exceeded. The *current* WQC for TDS has been exceeded only twice, and those values were much lower than Huntsville's proposed WQC for TDS on the upper reach of War Eagle Creek. ADEQ's assessment protocol for minerals currently allows a ten percent exceedance rate, and ADEQ informed the Minerals Subcommittee of the APCEC that it is considering raising the allowable exceedance rate to twenty-five percent for site-specific WQC for minerals. Approximately twenty percent of the chloride samples have exceeded the *current* WQC for TDS, but the proposed WQC for chloride on the upper reach of War Eagle Creek is still more than two and a halftimes the maximum concentration of chloride detected in War Eagle Creek

in over twenty years of monitoring. The actual concentrations of chloride, sulfate, and TDS in War Eagle Creek measured by Huntsville during July 2011 – June 2012 corroborate that the proposed changes are unnecessary (see Tables 5.1 and 5.2 and Appendix B of the Study).

The purpose of a study pursuant to Reg. 2.306 is to develop WQC that reflect site-specific conditions based on an investigation of those conditions. As the measured concentrations of chloride, sulfate, and TDS in War Eagle Creek demonstrate, the WQC proposed for War Eagle Creek do not reflect actual site-specific conditions. As a consequence, even though the biological field data in the Study may show that the aquatic life in War Eagle Creek is acceptable at the existing level of minerals in the stream, the impact on aquatic life if the in-stream concentrations of minerals are allowed to increase to the proposed levels is unknown. Because the proposed WQC for minerals for War Eagle Creek are much, much higher than historical and existing in-stream concentrations, the impact on aquatic life at the proposed levels must be addressed.

BWD understands the need to allow Huntsville's existing wastewater discharge in a manner consistent with the regulations and based on sound science. The proposed changes to the WQC for minerals for War Eagle Creek, however, go well beyond what is necessary to accommodate Huntsville's discharge, would potentially provide for new and increased discharges of minerals to War Eagle Creek, and are not scientifically justifiable. Thank you for your consideration of these comments.

Response: Concerning 4 cfs and other variables used to calculate proposed criteria:

Huntsville has revised its proposed site-specific criteria using the 95th percentile of data submitted in the site-specific criteria study and available ADEQ data. A background flow value of four (4) cubic feet per second (cfs) was not used to calculate the revised proposed water quality standards in Huntsville's Third Amendment to Petition to Initiate.

Concerning proposed Site Specific Criteria (SSC) on War Eagle Creek: Data were reviewed from ADEQ site WHI0116, which is located on War Eagle Creek downstream of the Holman Creek confluence. From May 1992 to November 2013, approximately 250 data points exist for chloride, sulfate, and TDS concentrations. For this period of record, the max recorded concentration for chloride, sulfate, and TDS are 49.1 mg/L, 15.4 mg/L, and 266

mg/L, respectively. Given the above-mentioned data, the Department notes that it may not be necessary to alter the SSC beyond these measured instream values.

Commenter: Debbie Doss
Comment: I am Debbie Doss conservation chair of the Arkansas Canoe Club. I am also chair of the Arkansas Conservation Coalition and recently served in the triennial review working group for ADEQ.

The Arkansas Canoe Canoe has over 1400 members with seven chapters in three states. The club is deeply concerned about issues that affect water quality in the state of Arkansas.

The quality of Arkansas streams is greater than that of nearly any within the United States. In 2001 a study undertaken for the Congress of the United States found that Ozark Mountain streams contain some of the very highest levels of aquatic biodiversity in the country and the most intact ecological systems of their kind on the North American continent.

We are deeply concerned about the steady degradation of our streams in the state of Arkansas. Since 2001 numerous streams sections have been added to the states 303D list of impaired water bodies. This is a very troubling trend.

Is it possible to lower water quality standards without damaging streams? Possibly but, downgrading water quality standards for these creeks should be based on good science, not a "mother may I" system of arbitrarily changing numbers because the ones in the regulation are inconvenient.

–War Eagle is a classic Ozark Stream that is used for recreation and fishing.

–The War Eagle passes through Hobbs Creek State Park, and flows into Beaver Lake.

–Ozark streams, state parks, and lakes are an important part of our tourist economy.

–Many people enjoy the water quality present in these streams to float and swim.

–Protecting such high quality waters is important to Arkansas.

–The War Eagle is also important to wildlife.

–The War Eagle is home to the potentially threatened Rabbits Foot Mussell, and has been listed as potential critical habitat for that species.

There was a time when our state understood the value of what we have and was ready to protect importance of protecting water quality in the natural state. Our standards were even better than those required of us by federal law. Both water quality and biodiversity are destined become even more important in the future.

The important characteristics of the War Eagle or any of our streams can only be maintained with high quality water standards—this rulemaking does not further that objective.
Response: The Department acknowledges these comments and clarifies that changes to the Regulation must follow the process set forth in APCEC Reg. 2 and Reg. 8.

Commenter: Mary Cameron
Comment: Are there any federal limitations for the discharge of chloride, sulfate, and total dissolved minerals into streams such as Town Branch, Holman Creek, and War Eagle Creek?
Response: There are no federal limitations for the discharge of chloride, sulfate, and total dissolved minerals into streams such as Town Branch, Holman Creek, and War Eagle Creek.

Federal criteria for minerals have been adopted as secondary standards to protect public drinking water supplies, and are defined under the federal Safe Drinking Water Act. These secondary standards are 250 mg/L, 250 mg/L, and 500 mg/L for chloride, sulfate, and TDS, respectively. The same criteria have been adopted in Arkansas to protect domestic water supply use.

With respect to chloride, in 1988, EPA published the "Ambient Aquatic Life Water Quality Criteria for Chloride," recommending an acute value of 860 mg/L and a chronic value of 230 mg/L for chloride.[1]

[1] EPA 440/5-88-001

Commenter: Ross Noland
Comment: First, the City of Huntsville improperly seeks to remove the drinking water designated use from Town Branch, Holman Creek, and War Eagle Creek. The City contends in its Petition to Initiate Rulemaking that the drinking water designated use for these streams is "designated, but not existing." Existing uses cannot be removed. Designated, but not existing, uses can only be removed in limited circumstances. The drinking water designated use on these stream portions cannot be removed for the following reasons:

1 – The receiving streams meet the water quality criteria for drinking water and their ecoregion found in APCEC Reg. 2.511. Because the criteria are met, the use is existing, and cannot be removed.

2 – The receiving streams flow into Beaver Lake, which is used for domestic water supply. Thus, the drinking water designated use is existing, and cannot be removed.

3 – Designated uses can only be removed when one of six specific conditions are present. See 40 C.F.R. § 131.10(g)(1)-(6). The documents submitted by the City of Huntsville do not demonstrate that one of those conditions is met. Huntsville contends that 40 C.F.R. § 131.10 requires a UAA to remove a fishable/swimmable use. This ignores the plain language of 40 C.F.R. § 131.10, which requires a UAA to remove any "designated use which is not an existing use." This language is not limited to the fishable/swimmable uses. Thus, the drinking water designated use cannot be removed unless one of the 40 C.F.R. § 131.10(g)(1)-(6) conditions are met.

Second, the City of Huntsville utilizes four cubic feet per second for its median flow in calculating mineral loads. This number is not based in science or fact. This practice must end due to its arbitrary application and lack of scientific or rational basis.
Response: *Concerning the removal of Domestic Water Supply designated use:*
Point l: Huntsville asserts that the domestic water supply use designation for certain segments of Town Branch and Holman Creek is not an existing use, and therefore can be removed. Huntsville does not propose to remove the domestic water supply use designation from War Eagle Creek.

APCEC Reg. 2.106 defines Existing Uses as "Those uses listed in Section 303(c)(2) of the [Clean Water] Act (i.e., public water supplies, propagation of fish and wildlife, recreational uses, agricultural and industrial water supplies and navigation) which were actually attained in the waterbody on or after November 28, 1975, whether or not they are included in water quality standards." No public water supply intake exists on those segments of Town Branch and Holman Creek.

Point 2: Town Branch is a tributary of Holman Creek, which is a tributary of War Eagle, which is a tributary to Beaver Lake. 40 CFR § 131.10(b) states, "...the State shall take into consideration the water quality standards of downstream waters and shall ensure that its water quality standards provide for the attainment and maintenance of the water quality standards of downstream waters." The Department has considered these downstream waters (War Eagle and Beaver Lake) and would not support removal of the Domestic Water Supply use designation in Town Branch or Holman Creek if removal would cause downstream segments to not meet their designated uses. The domestic water supply designated use is being maintained in War Eagle Creek and Beaver Lake.

Point 3: Huntsville does not propose to remove a designated use that requires a use attainability analysis (UAA) as described in 40 C.F.R. § 131.10(g). The Department acknowledges that a UAA may have been required at the time of this comment. Pursuant to 40 C.F.R. 131.10(k)(3), a UAA is not required to remove or revise a designated use that is a non-101(a)(2) use. Domestic water supply is not a use specified in 101(a)(2). Through this third-party rulemaking process, Huntsville must submit documentation that appropriately supports removal of Domestic Water Supply use in Town Branch or Holman Creek.

Concerning use of 4 cfs:
Huntsville has revised its proposed site-specific criteria using the 95th percentile of data submitted in the site-specific criteria study and available ADEQ data. A background flow value of four (4) cubic feet per second (cfs) was not used to calculate the revised proposed water quality standards.

Commenter: Arkansas Department of Health
Comment: 1. The Arkansas Department of Health (ADH) reiterates its previously submitted comments that the domestic

water supply use designation should remain in place for Town Branch Creek, Holman Creek, and War Eagle Creek. It is the ADH's position that it is appropriate for streams within the Beaver Lake watershed to retain domestic water supply use designations considering that Beaver Lake is the source of drinking water for approximately 390,000 Arkansans.

2. Separate correspondence containing comments pertaining to both the second amended Water Quality Study (UAA) and the recent feasibility study is attached to this letter and has been provided to GBMc. A primary concern regarding the feasibility report is that full consideration of pretreatment of the waste stream by industry prior to acceptance of the flow by the municipal wastewater system is not explored. Pretreatment is generally accepted to provide greater efficiencies and potential cost savings when compared to combined waste streams for municipal treatment. Smaller volumes can be treated, and greater flexibility with regards to process modifications and treatment schemes can be achieved.

3. The Water Quality Study posted August 1, 2013 utilizes an assumed background flow of 4 cfs for determination of site specific criteria (sections 7.2.2, 7.2.3, and 7.2.4). ADH disagrees with the assumption that this is representative of stream conditions at the outfall. In reality, Holman Creek and Town Branch Creek are intermittent losing streams and Holman Creek is listed as an impaired stream on the 2008 303(d) list for impairments resulting from the City of Huntsville WWTP discharge of Total Dissolved Solids. Furthermore, assuming 4 cfs of background flow is contrary to the EPA-approved "State of Arkansas Continuing Planning Process" (CPP) dated January 2000. Page IX-7 of the CPP specifically says that 4 cfs "may be calculated ... after mixing." In Sections 7.2.2-4, 4 cfs was assumed upstream. Per the CPP and a Huntsville WWTP flow rate of 3.1 cfs, the maximum dilution available upstream would be 0.9 cfs. Given the losing stream status, 0 cfs would be most appropriate.

Response: 1. The Department acknowledges AHD's position on retaining the DWS use in Town Branch, Holman Creek, and War Eagle Creek, and agrees that the DWS use should not be removed from War Eagle Creek. See Response to Comments from Ross Noland.

2. The Department acknowledges this comment.

3. Huntsville has revised its proposed site-specific criteria using the 95th percentile of data submitted in the site-specific criteria study and available ADEQ data. A background flow value of four (4) cubic feet per second (cfs) was not used to calculate the revised proposed water quality standards.

Commenter: Arkansas Department of Environmental Quality
Comment: ***Criteria Development***
The Department opposes the calculated site specific criteria as presented in the Petition to Initiate Rulemaking - Second Amendment for the following reasons:

1. Use of 4 cfs as the critical background flow for Town Branch and Holman Creek is inappropriate because it does not represent actual flow conditions. 7Q10 is appropriate and protective of designated and existing uses within the waterbodies.
2. The use of the effluent flow and effluent mineral concentration (Qe and Ce) in calculations for Holman Creek and War Eagle is inappropriate. Flow and minerals concentrations should reflect the entirety of the contributing waterbodies, not just the downstream effluent.
3. The Department opposes use of ecoregion values as background concentrations for minerals used for all stream segments. Data collected during the study (Tables 5.1 and 5.2 in the UAA) show that mineral concentrations above the outfall/confluence generally average higher than the ecoregion value. See Table 1 below. Actual instream values, not ecoregion values, should be used and are protective of designated and existing uses within these stream segments.

Table 1. Ecoregion values and average instream concentrations (mg/L) from UAA study.

	Chloride	TDS	Sulfate
Ecoregion Value	6	143	6
TB-1	17.6	195	15.3
TB-2	120.2	468.3	51
HC-1	7.7	156.7	12.4
HC-2	81.5	365.4	33.8
WEC-1	3.9	103.8	7.3
WEC-2	15.4	145.6	10.4
Outfall 001	208	604	51.7

The department does not recommend the proposed site-specific mineral criteria be calculated using the background flow and concentrations mentioned above.

An alternate approach to generating Site Specific Criteria instead of using mass balance equations is a percentile of actual conditions for minerals.

Order within APCEC Reg. 2 for proposed amendments to War Eagle

The two entries for War Eagle Creek should be in the following order:

War Eagle Creek (downstream from the confluence with Clifty Creek to Beaver Lake) War Eagle Creek (from the confluence with Holman Creek to Clifty Creek)

This also represents the proper wording in order to be consistent with the Petition to Initiate. See below.

Footnotes to APCEC Reg. No. 2

The footnote:

"# - At such time as Act 954 of 2013 is implemented using average flow and as average flow can be calculated for War Eagle Creek the site specific criteria shall revert to the Ecoregion Values."

is unnecessary as Act 954 of 2013 was repealed on October 21, 2013 (Act 4 of the 2013 Extraordinary Session) and should be removed.

The footnote:

"+ - Based on critical background flow of 7.2 cfs and 10.9 cfs (7Q10) at Holman and Clifty Creek confluences, respectively)."

is unnecessary and should be removed.

Discrepancies between Petition to Initiate – Second Amendment and amended APCEC Reg. 2-Second Amended

There are several discrepancies between the proposed amendments to Reg. 2 (Item 12. of Petition to Initiate Rulemaking - Second Amendment) and the proposed Reg. 2 markup.

1. The proposed Reg. 2 markup should be amended to the following to be consistent with the Petition to Initiate Rulemaking - Second Amendment:

<u>War Eagle Creek (downstream from the confluence with Clifty Creek to Beaver Lake)</u>

<u>War Eagle Creek (from the confluence with Holman Creek to Clifty Creek)</u>

<u>Holman Creek (from the confluence with Town Branch downstream to the confluence with War Eagle Creek)</u>

<u>Town Branch (from Point of Discharge of the City of Huntsville WWTP downstream to the confluence with Holman Creek)</u>

2. The proposed Regulation has a footnote (which ADEQ recommends be removed, see above) that is inconsistent with the text in Item 12. in the Petition to Initiate - Second Amendment:

Item 12 reads:

"A critical background flow of 4.0 cfs should be applied by Listing Town Branch, Holman Creek, and War Eagle Creek (with asterisks) in Reg. 2.511. Critical background flows of 7.2 and 10.9 the (7Q10 for War Creek [sic] at the Holman Creek and Clifty Creek confluence, respectively) should be applied to War Eagle Creek."

Amended Reg. 2 reads:

"+ - Based on critical background flow of 7.2 cfs and 10.9 cfs (7Q1O) at Holman and Clifty Creek confluences, respectively)."

and is applied to both entries for War Eagle Creek.

Firstly, Item 12 is inconsistent with itself as it states to apply 4.0 cfs to War Eagle Creek, then restates to apply 7.2 cfs and 10.9 cfs for specific reaches.

Secondly, Item 12 is inconsistent with the proposed footnote in Reg. 2.511 as the footnote does not specify use of 4 cfs.

Again, the Department recommends omission of the footnote in its entirety for the reasons stated.
Response: No response necessary.

WRITTEN COMMENTS RECEIVED DURING THE SECOND PUBLIC COMMENT PERIOD

Commenter: Arkansas Department of Health
Comment: This letter serves to reiterate ADH's objection to the removal of the domestic supply designated use for both Town Branch and Holman Creek as proposed in the referenced rulemaking. As you know, Town Branch and Holman Creek are tributaries of War Eagle Creek in the watershed of Beaver Lake, a source of drinking water to over 400,000 Arkansans. The Arkansas Department of Health has consistently maintained that the domestic water supply use designation is appropriate and necessary for all streams within the Beaver Lake watershed.

Pollution that enters the lake from Town Branch and Holman Creek will have a direct effect upon water quality in this drinking water supply lake. While the water supply intake structures on Beaver Lake themselves are not located on either Town Branch or Holman Creek, they are nevertheless vulnerable to mineral pollution that might occur on those reaches.

Originally, the Secondary Drinking Water Standards for chlorides, sulfates, and total dissolved solids were included in the federal Safe Drinking Water Act based solely upon issues relating to palatability. However, recent events in Flint, Michigan have clearly demonstrated that dissolved chlorides can have deleterious effects upon plumbing corrosion rates even when concentrations are below the secondary standards. This complicates drinking water system efforts to minimize consumer exposure to lead and copper and can also increase drinking water treatment costs.

Additionally, with regards to the protection of downstream designated uses, the federal regulations state, "In designating uses of a waterbody and the appropriate criteria for those uses, the State shall take into consideration the water quality standards of downstream waters and shall ensure that its water quality standards provide for the attainment and maintenance of the water quality standards for downstream waters." [40 C.F.R. §131.10(b)].

For these reasons, ADH requests that Exhibit E, Economic Impact/Environmental Benefit Analysis: 2B. ENVIRONMENTAL BENEFIT, be revised to reflect War Eagle Creek is a major tributary to Beaver Lake, a drinking water supply lake that serves a growing community of over 400,000 Arkansans, and that costs associated with any future degradation of the watershed could result in increased treatment costs for the four community public water systems located there.

Additionally, ADH requests that all Exhibits and documents mentioning ADH within the current proposed rulemaking reflect our opposition to the proposed rulemaking and the removal of the domestic supply designation for Town Branch and Holman Creek.

If public water supply sources—including Beaver Lake—are to remain high quality drinking water sources, it will require all relevant governmental bodies to include an awareness of and concern for drinking water protection as part of their decision-

making processes. The Arkansas Department of Health will continue to be a voice for drinking water source protection and to encourage all stakeholders to adopt regulations protective of drinking water sources in their policy decisions.
Response: The Department acknowledges AHD's position on retaining the domestic water supply use in Town Branch, Holman Creek, and War Eagle Creek, and the Department agrees that the domestic water supply use should not be removed from War Eagle Creek.

The Department acknowledges ADH's citation of 40 C.F.R. § 131.10(b). The Department has considered the attainment and maintenance of the water quality standards for these downstream waters (War Eagle and Beaver Lake). The Department has concluded that the domestic water supply designated use is being maintained in War Eagle Creek and Beaver Lake. To support this conclusion, the Department utilized a 2013 USGS report, "Ambient Conditions and Fate and Transport Simulations of Dissolved Solids, Chloride, and Sulfate in Beaver Lake, Arkansas, 2006-10."

This 2013 USGS report modeled increases in the estimated daily total dissolved solids, chloride, and sulfate loads. The 2013 USGS report demonstrated that a tenfold increase in total dissolved solids from War Eagle Creek would increase estimated daily total dissolved solids concentrations in Beaver Lake below Hickory Creek from a baseline of 86.1 mg/L to 264 mg/L at 2 meters below the surface. That tenfold increase TDS value would be below the Secondary Drinking Water Standard and APCEC Reg. 2.511(B) domestic water quality criteria of 500 mg/L TDS.

The baseline inflow conditions for War Eagle Creek used in the 2013 USGS report model were based on median values from 2006-2010 recorded near Hindsville. For this period, the median value for total dissolved solids in War Eagle Creek near Hindsville was 109 mg/L. The maximum total dissolved solids value in War Eagle Creek near Hindsville during this period was 275 mg/L. A tenfold increase of median values for War Eagle Creek from 2006-2010 near Hindsville would equate to a total dissolved solids value of greater than 1000 mg/L. Even with a tenfold increase, the Secondary Drinking Water Standard and APCEC Reg. 2.511(B) domestic water quality criteria of 500 mg/L TDS would be maintained in Beaver Lake. During this 2006-2010 period, Holman Creek was impaired for exceeding total dissolved solids and the

values for total dissolved solids were influenced by effluent discharges from Huntsville. Thus, based on baseline condition values, which account for historic Huntsville discharge, domestic water supply designated use in Beaver Lake is maintained. Based on DMR data, the effluent conditions for Huntsville have not increased to date.

Commenter: Ellis Collins
Comment: Writing to express my written disagreement on the proposed rule change found in APEC Docket No. 13-006-R. My comments are based on three concerns:

1. The drinking water designated use of these stream portions cannot be removed as the receiving streams meet the water quality criteria for drinking water and their ecoregion found in APCEC Reg. 2.511.
2. The receiving streams flow into Beaver Lake used for domestic water supply. The drinking water designated use is existing and should not be removed.
3. Designated uses can only be removed when one of six specific conditions are present per 40 C.F.R. 131.10(g)(1)-(6) and the documents submitted by the city of Huntsville do not demonstrate that one of those conditions is met.

Town Branch, Holman Creek and War Eagle Creek tributaries flow into Beaver Lake, the second largest drinking water utility in Arkansas. I understand the importance and economics of Butterball's production growth to Huntsville but opposed to the negative downstream impact on Arkansas streams, rivers and lakes due to the discharge water of poultry and/or hogs farms. If you will not consider for me, please consider on behalf of your grandchildren and their generations that follow. They will be those that never experience what "The Natural State" once meant.
Response: Huntsville asserts that the domestic water supply use designations for certain segments of Town Branch and Holman Creek are not existing uses, and therefore can be removed. Huntsville does not propose to remove the domestic water supply use designation from War Eagle Creek.

APCEC Reg. 2.106 defines Existing Uses as "Those uses listed in Section 303(c)(2) of the [Clean Water] Act (i.e., public water supplies, propagation of fish and wildlife, recreational uses, agricultural and industrial water supplies and navigation) which were actually attained in the waterbody on or after November 28,

1975, whether or not they are included in water quality standards." No public water supply intake exists on those segments of Town Branch and Holman Creek.

Town Branch is a tributary of Holman Creek, which is a tributary of War Eagle, which is a tributary to Beaver Lake. 40 CFR § 131.10(b) states, "...the State shall take into consideration the water quality standards of downstream waters and shall ensure that its water quality standards provide for the attainment and maintenance of the water quality standards of downstream waters." The Department has considered the attainment and maintenance of the water quality standards for these downstream waters (War Eagle and Beaver Lake). The Department has concluded that the domestic water supply designated use is being maintained in War Eagle Creek and Beaver Lake. See Response to the Comments from the Arkansas Department of Health.

Huntsville does not propose to remove a designated use that requires a use attainability analysis (UAA) as described in 40 C.F.R. 131.10(g). Pursuant to 40 C.F.R. 131.10(k)(3), a UAA is not required to remove or revise a designated use that is a non-101(a)(2) use. Domestic water supply is not a use specified in 101(a)(2). Through this third-party rulemaking process, Huntsville must submit documentation that appropriately supports removal of Domestic Water Supply use in Town Branch or Holman Creek.

Commenter: Beaver Water District
Comment: The following comments are submitted on behalf of Beaver Water District (BWD), the largest of the four public drinking water utilities whose source of raw water is Beaver Lake and the second largest drinking water utility in Arkansas. BWD produces the drinking water for over 330,000 people, businesses, and industries in Northwest Arkansas. The City of Huntsville's third-party rulemaking proposes changes to the Arkansas water quality standards and criteria for minerals in Arkansas Pollution Control and Ecology Commission (APCEC) Regulation No.2 (hereinafter, "Reg. 2"). The City of Huntsville (hereinafter, "Huntsville") seeks to remove the designated drinking water supply use from certain segments of Town Branch and Holman Creek, to increase the water quality criteria (WQC) for the minerals chloride, sulfate, and total dissolved solids (TDS) at Reg. 2.511 that apply to certain segments of Town Branch and Holman Creek, and to increase the WQC for chloride and TDS at Reg.

2.511 that apply to War Eagle Creek from its confluence with Holman Creek downstream to Clifty Creek.

War Eagle Creek is a major tributary of Beaver Lake. Its watershed constitutes approximately one third of the Beaver Lake watershed upstream of BWD. Any pollution in the War Eagle Creek watershed has the potential to adversely impact the Lake's water quality and can have a direct bearing on what it costs us to provide our customers with drinking water that meets or exceeds all federal and state regulatory requirements. The current and future economic condition of Northwest Arkansas is dependent upon the protection of the water quality of Beaver Lake.

BWD acknowledges with appreciation that Huntsville has limited its proposed changes to the minerals WQC for War Eagle Creek as compared to what it proposed when it initiated its third-party rulemaking in 2013. It has reduced the length of the segment of War Eagle Creek to which the proposed changes would apply and it has eliminated its proposal to increase the sulfate WQC for that segment of War Eagle Creek. It still, however, proposes increases (although not nearly as large) to the WQC for chloride and TDS for War Eagle Creek. Incongruently, the proposed changes to the upstream WQC for chloride, sulfate, and TDS for Town Branch and Holman Creek are substantially higher than what Huntsville proposed in 2013.

Although somewhat difficult to parse out of the numerous documents that have been filed in this rulemaking docket, the explanation for the changes from the WQC proposed in 2013 and those that are currently proposed is approximately three, double-spaced pages long and found at Section 7.1 of the June 2017 Section 2.306 Site Specific Water Quality Study: Town Branch, Holman Creek, and War Eagle Creek (hereinafter, the "Revised Study") prepared for Huntsville by GBMc & Associates. There is no discussion of why the WQC currently proposed by Huntsville have changed so dramatically from what was proposed in 2013. Section 7.1 provides mostly "summary statistics" and notes that the data used for the "percentile calculations" are provided in Appendix I. The data in Appendix I, however, is very limited. It appears, for example, that only twelve measured data points were used in the percentile calculations for chloride and TDS for Town Branch and War Eagle Creek and that only four measured data points were used in the percentile calculations for sulfate for those

two streams. The data for those two streams also was limited to the time period of July 2011 through June of 2012.

BWD objects to the use of such limited data sets for making changes to the WQC in Reg. 2 and also objects to the use of data that does not include current water quality analyses. The data used was primarily from samples collected by GBMc. Was all of the available water quality monitoring data collected by the Arkansas Department of Environmental Quality utilized? Why wasn't data collected by other entities, such as the United States Geological Survey, used? As reflected in the November 30, 2017, public comment letter filed in this proposed rulemaking by the Arkansas Department of Health, which BWD supports, changes to the WQC for minerals that apply to watersheds with a designated domestic water supply use should not be undertaken lightly. At a minimum, the water quality data used should be reasonably current and the sample size should be large enough, when viewed conservatively, to justify the changes. We do not believe that is the case in this proposed rulemaking.

BWD understands the need to allow Huntsville's existing wastewater discharge in a manner consistent with the regulations and based on sound science. We question, however, whether that standard has been met in this proposed rulemaking. Thank you for your consideration of these comments.
Response: Huntsville has revised its proposed site-specific criteria based on revisions to the water quality standards and development of site-specific mineral criteria (Regulation 2). The site-specific criteria proposed in 2013 were developed using calculation methods that assumed a background flow value of four (4) cubic feet per second (cfs). The Department advised Huntsville of its opposition to the calculation methods used to derive the proposed site-specific criteria.

In ADEQ's July 22, 2014 letter, ADEQ stated that it could support site-specific criteria values for chloride, sulfate, and total dissolved solids that are no higher than the 95th percentile of data submitted from the 2011 Section 2.306 Site Specific study and available ADEQ data. The Department considers these values to be generally protective of the aquatic life use. (Attachment B).

In Huntsville's third petition to initiate rulemaking, Huntsville revised the proposed site-specific criteria using the observed instream data from the 2011 Section 2.306 Site Specific study and

available ADEQ data. Huntsville's proposed site-specific criteria values for chloride, sulfate, and total dissolved solids are no higher than the 95th percentile of that data.

Regarding protection of downstream domestic water supply designated uses, please refer to the Responses to Comments from Ellis Collins and Arkansas Department of Health.

Commenter: White River Waterkeeper
Comment: The comments provided in this letter should be taken to reflect the opposition to the proposed removal of the domestic water supply designated uses for Holman Creek and Town Branch, and to the proposed criteria changes to Holman Creek, Town Branch, and War Eagle Creek.

Insufficient data and explanations have been provided to determine the necessity of removing the domestic water supply designated uses.

EPA requested that the City of Huntsville demonstrate that the domestic water supply uses for Holman Creek and Town Branch are "not attainable." While letters from Arkansas Department of Health and Arkansas Natural Resources Commission addressed the lack of current or planned domestic water supply use, it has yet to be demonstrated that these uses are not attainable for these stream reaches.

The cost of alternatives, based on literature over twenty years old, is not representative of current technology costs. Also, please explain the relevance of using implicit price deflator data for the adjustment of technological treatment costs. Inflation may be a significant way of determining relevant cost differences across time periods for commodities that are relatively static in their production costs. It is not understood how technological advances that provide greater treatment costs at more affordable rates could in any way be accurately represented by this approach. There were no quotes obtained to comprehensively evaluate potential alternatives or references to costs of similar infrastructure upgrades from the last decade. This effort is not sufficient.

In response to comments it was stated that land application was not a viable option because "land application requires characteristics, remote location, etc.) land. Significant areas of suitable (slope, soil characteristics, remote location, etc.) land. Because Huntsville is

situated in the Ozark Highlands, adequate nearby land having characteristics compatible with ADEQ restrictions for land application of treated effluent is not available." However, ADEQ has issued many land application permits within the Ozark Highlands. This alternative was not even remotely explored or considered.

Information provided by the Site-Specific Water Quality study are not sufficient to determine that existing uses will be maintained with the proposed criteria.

ADEQ has not developed unique mineral criteria specific to the protection of Agricultural Supply uses. The criteria used to assess those uses are the same as criteria for the assessment of Domestic Water Supply uses (250, 250, 500 for Cl, SO4, and TDS, respectively). Has there been any examination of whether these proposed criteria changes could impact livestock operations relying on water from these stream reaches? Are there any grazing cattle operations that could be negatively impacted by the proposed changes?

The aquatic life collections were not conducted in a fashion that allows for the evaluation of spatial or temporal differences to be examined (i.e., no replicate samples were collected). Without such, it is impossible to tell whether there are significant differences noted at upstream and downstream sampling locations on each stream.

While the selection of the reference reaches is suitable for determining the impacts from a particular point source in relation to other contributing factors, it does not mean that the reference reach was a suitable representation of least-disturbed streams in the Ozark Highland ecoregion.

There was no discussion of how reach length was determined.

It was stated that "the fish sampling was terminated when, in the opm1on of the principal investigator, a representative collection had been obtained." This infers that the entirety of the stream reach used for habitat characterization was not sampled. Since there is no information provided in the report that indicates the habitat conditions of the area sampled; then it is impossible to determine how much habitat differences factored into metrics based on the fish community.

What fish species were categorized as tolerant, intolerant, and intermediate? No comments on the appropriateness of such categorization can be provided without that pertinent information being included in the report.

Isn't WEC-1 the reference reach? Since the multimetric assessment is to be utilized to determine the impairment status of an impacted reach, then how was the % comparison to reference was only 94% and not 100%...seeing as how WEC-1 was the reference reach?

Are the biotic index values referenced in Appendix E the tolerance values for macroinvertebrate taxa utilized in the calculation of Hilsenhoff Biotic Index?

Proposed criteria are based on the 95th percentile of water quality data. However, the assessment of these streams allow for a 10-25% exceedance rate, depending on whether the Department is choosing to adhere to EPA approved water quality standards. Setting the criteria based on this percentile, along with allowing up to 25% exceedance of this standard, should in fact ensure that the City of Huntsville will not cause a future impairment listing to minerals to these stream reaches. This in no way translates to the protection of aquatic life, however.

Thank you for the opportunity to comment on this proposed rulemaking. I hope that ADEQ will prioritize the necessity to create standardized requirements for the review of aquatic life studies for Use Attainability Analyses. It appears that this has been a long process to propose these changes, and likely a costly endeavor for the City of Huntsville. However, this study design did not sufficiently evaluate the protection of aquatic life and inadequate consideration has been given to alternatives to removing domestic water supply uses.
Response: The Department acknowledges the commenter's specific questions on the site-specific study, protection of Agricultural designated uses, and documentation of the highest attainable condition and directs the commenter to Huntsville's Responsive Summary filed with the Commission on August 15, 2017. Please see Response to Comments to the Arkansas Department of Health.

Commenter: Vallie Graff
Comment: I OPPOSE the removal of the domestic water supply designated use from Holman Creek and Town Branch. Although domestic water supply use is not an existing use on these stream reaches, designated uses are meant to represent the goal of a particular waterbody. I feel strongly that the domestic water supply uses should remain a GOAL for these stream reaches.

I hope that your concern for the Well-Being of our Citizens will remain a priority over easy solutions for business.
Response: The Department acknowledges the commenter's concerns. Please refer to the Response to Comments to the Arkansas Department of Health and Ellis Collins regarding protection of domestic water supply designated use.

Commenter: Chuck Bitting
Comment: I OPPOSE the removal of the domestic water supply designated use from Holman Creek and Town Branch. Although domestic water supply use is not an existing use on these stream reaches, designated uses are meant to represent the goal of a particular waterbody. I feel strongly that the domestic water supply uses should remain a GOAL for these stream reaches.

The change proposed will allow a reduction in water quality in Holman Branch and allow Butterball to expand their operations in NE Arkansas. This will impact additional streams with increased pollution. These impacts must be analyzed and modeled prior to any decision. It does not matter that these will mostly be non-point source impacts. They will become point source where they drain into the streams. Table Rock Lake is downstream and already has enough problems with water quality. This is a cross state issue.
Response: The Department acknowledges the commenter's concerns. Please refer to the Response to Comments to the Arkansas Department of Health and Ellis Collins regarding protection of domestic water supply designated use.

Commenter: Gordon Watkins
Comment: I OPPOSE the removal of the domestic water supply designated use from Holman Creek and Town Branch. Although domestic water supply use is not an existing use on these stream reaches, designated uses are meant to represent the goal of a particular waterbody. I feel strongly that the domestic water supply uses should remain a GOAL for these stream reaches.

ADEQ should not allow degradation of Waters of the State which by definition belong to all Arkansawyers, just to benefit a private corporation such as Butterball. Butterball should upgrade their pretreatment facilities as a cost of doing business and not pass this cost along to public citizens by way of lowered water quality.
Response: The Department acknowledges the commenter's concerns. Please refer to the Response to Comments to the Arkansas Department of Health and Ellis Collins regarding protection of domestic water supply designated use.

Commenter: Laura Timby
Comment: I OPPOSE the removal of the domestic water supply designated use from Holman Creek and Town Branch. Although domestic water supply use is not an existing use on these stream reaches, designated uses are meant to represent the goal of a particular waterbody. I feel strongly that the domestic water supply uses should remain a GOAL for these stream reaches.

Clean water is of the utmost importance for our communities and must be safeguarded. Industry must look to expand without jeopardizing our clean water sources.
Response: The Department acknowledges the commenter's concerns. Please refer to the Response to Comments to the Arkansas Department of Health and Ellis Collins regarding protection of domestic water supply designated use.

Commenter: Shawn Porter
Comment: I OPPOSE the removal of the domestic water supply designated use from Holman Creek and Town Branch. Although domestic water supply use is not an existing use on these stream reaches, designated uses are meant to represent the goal of a particular waterbody. I feel strongly that the domestic water supply uses should remain a GOAL for these stream reaches.

ADEQ should be protecting (and improving) water quality…not enabling agriculture and industry to pollute and degrade our streams, lakes, and aquifers. Please do your jobs and live up to the name of your agency. Protect the quality of our environment.
Response: The Department acknowledges the commenter's concerns. Please refer to the Response to Comments to the Arkansas Department of Health and Ellis Collins regarding protection of domestic water supply designated use.

Commenter: Brian Thompson, John Murdoch, Aletha Petty
Comment: I OPPOSE the removal of the domestic water supply designated use from Holman Creek and Town Branch. Although domestic water supply use is not an existing use on these stream reaches, designated uses are meant to represent the goal of a particular waterbody. I feel strongly that the domestic water supply uses should remain a GOAL for these stream reaches.
Response: The Department acknowledges the commenter's concerns. Please refer to the Response to Comments to the Arkansas Department of Health and Ellis Collins regarding protection of domestic water supply designated use.

PUBLIC COMMENT SUMMARY OF THIRD PARTY, CITY OF HUNTSVILLE

1. The City of Huntsville ("Huntsville") for its Response to Comments, states:

On July 26, 2013, the Arkansas Pollution Control and Ecology Commission ("APCEC") granted Huntsville's Petition to Initiate Third-Party Rulemaking to Amend APCEC Regulation No. 2, Regulation Establishing Water Quality Standards for Surface Waters of the State of Arkansas ("Initial Petition"). APCEC Minute Order 13-23. A public hearing was held on October 28, 2013 in Huntsville, Arkansas. The public comment period ended on November 12, 2013. This public comment period is hereinafter referred to as "the Initial Public Comment Period."

2. Based on comments submitted in the Initial Public Comment Period, and an amendment to Regulation No. 2 that changed the criteria flow from 4 cfs to harmonic mean, Huntsville and ADEQ reached an agreement to recalculate the proposed site-specific criteria, which was reflected in a Response to Comments filed on August 15, 2017. Because the revised site specific criteria differed from the proposal contained in its Initial Petition the Commission directed Huntsville to file an Amended Petition and requested a second public hearing and public comment period ("Amended Petition"). Minute Order 17-19 (August 25, 2017) The Amended Petition was filed on October 10, 2017 (with a title of Third Amended Petition), and the second public hearing was held on November 13, 2017 in Huntsville, Arkansas. The second public comment period ended on December 4, 2017. The public comment is hereinafter referred to as the "the Second Public Comment Period."

3. The comments received during the Second Public Comment Period and Huntsville's Response to each is as follows:

Comments of Jessie J. Green (White River Waterkeeper)

Comment 1: *EPA requested that the City of Huntsville demonstrate that the domestic water supply uses for Holman Creek and Town Branch are "not attainable." While letters from Arkansas Department of Health and Arkansas Natural Resources Commission addressed the lack of current or planned domestic water supply use, it has yet to be demonstrated that these uses are not attainable for these stream reaches.*
Response: The data provided in the study report show that criteria for the domestic water supply use are not maintained in Town Branch and Holman Creeks. Existing uses are those that are actually attained in the water body on or after November 28, 1975 (See 40 C.F.R. §131.3). Town Branch and Holman Creek have insufficient flow to support the Domestic Water Supply use. The critical low flow used for permitting is the 7Q10, which for Town Branch and Holman Creeks is considered zero. This means that Town Branch and Holman Creek have a 10% probability of no flow each year.

Comment 2: *The cost of alternatives, based on literature over twenty years old, is not representative of current technology costs. Also, please explain the relevance of using implicit price deflator data for the adjustment of technological treatment costs. Inflation may be a significant way of determining relevant cost differences across time periods for commodities that are relatively static in their production costs. It is not understood how technological advances that provide greater treatment costs at more affordable rates could in any way be accurately represented by this approach. There were no quotes obtained to comprehensively evaluate potential alternatives or references to costs of similar infrastructure upgrades from the last decade. This effort is not sufficient.*
Response: EPA has developed a Guidance Manual (EPA 452B-02-001) and methodology to assist environmental stakeholders in development of cost estimates of various compliance options. Chapter 2 of the document is titled Cost Estimation: Concepts and Methodology and is current as of November 2017. The estimation methodology described therein is universal with regard to control technologies though it is contained within guidance tailored to air

pollution control. The manual states *"This chapter presents a methodology that will enable the user, having knowledge of the source being controlled, to produce study-level estimates of the costs incurred by regulated entities for a control system applied to that source. . . .If the regulation or permit establishes performance standards, with flexibility as to how the standards can be achieved, then the cost estimation methods can be used to estimate the costs of various options for achieving the standards."*

Further the EPA document refers to the same document (Perry's Chemical Engineers Handbook) used by the City of Huntsville to prepare the alternative cost estimates:

". . .the costs and estimating methodology in this Manual are directed toward the "study" estimate with a probable error of 30% percent. According to Perrv's Chemical Engineer's Handbook, a study estimate is ". . . used to estimate the economic feasibility of a project before expending significant funds for piloting, marketing, land surveys, and acquisition . . . [I]t can be prepared at relatively low cost with minimum data." The accuracy of the study-level estimate is consistent with that for a Class 4 cost estimate as defined by the Association for Advancement of Cost Engineering International (AACEI), which AACEI defines as a "study or feasibility"-level estimate."

None of the technologies available to remove or reduce dissolved solids from the City of Huntsville effluent are "off the shelf" items that generally benefit from mass production and therefore more competitive pricing compared to site-specific design and operational parameters. The study-level capital and operating cost estimates prepared by the City of Huntsville followed the EPA methodology by using available recognized cost indices for equipment, installation, and operation including consumables, then adjusting those costs to real present value dollars using a representative price index. The EPA Manual acknowledges several indices including the Gross Domestic Product implicit price deflator which measures broad price changes in the economy. Nonetheless, the Manual states *". . . the application of an appropriate factor requires the subjective application of the analyst's best judgment"* which the Professional Engineer with over thirty-years' experience utilized to prepare the alternative cost estimates.

Comment 3: *"There were no quotes obtained . . ." for the alternatives analysis submitted by the City of Huntsville.*
Response: The EPA Manual describes the information required to develop a study estimate as:

- Location of the plant;
- Location of the source within the plant;
- Design parameters, such as source size or capacity rating, uncontrolled pollutant concentrations, pollutant removal requirements, etc.
- Rough sketch of the process flow sheet (i.e., the relative locations of the equipment in the system);
- Preliminary sizes of, and material specifications for, the system equipment items;
- Approximate sizes and types of construction of any buildings required to house the control system;
- Rough estimates of utility requirements (e.g. electricity, steam, water, and waste disposal);
- Quantity and cost materials consumed in the process (e.g., water, reagents, and catalyst);
- Preliminary flow sheet and specifications for ducts and piping; Approximate sizes of motors required;
- Economic parameters (e.g. annual interest rate, equipment life, cost year, and taxes.)

Note that equipment quotes are not necessary to develop the study-level estimates. The most accurate estimation type (detailed level) requires complete drawings, specifications, site surveys and potentially equipment quotes. A detailed estimate is not available until right before construction since its preparation requires detailed and process-specific information that is *"very expensive for an entity to prepare . . . "*. Thus, the study-level and not the detailed level is the estimation method promoted by the EPA Manual and recognized by several States for evaluation of control technologies to comply with the regulations.

In summary, the City of Huntsville relied on the best information available and followed the accepted method for developing study-level estimates of capital and operating costs for the comparison of dissolved solids treatment alternatives.

Comment 4: *In response to comments it was stated that land application was not a viable option because "land application requires characteristics, remote location, etc.) land. Significant areas of suitable (slope, soil characteristics, remote location, etc.)*

land. Because Huntsville is situated in the Ozark Highlands, adequate nearby land having characteristics compatible with ADEQ restrictions for land application of treated effluent is not available" However, ADEQ has issued many land application permits within the Ozark Highlands. This alternative was not even remotely explored or considered.

Response: Disposal of wastewater via sprinkler irrigation of cropland is a widely accepted practice in locations where large contiguous tracts of relatively inexpensive suitable land exist. Suitable land is considered as:

- Less than 6% slope (per ADEQ),
- Soils with sufficient hydraulic conductivity to allow irrigation without runoff or ponding;
- Soils with adequate depth above a restrictive layer to sustain continuous irrigation without runoff, ponding, or development of anoxic/anaerobic conditions;
- Within a ten-mile distance from the corporate boundary to be subject to eminent domain statutes, or be outside that distance and currently listed for sale;
- Soils with characteristics (SAR, CEC, pH, etc.) compatible with the long term application of wastewaters.

Study-level engineering calculations to determine the initial land requirements were performed using information from the National Resources Conservation Service (NRCS) regarding suitabilities and limitations for disposal of wastewater by irrigation for Madison County, Arkansas. Those calculations based solely on hydraulic conductivity indicate that an approximate 450 acre tract is necessary for the irrigation and storage facilities plus buffers to accommodate the City of Huntsville effluent. A review of the NRCS soil survey for an Area of Interest (AOI) within ten-miles of Huntsville results in some areas that are classified as "somewhat limited" for wastewater irrigation but none that meet the minimum area required.

While ADEQ has issued land application permits within the Ozark Highlands mostly for agricultural operations, those permits are somewhat controversial and have met rigorous opposition from members of the community including White River Waterkeeper. While not an absolute technical disqualification of the alternative, the potential negative social impacts of land application of wastes coupled with the physical restrictions described above results in confirmation that adequate nearby land having characteristics

compatible with ADEQ restrictions for land application of treated effluent is not available.

Comment 5: *ADEQ has not developed unique mineral criteria specific to the protection of Agricultural Supply uses. The criteria used to assess those uses are the same as criteria for the assessment of Domestic Water Supply uses (250, 250, 500 for Cl, SO4, and TDS, respectively). Has there been any examination of whether these proposed criteria changes could impact livestock operations relying on water from these stream reaches? Are there any grazing cattle operations that could be negatively impacted by the proposed changes?*
Response: Arkansas does not have unique mineral criterion specific to Agricultural Supply uses. However, Oklahoma has regulations for total dissolved solids (TDS) that are specific to protect Livestock Agriculture which are less stringent than requirements for protecting Irrigation Agriculture. The Oklahoma Water Resources Board states in the Oklahoma Water Quality Standards (Section 785:45-5-12) that "For the purpose of protecting the Livestock Agriculture subcategory, neither long-term average concentrations nor short term average concentrations of minerals shall be required to be less than 2500 mg/L for TDS." TDS concentrations are not to exceed 2500 mg/L in any of the stream reaches. The United States Department of Agriculture, NRCS, Environment Technical Note No. MT-1 (June 2011) describes water that is less than 1000 mg/L as a "Relatively low level of salinity. Excellent for all classes of livestock and poultry." For water that is between 1,000 and 3,000 mg/L TDS they note that it is "Very satisfactory for all classes of livestock and poultry. May cause temporary and mild diarrhea in livestock not accustomed to saline water. Poultry may exhibit watery droppings."

Comment 6: *The aquatic life collections were not conducted in a fashion that allows for the evaluation of spatial or temporal differences to be examined (i.e., no replicate samples were collected). Without such, it is impossible to tell whether there are significant differences noted at upstream and downstream sampling locations on each stream.*
Response: Macroinvertebrates were collected according to the QAPP that was approved by ADEQ and EPA.

Comment 7: *While the selection of the reference reaches is suitable for determining the impacts from a particular point source*

in relation to other contributing factors, it does not mean that the reference reach was a suitable representation of least-disturbed streams in the Ozark Highland ecoregion.
Response: Reference reaches were selected and sampled according to the QAPP that was approved by ADEQ and EPA.

Comment 8: *There was no discussion of how reach length was determined.*
Response: Reach lengths were determined by habitat assessments. Habitat assessment reach length is equal to 20 times the bank full width, or at least 100 yards of in-stream distance.

Comment 9: *It was stated that "the fish sampling was terminated when, in the opinion of the principal investigator, a representative collection had been obtained." This infers that the entirety of the stream reach used for habitat characterization was not sampled. Since there is no information provided in the report that indicates the habitat conditions of the area sampled; then it is impossible to determine how much habitat differences factored into metrics based on the fish community.*
Response: The semi-quantitative habitat sampling reach length coincided as much as possible with that of the fish and macroinvertebrate collection reaches. Fish were collected from available habitats until the same repeats fish species were being collected and/or there were no new or different habitat types that had not already been sampled.

Comment 10: *What fish species were categorized as tolerant, intolerant, and intermediate? No comments on the appropriateness of such categorization can be provided without that pertinent information being included in the report.*
Response: The report was revised to include the categorization of tolerant, intolerant, and intermediate fish species in Appendix G, the appendix with the fish species list.

Comment 11: *Isn't WEC-1 the reference reach? Since the multimetric assessment is to be utilized to determine the impairment status of an impacted reach, then how was the % comparison to reference was only 94% and not 100% seeing as how WEC-1 was the reference reach?*
Response: Multimetric assessments were analyzed using ADEQ's variation on Rapid Bioassessment Protocol III, developed by the EPA that was modified from Plafkin et al., 1989. There are six metrics used in this assessment Protocol. Comparisons of the study

site to the reference are made for five of the six metrics in the analysis, except for percent dominant taxa. Percent dominant taxa is not a comparison to the reference value, but rather actual percent contribution for the given site therefore the reference reaches are also given a value for the metric.

When analyzing the data further in response to these comments an error was realized in the comparison on WEC-1 to WEC-2. The reference reach, WEC-1, macroinvertebrate multimetric total score was 34. The reference stream score should have been used to compare WEC-1 to WEC-2 to evaluate if WEC-2 was impaired. The error realized was that 36 (the highest score possible) was used to compare to the downstream reach, WEC-2, instead of 34. The percent comparison to reference for WEC-2 was 89% but should have been 94%. The outcome of the study has not changed since both scores are considered nonimpaired.

Comment 12: *Are the biotic index values referenced in Appendix E the tolerance values for macroinvertebrate taxa utilized in the calculation of Hilsenhoff Biotic Index?*
Response: Yes, the biotic index values in Appendix E are Hilsenhoff Biotic Index values. (See Section 5.4 of the report also).

Comment 13: *Proposed criteria are based on the 95th percentile of water quality data. However, the assessment of these streams allow for a 10-25% exceedance rate, depending on whether the Department is choosing to adhere to EPA approved water quality standards. Setting the criteria based on this percentile, along with allowing up to 25% exceedance of this standard, should in fact ensure that the City of Huntsville will not cause a future impairment listing to minerals to these stream reaches. This in no way translates to the protection of aquatic life, however.*
Response: The request for amendment of the minerals criteria is being made to adjust the criteria to reflect the historical discharge from the City of Huntsville, not to allow future increases in allowable discharge of minerals. The results of the study indicated aquatic life in each of the streams was fully supported at levels higher than the 95th percentile.

Comments of Jeff Stone (Arkansas Health Department)

Comment 1: *Additionally, with regards to the protection of downstream designated uses, the federal regulations state, "In designating uses of a water body and the appropriate criteria for*

those uses, the State shall take into consideration the water quality standards of downstream waters and shall ensure that its water quality standards provide for the attainment and maintenance of the water quality standards for downstream waters." (40 C.F.R. § 131.10(b)].
Response: Domestic Water Supply water quality criteria for minerals are being maintained in War Eagle Creek; thus, this proposed rulemaking does maintain the water quality standards of downstream waters.

Comment 2: *ADH requests that all Exhibits and documents mentioning ADH within the current proposed rulemaking reflect our opposition to the proposed rulemaking and the removal of the domestic supply designation for Town Branch and Holman Creek.*
Response: ADH opposition to the proposed rulemaking is documented in the rulemaking record.

Comments of Colene Gaston (Beaver Water District)

Comment 1: *There is no discussion of why the WQC currently proposed by Huntsville have changed so dramatically from what was proposed in 2013. Section 7.1 provides mostly "summary statistics" and notes that the data used for the "percentile calculations" are provided in Appendix I. The data in Appendix I, however, is very limited. It appears, for example, that only twelve measured data points were used in the percentile calculations for chloride and TDS for Town Branch and War Eagle Creek and that only four measured data points were used in the percentile calculations for sulfate for those two streams. The data for those two streams also was limited to the time period of July 2011 through June of 2012.*
Response: The criteria changed as a requirement of the Department to use the 95th percentile of data collected during the study period. Section 2.306 studies at one time used a calculation process that projected a 95th percentile value instream using effluent data, and a 4.0 cfs upstream flow. The Department determined that using the 95th percentile values of instream data was a superior method and the proposed WQC reflect that change in calculation methods. The data provided in Appendix I contain the instream data collected by GBMc during the study period and data collected by the Department for a five-year period that bracketed the study. The year-long study was required by the Department.

Comment 2: *Beaver Water District (BWD) objects to the use of such limited data sets for making changes to the WQC in Reg. 2 and also objects to the use of data that does not include current water quality analyses. The data used was primarily from samples collected by GBMc.*
Response: The study was completed following an approved QAPP that was approved by ADEQ and EPA. Five-years of data collected by ADEQ for sulfate, chloride, and TDS were used also.

Comment 3: *Was all of the available water quality monitoring data collected by the Arkansas Department of Environmental Quality utilized?*
Response: The study did not use all ADEQ collected data as the Department limited the dataset to a five-year period bracketing the study.

Comment 4: *Why wasn't data collected by other entities, such as the United States Geological Survey, used?*
Response: Modeling work conducted by the United States Geological Survey (which indicated that a doubling of the minerals load from Huntsville would have negligible to no effect on Beaver Lake and a 2 mg/L increase in War Eagle Creek at Hindsville) was used for the study. Other than Department ambient monitoring data, which was used, we are not aware of data collected within the study reaches during the study period.

Comment 5: *At a minimum, the water quality data used should be reasonably current and the sample size should be large enough, when viewed conservatively, to justify the changes. We do not believe that is the case in this proposed rulemaking.*
Response: This opinion is acknowledged however; the study was completed following the QAPP that was approved by ADEQ and EPA.

Comment 6: *BWD understands the need to allow Huntsville's existing wastewater discharge in a manner consistent with the regulations and based on sound science. We question, however, whether that standard has been met in this proposed rulemaking.*
Response: This question is acknowledged however; the study was completed following an approved QAPP, and is supported by the Department.

Comments of Aletha T. Petty, Brian Thompson, and John Murdoch

Comment 1: *I OPPOSE the removal of the domestic water supply designated use from Holman Creek and Town Branch. Although domestic water supply use is not an existing use on these stream reaches, designated uses are meant to represent the goal of a particular waterbody. I feel strongly that the domestic water supply uses should remain a GOAL for these stream reaches.*
Response: Arkansas Department of Pollution Control and Ecology Commission Regulation 2.306 provides that a process for removal of a Domestic Water Supply use if that use is not existing under certain conditions. Those conditions include a determination that existing uses, such as fishable/swimmable uses are maintained and protected fully. The results of the biological evaluation performed as a requirement of the study shows that the aquatic life in Holman Creek and Town Branch (and War Eagle Creek) are not being impaired by the Huntsville discharge and are in good condition. The Domestic Water Supply designated use for a 2.25-mile reach of Town Branch/Holman Creek is being proposed for removal only because there is no other feasible alternative. This removal has no effect upon the designated use of War Eagle Creek as the Domestic Water Supply criteria applicable to the creek are required to be maintained by the discharge. According to Reg. 2.306, *"As community water needs change, or technological advancement, including long-term environmental improvement projects, make treatment options more practicable, the Commission may reevaluate the need for the reestablishment of the more stringent water quality criteria or the removed use."*

Comments of Chuck Bitting

Comment 1: *I OPPOSE the removal of the domestic water supply designated use from Holman Creek and Town Branch. Although domestic water supply use is not an existing use on these stream reaches, designated uses are meant to represent the goal of a particular waterbody. I feel strongly that the domestic water supply uses should remain a GOAL for these stream reaches.*
Response: See response to Comments of Aletha T. Petty, Brian Thompson, and John Murdoch above.

Comment 2: *The change proposed will allow a reduction in water quality in Holman Branch and allow Butterball to expand their operations in NE Arkansas. This will impact additional streams*

with increased pollution. These impacts must be analyzed and modeled prior to any decision. It does not matter that these will mostly be non-point source impacts. They will become point source where they drain into the streams. Table Rock Lake is downstream and already has enough problems with water quality. This is a cross state issue.
Response: The proposed change does not allow for a reduction in historical water quality as a turkey processing plant has discharged wastewater to the City of Huntsville Waste Water Treatment Plant since 1973. The Department has data from Holman Creek going back to 1990. Trend analysis for TDS indicates that concentrations have not increased (or decreased) over time. The proposed rulemaking does not allow Butterball to increase the minerals loads to the City because the criteria development process (use of the 95th percentile value) will lead to discharge limitations that the City would not be able to meet should Butterball's load increase. The USGS has modeled the system and determined that a doubling of Huntsville's load (which can't happen because of permit limits based upon the rulemaking) would likely result in a minimal 2 mg/L increase of TDS in War Eagle Creek at Hindsville.

Comments of Gordon Watkins

Comment 1: *I OPPOSE the removal of the domestic water supply designated use from Holman Creek and Town Branch. Although domestic water supply use is not an existing use on these stream reaches, designated uses are meant to represent the goal of a particular waterbody. I feel strongly that the domestic water supply uses should remain a GOAL for these stream reaches.*
Response: See response to Comments of Aletha T. Petty, Brian Thompson, and John Murdoch above.

Comment 2: *ADEQ should not allow degradation of Waters of the State, which by definition belong to all Arkansawyers, just to benefit a private corporation such as Butterball. Butterball should upgrade their pretreatment facilities as a cost of doing business and not pass this cost along to public citizens by way of lowered water quality.*
Response: There are no conventional pretreatment process changes that could be made at the Butterball facility that would appreciably reduce the levels of dissolved minerals. Due to the characteristics of the Butterball effluent and the membrane technologies (reverse osmosis or electrodialysis reversal) required to reduce dissolved minerals, secondary treatment levels that occur

in the Huntsville Waste Water Treatment Plant must be attained before considering advanced minerals removals technologies due to their susceptibility to fouling.

Comments of Laura Timby

Comment 1: *I OPPOSE the removal of the domestic water supply designated use from Holman Creek and Town Branch. Although domestic water supply use is not an existing use on these stream reaches, designated uses are meant to represent the goal of a particular waterbody. I feel strongly that the domestic water supply uses should remain a GOAL for these stream reaches.*
Response: See response to Comments of Aletha T. Petty, Brian Thompson, and John Murdoch above.

Comment 2: *Clean water is of the utmost importance for our communities and must be safeguarded. Industry must look to other avenues to expand without jeopardizing our clean water sources.*
Response: See response to Comment 2 of Chuck Bitting above.

Comments of Shawn Porter

Comment 1: *I OPPOSE the removal of the domestic water supply designated use from Holman Creek and Town Branch. Although domestic water supply use is not an existing use on these stream reaches, designated uses are meant to represent the goal of a particular waterbody. I feel strongly that the domestic water supply uses should remain a GOAL for these stream reaches.*
Response: See response to Comments of Aletha T. Petty, Brian Thompson, and John Murdoch above.

Comment 2: *ADEQ should be protecting (and improving) water quality not enabling agriculture and industry to pollute and degrade our streams, lakes, and aquifers. Please do your jobs and live up to the name of your agency. Protect the quality of our environment.*
Response: For the reasons explained in the prior responses to comments, this rulemaking protects water quality, and implements the responsibility of ADEQ under the laws and regulations that it administers for protection of water quality.

Comments of Vallie Graff

Comment 1: *I OPPOSE the removal of the domestic water supply designated use from Holman Creek and Town Branch. Although domestic water supply use is not an existing use on these stream reaches, designated uses are meant to represent the goal of a particular waterbody. I feel strongly that the domestic water supply uses should remain a GOAL for these stream reaches.*
Response: See response to Comments of Aletha T. Petty, Brian Thompson, and John Murdoch above.

Comment 2: *I hope that your concern for the Well-Being of your Citizens will remain a priority over easy solutions for business.*
Response: The procedure and documentation required for establishing site specific water quality criteria are not easy solutions. For the reasons explained in the prior responses to comments, this rulemaking protects water quality, and implements the responsibility of ADEQ under the laws and regulations that it administers for protection of water quality.

Rebecca Miller-Rice, an attorney with the Bureau of Legislative Research, asked the following questions:

(1) In the Executive Summary submitted with your packet, there is a chart that sets forth the amendments to mineral criteria being requested. The final entry on the chart references proposed numbers for "War Eagle Creek downstream from the confluence with Clifty Creek to Beaver Lake"; however, I am not seeing any such proposed change in the mark-up copy of the regulation. Was this one of the prior proposals from 2013 that is no longer being sought? **RESPONSE:** The Executive Summary and chart you referenced is no longer applicable. A revised and updated Executive Summary is attached (filed with the Arkansas Commission on Pollution Control and Ecology on February 27, 2018). The revised Executive Summary describes the current proposed changes to the regulation.

(2) On page A-5 of the mark-up provided, it appears that the sulfate number has been omitted from the entry for "War Eagle Creek from the confluence with Holman Creek to Clifty Creek." I was not sure if this was an intentional omission or not?
RESPONSE: Page A-5 reflects the site specific standards that are supported by the Use Attainability Analysis and are being adopted for each of the three stream segments. No Use Attainability

Analysis was submitted, and no site specific standard is proposed for sulfates for War Eagle Creek from the confluence with Holman Creek to Clifty Creek. Therefore there is no sulfate value shown for that stream segment. As shown on page 5-10, the sulfate standard for that stream segment remains at 17 mg/L, which is the Ecoregion Reference Stream Value for the Ozark Highlands, as shown on page 5-13.

(3) When does the public comment period actually expire for this rule? The public notice states December 4, 2017, as the last day to submit written comments; however, the legislative questionnaire states that the public comment period expires on November 23.
RESPONSE: Revisions were made to the initial proposal and an additional comment period and public hearing were held. The public hearing was conducted in Huntsville, Arkansas on November 13, 2017, and the comment period closed on December 4, 2017. Attached are the revised Legislative Questionnaire with Financial Impact Statement, and the Public Notice for the revised regulation (filed with the Arkansas Commission on Pollution Control and Ecology on October 12, 2017), all confirming the close of the public comment period on December 4, 2017.

The proposed effective date is December 8, 2018.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: This amendment to Regulation No. 2, Water Quality Standards, stems from a third-party rulemaking request made to the Arkansas Pollution Control and Ecology Commission ("Commission") by the City of Huntsville. Arkansas Code Annotated § 8-4-202(c)(1) bestows upon any person the right to petition the Commission for the issuance, amendment, or repeal of any rule or regulation. *See also* Ark. Code Ann. § 8-4-102(5) (defining "person" as "any state agency, municipality, governmental subdivision of the state or the United States, public or private corporation, individual, partnership, association, or other entity"). Pursuant to Ark. Code Ann. § 8-4-202(a), the Commission is given and charged with the power and duty to adopt, modify, or repeal, after notice and public hearings, rules and regulations implementing or effectuating the powers and duties of the Commission and the Arkansas Department of Environmental Quality. It is further given and charged with the power and duty to promulgate rules and regulations, including

water quality standards. *See* Ark. Code Ann. § 8-4-201(b)(1)(A). *See also* Ark. Code Ann. § 8-4-202(b)(3).

4. DEPARTMENT OF FINANCE AND ADMINISTRATION, ARKANSAS MEDICAL MARIJUANA COMMISSION
(Mary Robin Casteel and Brian Bowen)

a. SUBJECT: Application for Issuance and Renewal of Licenses for Medical Marijuana Cultivation and Dispensaries in Arkansas

DESCRIPTION: The instant proposed rules are an amendment to rules already adopted and in effect. The Commission's emergency rule changes were approved by the Executive Committee on July 19, 2018. The purpose of the changes is to:

1. Create authority to allow the commission to hire a consultant to score the 203 dispensary applications, currently before the commission for review, scoring, and licensure. Time is of the essence, as two of the commission's five members will roll-off the commission at the end of November 2018 when their terms expire. The commission is concerned with the feasibility of completing this task prior to those term expirations, and also with the public need for this task to be completed as soon as possible. Given the overwhelming magnitude of this scoring endeavor, the commission desires authority to hire a consultant to complete this task, in the event the commission assesses themselves unlikely to complete scoring by the time the aforementioned commissioner terms expire.

2. Allow the commission the option to hold applications and scores from any given scoring period for up to 24 months. The immediate need for this is the commission currently has cultivation scores which it wishes to hold in reserve for the 24-month period and with the dispensary scoring to be completed within months, the commission also wishes to hold the dispensary scores in reserve. This is crucial to prevent the commission from restarting the entire lengthy application and scoring process in the event the commission determines a need for more licenses, a licensee surrenders a license, or a license is revoked.

3. Create a mechanism by which the commission shall select the winner of a tie. In the event two or more applicants receive identical cumulative scores and the number of tied scores exceeds

the number of licenses available, the commission wishes to institute a "double-blind" lottery. The immediacy of the rule change is due to the fact that a tie currently exists between the first two runners up of the cultivation scores, and that the dispensary applications will be scored shortly and a tie may also present among those scores.

PUBLIC COMMENT: A public hearing was held on September 5, 2018. The public comment period expired on September 5, 2018. The Commission provided the following comments summary:

The Medical Marijuana Commission published notice of the proposed rules listed below on July 20, 2018, and began accepting comments from the public. To date, there have been no written comments received by mail and email. Comments were received at a public hearing on September 5, 2018. The comments received and considered are summarized below.

Section IV.9 (g. – h.) Holding cultivation applications from any application period in reserve for up to 24 months

- Negative comment received from Tammy Quick, stating she believes holding applications in reserve for up to 24 months is "[denying] due process."
- Negative comment received from Joan Warren, questioning how a business can wait 24 months.

COMMISSION RESPONSE:
This rule change is crucial to prevent the Commission from restarting the entire lengthy application and scoring process in the event the Commission determines a need for more licenses, a licensee surrenders a license, or a license is revoked. The Commission feels this is the most efficient and expedient method by which to address a possible future need to issue new licenses.

Section IV.9 (i.) Breaking a tie in scoring among cultivation applicants

- No Comments Received

Section IV.20 Retention of a consultant or contractor regarding cultivation licenses

- Negative comment received from Joan Warren, stating the State is "spending all this money on consultants when we already have five (5) commissioners" to do the scoring.

COMMISSION RESPONSE:

Time is of the essence, as two (2) of the Commission's five (5) members will roll-off the Commission at the end of November 2018 when their terms expire. The Commission is concerned with the feasibility of completing this task prior to those term expirations, and also with the public need for this task to be completed as soon as possible. Given the overwhelming magnitude of this scoring endeavor, the Commission has hired a consultant to assist in completing this task and present to the Commission for final approval.

Section V.9 (g. – h.) Holding dispensary applications from any application period in reserve for up to 24 months

- Negative comment received from Tammy Quick, stating she believes holding applications in reserve for up to 24 months is "[denying] due process."
- Negative comment received from Joan Warren, questioning how a business can wait 24 months.

COMMISSION RESPONSE:

This rule change is crucial to prevent the Commission from restarting the entire lengthy application and scoring process in the event the Commission determines a need for more licenses, a licensee surrenders a license, or a license is revoked. The Commission feels this is the most efficient and expedient method by which to address a possible future need to issue new licenses.

Section V.9 (i.) Breaking a tie in scoring among dispensary applicants

- No comments received

Section V.21 Retention of a consultant or contractor regarding dispensary licenses

- Negative comment received from Joan Warren, stating the State is "spending all this money on consultants when we already have five (5) commissioners" to do the scoring.

COMMISSION RESPONSE:

Time is of the essence, as two (2) of the Commission's five (5) members will roll-off the Commission at the end of November 2018 when their terms expire. The Commission is concerned with the feasibility of completing this task prior to those term expirations, and also with the public need for this task to be completed as soon as possible. Given the overwhelming magnitude of this scoring endeavor, the Commission has hired a consultant to assist in completing this task and present to the Commission for final approval.

Pursuant to the approved emergency rule, a consultant was awarded a contract to score the dispensary applications. The effective date of the proposed permanent rule changes is pending legislative review and approval.

FINANCIAL IMPACT: The question on the financial impact, "In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered"?, the agency answered, "yes."

Question: "If an agency is proposing a more costly rule, please state the following: (a) How the additional benefits of the more costly rule justify the additional cost;" **Agency response:** "This rule has the potential to create additional cost, as it gives the Commission the authority to hire a consultant. That said, this rule does not obligate the state to increased costs. It merely creates the possibility of such costs. The benefits far outweigh the increase in cost, as the commission is under a tremendous time constraint, which it risks not meeting without the assistance from a consultant."

Question: "(b) The reason for adoption of the more costly rule;" **Agency response: "**Currently, the commission does not have the authority to hire a consultant. Without such authority, it risks catastrophic delays in the scoring of the dispensary applications, and ultimately the implementation of The Medical Marijuana Amendment of 2016."

Question: "(c) Whether the more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain;" **Agency response:** "The people of Arkansas voted to amend the Arkansas Constitution in November of 2016 through The Medical Marijuana Amendment of 2016. The Commission requires this rule, immediately, in order to implement the Amendment efficiently and expeditiously for the people of Arkansas. The Commission fears further delays would be catastrophic to the people who voted for this."

Question: "(d) Whether the reason is within the scope of the agency's statutory authority; and if so, please explain," **Agency response:** Yes. Amendment 98 to the Arkansas Constitution charges the Medical Marijuana Commission with all action necessary to implement the licensure of cultivation facilities and dispensaries."

There will be no cost by fiscal year to any private individual, entity and business subject to the proposed, amended, or repealed rule.

"The total estimated cost by the current and next fiscal year to state, county, and municipal government to implement this rule is to be determined. It is unclear the extent of the costs which may be created by this rule. The rule does not inherently obligate funds, but the emergency need for the rule is the Commission's desire to use the authority created by this rule to hire a consultant. It is not possible, prior to implementation and solicitation of bids from consultants, to estimate the possible increase of costs."

LEGAL AUTHORIZATION: The Medical Marijuana Commission ("Commission") was created within the Department of Finance and Administration to determine the qualifications for receiving a license to operate a dispensary or a license to operate a cultivation facility. The Commission has a constitutional duty to adopt rules necessary for its "fair, impartial, stringent, and comprehensive administration" of the Arkansas Medical Marijuana Amendment of 2016. *See* Ark. Const. amend. 98, § 8(d)(3). The Commission is constitutionally mandated to implement the rules regarding licensure of marijuana cultivation facilities and dispensaries. *See* Ark. Const. amend. 98, § 8(f).

5. DEPARTMENT OF HUMAN SERVICES, ADULT, AGING AND BEHAVIORAL HEALTH SERVICES (Paula Stone)

a. SUBJECT: Outpatient Behavioral Health Services Program Provider Manual 3-18 and Certification Manual

DESCRIPTION: This removes the home and community behavioral health services from the current program manual and moves it to PASSE manual and defines the certification manual to include fee-for-service only.

This amendment coincides with the implementation of the Provider-Led Arkansas Shared Savings Entity (PASSE) model of organized care. Under the PASSE model, beneficiaries who are in need of a full array of home and community based behavioral health services have received or will receive a BH Independent Assessment and have or will attribute to a PASSE if the assessment shows a functional deficit. The services to treat those

deficits will be provided through a 1915(i) state plan amendment and be subject to the home and community based services requirements. Providers who provide 1915(i) services to beneficiaries in a PASSE will be credentialed through the PASSE as home and community based service (HCBS) providers.

The services that remain in the Outpatient Behavioral Health Services Program manual will be available to individuals with a behavioral health diagnosis who need counseling and medication management services only and will be accessible without an Independent Assessment and the Certification manual will apply only to services provided in fee-for-service environment.

PUBLIC COMMENT: DHS held three public hearings, one in Little Rock on August 20, 2018, one in Monticello on September 4, 2018, and one in Hope on September 6, 2018. The public comment period ended on September 12, 2018. DHS received the following comments and provided its responses:

Responses to Public Comments Regarding the OBHS Manual

Kathy D. Harris
Comment: COMMENTS ON THE PROPOSED REVISIONS.
1. Section 223.000 - Exclusions Item G Services provided to nursing home and ICF/IDD residents other than those specified in Section 252.150 (unable to locate Section 252.150 in this draft Manual). Is the intent to eliminate any Tier 1 services to persons residing nursing homes?
2. Section 256.300 Services Available to Residents of Long Term Care Facilities Billing Information. Again, all services to nursing homes are eliminated—is this the intent?
3. Section 255.001 Crisis Services
There is no service code or modifier included in this service that allows for telemedicine billing. Please consider adding this as an allowable method of delivering this service. It allows providers to be more timely and responsive to crisis intervention needs.
Response: No, it is not the intent to eliminate services for residents of nursing homes.
The allowable services for those beneficiaries in long term care facilities are addressed in the Applicable Populations section of the service definitions in this manual. Section 223.000 will be updated to remove section 252.150.
DHS has determined that telemedicine will not be added for this service code at this time.

Dr. R. Kevin Rowell

Comment: I hope that you will reinstate the provision to allow doctoral level interns to practice and bill under Medicaid. They serve the people of Arkansas who are in need. This letter in no way represents the University of Central Arkansas. I am simply commenting as a trainer of psychologists and counselors. Thank you for your consideration in this matter.

Response: In the current OBH manual there is a provision for the enrollment of Provisionally Licensed Psychologists. The appropriate licensing board should be consulted.

Cody Jeffries

Comment: Please add a provision to permit doctoral level psychology interns to bill Medicaid again so the underserved persons of Arkansas may receive the quality healthcare they deserve.

Response: In the current OBH manual there is a provision for the enrollment of Provisionally Licensed Psychologists. The appropriate licensing board should be consulted.

Bridget Atkins

Comment: In Section 211.300 of the proposed Manual, I noticed that DPSQA is specifically referenced for the certification of Performing Providers. Since the Division of Aging, Adult & Behavioral Health Services is retaining responsibility for approving therapists to provide Infant Mental Health Services (whether they are with a BHA or are an ILP), I wondered if that Division needs to also be mentioned in that section.

Response: Qualifications for the provision of Infant Mental Health services are addressed in section 214.100.

Christopher Westfall

Comment: Request that we include the original language developed in the 2014 rules and allow reimbursement for supervised doctoral psychology interns.

Response: In the current OBH manual there is a provision for the enrollment of Provisionally Licensed Psychologists. The appropriate licensing board should be consulted.

Glenn Mesman

Comment: Please add a provision to permit doctoral level psychology interns to bill Medicaid again so the underserved

persons of Arkansas may receive the quality healthcare they deserve.
Response: In the current OBH manual there is a provision for the enrollment of Provisionally Licensed Psychologists. The appropriate licensing board should be consulted.

Karin Vanderzee
Comment: I would welcome the opportunity to meet with leadership at OBHS to provide further information about the role of psychology interns in facilitating access to much needed services for children in the state and their families. I would also welcome the opportunity to meet with OBHS leadership regarding CPP so that the Proposed OBHS-3-18 Provider Manual Update may be revised so that clinicians may be able to complete their Infant Mental Health Certification training, so young children can continue to receive CPP as it was designed, and so we can achieve our common goal of improving the system of care for our youngest and most vulnerable children.
Response: In the current OBH manual there is a provision for the enrollment of Provisionally Licensed Psychologists. The appropriate licensing board should be consulted.

Lisa Evans
Comment: I am a licensed psychologist in the State of Arkansas and very familiar with the training needs of doctoral-level psychology trainees. Allowing the trainee to bill under the license of the psychologist has the following advantages for the State and Medicaid beneficiaries.
- Allows highly trained psychologists in training to provide services to Medicaid beneficiaries. Psychologists in training are highly skilled, have excellent knowledge and background in evidence-based practices, and come from all over the country, bringing diversity to our provider pool. Medicaid recipients may not otherwise be provided this skill level.
- Allows the psychologist in training to have a training experience that includes serving Medicaid beneficiaries, broadening and improving their education.
- Will allow psychology internship programs in the state to continue functioning – removing the ability for the interns to serve and bill for Medicaid clients will likely cause some of the internship programs in the state to cease operation. In state psychology internship programs allow us to increase the number of well-trained psychologists in communities around Arkansas.

Response: In the current OBH manual there is a provision for the enrollment of Provisionally Licensed Psychologists. The appropriate licensing board should be consulted.

Betty Everett

Comment: Please include the original language that was developed in the rules in 2014 and permit reimbursement for supervised doctoral psychology interns.

Response: In the current OBH manual there is a provision for the enrollment of Provisionally Licensed Psychologists. The appropriate licensing board should be consulted.

American Psychological Association, Dr. Jaime Diaz-Granados and Dr. Jared Skillings

Comment: Please include the original language that was developed in the rules in 2014 and permit.
Reimbursement for supervised doctoral psychology interns. This system has worked well for Arkansas and no rationale has been offered for its change.

Response: In the current OBH manual there is a provision for the enrollment of Provisionally Licensed Psychologists. The appropriate licensing board should be consulted.

Joy Pemberton

Comment: I am extremely concerned about these changes and ask that the following language be reinstated to the OBHS manual.

Response: In the current OBH manual there is a provision for the enrollment of Provisionally Licensed Psychologists. The appropriate licensing board should be consulted.

Professional Staff of South Arkansas Regional Health Center- Dr. Jamie Frank

Comment: 202.100 Certification Requirements by the Division of Provider Services and Quality Assurance (DPSQA)
Under this section it states exemptions would be granted, but there was not conditions listed under which an exemption could be granted. The link in the manual did not take the reader to the applicable section or any document that covered it.

Response: This will be removed.

Comment: 211.200 Staff Requirements
These two allowable providers under RSMPI, Provisionally Licensed Master Social Worker (PLMSW) and Pre-Doctoral Student under Ph. D. supervisor with The Psychology Board

providing quarterly monitoring of supervision, but not included in this proposed OBHS manual. Given the shortage of professionals in the State, both levels of providers are recognized as practitioners that have the knowledge and experience to provide services with appropriate levels of supervision. Please approve these two types of providers in the final OBHS manual.
In order for the practitioner to have a PLMSW through the Arkansas Social Work Licensure Board, the practitioner has completed course work and internships to obtain the Master of Social Work (MSW) and has the same supervision requirements as a Licensed Master Social Work practitioner. The practitioner has one year to successfully pass the licensure exam, but can practice at the master level.
Pre-doctoral Student under Ph.D. supervisor with The Psychology Board providing quarterly monitoring of supervision.
Please add to the list Non-Independently Licensed Clinicians, the Provisionally Licensed Master Social Worker and Pre-Doctoral Interns as providers and allow to perform the specific services other Non- Independently Licensed Clinicians can perform. These codes are: 252.111, 252.112, 252.1113, 252.114, 252.115, 252.116, 252.117, 252.118, 252.119, 255.001.
Response: Until the practitioner has completed the licensure exam they can practice as QBHPs. In the current OBH manual there is a provision for the enrollment of Provisionally Licensed Psychologists. The appropriate licensing board should be consulted.

Comment: 217.100 Primary Care Physician (PCP) Referral
Ask for exclusion of Crisis Intervention to the 3 Counseling Level Services and obtaining a PCP to receive this type of service. While obtaining a PCP is a critical task in the provision of care in a managed care environment, Crisis Intervention should be available regardless of whether the individual has a PCP or not.
Response: The Manual will be updated to mention that Crisis Intervention will excluded.

Comment: 233.000 Exclusions G.
What are the services that can be provided to nursing home and ICF / IDD residents? Could not locate 252.150 in this proposed manual.
Response: The allowable services for those beneficiaries in long term care facilities are addressed in the Applicable Populations section of the service definitions in this manual. Section 223.000 will be updated to remove section 252.150.

Comment: 227.000 Prescription for Outpatient Behavioral Health Services
No timeline for which the subsequent renewals need to be obtained. This needs to be clearly stated given its importance. Examples: Every 12 month, six months or three months.
Response: Please see section 1 of the Medicaid Manual for timelines for renewal of PCP referrals.

Comment: 231.3000 Substance Abuse Covered Codes
Independently licensed practitioners may provide Substance Abuse Service within the scope of their practice.
ADD Non-independent licensed practitioners may provide Substance Abuse Services within the scope of their practice and under licensure required supervision. For those diagnosed with Substance Abuse dx as primary or co-occurring with substance abuse disorder(s) as secondary dx. This exclusion conflicts with 252.119 Substance Abuse Assessment - Allowable Performing Providers, which clearly states Non-independent licensed clinicians.
Also include as allowable Non-independent practitioners - Provisionally Licensed Psychologist, Pre-Doc. Psychology Interns and Provisionally Licensed Master Social Work as long as training and supervision requirements are met.
Response: Behavioral Health Agencies employ Non-Independently Licensed Practitioners. Please see applicable service definitions for performing providers allowable under each service.

Comment: 252.100 Procedure Codes for Types of Covered Services
In 3rd paragraph last sentence - The beneficiary must then also be determined by an Intensive level Services Independent Assessment to be eligible for Inpatient Psychiatric Care.
For Psychiatric Acute Care placement, any licensed practitioner should be allowed to assess the need and assist in the accessing in the initial placement. Following this initial placement, a third party can perform utilization review to determine the need for continued stay. The option of obtaining an Independent Assessment prior to an acute psychiatric care admission can't be completed quickly enough to insure safety of the individual and others.
Response: This paragraph will be removed.

Comment: 252.117 Mental Health Diagnosis

Need to make provision for more than one intake benefit per year, as people leave services and need to reenter, or move from one facility to another, and need to initiate services.
Response: Providers may request extension of benefits for services deemed to be medically necessary.

Comment: 252.120 Psychological Evaluation
Also include as allowed providers - Please Include as allowed providers those that are Provisionally Licensed Psychologist and Pre-Doc. Psychology Interns.
Response: In the current OBH manual there is a provision for the enrollment of Provisionally Licensed Psychologists. The appropriate licensing board should be consulted.

Richard Sylvester
Comment: If doctoral level psychology interns are not permitted to bill Medicaid, then the internship programs may no longer be able to offer internship opportunities. One must complete a doctoral level internship to obtain licensure as a psychologist. Without internship opportunities Arkansas will be further deprived of quality mental health professionals. Please add a provision to permit doctoral level psychology interns to bill Medicaid again so the undeserved persons of Arkansas may receive the quality healthcare they need and deserve.
Response: In the current OBH manual there is a provision for the enrollment of Provisionally Licensed Psychologists. The appropriate licensing board should be consulted.

Patricia Walz
Comment: Doctoral interns, for your information, are completing their final step to become doctoral psychologists, having completed their doctoral academic training, as well as prior supervised clinical experience. This final step gives them supervised clinical experiences that are critical for their development as psychologists. Psychologists are highly and uniquely trained professionals, who deliver quality healthcare services. Interns expense as providers is well below that of fully licensed psychologists, yet their contributions to healthcare in Arkansas are critical and of very high quality. Please reconsider the language in question and reverse this potentially disastrous policy change that could have serious long- term consequences for healthcare in Arkansas. Without internship opportunities, Arkansas will be further deprived of quality mental health professionals and Arkansans will be underserved. Please reinstate the provision to

permit doctoral level psychology interns to bill Medicaid again so the underserved persons of Arkansas may receive the quality healthcare they deserve.
Response: In the current OBH manual there is a provision for the enrollment of Provisionally Licensed Psychologists. The appropriate licensing board should be consulted.

Dr. Donala Jordan
Comment: To ameliorate this dilemma, I strongly urge you to reconsider allowing pre-doctoral psychology interns to bill Medicaid for psychological services. Failing to do so will prevent current psychology internship programs such as South Arkansas Regional Health Center (which is accredited by the American Psychological Association [APA]) and future community-based psychology internship programs from being able to offer internship opportunities. Such training is critical because interns must complete a doctoral level internship to obtain licensure as a psychologist.
Response: In the current OBH manual there is a provision for the enrollment of Provisionally Licensed Psychologists. The appropriate licensing board should be consulted.

Meggie P. Rowland
Comment: If doctoral interns are not allowed to bill Medicaid, they may not be offered internship opportunities in Arkansas. Completing a doctoral level internship is a requirement to obtain licensure as a psychologist. If internship opportunities are not offered in Arkansas due to no provision for agencies to bill for doctoral intern mental health services, Arkansas will continue to experience a drought of mental health professionals, which only worsens the problems Arkansas residents already experience as an underserved population.
Response: In the current OBH manual there is a provision for the enrollment of Provisionally Licensed Psychologists. The appropriate licensing board should be consulted.

Hilary Casner
Comment: The doctoral level psychology internship is a required, year-long experience for psychology graduate students pursuing their Ph.D. in clinical psychology. One must complete a doctoral level internship to obtain licensure as a psychologist. If doctoral level psychology interns arc not permitted to bill Medicaid, then the internship programs may no longer be able to offer internship opportunities, 11nd without internship opportunities Arkansas will

be further deprived of quality mental health professionals. Please add a provision to permit doctoral level psychology interns to bill Medicaid again so the underserved persons of Arkansas may receive the quality healthcare they deserve and future psychologists will continue to come to Arkansas for training.
Response: In the current OBH manual there is a provision for the enrollment of Provisionally Licensed Psychologists. The appropriate licensing board should be consulted.

Jamie Frank
Comment: If doctoral level psychology interns are not permitted to bill Medicaid, then the internship programs may no longer be able to offer internship opportunities. One must complete a doctoral level internship to obtain licensure as a psychologist. Without internship opportunities Arkansas will be further deprived of quality mental health professionals. Please add a provision to permit doctoral level psychology interns to bill Medicaid again so the underserved persons of Arkansas may receive the quality healthcare they deserve.
Response: In the current OBH manual there is a provision for the enrollment of Provisionally Licensed Psychologists. The appropriate licensing board should be consulted.

Dr. Jennifer Sue Kleiner
Comment: Please reinstate the following provision to the OBHS manual to permit psychology interns to continue to bill Medicaid:

Psychology Interns
The Division of Medical Services will allow psychology interns to provide limited services under the following provisions:
OBHS facilities must retain written documentation of each intern's:
A. Enrollment in an American Psychological Association internship program that is fully accredited or accredited on contingency.
B. Agreement with the Arkansas Psychology Board regarding oversight and supervision as defined by the American Psychological Association and the Arkansas Psychology Board (APB) Rules and Regulations.

Supervision of psychology interns in the OBHS Program

The psychological procedures covered under the OBHS Program are allowed as a covered service when provided by a psychology

intern authorized by the Arkansas State Board of Psychology to provide such psychological services. When a psychology intern provides the services, the intern must be under the "direct supervision" of the supervising psychologist. For the purpose of psychological services only, the term "direct supervision" means the following:

A. The supervising psychologist must monitor and be responsible for the quality of work performed by the psychology intern under his/her "direct supervision." The supervising psychologist must be immediately available to provide assistance and direction throughout the time the service is being performed. "Immediately available" is defined as the supervising psychologist being accessible to the psychology intern at any point during the supervisory relationship.

B. Oversight:

1. Each supervising psychologist must monitor and be responsible for the quality of the clinical work assigned to his/her supervisee (intern). Monitoring must include personal observation of randomly selected patient interactions;

2. The supervising psychologist must assist and direct the intern in the delivery of internship services. Assistance and direction must comply with the American Psychology Association Guidelines and Principles for Accreditation of Programs in Professional Psychology and the Arkansas Psychology Board Rules and Regulations;

3. Internship services will be provided under the license of the supervising psychologist; and

4. The supervising psychologist must assure compliance with Medicaid laws, rules, and regulations, and be accountable for any noncompliance.

As a condition of Medicaid payment, claims must list the supervising psychologist as the performing provider. Provisions must be made requiring:

A. The Arkansas Psychology Board to certify in writing that the psychology intern is receiving training in a qualified internship program for a prescribed period of time and this written certification shall be retained in the psychology intern's personnel record; and

B. The accredited program's training director to certify in writing and retain in the psychology intern's personnel record:

1. The requirements of the training program in which the intern is participating;

2. The training dates for each intern;

3. The name of each participating intern;

4. The name and Medicaid provider number of:
a. Each participant's supervising faculty member, or
b. The Medicaid-enrolled practice clinic in which the supervising faculty member participates; and
5. All services for which a Medicaid claim will be filed are provided under the supervision of a licensed psychologist who is in good standing with the Arkansas Psychology Board.
Response: In the current OBH manual there is a provision for the enrollment of Provisionally Licensed Psychologists. The appropriate licensing board should be consulted.

Dr. Jennifer L. Guess and Maurice Rigsby at UAMS
Comment:
1. Director of Psychology Training at UAMS and have been alerted to a change in status of psychology interns under the new OBHS rules. Extremely concerned about the changes and ask that the following language be reinstated to the OBHS Manual:

- Psychology Interns
- Supervision of Psychology interns in the OBHS

2. Dr. Gess and several other clinical psychologists have submitted comments according to the notice requirements during the last week. I wanted to emphasize that the UAMS program is a nationally respected fellowship program. The program produces many of the specialized clinical child psychologists in the State. The term "internship" is a bit of a misnomer and inconsistent with our traditional understanding of the term. In the academic sense, these doctors have committed to achieving a higher level of focused training above standard training. Our goal is to keep this important academic and clinical program in place for the people of Arkansas. I will be happy to host your team to learn more about the state-wide impact of the Psychological Research Institute (PRI) academic and clinical programs. Thanks.
Response: In the current OBH manual there is a provision for the enrollment of Provisionally Licensed Psychologists. The appropriate licensing board should be consulted.

Cindy Brown
Comment: 252.114 Of the Proposed OBHS-3-18 Provider Manual: Martial/Family Behavioral Health Counseling without Beneficiary present does not show an allowance for 90846 for 0-47 month population.
Response: Treatment for 0-47 months is intended to provide dyadic treatment which requires the beneficiary to be present.

Comment: 252.113 Of the Proposed OBHS-3-18 Provider Manual: Evidence based interventions such as child parent psychotherapy & parent child interaction often require 20 or more sessions.
Response: Providers may request extension of benefits for services deemed to be medically necessary once the 12 encounter benefit per fiscal year is exhausted.

ARKANSAS HOSPITAL ASSOCIATION
Comment:
1. Hospitals have long recognized the need for greater access to behavioral health services for our patients. Accordingly, we applaud and encourage the Outpatient Behavioral Health Services (OBHS) program and the PASSE program in seeking to expand such access. The OBHS program at DHS has undergone recent changes. As of June 30, 2018, Arkansas Medicaid eliminated the Rehabilitative Services for Persons with Mental Illness (RSPMI), Licensed Mental Health Practitioner (LMHP) and the Substance Abuse Treatment Services (SATS) programs, transitioning all patients under these programs to OBHS. As this transition occurred, DHS overlooked the fact that hospitals were not referenced in these previous provider manuals. Therefore, the Department may have inadvertently left out any reference to hospitals in the OBHS manual. Hospitals regularly provide excellent outpatient behavioral health services and should be recognized as an appropriate and easily accessible provider for Medicaid Fee-for-Service and PASSE patients. In fact, for many Arkansans, their local hospital may be the only nearby provider available.
2. In recognition of the fact that hospitals are a core component to assure access to behavioral health services, both the current hospital manual and the proposed OBHS manual should be amended to expressly allow hospitals to provide and be reimbursed for outpatient behavioral health in both the fee-for-service and PASSE models.
Response: The Outpatient Provider Manual allows for multiple POS codes. Emergency room was added for provision of crisis services within a hospital setting.
The Outpatient Behavioral Services Program is intended to serve people with mental illness and the Inpatient Manual covers allowable services to be provided within a hospital setting. In addition, physicians associated with a hospital that are housed in clinics can serve clients or allow co-location of Mental Health Professionals in that setting through POS codes including those

covering independent clinics, FQHC, public health clinics and rural clinics.
The PASSEs will be able to develop services in additional settings based on member's needs.

FAMILIES INC.

Comment: Non Refusal Requirement - 211.500
If a provider does not possess the services or program to adequately treat the beneficiary's behavioral health needs, the provider must communicate this with the Primary Care PCP or PCMH for beneficiaries receiving Counseling Services so that appropriate provisions can be made. Will the provider's medical record be audited for notification of PCPs?
Response: All requirements outlined in the OBH manual are subject to audit.

Comment: Reimbursement - 240.100
Regarding the 15 Minute Unit table, would you please clarify why the Timeframes are not 15 minutes in duration?
Response: The table was developed in alignment with the requirement that no more than 4 units can be billed in a single hour.

Comment: POS: 212.000 - Under COUNSELING SERVICES and in 214.000 Role of Providers, the Manual refers to Group Home as an applicable place of service for Individual Therapy, Group Therapy, Families with and without Client, Psychoeducation, Mental Health Diagnosis (Intake), Interpretation of Diagnosis, Psychological Evaluation, Pharmacologic Management, Psychiatric Assessment, and Crisis Intervention, but does not list Group Home in the Service Code definition, Place of Service section. Please clarify.
Response: Appropriate POS codes are indicated within the Applicable Populations section of the service definitions in this manual.

Comment: Additionally, is the POS code for Other (99) an acceptable place of service for any/all services noted above?
Response: No. POS codes for each service are listed within the service definition.

Comment: CMS lists the Other POS as (99) whereas the OBHS Manual lists (99) as Outpatient Behavioral Health Services Clinic (Telemedicine). Which is correct?

Response: This will be corrected to indicate POS code (99) as Other.

Comment: 252.111
The IT service states 'residents of long term care facilities' as an applicable population yet does not list a POS code in this section and it is stricken-through on p.173. Please clarify, will this POS apply to Tier 1 clients?
Response: Appropriate POS codes are indicated within the Applicable Populations section of the service definitions in this manual.

Comment: 252.114 - What defines the POS, 'independent clinic'?
Response: CMS defines Independent Clinic as "a location, not part of a hospital and not described by any other POS code, that is organized and operated to provide preventative, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only."

Comment: Service Codes
Encounter-based services that should be referred to as 'encounters' in the Manual are frequently referred to as UNITs. Please consider correcting the Manual to avoid confusion.
Response: DHS will edit the manual to correctly identify units and encounters.

Comment: 252.115
Regarding psychoeducation, the Draft for Public Comment contradicts the 8-1-18 Manual when it states that the service may be provided to the beneficiary and/or spouse/family. Please clarify who the recipient(s) of this service should be.
Response: The manual will be corrected to state beneficiary AND spouse/family.

DHS has sought approval from CMS, and formal approval is pending.

The proposed effective date of the rule is January 1, 2019.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: DHS is authorized to "make rules and regulations and take actions as are necessary or desirable to carry out the provisions of this chapter [Public Assistance] and that

are not inconsistent therewith." Arkansas Code Annotated § 20-76-201(12). DHS may promulgate rules as necessary to conform to federal rules that affect its programs as necessary to receive any federal funds. *See* Ark. Code Ann. § 25-10-129(b). DHS may promulgate rules to implement state statutes that provide fairness and due process for Medicaid providers. *See* Ark. Code Ann. § 20-77-1716. DHS may rely, by reference, on federal rules and regulations that apply to the Medicaid program. *See* Ark. Code Ann. § 20-77-107.

Act 775 of 2017, sponsored by Representative Aaron Pilkington, required DHS to submit an application for any federal waivers, federal authority, or state plan amendments necessary to implement the Medicaid Provider-Led Organized Care System. The Act authorized DHS to promulgate rules necessary to implement the system. *See* Ark. Code Ann. § 20-77-2708.

6. <u>DEPARTMENT OF HUMAN SERVICES, CHILD CARE AND EARLY CHILDHOOD EDUCATION</u> (Beverly Wright)

a. <u>SUBJECT</u>: Minimum Licensing Requirements for Child Care Centers; Child Care Family Homes; Out of School Time Facilities; and Registered Child Care Family Homes

<u>DESCRIPTION</u>: Summary of DCCECE Rule Revision/Promulgation

The Division is proposing changes to the Minimum Licensing Requirements for Child Care Centers, Minimum Licensing Requirements for Child Care Family Home, Minimum Licensing Requirements for Out of School Time Facilities, and Minimum Licensing Requirements for Registered Child Care Family Homes, to define, simplify and clarify the intent of current regulations and to increase the overall quality of care for the children of Arkansas.

The following recommended changes are the result of recent legislation:

Minimum Licensing Requirements for Child Care Centers

In order to come into compliance with Act 23 of 2015 regarding the requirements for insurance the following standards have been added:

Regulation

101.5 To exempt state institutions, political subdivisions, or other entities entitled immunity for liability under 21-9-301 to have general liability insurance coverage to be licensed

1301.6 To exempt state institutions, political subdivisions, or other entities entitled immunity for liability under 21-9-301 to have commerical insurance coverage in order to transport

In order to come into compliance with Act 572 of 2017 regarding the requirements for FBI Background Checks, the following standards have been revised which will require additional staff to have FBI Background Checks:

110.1b To require all direct care staff to submit an FBI Background Check within 10 business days of their hire/start date in order to bring these requirements into compliance with the Federal Block Grant Requirements

110.1c To require all administrative persons who have direct contact with children to submit an FBI Background Check within 10 business days of their hire/start date in order to bring these requirements into compliance with the Federal Block Grant Requirements

110.1d To require all therapists, volunteers or other persons who have supervisory control, disciplinary control over children or who may be left alone with children to submit an FBI Background Check within 10 business days of their hire/start date in order to bring these requirements into compliance with the Federal Block Grant Requirements

The following proposed changes are necessary to explain or clarify existing standards and provide child care providers with clarifications for the standards:

Regulation

102.6 To clarify possible consequences of falsification of any documents and/or submission of false information to the Child Care Licensing Unit or any division of DHS

306.3 To add a review of the Minimum Licensing Requirements for Child Care Centers to new staff orientation

401.5 Staff shall plan and provide experiences that meet children's needs and stimulate learning in the following developmental area: physical, social/emotional, creative/aesthetic, cognitive/intellectual and language, found in Arkansas' Early Learning Standards

Minimum Licensing Requirements for Child Care Family Home

In order to come into compliance with Act 572 of 2017 regarding the requirements for FBI Background Checks, the following standards have been revised which will require additional staff to have FBI Background Checks:

109.1b To require each staff person to submit an FBI Background Check within 10 business days.

109.1c To require all therapists, volunteers or other persons who have supervisory control, disciplinary control over children or who have routine contact with children to submit an FBI Background Check within 10 business days of their hire/start date.

305 Sections 305.1, 305.2, 305.3 and 305.4 are being added to define those individuals who would be considered volunteers and the qualifications and responsibilites required of them including background checks. In addition, Section 305 will ensure the definition of volunteers is outlined and defined in the same manner as it is in the Minimum Licensing Requirements for Child Care Facilities, Minimum Licensing Requirements for Registered Family Homes and Minimum Licensing Requirements for Out of School Time Programs.

The following proposed changes are necessary to explain or clarify existing standards and provide child care providers with clarifications for the standards:

Regulation

201.2 To clarify possible consequences of falsification of any documents and/or submission of false information to the Child Care Licensing Unit or any division of DHS

401.2 Staff shall plan and provide experiences that meet children's needs and stimulate learning in the following developmental area: physical, social/emotional, creative/aesthetic, cognitive/intellectual and language, found in Arkansas' Early Learning Standards.

Minimum Licensing Requirements for Registered Child Care Family Home

In order to come into compliance with Act 572 of 2017 regarding the requirements for FBI Background Checks, the following standards have been revised which will require additional staff to have FBI Background Checks:

109.1b To require each staff person to submit an FBI Background Check within 10 business days.

109.1c To require all therapists, volunteers or other persons who have supervisory control, disciplinary control over children or who have routine contact with children to submit an FBI Background Check within 10 business days of their hire/start date.

303 Sections 303.1, 303.2, 303.3 and 303.4 are being added to define those individuals who would be considered volunteers and the qualifications and responsibilites required of them including background checks. In addition, Section 303 will ensure the definition of volunteers is outlined and defined in the same manner as it is in the Minimum Licensing Requirements for Child Care Facilities, Minimum Licensing Requirements for Child Care Family Homes and Minimum Licensing Requirements for Out of School Time Programs.

The following proposed changes are necessary to explain or clarify existing standards and provide child care providers with clarifications for the standards:

Regulation

201.3 To clarify possible consequences of falsification of any documents and/or submission of false information to the Child Care Licensing Unit or any division of DHS

401.2 Staff shall plan and provide experiences that meet children's needs and stimulate learning in the following developmental area: physical, social/emotional, creative/aesthetic, cognitive/intellectual and language, found in Arkansas' Early Learning Standards.

Minimum Licensing Requirements for Out of School Time

In order to come into compliance with Act 23 of 2015 regarding the requirements for insurance, the following standards have been added.

Regulation

101.4 To exempt state institutions, political subdivisions, or other entities entitled immunity for liability under 21-9-301 to have general liability insurance coverage to be licensed.

1301.6 To exempt state institutions, political subdivisions, or other entities entitled immunity for liability under 21-9-301 to have commerical insurance coverage in order to transport.

In order to come into compliance with Act 572 of 2017 regarding the requirements for FBI Background Checks, the following standards have been revised which will require additional staff to have FBI Background Checks:

110.1b To require all direct care staff to submit an FBI Background Check within 10 business days of their hire/start date in order to bring these requirements into compliance with the Federal Block Grant Requirements

110.1c To require all administrative persons who have direct contact with children to submit an FBI Background Check within 10 business days of their hire/start date in order to bring these requirements into compliance with the Federal Block Grant Requirements

110.1d To require all therapists, volunteers or other persons who have supervisory control, disciplinary control over children or who may be left alone with children to submit an FBI Background Check within 10 business days of their hire/start date in order to bring these requirements into compliance with the Federal Block Grant Requirements

The following proposed changes are necessary to explain or clarify existing standards and provide child care providers with clarifications for the standards.

Regulation

102.6 To explain, or clarify possible consequences of falsification of any documents and/or submission of false information to the Child Care Licensing Unit or any division of DHS

1101.7 To correct a typographical error which left off the end of a sentence

PUBLIC COMMENT: DHS held a public hearing on August 14, 2018. The public comment period ended on September 4, 2018. The Department received no comments.

The proposed effective date of the rule is November 1, 2018.

FINANCIAL IMPACT: The financial impact is $293,040 in federal funds for the current fiscal year and $73,260 in federal funds for the next fiscal year.

LEGAL AUTHORIZATION: The Division of Child Care and Early Childhood Education within the Department of Human Services has the authority to promulgate rules setting standards governing the granting, revocation, refusal, and suspension of licenses for a child care facility and the operation of a child care facility. *See* Ark. Code Ann. §§ 20-78-205(b)(4) and 206(a).

Act 572 of 2017, sponsored by Representative Clarke Tucker, clarified that a service provider must require an applicant, seeking employment at a child care facility or a church-exempt child care facility, regardless of the length of time that the applicant has lived in the state, to submit a criminal history records check form and a complete set of fingerprints. The service provider will send the form and fingerprints to the State Police to initiate state and national criminal history records checks and also conduct a registry records check on the applicant in accordance with the rules of the appropriate licensing or certifying agency. *See* Ark. Code Ann. § 20-38-103. Additional authority can be found in Act 23 of 2015, sponsored by Representative Jeremy Gillam, which exempted state institutions, political subdivisions, and other entities, like school

districts, that are statutorily immune from tort liability, from the requirement to have general liability insurance coverage in order to obtain licensure for an early childhood education program. *See* Ark. Code Ann. § 20-78-227.

7. DEPARTMENT OF HUMAN SERVICES, DEVELOPMENTAL DISABILITIES SERVICES (Paula Stone)

a. SUBJECT: Repeal of Community and Employment Supports Waiver Medicaid Provider Manual and Community and Employment Supports Waiver Minimum Certification Standards and Amendments to DDS Policy 1091

DESCRIPTION: The proposed changes coincide with the implementation of the PASSE program. The amendments to Policy 1091 are to remove all references to the certification and monitoring of CES Waiver providers. This amendment is proposed in conjunction with the repeal of the CES Waiver Minimum Certification Standards and CES Waiver Provider Manual.

PUBLIC COMMENT: DHS held three public hearings, one in Little Rock on August 20, 2018, one in Monticello on September 4, 2018, and one in Hope on September 6, 2018. The public comment period ended on September 12, 2018. DHS received no comments.

DHS has sought approval from CMS, and formal approval is pending.

The proposed effective date of the rule changes is January 1, 2019.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: DHS is authorized to "make rules and regulations and take actions as are necessary or desirable to carry out the provisions of this chapter [Public Assistance] and that are not inconsistent therewith." Arkansas Code Annotated § 20-76-201(12). DHS may promulgate rules as necessary to conform to federal rules that affect its programs as necessary to receive any federal funds. *See* Ark. Code Ann. § 25-10-129(b). DHS may rely, by reference, on federal rules and regulations that apply to the Medicaid program. *See* Ark. Code Ann. § 20-77-107.

The Board of Developmental Disabilities Services may promulgate rules and regulations respecting the care, custody, training, and discipline of developmentally or intellectually disabled individuals in centers or individuals receiving services. *See* Ark. Code Ann. § 20-48-205. The Board of Developmental Disabilities Services is authorized to establish and promulgate regulations fixing standards for programs and activities for developmentally or intellectually disabled individuals. *See* Ark. Code Ann. § 20-48-209.

8, DEPARTMENT OF HUMAN SERVICES, MEDICAL SERVICES (Paula Stone)

a. SUBJECT: State Plan Amendment #2018-012: Include Managed Care Organizations in the State Supplemental Rebate Program

DESCRIPTION: Effective January 1, 2019, the state supplemental rebate agreements will apply to the drug benefit, both fee-for-service and those paid by contracted managed care organizations (MCO), under prescribed conditions of the State of Arkansas Supplemental Rebate Agreement. State supplemental rebate agreements will apply to beneficiaries receiving fee-for-service benefits under the Affordable Care Act that are assigned to MCOs. This change is to allow the State to collect supplemental rebates from manufacturers for encounter data for claims paid under the MCO's plans.

PUBLIC COMMENT: DHS held three public hearings, one in Little Rock on August 20, 2018, one in Monticello on September 4, 2018, and one in Hope on September 6, 2018. The public comment period ended on September 12, 2018. DHS received no comments.

DHS has sought approval from CMS, and formal approval is pending.

The proposed effective date of the rule is January 1, 2019.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: DHS is authorized to "make rules and regulations and take actions as are necessary or desirable to

carry out the provisions of this chapter [Public Assistance] and that are not inconsistent therewith." Arkansas Annotated § 20-76-201(12). DHS may promulgate rules as necessary to conform to federal rules that affect its programs as necessary to receive any federal funds. *See* Ark. Code Ann. § 25-10-129(b).

b. SUBJECT: Provider-Led Arkansas Shared Savings Entity (PASSE) 1-18 Program Medicaid Provider Manual

DESCRIPTION: This manual is being promulgated pursuant to Act 775 of 2017. It implements Phase II of the PASSE model, in which the PASSEs begin operating as Managed Care Organizations (MCOs) under CMS's regulations and assume full risk for providing all Home and Community Based Services (HCBS) under the 1915(c) Community and Employment Supports (CES) Waiver and all State Plan Medicaid Services, including HCBS services provided through the 1915(i) State Plan Amendment. The PASSE Manual incorporates requirements of the CES Waiver, the 1915(b) PASSE Waiver, and the 1915(i) State Plan Amendment. This model will allow for more flexibility in the provision of HCBS services to individuals with high behavioral health or developmental disabilities service needs. Under this model, the PASSE will be responsible for developing the Person Centered Service Plan (PCSP) and delivery of all needed services.

PUBLIC COMMENT: DHS held three public hearings, one in Little Rock on August 20, 2018, one in Monticello on September 4, 2018, and one in Hope on September 6, 2018. The public comment period ended on September 12, 2018. DHS received the following comments and provided its responses:

DHS Responses to Public Comments Regarding the PASSE Program

EMPOWER
Comment: "Appropriate level of care or coding" What does coding mean here?
Response: This references how a provider codes a service.

Comment: 9. "Inspections"- Please clarify what this means and if there will be a requirement of the PASSE to perform "Inspections."

Response: This is the current Medicaid definition of adverse action. There is a requirement that the PASSE conducts inspections of HCBS providers.

Comment: It is our understanding that an estimated 70,000-90,000 individuals receive a Tier 1 service today. How will this many individuals receive an IA in order to voluntarily enroll in the PASSE program beginning on 7/1/19. Please explain how the IA process will work for Tier 1 individuals.
Response: DHS does not anticipate that every individual who may have received limited behavioral health services will be referred and be screened as appropriate for an Independent Assessment.

Comment: Does an individual have to receive a Tier determination of Tier 1 to be eligible to voluntarily enroll? Does an individual receiving Tier 1 Behavioral Health or Intellectual or Developmental Disability services qualify to voluntarily enroll July 1 2019?
Response: Yes. DHS anticipates individuals who receive a Tier determination of Tier 1 (BH/DD) can voluntarily enroll on or after July 1, 2019.

Comment: Empower recommends that any one receiving a Tier 1 service be eligible to enroll in the PASSE program beginning 7/1/19.
Response: The requirement is that an individual who has received a tier determination of Tier 1 (BH/DD) may voluntarily enroll in the PASSE.
DHS does not anticipate that every individual who may have received limited behavioral health services will be referred and be screened as appropriate for an independent assessment.
The rate cells for these populations have not been developed by DHS actuaries at this point.

Comment: Medical Loss Ratio
Does the mega rule MLR expectations apply based on when the legislation was passed, PASSEs certified, etc.?
Response: The Federal Medicaid Managed Care mega rule with respect to Medical Loss Ratio (MLR) applies beginning January 1, 2019.

Comment: Open Enrollment Period
When is the open enrollment period?

Response: The first open enrollment period will be from March 1, 2019 to March 30, 2019. Subsequent open enrollment periods will be established by DHS no less frequently than annually.

Comment: PASSE Equity Partner
The definition should include an administrator of healthcare services.
Response: DHS agrees an administrator of healthcare services will be added to the definition of PASSE Equity Partner.

Comment: Risk-Based Comprehensive Global Payment
Defined as "Risk-based comprehensive global payment is a capitated payment that is made in monthly prorated payment to the PASSE for each assigned PASSE member. Only a licensed Risk-Based Provider Organization/ Provider-Led Arkansas Shared Savings Entity (PASSE) in good standing in the State of Arkansas is eligible to receive a global payment under the program. "
Please define in good standing.
Response: "Letter to Empower language"

Comment: What will be the process and timeframes to get these proposed services approved?
Response: "In lieu of services" will be sent to DHS for approval. Prior to utilizing "in lieu of services," they must be approved by DHS.

Comment: A. Excluded Services-Skilled Nursing Facility
Will the exception for the short term Skilled Nursing be added?
Response: Provider Agreement Language – short term SNF

Comment: Please define the word "Moratorium" as used above?
How often will the 53% be assessed? Monthly, Quarterly, Yearly?
During Phase 1, a state algorithm was established for attribution. What are the reasons that the DHS is transitioning to a proportional based assignment?
Response: Moratorium has the common language definition meaning a waiting period set by an authority.
53% will be assessed on a monthly basis.
During Phase I, DHS had access to FFS claims and had the ability to make the matches necessary for attribution. In Phase II, all members would be new to the system.
In addition, the OBHS changes allow additional providers which were not in place during Phase I attribution.

Comment: DHS reserves the right to cap assignment of additional members to the PASSE for any of the following reasons:

1. Consistently poor-quality performance;
2. Inadequate provider network capacity;
3. High number of member complaints about PASSE services or about access to care; and
4. Financial solvency concerns.

- As listed in C. [3.] above, please define "high number"

Response: The "high number" of complaints will be evaluated by DHS based on actual experience. Prior to taking action against a PASSE, DHS will provide a PASSE with notice.

Comment: A. The enrollee has access to services consistent with the access they previously had, and is permitted to retain their current provider for a period of time if that provider is not in the PASSE's network. Please define "period of time"?
Response: The question is raised in the context of transition plan. Period of time may vary by types of provider and should be described in an individual's PCSP.

Comment: Will ILPs currently employed with an OBHS Provider Type 26 be counted to meet adequacy standards?
Independently Licensed Clinicians (Provider Type 19, ILP)) only provides Tier 1 services. The PASSE program is for individuals who have been assigned a Tier 2 or Tier 3 due to their BH/IDD need. Empower is concerned that the providers who treat Tier 2 and Tier 3 members are not being included in network adequacy standards. It is critical that PASSEs have adequate networks of providers that treat the individuals that are being attributed to PASSEs. At a minimum, we request the addition of OBHS Provider Type 26 added to the network adequacy standards through 2019 until providers are credentialed/contracted as a HCBS provider.
There are also not enough ILPs in the state for any PASSE to meet network adequacy. The statement by DHS in section 226.000 also states: "Any provider that is not accepting new members or providing services to existing PASSE members cannot be counted towards meeting network adequacy." In the current system, it is rare for an ILP to treat a Tier 2 or Tier 3 member, so very few ILPs would count.
The ILP provider type 19 was previously the LMHP program which only treated children/adolescents. Therefore, the ILP provider type is not well developed.

The exclusion of OBHS providers from network adequacy does not hold PASSEs to the standards laid out in the manual of "A PASSE must maintain a network that is sufficient in numbers and types of providers to ensure that all needed services to attributed members will be adequately accessible without unreasonable delay and within the time and distance requirements set out in this policy."

What is DHS's rationale for not including the Provider Types 26 in the network adequacy standards that treat the Tier 2 and Tier 3 Behavioral Health members? Empower understands that Tier 2 and Tier 3 services are being removed from the OBHS (provider type 26) manual but if in fact provider type 26 will be grandfathered to provide HCBS services until 1/1/20, please accept their current provider type for network adequacy.

Will provider type 26 (OBHS) and provider types for IDD CES Waiver services such as 67, be grandfathered in during 2019 to provider HCBS services until such time as PASSEs credential HCBS prior to 1/1/20? If so, what HCBS services will these grandfathered providers during 2019 be able to provide, all services or a limited amount of services under the HCBS (1915i)? In addition, can provider type 26 be counted to meeting adequacy standards for Board Certified Psychiatrist as each provider type 26 must have a Psychiatrist?

Response: Yes, if the ILP is enrolled in the Medicaid program as a Provider Type 19, they will be counted to meet network adequacy. Provider Type 19s only provide Tier 1 services in Medicaid FFS. DHS believes that requiring Provider Type 26 providers within network adequacy would be too restrictive for the PASSEs as they build their networks which now may include new types of providers due to the adoption of the OBHS manual. They will be counted during calendar year 2019, but other provider types for behavioral health services will also.

DHS agrees with comment regarding the statement and the entire sentence "*Any provider that is not accepting new members or providing services to existing PASSE members…*" and it will be deleted from the PASSE manual.

Provider Type 26s will be counted during calendar year 2019, but other provider types for behavioral health services will also.

A provider type 26 cannot be used for network adequacy of a Board Certified Psychiatrist as they are required to be enrolled as a Medicaid provider.

Provider Type 67s will be counted for network adequacy during calendar year 2019.

Comment: Will the PASSEs not be responsible for credentialing non-independently licensed staff?
Can LMSWs, LAMFTs, LACs, LPE-Is continue to provide therapy services such as Individual Therapy for Medicaid only beneficiaries?
When will PASSEs be held to adequacy standards for Mobile Crisis Available 24/7 as that is currently not a reimbursable service and only provided in some areas of the state?
Will Mobile Crisis and the other new HCBS services (Therapeutic Host Home, etc.) not need to meet adequacy standards until 1/1/20?
Response: The PASSE will be responsible for credentialing providers and have options for how they will complete the credentialing process. Each PASSE must inform DHS of how they credential providers.
The PASSE has the ability to determine if they will allow these providers to provide services.
Access to care requirements will be monitored by DHS and is required to be reported by the PASSEs to DHS.

Comment: Does the DHS currently collect all information as listed in A. in order for the PASSEs to add 1-8 to the Provider Directory? Or will the specific information that DHS does not collect currently be waived in 2019.
The PASSE Provider Agreement has removed the requirement to add cultural competency training; can this be removed from the PASSE Manual?
The PASSE manual states that the PASSE has to attest to meeting network adequacy standards in the directory, when this will be required as there are graduated adequacy standards in the PASSE agreement, as well as an allowance for Variances.
Response: DHS will provide further guidance based upon CMS approval. DHS recognizes there is some flexibility regarding cultural competency training within the provider directory and will provide further guidance.
Attestation of meeting network adequacy is required monthly to DHS from the PASSE.

Comment: Will the DHS send each PASSE information about identified TPLs? If so, how often?
How will the PASSEs report TPL information to the DHS?
Response: This is contained on the enrollment file. Exact timing will be discussed during the operational/IT meetings between the PASSEs and DHS.

This will be discussed during the operational/IT meetings between the PASSEs and DHS.

Comment: What if Empower denies a Prior Authorization (PA) of services such as acute psychiatric admission? This appears to say we must notify the member 10 days before we deny a PA.
Response: DHS will clarify when the 10-day prior notice is required. The manual will be clarified.

Comment: DHS has sought waivers on some of these edits? Do the waivers that DHS has obtained apply to the PASSE?
Can PASSEs seek NCCI edit waivers?
Will PASSEs be given a list of current approved edits for all Medicaid services?
Response: No, the PASSEs cannot seek or utilize any NCCI edit waivers.

Comment: Will provider sanctions imposed by one PASSE be shared with the other PASSEs with which the provider is in network with?
Response: Yes, DHS expects that if a PASSE sanctions a provider that it will be reported to DHS and other PASSEs.

Comment: There are no criteria listed for how you will be able to attain these payments. Is there an attachment we should be referencing?
Response: DHS will be developing the quality incentive pool in consultation with the PASSEs. There is not an attachment or criteria to be referenced.

Comment: Empower requests that the ratios be removed and that PASSEs are allowed to risk stratify our members, and report on the Quality Metrics as defined by DHS. Assigning caseloads based on need allows the highest need members to receive the clinically necessary follow up to attain their best functioning. We acknowledge the need to provide high quality care coordination services to all members, but also see the need to individualize services provided.
Response: The care coordinator to client ratios as defined in the PASSE manual will not be removed.

ARKANSAS TOTAL CARE
Comment: The PASSE Manual states, "DHS will, on an annual basis, offer an open enrollment period for all current enrollees to

choose a different PASSE for coverage beginning January 1 of the following year." How does this work with open enrollment in 2019 being March 1 – March 31?
Response: There will be 2 open enrollment periods in 2019.

Comment: What are the current alternate formats available from Arkansas Medicaid?
Response: Information in alternative formats are made available per requests.

Comment: Can "skilled nursing facility services" be changed to "residential nursing home?"
Under medical hospitalization we often use a skilled nursing facility as a sub-acute setting to bridge from home or rehab when the member is too deconditioned to leave the hospital.
Response: This exclusion is specifically stated in Act 775 of 2017.

Comment: Is it possible to remove the approval requirement? In 2019 the PASSE is going to be at full risk. Requiring approval by DHS of all "In Lieu of Services" prior to service delivery will impact the PASSE's ability to assure timely and quality care is provided to the member.
Response: DHS agrees that prior approval of "flexible supports" and "in lieu of" services would be administratively burdensome and therefore will remove the approval requirement. DHS reserves the right to review the appropriateness of "flexible supports" and "in lieu of" services via retrospective review.

Comment: What is the formula for calculating the 53%? Is it based on county or region? Could it change based on the number of PASSE entities? Would it be more appropriate to address the methodology in the manual as opposed to specific percentages so that the formula could be changed if needed?
Response: The 53% is total of assigned members.

Comment: Sections 231.100, 231.200 and 231.300 cover the information more thoroughly.
Can 221.700 be removed?
Response: Section 221.700 is located in the state responsibility section of the provider manual, while the others are located in the rights and member protection section.

Comment: Currently, the PASSE does not receive an indicator of who the member is transitioning to in order for this to occur. Will

the PASSE receive this information in order to offer more continuity of care between the PASSEs and if so, how will it be received?
Response: The PASSE is responsible for checking the eligibility of their members which would indicate previous PASSE membership.

Comment: Ratios for access to ALL provider types are problematic. Given the limited population that the PASSE will serve this standard defaults to a minimum of one specialty provider per provider type per county. Can a county be covered for the ratio test if the provider is located in another county?
Is it possible to allow specialty providers to service a 60-mile radius and PCPs to service a 30-mile radius so that both may serve across county lines? Other service providers may also have a broader service area than just their own county and may also need to be reviewed for consistency.
Response: Yes, the ratios are not county specific except for Providers that are certified/licensed by county. For example: Provider Type 24, AN.
The radius can cross county lines

Comment: The PASSEs have already established applications for network participation, credentialing and contracting that are already in place and in use. Mandating use of a universal process in this document will likely create issues among the PASSE entities. Can this statement be removed from the manual? Perhaps submission of current forms being utilized for review and approval by DHS is more appropriate option that the PASSEs could consider? The outlined process does not recognize current propriety processes and already credentialed providers.
Response: We are clarifying the language to state "The PASSE must utilize a universal process for providers" … 226.000, Paragraph 4

Comment: Would DHS consider a threshold of 80% to 90% since CMS uses a 90% of their required standard as a threshold and still allows some waivers for special circumstances?
Response: DHS allows a network adequacy variance request as specified in Section 226.200.

Comment: What providers make up each specialty? Is there a taxonomy that can be used? Is it possible to narrow down the list of specialties?

Response: DHS has shared the specialties of Providers with each PASSE.

Comment: What area does the FQHC cover? Is it county or network?
Response: Each PASSE must have at least one FQHC in their network.

Comment: What providers fall into each provider specialty? Is there a taxonomy for each specialty and what is included? Where do we find it?
Response: DHS has shared the specialties of Providers with each PASSE.

Comment: How will a consistent standard will be applied?
Response: DHS & Contractors will apply the same standards to all PASSEs.

Comment: If membership within the county is less than the ratio for one member, will reporting that 1 provider is contracted be sufficient to meet this reporting requirement?
Response: Network Adequacy is measured on a statewide basis.

Comment: If the category is a service instead of a provider specialty, where the service may also be imbedded within a facility/group/organization such as an acute care hospital, should it be tracked and reported separately or included in the larger facility category?
Response: It should be tracked and reported separately.

Comment: Wouldn't it be difficult to reach this ratio in Arkansas counties that have only one Acute Inpatient Hospital? How would this ratio for Acute Inpatient Hospitals or Critical Care Services in the rural counties be met?
Response: Network Adequacy is measured on a statewide basis.

Comment: Can Emergency Rooms be used to meet this measure?
Response: Yes

Comment: What is the criteria for the waiver? Is it possible to have permanent waivers for known specialties/providers not available in the network? What's the timing to get a waiver? Is there an appeal process? Is there a threshold or cap on waiver requests?

Response: Variance requests are handled on a case by case basis. Any action by DHS can be appealed.

Comment: Does this statement refer to the time and distance by specialty, county and ratios by specialty and county, as well as the preceding table of Access to Service/Waiting times, collectively?
Response: Yes

Comment: Care Coordinator to Client Ratio does not seem to fit within the network adequacy section. This service is provided by PASSE employees and is not part of the actual network. Can this be removed from Network Adequacy Reporting 226.300 as it is reported in Reporting and Quality Metric Requirements 259.300?
Response: This will be removed from the section.

Comment: Why is this information included in this quarterly report? This is part of the information that is listed on our Find a Provider website tool.
Response: This is an annual report, so the EQRO can analyze their quality.

Comment: Why were Cultural/Linguistic Capabilities and ADA Accommodations left off of this list? Does DHS have an exception from CMS to not include this?
Response: It is number 7 and 8 on the list.

Comment: The waiver states:
"The State permits the PASSEs to market to potential enrollees. Specifically, each PASSE may create and run a website for information regarding its PASSE, provider network, and care coordination services. This website may be linked to the DHS PASSE webpage and is designed to provide information for beneficiaries when making the decision to change PASSEs. The PASSE may also produce written marketing materials, radio and television ads, and print ads to distribute to enrollees and potential enrollees. The written materials may be distributed by the DHS PASSE Member support team, PASSE care coordinators, and PASSE network providers. All marketing materials and marketing strategies must be approved by DHS."
This conflicts with the manual. Will one of the documents, either manual or waiver, be updated? If so, which one?
Response: The manual language will be used regarding marketing activities. The waiver will be released for public comment in the near future.

Comment: If the PASSE entities are at risk in 2019 why is the PASSE provider manual prescribing the detail processes for the PASSE entities to follow for recoveries/recoupments related to TPL? Recoupment processes are typically determined in the PASSE contracts with their providers and described in their standard provider manuals and billing practice guides. TPL and Subrogation may also involve vendors who have detailed expertise in identifying potential opportunities for other insurance unknown at the time of payment. Would it be better to consider requiring approval by DHS of any vendor, policies/procedures and correspondence utilized? Reporting is also available for these activities.
Requiring approval by DHS prior to taking action on these items would limit the effectiveness of these programs by the PASSE entities and their vendors.
Response: The purpose is that the PASSEs understand their obligations under Federal law and Regulation. The activities described in this section are the responsibility of the PASSEs and will be monitored by DHS.

Comment: Can the 10-day window be given more flexibility? It is a very tight turn around for reporting, sanctions or other administrative remedy if violated.
Response: No, it will remain 10 business days. It is unclear why the PASSE would be unable to report this to DHS in 10 business days, after it has been identified.

Comment: The requirement contradicts current practice in the private sector. Credentialing is a required process dictated by an executed contract. Currently, the PASSE typically negotiates the contract and executes it with a requirement that all providers' must be credentialed to render services under the contract before implementation of the contract. Once the credentialing has been completed, the provider will then be loaded as participating in the network and displayed in the provider directory.
Response: We agree that our language was unclear as to the proper sequencing of contracting and credentialing. We will make this clear that the description provided here is an acceptable process.

Comment: Can the member or the PASSE be referenced? What if the PASSE wants to dispute or appeal? Sections 160.000 and 190.000 are not found in the manual. Where can they be found?

Response: Sections 160.000 & 190.000 can be found in section 1 of all Medicaid manuals and can be found on the Medicaid website.

Comment: Does Medicaid have non-par providers? If so, does Arkansas Medicaid allow non-par providers to appeal on behalf of a member? If not, can it be indicated in this section?
Response: No

Comment: The definition of adverse action is extremely broad and includes items such as denial of a concurrent review. It is impossible to give 10 days' notice before a denial of a concurrent review. Would it be possible to better define the adverse actions that specifically need to have action taken?
Response: Adverse action is defined within existing Medicaid Manuals (Section 190.002). The PASSE manual utilizes the same definition to ensure consistency.

Comment: What are these policies and where can they be found? Will the PASSE be provided these policies?
Response: They are contained within the existing Section II of each Medicaid manual.

Comment: If the PASSE is at risk in 2019 why are the PASSEs being asked to detail the processes for recoveries/recoupments? Recoupment processes are typically determined in the proprietary PASSE contracts with their providers and described in their standard provider manuals and billing practice guides.
Response: The Office of Medicaid Inspector General (OMIG) and DHS wants to review these policies and procedures.

Comment: If the PASSE is at risk in 2019 why are the PASSEs being asked to detail the processes for recoveries/recoupments? Recoupment processes are typically determined in the proprietary PASSE contracts with their providers and described in their standard provider manuals and billing practice guides.
Response: The Office of Medicaid Inspector General (OMIG) and DHS wants to review these policies and procedures.

Comment: "The PASSE may deem the credential for providers who have already been approved and credentialed by another PASSE for up to 6 months pending completion of the full credential review. DHS may grant a variance for extending the

temporary period." This does not comply with national quality accreditation guidelines.
Response: The PASSE is allowed the opportunity to use the credentialing from another PASSE if they choose. It is not a requirement, only an allowance.

Comment: Why would the PASSE credential a non-contracted provider? Currently, it is not standard practice to credential a non-contracted provider. Contracting occurs as a stipulation for network participation. Normally, credentialing occurs prior to a service being rendered, not after a provider is seeing members and provided directory display.
Response: If an out of network provider is providing services to more than 50 members, DHS requires that the PASSE credential the provider.

Comment: Is the PASSE required to join the CVO work group and share in the expense if the PASSE has already established an application, credentialing and contracting process? Many of the providers that will make up the provider network have already been credentialed, therefore the expense has already occurred. Will the CVO workgroup meet all national quality accreditation standards?
Response: This is a requirement starting January 1, 2020. The accreditation of the CVO will be discussed during the credentialing work group.

Comment: How does this requirement co-exist with uses of the state medical board's CCVS program?
Response: The CCVS may continue to be utilized even within the CVO.

Comment: Can this be clarified to be HEDIS and CAHPS?
Response: These are CMS requirements set forth in the Act.

Comment: The "Metrics" column is using effective date as the measurement but "Target" and "Reporting to DHS" are using attribution date. Is it possible to make these consistent and use the same date across all three?
Response: This will be clarified; it is within 15 business days after effective date.

Comment: Metric-Care coordinators must follow up with members within seven (7) business days of visit to Emergency

Room or Urgent Care Clinic, or discharge from Hospital of In-Patient Psychiatric Unit/Facility. Target->50% of care coordinators will follow up with members within seven (7) business days of visit to Emergency Room, or discharge from Hospital or In-Patient Psychiatric Unit/Facility. Reporting to DHS (Frequency/Content)-Quarterly/Details of follow up with members within (7) business days of visit to Emergency Room, or discharge from Hospital or In-Patient Psychiatric Unit/Facility, including but not limited to action or treatment plan to prevent/avoid such visits in the future. Can urgent care be removed from this list? Urgent care is not considered emergent services. It is recommended to be used as an alternative to the ER when a member can't get in to see their PCP. Currently, notifications for urgent care visits are limited as the first notification we receive is when the claim is submitted and there is little to no opportunity to follow-up within 7 days.
Response: Urgent Care will be removed.

Comment: Regarding "the PASSE is responsible for the credentialing of home and community based service providers. All home and community based service providers must be nationally accredited."
Does this mean credentialing is required for all providers/services listed in section 283.000-284.002 or only those listed in section 248.300?
Which national accreditation will they be expected to meet? (Ex: there is no national accreditation for Meals on Wheels)
Is there going to be a grandfather period or time limit to obtain required accreditations for these providers? Our concern is smaller HCBS won't be able to afford to live up to this expectation and members will be affected.
Response: Credentialing of HCBS by the PASSE is required for an HCBS provider to be enrolled in Arkansas Medicaid.
National accreditation may be a best practice that the PASSE may wish to adopt, but it is not required to be credentialed as an HCBS provider.

Comment: Regarding "Crisis Intervention"
This makes more sense for the definition of Mobile Crisis Intervention 282.012. Can the PASSE be given more information/clarification on Crisis Intervention?
Response: Crisis intervention is currently contained within the OBHS manual and CES waiver and can be provided in a variety of settings within the normal course of treatment.

Mobile crisis intervention requires 24/7 availability of staff to respond to a member who is experiencing a crisis situation.

Comment: Regarding "Caregiver Respite"
Can the PASSE be given more information on Caregiver Respite? Are there units? Defined Hours/days? Are "planned" or "Emergency" are pooled?
Response: As you are working with members to develop the PCSP, a course of treatment would be created that would address these answers.

SUMMIT COMMUNITY CARE
Comment: Adverse Decision/Adverse Action – recommend definition include the right to appeal attribution and tier assignment.
Response: Every member has 90 days to switch their PASSE if they so choose. Members have the right to appeal their Tier assignment. Of the total 36,940 independent assessments for behavioral health needs, DHS has received 139 beneficiary appeals and 100 provider appeals for Tier assignment. 4 appeals went to a hearing, 2 of which the tier determination was upheld and 2 were reassessed.

Comment: Care Coordination—(a) The definition includes "assessing" and "reevaluating the patient for medically necessary care and service," which sounds like reassessment. Assessment and reassessment are not the job of the PASSE. (b) This does not match all the definitions in the draft 1915(b) and 1915(c) waivers and 1915(i) SPA. Are the others being changed to match? (c) Concepts from Act 775 such as assistance with social determinants do not appear to be included.
Response: In order to develop a PCSP for the member, the PASSE will need to complete a full assessment of the client, including face-to-face, review of client records and use other completed assessments, including the results of the independent assessment, and plans of care.
Care coordination is not a one-time activity. Assessment and reassessment will be continually performed by the care coordinator. Please reference PCSP development portions of the applicable waivers and SPA.

Comment: Case Management – What is the functional difference between "care coordination" and "case management"? Is there a need for two separate terms?

Response: PASSE Care Coordination is the equivalent of Waiver Case Management. The PASSE must follow the conflict-free case management rules.

Comment: Flexible Service – How does this differ from "in lieu of" services in 221.200?
Response: DHS recognizes the similarities and anticipate that the PASSEs will develop their own menus of flexible services for DHS approval.

Comment: Network Provider—Will PASSEs be required to get agreements with each provider to participate *specifically* in the Medicaid PASSE program? We believe Providers must indicate somehow that the provider is intending to participate in the PASSE program before they can be counted as part of the PASSE provider network.
Response: Yes, this is necessary in order to contract with individual providers or a group of providers, such as a physician group practice, for the services of a provider. In order to count towards network adequacy, contracts for the PASSE program will be reviewed. In order to bill for services and be paid, individual providers or provider groups will be entering into contracts with the PASSE.

Comment: PASSE Equity Partner – Equity partners include MCOs that do not deliver services. Proposed revising definition.
Response: Previously answered

Comment: Telemedicine— The definition of Telemedicine mixes the lawful professional use of telemedicine with coverage. The first paragraph is correct. But the excluded items A- D are excluded in Act 203 of 2017 only for purposes of mandated reimbursement. Summit asks that those activities be permitted as those are useful and effective methods of communication.
Response: Exclusion from reimbursement in Act 203 does not prevent the PASSE from using those methods of communication, but it is not considered a medical service delivered via telemedicine.

Comment: Virtual and Home Visit Provider Services—It is not clear whether this section is establishing different standards for telemedicine than those under state law and whether those standards are more or less stringent. Or is this an amalgamation of telemedicine and home and community-based services? This

should be clarified. Also, while this definition appears to include mobile devices, it is not clear that it includes non-mobile telephonic communications. Similarly, if a client with limited technology consents, they should be allowed to use non-secure technology.
Response: These include all types of medical services including speech, occupational, and physical therapy services. DHS recognizes the importance providing these services via telemedicine in order to expand access for rural, remote, and mobility impaired members who otherwise lack access.

Comment: Recommend edit in second paragraph of this section to refer to PASSE "program."
Section "A" refers to care coordination activities in Arkansas Code 20-77-2703(3), but the four activities listed are the "conflict-free" functions from the federal HCBS regs, not the activities in the Arkansas Act. Summit recommends aligning with the cited statute as indicated in next column.
Response: DHS disagrees with the proposed edit because the PASSE program includes the responsibility of DHS while the PASSE organization is specific to the entity. DHS recognizes this has been an issue of discussion for several months and DHS maintains our position as previously described.

Comment: Item A and B appear to run afoul of the requirement that the PASSEs comply with the "Any Willing Provider" Act (Patient Protection Act). Under Arkansas law, any provider that meets a PASSE's terms and conditions must be able to participate in that PASSE under AWP.
Response: PASSEs must comply with all applicable federal, state regulations including the "Any Willing Provider" Act as DHS has consistently indicated throughout the development of the PASSE program.

Comment: Last Paragraph— "In Lieu Of" Services:
The requirement for DHS approval could be administratively burdensome for everyone and deter use of this valuable option. As we read the federal managed care rule, the state could identify types of approved "in lieu of" services in the PASSE Agreements, but not require approval on a case-by-case basis by DHS. Also, it should be considered a medical expense if it replaces a medical expense.
Response: The "in lieu of" services would be considered a medical expense if it replaces a medical expense.

"In lieu of" – array of services that might be provided to multiple individuals, such as a stay in an IMD in accordance with federal managed care rules
Flexible supports – more person centered approach, such as pest extermination for an individual with asthma
DHS agrees that prior approval of "flexible supports" and "in lieu of" services would be administratively burdensome and therefore will remove the approval requirement. DHS reserves the right to review the appropriateness of "flexible supports" and "in lieu of" services via retrospective review.

Comment: What is the basis for the 53% cap? This takes away client choice. Will the cap remain regardless of how many PASSEs participate in the program?
Summit requests that the methodology/algorithm be included in more detail in the Provider Manual.
Proportional auto-assignment will reduce the incentive for PASSEs to provide better services and better value to attract beneficiaries. For some small providers in particular, random/proportional assignment that requires the provider to deal with four different care coordinators, four billing systems, four UR systems, etc. results in a significant cost to the provider. Summit believes assignment should be deliberate and align with PASSE provider networks in order to further the goals of the program.
Response: The 53% is only for auto-assignment. A member has the ability to switch to the PASSE of their choosing within 90 days of assignment.
DHS has indicated that we may adopt additional criteria for auto-assignment based upon quality in the future.
The number of PASSEs a provider wishes to join is up to them.

Comment: Are there limitations on the types of providers that can serve dually diagnosed individuals or the services they can receive? Any exclusion criteria?
What is the distinction now between the DD Tiers II and III? Specifically, what qualifies a member for Tier III? Edit recommended in 221.520(A)(2).
Response: There are no limitations on the types of providers that can serve dually diagnosed individuals as long as they are qualified to provide the service.
DD Tiers II and III are defined within the Independent Assessment manual.
The language in the PASSE manual will not be edited as it would represent a significant change in eligibility.

Comment: Exclusion of medical spenddown misses an opportunity to benefit some of the clients who need it the most. If spenddown members will be excluded, how will DHS ensure these members are taken care of?
Response: Individuals who qualify for Medicaid through spenddown eligibility will be served by FFS. DHS did not believe that the PASSEs should be held financially liable for cost incurred prior to Medicaid eligibility.

Comment: How will capitation rates be determined for voluntary enrollees (Tier I)? Will the rate include the same amount for care coordination as for Tier II and Tier III enrollees? Will care coordination be required or will it be at the PASSE's discretion? If required, at what ratio?
Will the state be requiring a PCP referral or setting any parameters (e.g., medical condition, total spend, etc.) around who can enter a PASSE as a voluntary enrollee?
Response: The rates for voluntary enrollees will be developed by DHS actuaries in the future.
DHS will be setting criteria for Tier 1 and will provide for public comment. The requirement is that an individual who has received a tier determination of Tier 1 (BH/DD) may voluntarily enroll in the PASSE.

Comment: A sanction resulting in for cause transition should not be just any sanction. It should be a serious sanction, and it should relate in some way to the reason for the transition.
How will Item D be determined in order to ensure proper notice and advocacy for the beneficiary?
Response: DHS agrees that a sanction for cause would be a serious violation as enumerated in the CFR.
DHS must follow all federal and state regulations regarding notification of adverse action.

Comment: Almost any service could potentially fall into category F. This should be more clearly defined or notification given to PASSEs of which provider types will be included in this criterion before the access measurement period begins.
Response: DHS will inform the PASSE of what will be measured.

Comment: What is the rationale for basing measurement of provider ratios on 120% of a PASSE enrollment? Once Phase II begins in 2019, enrollment will be largely static—no PASSE is

going to experience a sudden 20% increase in enrollment. This seems arbitrary and should be changed to 100%.
Are any of these standards based on national standards? Does it make sense that the ratio for primary care and OB/GYN is the same when only a small portion of the clients are likely to get pregnant and presumably about half will be male? Do the number of board-certified psychiatrists required to meet the ratio even exist within the state?
We agree that telemedicine should be a valuable resource in meeting the access standards, but it is not clear how the use of telemedicine impacts compliance with this standard or how DHS will determine adequate access for these vulnerable populations exists through telemedicine. This section states that a provider will not be counted for access purposes if the provider "is not accepting new members and is not providing services to existing PASSE members." These are two different situations. Did you mean "or" instead of "and"?
Is "Intermediate Care Facility" a reference to large or small ICFs? There are not ICFs in all Arkansas counties.
Need to clarify that "Supportive Living/Respite/Supplemental Support" is DD.
Is "Supported Employment" in this context DD or BH? A provider should not be considered interchangeable for access purposes.
What is "mobile crisis response" service for DD? DD has not typically had this service. ArkSTART exists, but it is not a mobile crisis unit in the BH sense and not what is described in the draft 1915(c) waiver on page 69.
"Early Intervention Day Treatment" is missing.
Response: Based upon review of practices in other States, DHS chose to use the 120% of the PASSEs actual enrollment to ensure sufficient member access to services.
The network adequacy standards were developed based upon information gathered from multiple sources.
For all provider types, there is the availability of a network adequacy variance.
DHS agrees with comment regarding the statement and the entire sentence "*Any provider that is not accepting new members or providing services to existing PASSE members…*" and it will be deleted from the PASSE manual.
The requirement is that the PASSE must have providers with the ability to provide services within an ICF for a member, regardless of where that member is located within the State.
The provider types that will be assessed for network adequacy purposes are defined within the manual.

The PASSE program allows the same provider to provide services to individuals with developmental disability service needs as well as behavioral health service needs.
Access to care requirements will be monitored by DHS and is required to be reported by the PASSEs to DHS. Mobile crisis response is defined within the PASSE manual.
EIDT providers were not included for network adequacy purposes as the majority of individuals on the CES waiver do not receive services at EIDT providers.

Comment: Can mobile crisis response be satisfied through the use of telemedicine and other technology?
What is the definition of "urgent care"? Depending on the definition, a 24-hour time frame may not be reasonable, particularly since the next category goes all the way to 21 days.
Why is DD not included except for crisis?
Response: No, mobile crisis response cannot be satisfied through the use of telemedicine.
Urgent care, in this section of the manual for network adequacy access standards, means medical services that are necessary within 24 hours to prevent further deterioration of the member's condition.
DD services are HCBS services that are identified on the individual's PCSP and typically are non-medical in nature and therefore will not be considered for network adequacy access standards.

Comment: Request that a set of guidelines be developed that PASSEs can use to determine when a standard does not have to be met. Summit recommends a request template that can be used to request a variance.
Response: Variance requests are handled on a case by case basis.

Comment: These two requirements (freedom to choose vs. PASSE making assignment) appear to be contradictory. Summit proposed the language as edited in next column.
Response: The PASSE is required to make assignment to a PCP in the case where a member has not made a choice of PCP.

Comment: While we understand the need for marketing materials to be accurate and appropriate, these provisions eliminate necessary business communications. For example, at a minimum, a provider should be able to tell an existing patient which PASSE(s) that provider is in-network for, and which one(s) it is an investor

in, both for disclosure purposes and as a demonstration of the provider's commitment, which may be relevant to a patient. Members need this basic information to make informed choices, just as members in commercial insurance plans are allowed to obtain that type of information from their providers.
Response: DHS will not make any changes to the marketing material requirements. The examples provided do not seem relevant to member choice. Individuals will have access to the PASSE's provider network at all times. Any materials to be used for marketing purposes must be submitted for review and approval by DHS.

Comment: 242.100 is not related to 242.000 Coordination and Continuity of Care and should be placed elsewhere for better understanding and flow.
Response: DHS agrees and will amend the manual to make this stylistic change.

Comment: Will Summit provide subrogation services for the it's program? Or is DHS keeping recovery in-house?
Response: Each PASSE is responsible for the recovery of any TPL payments.

Comment: Add educational requirement to (A).
Response: The PASSE is free to add these additional educational requirements of their care coordinators.

Comment: The language says providers do not have standing to appeal on a non-payment decision if provider has not furnished any service for which payment has been denied. This is contrary to the Medicaid Fairness Act, 20-77-1702, which permits providers to appeal denials of prior authorizations and other adverse actions for which no service has been provided if the action has a monetary consequence. While the provider can still appeal to the state under the MFA, it would seem best to make the appeals to the PASSE align with the MFA.
Where it says the PASSE must adhere to the Administrative Procedure Act, it also should say the PASSE must adhere to Sections 160.000 and 190.000 of the Medicaid Provider Manual on beneficiary and provider appeals and hearing rights.
Response: DHS intention is to ensure compliance with the Medicaid Fairness Act and will clarify any language which conflicts with those provisions.

By reference, those sections are also included as PASSE requirements.

Comment: We maintain that our rates are proprietary trade secrets. Mandating disclosure of upper and lower rates in a public hearing would reveal that information. Therefore, Summit proposes striking that language.
Response: DHS acknowledges that providers and payors are willing to accept different payment levels based upon a number of variables, including volume. DHS recognizes that there are competing interests and that the current manual is a reasonable balance of those competing interests and will not be amended.

Comment: Uses term HCBS Occupational Therapists category is missing.
Why are dental hygienists included if dentistry is excluded from the PASSE program?
Where is provider right to appeal adverse credentialing decisions?
Response: DHS agrees and will add occupational therapists to the credentialing requirement.
Credentialing of Dental Hygienists are covered through the Dental Managed Care contracts which is excluded from PASSE contracts and therefore, DHS will remove the reference of Dental Hygienists from the manual.
Each PASSE must have provider appeal rights. DHS also has appeal rights as specified in the Medicaid Provider Manual.

Comment: Item E references LTSS. Does that include the PASSE?
Is Item L applicable to the PASSE population?
Response: Yes, both of these items are applicable to the PASSE program.

Comment: Use of the word "may" indicates that the Quality Incentive Pool is discretionary. That is not what was discussed in the early development of the provider-led program and is contrary to the language in Act 775.
Response: DHS intends to fund a quality incentive pool and will work with interested parties to define the quality measures. DHS believes "may" is appropriate as it would not allow payments to a PASSE if the quality measures are not met.

Comment: In Item E, "any" sanction is too broad. Any sanction imposed should be proportionate to the particular failure to meet

the quality metric.
Two “E”s are used by mistake.
Response: Section 258.200 provides for a variety of sanctions based upon the severity of the deficiency. DHS believes these variations are appropriate based upon federal regulation. PASSEs have the authority to appeal any sanction.
This will be corrected.

Comment: How will responsibility for sanctioned behavior be apportioned between the PASSE and the involved provider?
Item L—Any sanction imposed should be proportionate to the failure to comply.
Response: Sanctions are assessed against the PASSE. Whatever action the PASSE takes against a provider is up to the PASSE. PASSEs have the authority to appeal any sanction.

Comment: Item B—The “directly or indirectly” language seems to make the PASSE responsible for all network providers, even if the provider acts contrary to directives from the PASSE. Again, this gets back to the question of apportioning responsibility between the PASSE and the provider for sanctions.
Response: The PASSE is responsible for the actions of its providers.

Comment: The prescriptive manner behind many of the service requirements limits the ability of the PASSE to determine the best and most appropriate manner of addressing beneficiary needs.
If it not specifically described as a BH or DD service, can it be provided to either population as needed? It is not clear in each case, which population the service applies to. In 282.006 it is confusing. It appears to be for both BH and DD, but the language for DD is more descriptive of Personal Care, not DD services. There is language in the 1915(c) DD waiver for this.
In 284.001, CES Supported Employment should not be an “all or nothing” description or it further deters providers from offering this underused service.
Item 284.002 Supportive Living does not include a reference to habilitation, which is the category under the waiver that these services fall.
Response: DHS believes that the PASSE has the ability to determine the best and most appropriate manner of addressing member needs identified through the development of the PCSP. Yes, the PASSE has sufficient flexibility to deliver services as identified in the member’s PCSP.

DHS disagrees with the characterization that Supported Employment has an "all or nothing" description and will appropriately encourage PASSEs and providers to expand the use of these services.
Supportive Living under Section 284.002 specifically references habilitation.

DDPA

Comment: Adverse Decision/Adverse Action – Please add the right to appeal attribution or tier assignment?
Response: Previously answered in response to Summit Community Care

Comment: Care Coordination—(a) The definition includes "assessing" and "reevaluating the patient for medically necessary care and service," which sounds like reassessment. Assessment and reassessment are not the job of the PASSE. (b) This does not match all the definitions in the draft 1915(b) and 1915(c) waivers and 1915(i) SPA. Are the others being changed to match? (c) Concepts from Act 775 such as assistance with social determinants do not appear to be included.
Response: Previously answered in response to Summit Community Care

Comment: Case Management – What is the functional difference between "care coordination" and "case management"? Is there a need for two separate terms?
Response: Previously answered in response to Summit Community Care

Comment: Flexible Service – How does this differ from "in lieu of" services in 221.200? (There is a grammatical mistake in this definition.)
Response: Previously answered in response to Summit Community Care

Comment: Independent Assessment – This wording sounds as though Tier I voluntary enrollees get to choose which PASSE to join rather than being auto-assigned under proportional attribution. Is that correct?
Response: Yes.

Comment: Network Provider—What does the language mean "under contract with a PASSE or its contractor/subcontractor"?

PASSEs should be required to get an agreement with each provider to participate specifically in the Medicaid PASSE program. To include them without their consent or knowledge does not give a true indication of access since there is no way to know if the provider is intending to participate in the program.
Response: Previously answered in response to Summit Community Care

Comment: Person-Centered Service Plan—It is not clear what constitutes the "total plan of care" or who is responsible for its development. This definition is generally confusing, and it is not clear what the difference is among the components. Clarification is required to indicate whether Care Coordinator is responsible for developing/writing the PCSP or coordinating its development with other parties.
Response: The PASSE is responsible for the development of the PCSP.

Comment: Will PMPM rates includes the cost for preparing the currently required care plans as well as the additional plans includes in the "total plan of care"?
Response: This is not a PASSE Manual question. Rate Setting is a separate process.

Comment: Telemedicine— The definition of Telemedicine mixes the professional use of telemedicine with coverage. The first paragraph is correct. But the excluded items A- D are excluded Act 203 of 2017 only for purposes of mandated reimbursement. It would be ill advised to exclude those activities from the definition itself as the PASSEs will make use of those methods of communication.
Response: Previously answered in response to Summit Community Care

Comment: Virtual and Home Visit Provider Services—It is not clear whether this section is establishing different standards for telemedicine than those under state law and whether those standards are more or less stringent. Or is this an amalgamation of telemedicine and home and community-based services? This should be clarified. Also, while this definition appears to include mobile devices, it is not clear that it includes non-mobile telephonic communications. Similarly, if a client with limited technology consents, they should be allowed to use non-secure technology.

Response: Previously answered in response to Summit Community Care

Comment: Section "A" refers to care coordination activities in Arkansas Code 20-77-2703(3), but the four activities listed are the "conflict-free" functions from the federal HCBS regs, not the activities in the Arkansas Act.
Response: Previously answered in response to Summit Community Care

Comment: Item A and B appear to run afoul of the requirement that the PASSEs comply with the "Any Willing Provider" Act (Patient Protection Act). Under Arkansas law, any provider that meets a PASSE's terms and conditions must be able to participate in that PASSE under AWP.
Response: Previously answered in response to Summit Community Care

Comment: The requirement for DHS approval could be administratively burdensome for everyone and deter use of this valuable option. As we read the federal managed care rule, the state could identify types of approved "in lieu of" services in the PASSE Agreements, but not require approval on a case-by-case basis by DHS.
What is the rationale for restricting "in lieu of" services to those that avoid institutionalization? That is more restrictive than the federal managed care rule, 42 CFR 438.3, and Arkansas Act 775 ("flexible benefits"). If it improves the client's health status or reduces costs without reducing care, it should be allowed even if it doesn't make the difference between institutionalization and staying in the community.
This section says "The benefit to the PASSE is that provision of an 'In Lieu of Service' should reduce medical expenditures for institutional care." Given that nursing facilities and HDCs are exempt from the PASSE, this does not seem to be true. In early discussions, the state intended to incentivize the PASSES to provide HCBS for more complex conditions in order to avoid a perverse incentive favoring institutionalization (otherwise, the PASSEs actually fare better financially by allowing someone to be placed in an institution).
Response: Previously answered in response to Summit Community Care

Comment: What is the basis for the 53% cap? This takes away client choice. Does it make sense to have the same cap no matter how many PASSEs are in the program? Does this same cap encompass Tier I voluntary enrollees too?
Response: Previously answered in response to Summit Community Care

Comment: The quality metrics that must be met should be specified and promulgated in the manual rather than just being left for DHS to define when the time comes.
Response: DHS expects that future Quality metrics will be promulgated.

Comment: Proportional auto-assignment will reduce the incentive for PASSEs to provide better services and better value to attract beneficiaries.
Response: Previously answered in response to Summit Community Care

Comment: What is "geographical competitive balance"? How will it be determined and monitored? If this is to be used, the criteria should be promulgated beforehand with adequate opportunity for public notice and comment.
Response: Section 221.500 does not reference geographical competitive balance.

Comment: Criteria for all of the reasons for DHS to cap assignment should be spelled out; without the criteria it could become extremely arbitrary.
Response: DHS may cap enrollment based on actual experience. Prior to taking action against a PASSE, DHS will provide a PASSE with notice.

Comment: Random/proportional assignment that requires the provider to deal with four different care coordinators, four billing systems, four UR systems, etc. results in a significant cost to the provider. If clients are to be assigned, the assignment should be deliberate and further the goals of the program rather than being simply proportional. A fundamental premise of the provider-led model was that DD and BH providers would help lead a PASSE in which their clients were members since that takes advantage of the frequent contact by the direct provider, the knowledge, history and close relationship between the provider and member, thereby enhancing the ability to keep the client healthy. Another premise of

the PASSE process is that the different PASSEs would be motivated to orchestrate their services in a manner that would encourage consumers to select their PASSE. Auto assignment basically destroys this incentive.
Response: Previously answered in response to Summit Community Care.

Comment: Exclusion of medical spenddown cases raises serious problems. By excluding spenddown clients from the benefits of care management in a PASSE, the state is missing an opportunity to benefit some of the clients who need it the most.
Response: Previously answered in response to Summit Community Care.

Comment: Are there limitations on the types of providers that can serve dually diagnosed individuals or the services they can receive? Any exclusion criteria?
Response: Previously answered in response to Summit Community Care.

Comment: The DD Tiers have been reworded. What is the distinction now between Tiers II and III – what make someone "intensive" enough to qualify for Tier III?
Response: Previously answered in response to Summit Community Care.

Comment: What is the reason for adding "and is eligible…" for each DD tier?
Response: Previously answered in response to Summit Community Care.

Comment: How will capitation rates be determined for voluntary enrollees (Tier I)? Will the rate include the same amount for care coordination as for Tier II and Tier III enrollees? Will care coordination be required or at the PASSE's discretion? If required, at what ratio?
Response: Previously answered in response to Summit Community Care.

Comment: Does DHS or its contractor have the necessary capacity to assess the large number of Tier 1 clients who are potentially voluntary enrollees?

Response: Yes, we believe Optum has the capacity to complete Independent Assessments on clients who are identified as possibly Tier I.

Comment: Will the state be requiring a PCP referral or setting any parameters (e.g., medical condition, total spend, etc.) around who can enter a PASSE as a voluntary enrollee?
Response: Previously answered in response to Summit Community Care.

Comment: A sanction in Item B that results in cause for transition should not be just any sanction. It should be a serious sanction, and it should relate in some way to the reason for the transition.
Response: Previously answered in response to Summit Community Care.

Comment: How will Item D be determined in order to ensure proper notice and advocacy for the beneficiary?
Response: The PASSE must identify how a member can transition to a different PASSE in their member handbook. In addition, the Beneficiary Support Center will provide information on member rights. The member will make the request to transition to a different PASSE 'for cause.'

Comment: When will we see the DHS "transition of care policy"?
Response: DHS and the PASSEs are developing the transition of care policy plans which must be approved by CMS prior to the implementation of Phase II.

Comment: Almost any service could potentially fall into category F. This should be more clearly defined or notification given to PASSEs of which provider types will be included in this criterion before the access measurement period begins.
Response: Previously answered in response to Summit Community Care.

Comment: What is the rationale for basing measurement of provider ratios on 120% of a PASSE enrollment? Once Phase II begins in 2019, enrollment will be largely static—no PASSE is going to experience a sudden 20% increase in enrollment. This seems arbitrary and should be changed to 100%.
Response: Previously answered in response to Summit Community Care.

Comment: The number of categories for which there are ratio and timeframe requirements seems excessive. This creates unnecessary administrative burden on the PASSE without resulting in any improvement in access to care.
Response: The PASSEs will be serving very vulnerable populations and these requirements have been developed to ensure access to services for members.

Comment: Are any of these standards based on national standards? Does it make sense that the ratio for primary care and OB/GYN is the same when only a small portion of the clients are likely to get pregnant and presumably about half will be male? Do the number of board-certified psychiatrists required to meet the ratio even exist within the state?
Response: Previously answered in response to Summit Community Care.

Comment: We agree that telemedicine should be a valuable resource in meeting the access standards, but it is not clear how the use of telemedicine impacts compliance with this standard or how DHS will determine adequate access for these vulnerable populations exists through telemedicine. This section states that a provider will not be counted for access purposes if the provider "is not accepting new members and is not providing services to existing PASSE members." These are two different situations. Did you mean "or" instead of "and"?
Response: Previously answered in response to Summit Community Care.

Comment: Is "Intermediate Care Facility" a reference to large or small ICFS? There are not ICFs in all Arkansas counties.
Response: Previously answered in response to Summit Community Care

Comment: Need to clarify that "Supportive Living/Respite/Supplemental Support" is DD.
Response: Previously answered in response to Summit Community Care.

Comment: Is "Supported Employment" in this context DD or BH? A provider should not be considered interchangeable for access purposes.
Response: Previously answered in response to Summit Community Care.

Comment: What is "mobile crisis response" service for DD? DD has not typically had this service. ArkSTART exists, but it is not a mobile crisis unit in the BH sense and not what is described in the draft 1915(c) waiver on page 69.
Response: Previously answered in response to Summit Community Care.

Comment: "Early Intervention Day Treatment" is missing.
Response: Previously answered in response to Summit Community Care.

Comment: Can mobile crisis response be satisfied through the use of telemedicine and other technology?
Response: Previously answered in response to Summit Community Care.

Comment: What is the definition of "urgent care"? Depending on the definition, a 24-hour time frame may not be reasonable, particularly since the next category goes all the way to 21 days.
Response: Previously answered in response to Summit Community Care.

Comment: Why is DD not included except for crisis?
Response: Previously answered in response to Summit Community Care.

Comment: Giving DHS sole discretion to grant waivers with no guidelines provided is vague and subjective and will require a costly waiver process. Either something less than 100% of the network adequacy standards should be required, or a set of guidelines developed that a PASSE can use to determine when a standard does not have to be met.
Response: DHS allows a network adequacy variance request as specified in Section 226.200. Variance requests will be handled on a case by case basis.
If the PASSE meets 100% of the network adequacy requirements, there is no need to seek a variance from DHS.

Comment: What mechanism will DHS use to ensure the stakeholder engagement?
Response: DHS has been provided for stakeholder engagement in a variety of methods over many months.

Comment: What training and qualifications will the "choice counselors" have and how will they help members choose a PASSE? Will they inform members if they are currently receiving services from a provider that does not have a relationship with the PASSE they are auto assigned to?
Response: DHS employees who have expertise in serving both DD and BH clients will staff the Beneficiary Support Center. They will have access to the provider directories that each PASSE is required to have and update on a monthly basis.

Comment: A PASSE should not be allowed to deny services based on moral or religious objections. If one provider will not provide a service, the PASSE should have other providers who will.
Response: If the PASSE has no religious or moral objection to providing coverage for a particular service, then there is no issue. This is a federal requirement that a Medicaid Managed Care Organization may not cover particular services based upon moral or religious objections.
In the case in which a PASSE does have a moral or religious objection for a particular service, then it is the responsibility of DHS to provide access to those services.

Comment: These two requirements (freedom to choose vs. PASSE making assignment) appear to be contradictory. Can a PASSE auto-assign to a PCP as long as the client has the opportunity to change within a certain time period? Will the capitation rate take this requirement into account, given that not all clients currently have a PCP, and financial premiums may be required to reach 100% PCP coverage?
Response: Previously answered in response to Summit Community Care.

Comment: While we understand the need for marketing materials to be accurate and appropriate, these provisions eliminate necessary business communications. For example, at a minimum, a provider should be able to tell an existing patient which PASSE(s) that provider is in-network for, and which one(s) it is an investor in, both for disclosure purposes and as a demonstration of the provider's commitment, which may be relevant to a patient. Members need this basic information to make informed choices, just as members in commercial insurance plans are allowed to obtain that type of information from their providers.

Response: Previously answered in response to Summit Community Care.

Comment: A timeframe should be specified within which DHS must approve or disapprove marketing materials submitted by the PASSE.
Response: DHS has reviewed a number of marketing materials and timeliness has not been an issue.

Comment: In the third paragraph, the last sentence could have unintended consequences. Clients will expect their providers to help them navigate the PASSE program and the benefits available through each PASSE without being confined only to materials provided by DHS. This should not be swept up as "marketing."
Response: This policy is in conformance with federal requirements. Restrictions on marketing are intended to protect members from undue pressure.

Comment: High school diploma or GED is missing.
Response: Previously answered in response to Summit Community Care.

Comment: 242.100 is not related to 242.000 and should be placed elsewhere for better understanding and flow.
Response: Previously answered in response to Summit Community Care.

Comment: There is no reference to provider grievance and appeal rights. Providers must have the right to file grievances as well as appeal to the state under the Medicaid Fairness Act.
Response: Previously answered in response to Summit Community Care.

Comment: This section does not address rights under the Medicaid Fairness Act, which applies to contractors including PASSEs.
Response: Previously answered in response to Summit Community Care.

Comment: The language says providers do not have standing to appeal on a member's behalf if provider has not furnished any service for which payment has been denied. This is contrary to the Medicaid Fairness Act, 20-77-1702, which permits providers to appeal denials of prior authorizations and other adverse actions for

which no service has been provided if the action has a monetary consequence. While the provider can still appeal to the state under the MFA, it would seem best to make the appeals to the PASSE align with the MFA.
Response: Previously answered in response to Summit Community Care.

Comment: Where it says the PASSE must adhere to the Administrative Procedure Act, it also should say the PASSE must adhere to Sections 160.000 and 190.000 of the Medicaid Provider Manual on beneficiary and provider appeals and hearing rights.
Response: Previously answered in response to Summit Community Care.

Comment: Claims payment in 30 days would be significantly less than what providers are used to under the current Medicaid fee-for-service system. This may create serious cash-flow problems
Response: This issue is between the provider and the PASSE.

Comment: Occupational Therapists category is missing.
Response: Previously answered in response to Summit Community Care.

Comment: Where is provider right to appeal adverse credentialing decisions?
Response: Previously answered in response to Summit Community Care.

Comment: What type of "accreditation" is referred to here for the PASSE?
Response: Each PASSE must inform DHS if they have been accredited by a private independent accrediting entity pursuant to Section 254.000 of the manual.

Comment: Item E references LTSS. Does that include the PASSE? Is Item L applicable to the PASSE population?
Response: Previously answered in response to Summit Community Care.

Comment: Use of the word "may" indicates that the Quality Incentive Pool is discretionary. That is not what was discussed in the early development of the provider-led program and is contrary to the language in Act 775.

Response: Previously answered in response to Summit Community Care.

Comment: Is this exemption requirement already applicable for any of the licensed PASSEs?
Response: If the PASSE informs DHS that they meet the exemption requirement, DHS will honor that upon verification.

Comment: In Item E, "any" sanction is too broad. Any sanction imposed should be proportionate to the particular failure to meet the quality metric.
Response: Previously answered in response to Summit Community Care.

Comment: Two "E"s are used by mistake.
Response: Previously answered in response to Summit Community Care.

Comment: How will responsibility for sanctioned behavior be apportioned between the PASSE and the involved provider?
Response: Previously answered in response to Summit Community Care.

Comment: Item L—Any sanction imposed should be proportionate to the failure to comply.
Response: Previously answered in response to Summit Community Care.

Comment: Item B—The "directly or indirectly" language seems to make the PASSE responsible for all network providers, even if the provider acts contrary to directives from the PASSE. Again, this gets back to the question of apportioning responsibility between the PASSE and the provider for sanctions.
Response: Previously answered in response to Summit Community Care.

Comment: Why is DHS specifying in such prescriptive manner the services that PASSEs must provide? The idea behind the provider-led model is to let the providers through the PASSE determine the best and most appropriate means for addressing beneficiary needs. Requiring the PASSEs to essentially duplicate the Medicaid fee-for-service model but paying the PASSE less money to do so is setting the provider-led program up for failure

Response: Previously answered in response to Summit Community Care.

Comment: If it not specifically described as a BH or DD service, can it be provided to either population as needed? It is not clear in each case, which population the service applies to. Again, why is the state mandating services in such specificity rather than allowing the provider-led model more flexibility? In 282.006 is confusing. It appears to be for both BH and DD, but the language for DD is more descriptive of Personal Care, not DD services. There is language in the 1915(c) DD waiver for this.
Response: Previously answered in response to Summit Community Care.

Comment: In 284.001, CES Supported Employment should not be an "all or nothing" description or it further deters providers from offering this underused service.
Response: Previously answered in response to Summit Community Care.

Comment: Item 284.002 Supportive Living does not include a reference to habilitation, which is the category under the waiver that these services fall.
Response: Previously answered in response to Summit Community Care.

Stephanie Hall
Comment: Section 221.200-A: School-based services provided by school employees are listed as Excluded Services. Does this mean that the schools cannot bill Medicaid for ST provided by an SLP employed by the school system? If this is the case, I agree with the proposed ruling. Schools receive federally directed funds for special education services and restricting the school's ability to double-bill for these services will certainly save Medicaid money.
Response: School-based services provided by school employees are excluded from being paid by the PASSE.
This manual only applies to services being reimbursed by the PASSE.

Comment: The PASSE cannot provide an incentive, monetary or otherwise, to Provider for withholding medically necessary services. With the exception of flexible services, all services provided to PASSE members must be medically necessary for each member. The PASSE must ensure that services are sufficient in

amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.
The PASSE may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of the enrollee. The PASSE may place appropriate limits on a service for utilization control, provided the services furnished can reasonably achieve their purpose.
I am happy to see this listed in the PASSE Requirements. I feel that abuse of providers could occur, as the PASSEs are financially motivated and incentivized to save money.
Response: Thank you for your comment.

Comment: DHS must arrange for Medicaid services to be provided without delay to any member of a PASSE of which the PASSE Provider Agreement is terminated and for any member who is disenrolled from a PASSE for any other reason than ineligibility for Medicaid.
Does this mean that when a beneficiary's Medicaid account is "turned off" during processing after re-applying, the beneficiary will be disenrolled from the PASSE temporarily? What will the re-enrollment process be like? I am concerned that the beneficiary will have to re-apply for Medicaid during routine re-application periods, and subsequently have to re-enroll with their PASSE, potentially losing months of coverage. Or, conversely, would the beneficiary be automatically re-enrolled into their PASSE once Medicaid has been reinstated?
Response: When a member is transitioned from one PASSE to another because the Provider Agreement is terminated with the original PASSE, there should be no break in Medicaid eligibility or their services described within the members PCSP as those would be carried over into the second PASSE.
In the second example, if an individual loses Medicaid eligibility but is subsequently reenrolled, they would go back into their most recent PASSE if the break in Medicaid eligibility is less than 180 days.

Comment: Section 242.100: If a third-party insurer other than Medicare requires the member to pay any copayment, coinsurance or deductible, the PASSE is responsible for making these payments for Medicaid covered services. This is in compliance with Arkansas Medicaid services. Thanks for including this.
Response: Thank you for your comment.

Comment: Section 248.300 Provider Credentialing and Re-Credentialing: SLPs and PTs are required to be credentialed. OT is not listed. Why?
Response: Previously answered in response to Summit Community Care.

Debbie Riggs
Comment: Concerns about equality in the attribution to PASSE from all that I have been seeing there seems to be 2 PASSE entities that have the majority of attributions. We have changes coming to eliminate the concerns of "conflict" in case management.
Response: In Phase II, a member will be assigned to a PASSE based upon proportional assignment. A member has the ability to switch to the PASSE of their choosing within 90 days of assignment. Any PASSE with more than 53% of the market share will be excluded from the attribution methodology. The 53% will be assessed on a monthly basis.

Amy Jamison-Casas
Comment: As a private clinic owner and provider, as well as the mother to an amazing young man with autism (Steven, age 25), I am submitting my current concerns. First, as a mother…then, as a clinician.
Prior to sharing my concerns, however, I will list some positive changes I think are being made at this time. Section 215.00: All materials provided by the PASSE must be available in English and Spanish. There is such a growing need for Spanish correspondence. Thank you for making this available. Section 221.200-A: School-based services provided by school employees are listed as Excluded Services. Does this mean that the schools cannot bill Medicaid for ST provided by an SLP employed by the school system? If this is the case, I agree with the proposed ruling. Schools receive federally directed funds for special education services, and restricting the school's ability to double-bill for these services. I have seen so many Medicaid Provider violations through the years with school therapies, and I believe this will save money for Medicaid, halt abuse of Medicaid funds by lazy therapists and greedy school districts, protect the amazing therapists who would rather spend their time working with the children versus additional paperwork required by Medicaid in addition to their already suffocating paperwork loads, and ultimately, ensure that the children receive the most appropriate therapies, which is the most important. Section 242.100: If a third-party insurer other than Medicare requires the member to pay any

copayment, coinsurance or deductible, the PASSE is responsible for making these payments for Medicaid covered services. This is in compliance with Arkansas Medicaid services. Thanks for including this. To be clear, the PASSES cannot take that out of clinician's reimbursement either, correct?
Now, to my lengthy concerns:
To be honest, as a private clinic owner and speech-language pathologist, I am EXTREMELY concerned about how I'm going to be able to make a living with the new changes, and I will address those at the end of this letter. HOWEVER, my primary concern at this time is the effect on the individuals who need speech/language therapy that will be disqualified from it given Medicaid's insistence on keeping an outdated and discriminatory means of rationing care/disqualifying children aged 10 and over from speech-language services. This absolutely archaic practice is known as cognitive referencing and it violates many of the assertions of practice promised in the PASSE and Medicaid manuals being proposed at this time (in the year 2018, mind you!). By going against current best practice, this rule invites clinicians to operate outside of their professional integrity by submitting to practices that have been outdated for years… and of most harm, discourages families of children with special needs (and the children themselves!) by halting the opportunity to continue growth in language areas with the support of trained clinicians.

To review: Currently, the Medicaid Provider Manual (of which the PASSES will be required to follow) is supporting cognitive referencing for children 10 years old and above. As of a child's 10th birthday, in order for the child to continue to receive language services, the child's I.Q. must be higher than their language standard scores. Essentially, cognitive referencing assumes the child cannot acquire more language (functional or otherwise) because the "IQ" says the child isn't smart enough to! While this was considered evidenced-based practice in the 1970's, it is not now and is flawed on so many levels!

First of all, let's just say that this WAS still "evidenced-based practice" (which, it is not! Neither is "bleeding" patients for infections, but I don't see Medicaid requiring physicians to do it in 2018!) On the contrary, it has been quite disproven. But, let's just use the existing assumption, shall we? How unfortunate is it when a child does not have access to an examiner that is qualified in that child's particular diagnosis or an examiner who has any interest in establishing rapport with that child or finding a test that that child

responds to? Some examiners are only willing to purchase just enough test kits to meet the Medicaid requirements for the bulk of the kids they see. Are you aware of that? Do you even understand what these I.Q. tests look like? Because here is an example of a typical stimulus item on a Medicaid accepted "non-verbal" IQ test.

Now, looking at this one isolated page from one of the most well-known "non-verbal" IQ tests on the Medicaid list, you are assuming that a) the child can point, b) the testing area is calm and quiet, and c) the examiner is able to establish trust and rapport with the child and can handle aversive behaviors that prevent some children from showing their intelligence in traditional settings and/or with novel examiners.

Please look at that test plate example in Appendix A again. What on EARTH does that stimulus item has to do with learning to ask for desired items/activities, comment on things seen in the environment, asking for help or a break from activities, learning how to tell if someone hurt them or if they have a body part that is aching? etc.? That is simply a spatial analytical reasoning task! And that is what the entire test is made up of! Are you, Medicaid, going to continue to tell parents that you no longer support their children learning to do these things once they turn 10 years old if they cannot answer ridiculous questions such as seen in Appendix A? A child's 10th birthday should be a happy occasion…not the moment a parent realizes therapy will now be allowed from generous clinicians only. Ones who are willing to get audited and have to pay back all the therapies since the child turns 10!

At age 10, my son was disqualified from therapies because his I.Q. was not above his language scores. I was devastated. He had been making progress with The Picture Exchange Communication System© and I wanted continued support of a Speech-Language Pathologist! Well, guess what? No one would see him because of this rule! Fortunately for my son, he had a mom who was studying to be a Speech-Language
Pathologist who kept working with him and recruiting friends and family and staff to work with him on functional communication skills. But, that is NOT the case for most children in our state! Ironically, at the bottom of every page of DHS paperwork is this:

- humanservices.arkansas.gov
- Protecting the vulnerable, fostering independence and promoting better health

Well? How is cutting a child off help at 10 years old from continuing language training “protecting the vulnerable” or “Fostering Independence”?

When we look at a child’s developmental skill level and knowledge in decontextualized situations, it is clear that standardized I.Q. testing for the child’s chronological age is inappropriate and ineffective methodology for determining specific deficits and strengths. Clinical observation skills and evidence of progress in treatment should be the determinant for continued treatment, not I.Q.! Occupational Therapists and Physical Therapists are not held to this same standard at all and what is a more basic need in this life than communication? Functional communication and language development goals are very measurable. Outcome can be easily documented with data, video, and family report in the community and when guided by a skilled speech-language pathologist, the results can be phenomenal! I have over two decades of proof in video (of my son and many other clients!) and I am certain that others do, as well!

I realize that perhaps this I.Q. issue may not seem relevant to the sections in the public comment areas. But, look! It is!

For instance, look at this section of the proposed PASSE manual:

Adverse Decision/Adverse Action
Any decision or action by the PASSE or DHS that adversely affects a Medicaid provider or beneficiary in regard to receipt of and payment for claims and services including but not limited to decisions or findings related to:
A. Appropriate level of care or coding,
B. Medical necessity,
F. Least restrictive setting,

How can denying therapy at age 10, even when progress is being made, NOT be adversely affecting the client? How is appropriate level of care being addressed when current best practices and research are being kicked to the curb? How is it not medically necessary to a child to not be taught how to label pain or abuse in some manner? These things take time!

Example: My son was finally able to tell a teacher his JUNIOR YEAR OF HIGH SCHOOL via his communication app on his iPad, “I hurt foot.” He had been breaking our hearts for days and

crying and having tantrums we couldn't figure out and after days of this, he said that to his teacher via his app "I hurt foot" …she took off his shoe and guess what! He had a blister that I had not seen! I had looked, but it was not super noticeable. What saved that blister from becoming worse and requiring antibiotics and doctor's visits or continued pain? COMMUNICATION!
Guess what? He learned that after the age of 10! And it saved the cost of a PCP visit and Rx! That was after 17 years of hard work, folks! And most of that since he was 10 UNFUNDED by Medicaid because of cognitive referencing. I can't help but wonder if he could have told me sooner if I'd had more help by getting those therapies funded! As a single mom, I could NOT pay out of pocket in those years! I will say, in his later teen years, I found a clinician who would see him and take a chance…but, it was because I worked with her and she was kind when I begged. She took a chance she'd have to pay back every single session if she got audited. How is that not a decision that adversely affects a Medicaid Provider?

Listen, I am in that same position constantly with the children I serve. How could I not be after what I've seen with my own child? How can I not take the chance I'll go broke treating those 10 and over whose families are working so hard for them? Especially when I KNOW how positive outcomes can be for these kids when given intensive and appropriate EVIDENCED-BASED intervention? Intervention?

Finally, how is denying the opportunity to learn language and functional communication skills preparing these children for a lifetime of least restrictive setting? No, dear sirs and madams… this archaic means of discriminating against children is quite the opposite. And if you want to look at it from a fiscal perspective, costing your system way more money on the other end when their poor parents die or poop out!

I see so many amazing young people whose conditions do truly make it difficult to obtain typical communication abilities. HOWEVER, it does NOT prevent them from learning functional communication skills and improve their functional vocabulary! On the contrary, these things improve their levels of independence, which ultimately reduces Medicaid's cost over the course of a lifetime! I can use my son as an example, freely and have parents who would be willing to share their children's similar successes at older ages should you be interested in speaking with them. But, let

me share just one example from last week with my own son with autism. Look at Appendix B. Last week, he was missing his little sister. She graduated from college last year and moved from Savannah, GA to Salt Lake City, Utah. We haven't visited her in Utah yet, so he doesn't have a tangible experience about her being in a different place. Well, look what he brought me with his ProLoQuo2Go Communication app on his iPad! I have NEVER taught him state icons! This was all him! At age 25! He is growing all the time! But, Medicaid, at age 10 years old, told me by cutting him off of therapies because of his I.Q. score, that he would never progress! If you don't think this is amazing, let me take this a little deeper. We are a family that eats at home most every night (Like I said, we are frugal). It is a RARE treat for us to go out to eat. Exception? When we go see his sister or other family on road trips. Are you following me here? Chances are, he wanted to go out to eat and perhaps didn't even really want to see his sister, but the only way he could figure out how to do so was to request to go see her the last place we ever got to eat out with her…GEORGIA! Now, if that's not high level reasoning that could not possibly be shown on some ridiculous I.Q. stimulus item as in Appendix A…I don't know what is! Can you imagine what he could be doing if he'd been able to receive services all those years?

Let's look at another section of the PASSE manual:
Person-Centered Service Plan (PCSP)
The total plan of care made in accordance with person centered service planning as described in 42 CFR 441.301(c)(1) that indicates the following:

A. Services necessary for the member;
B. Any specific needs the member has;
C. The member's strength and needs; and,
D. A crisis plan for the member.

I would think that EVERY human's necessary services should include how to communicate need better. I would think that specific needs of any client would be to be able to communicate, and the means to communicate how to do that could include the individual's STRENGTHS and needs, not just a deficit in an intellectual quotient that in no way represents those very strengths and needs. And as the mother of a young man who was attacked by a waiver care-giver in 2016 and the only thing that withheld the monster from having criminal charges brought against him was my son's lack of ability to describe exactly what had transpired… I would say, communication is absolutely proactively planning

against having to make a crisis plan for the member. Please note: This is the first I have spoken about an incident that broke my entire family's heart. I'm shaking as I type this, as I will never stop aching to think someone could try to hurt my baby (and then went unpunished because my son couldn't follow through with testimony). BUT, I am only speaking of this now in hopes to protect children in the future who are being denied the opportunity to develop functional communication skills that could protect them! This is VERY difficult for me to write about.

MORE PASSE MANUAL AREAS THAT SUPPORT THIS:
Quality Improvement
Activities that improve healthcare quality as defined in 42 CFR § 438.8. These activities must be designed to:
A. Improve health quality;
B. Meet specified quality performance measures;
C. Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and or producing verifiable results and achievements;
D. Be directed toward individual members incurred for the benefit of specified segments of members or provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-members; and
E. Be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations.
C. Integrated care services that supports the beneficiary in the least restrictive setting and assists member's full access to the benefits of supportive services and community living to prioritize the member's choice of living in their own home or choosing an Alternative HCBS Setting rather than residing in an institution.
I feel like I'm being redundant here, but should we talk about the idea that the PASSES will be grounded in evidenced based medicine, widely accepted best clinical practice, or criteria issues by recognized professional medical associations, accreditation bodies?
A. Be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations.
Well, here you go. I am concerned that I am being asked by Medicaid to operate outside of The Code of Ethics as put forth in

The Ethics Session of the American Speech/Language/Hearing Association (ASHA). ASHA is our national accreditation agency that Arkansas Medicaid requires to reimburse SLPs in the state and is considered the utmost authority regarding current evidenced-based practice for our discipline. So, not only does ASHA not recognize IQ scores as a determinant of whether a child will benefit from Speech/Language services and supports, (for the record, neither does The Department of Education) …but, as speech-language pathologist who is very proud of her chosen field and who strives to operate within the scope of her credential's CODE OF ETHICS, I feel Arkansas Medicaid is trying to force me to operate outside of my own personal integrity and turn clients of a certain age away or see them for free (which I do! Lots!!) I feel that Medicaid does not support me providing care based on current evidenced-based practices. Note, this stance was put in force in 2003…that is FIFTEEN YEARS AGO! The same time my own beautiful child was first denied services. How many more children were unfairly denied treatment during that time… and where are they now?

In addition to asking the speech-language pathologists to adhere to this rule, Medicaid is thusly holding the RN, SLP, and MD on the auditing teams to the same standard… jeopardizing each of their licensures, as well, should a lawsuit commence. This is haphazard care of your providers and again, in direct violation of the standards you are proposing.

Again, here in the proposals, it sounds like discrimination will not be allowed in the PASSES. If this is true, how can this antiquated cognitive referencing method not be discrimination or arbitrary denials of services? Is it not, in fact, basing a decision solely on a diagnosis of intellectual disability (formerly labeled mental retardation?)

B. 221.200 Covered Services

C. The PASSE may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of the enrollee. The PASSE may place appropriate limits on a service for utilization control, provided the services furnished can reasonably achieve their purpose.

D. The PASSE is responsible for the provision of services (except as excluded below) as described in each specific programmatic Medicaid Manual located at https://medicaid.mmis.arkansas.gov/Provider/Docs/Docs.aspx. All

services described in Section II of the manuals must be made accessible to PASSE members if medically necessary.

And will DHS not withhold patient outcomes, quality measures, and implementation of Person-Centered Services by insuring that children age 10 and over have access to this much-needed service?

259.100 DHS Review of Outcomes 1-1-19
E. Pursuant to Act 775 of the 2017 Arkansas General Session, DHS will utilize data submitted from the PASSE to measure the performance of the following:
F. A. Delivery of services;
G. B. Patient outcomes;
H. C. Efficiencies achieved; and
I. D. Quality measures, which include:
J. 1. Reduction in unnecessary hospital emergency department utilization;
K. 2. Adherence to prescribed medication regimens;
L. 3. Reduction in avoidable hospitalizations for ambulatory-sensitive conditions; and
M. 4. Reduction in hospital readmissions.
N. E. Implementation of Person-Centered Service Plan.

You have now heard my concerns as a mother and provider of children with delayed language development who truly believes in her life's work with speech and language impairments.
Now, I will attend to the lesser of my concerns, albeit important ones.
As a clinician who is a small, private clinic owner and dual breadwinner for my family, I have personally opted to keep my clinic small and simple, so that I can focus on my patients and their needs without generating costly overhead. My personal family lives simply and frugally and even the way it is right now (I bill on Fridays to Medicaid, call in on Saturdays to see what my next Friday's paycheck will be) and repeat that weekly. That is uncertainty enough, right? With insurance companies, I never know when or what I will get paid. Sometimes, insurance companies pay less than minimum wage! And I just have to sit and wait, as they do not have a timely paying system like Medicaid's current one. From everything I see in writing in this PASSE manual, as well as the individual PASSE's information that is currently available to us, it appears we will not have any predictable pay pattern and each PASSE will be different in how they execute this. How are clinics supposed to survive this? From

what I read below, the PASSES have 30 days to reimburse. Is that correct? When I was reading the intro packet to one of the PASSES, it said 45 days! How do you think ANY clinic, large or small, can afford this? AND, going back to any decision or action by the PASSE or DHS that adversely affects a Medicaid provider how do DHS and the PASSES justify this lack of commitment to keeping our paydays consistent and reliable? We accept in this field, that if a patient doesn't show up or is late or we/they cancel…we don't get paid. But, I do not believe not knowing exactly WHEN we're getting paid each week or month is acceptable at all! Even employees in fast food chains know when they are getting paid, why do licensed professionals with Master's and Doctorate degrees and hundreds of thousands of dollars in student loan debt not have that right? IN FACT, I imagine that the very decision makers who developed this have a regular pay check to count on for THEIR families. Am I right?

This lack of commitment to timely and predictable reimbursement rates to providers is in direct defiance of the commitment to not adversely affect Medicaid providers. We already know we are each getting pay reductions (of course, we don't know how much, because no PASSE is being required to tell us yet! And it is September and this goes into effect January 1st! Sorry kids, it's poetry again for you for Christmas this year, to be certain we have groceries in January!). This is such absolute nonsense. Providers can't even make a clinic or personal budget for 4 months from now! How is that promoting fiscal responsibility? Here is what I believe you will see as a result of this lack of concern for Medicaid Providers:

- More clinics refusing to see Tier 2 and Tier 3 individuals…the very ones who need care the most
- Bankrupted clinics and providers
- Increased Fraudulent Practices as clinics panic about the situation and scramble to figure out how to pay their staff and keep the doors open
- Layoffs of providers, forcing them to change career paths, relocate, etc. worsening waiting lists and increasing need
- Decreased services to PASSE members, in general
- More dependence on the system, long term, from the clients who lost services because of this
- Perhaps even, death, for the fragile children who will sit on waiting lists

Claims Payment Process

A claims payment process involves all the business and operational processes, claims management information systems, and banking processes that are necessary to receive, validate, adjudicate, audit, and reimburse providers for services provided to eligible beneficiary. These business and operational activities, processes, and systems are performed and managed by the PASSE organization to meet the claims payment standards of the State.

211.200 Standard Contract Requirements 1-1-19

The Centers for Medicare & Medicaid Services (CMS) must review and approve the PASSE Provider agreement. The proposed final PASSE Provider Agreement must be submitted in the form and manner established by CMS. The proposed final PASSE Provider Agreement must be submitted to CMS for review no later than 90 days prior to the effective date of the contract.

The PASSE Provider Agreement must comply with 42 CFR § 438.3. The PASSE Provider Agreement includes:

A. Specific terms and conditions,
B. Capitation rate sheet;
C. Termination provision;
D. Notices and reporting provisions;
E. Performance period;
F. Dispute resolution;
G. Indemnity provisions; and,
H. And any other relevant information regarding the agreement between DHS and the PASSE.

221.300 Payment 1-1-19

The global capitation payment made to a PASSE covers the costs of services, administration, and care coordination of members assigned to the PASSE in accordance with 42 CFR § 438.2. The global payment will be actuarially sound and made to each PASSE on a Per Member Per Month (PMPM) basis. The global capitation payment amount is determined on an annual basis and includes a variety of factors including the results of the Independent Assessment and cost trends.

245.400 Assurance of Payment Methodology Requirements by the Arkansas Insurance Department 1-1-19

The PASSE must provide DHS an assurance of compliance with payment methodology requirements by the Arkansas Insurance Department.

247.300 Request for DHS Hearing for Anti-Competitive Practices 1-1-19

In general, payment to providers is based on good faith negotiation between the PASSE and providers reflecting rates and quality. If a PASSE or a provider believes that the other party is not negotiating

in good faith and is engaged in anti-competitive practices, either party may request DHS to convene a hearing to present evidence to support its claim. Such evidence must include upper and lower payment amounts paid for the same services, except for value-based payments, to other providers. The hearing will be public. Such a hearing is not mediation. There is no obligation on the part of DHS to make a determination of wrong doing. A PASSE must disclose the use of value based payments to the provider type at issue, but shall not be required to disclose the methodology for making value based payments.

248.220 Claims Payment and Claims Processing 1-1-19

The PASSE shall operate and maintain claims operational processes and systems that ensure the verification, processing, accurate and timely adjudication and payment of claims. This includes appropriate auditing of claims for NCCI edits. The claim process and systems shall result in timely payment of provider claims for eligible PASSE members. The PASSE shall have a process for resolution of provider claim disputes and member grievance and appeals for denial of claims payment. [42 CFR § 438.242(a)].

A. The PASSE must utilize nationally recognized methodologies to correctly pay claims including but not limited to:

1. Medicaid National Correct Coding Initiative (NCCI) for Professional, ASC and Outpatient services,
2. Multiple Procedure/Surgical Reductions, and
3. Global Day E & M Bundling standards.

B. The claims payment management must be able to monitor and access the claims system and apply appropriate claims edits. Claims management must have oversight of the claims process and system handling of:

1. Timeliness standards
2. Adherence to DHS payment policies.
3. Provider rate schedules changes

The PASSE shall ensure that for each form type (Professional/Institutional), that 95% of all clean claims are adjudicated within 30 days of receipt of the clean claim and 99% are adjudicated within 60 days of receipt of the clean claim.

The provider shall have 90 days from the date they become aware that payment will not be made to submit a new claim to the PASSE which includes the documentation from the primary insurer that payment will not be made. Documentation includes but is not limited to any of the following items establishing that the primary insurer has or would deny payment based on timely filing limits or lack of prior authorization.

So, not only will providers be having their reimbursement rates decreased by the PASSES taking what they deem fit out of the rates we have been accustomed to and have planned our budgets around… NOW, providers will also have the following issues to face that take away from attention to our clients:

- There will now be multiple billing systems to attend to weekly. Medicaid, each separate private insurance, and then the PASSES. For me, a single provider who does all my own billing, that is 8 separate billing systems I will be attending to weekly so far, while I attempt to still see my full caseload of clients. My one on one time with them does not count any time spent writing evaluations, planning for their sessions, sending for their prescriptions, visiting on the phone with their parents when they need me, advocating for them in the schools and community, etc. This excessive paperwork and new billing load… long term will only create apathetic providers, much like the school districts caseloads and work requirements have been doing to providers for years! This only hurts our clients!
- Also, we will now have quarterly audits, not just from AFMC, but from each PASSE. That is increased paperwork and reduced attention to clients, as well.
- Then, I'm assuming this will mean waiting on even more 1099's each January at tax time, yes?
- Does DHS just WANT people to stop becoming physicians, pharmacists, therapists, etc? Will ALL of Arkansas become like the rural delta where there aren't enough providers to serve the people and then DHS can say, "Oh well! Can't help it! No one wants to work here!" There's your cost savings right there, right?
- And finally, how are the kickbacks to Providers/PASSE Equity Owners NOT illegal and a conflict of interest? How will this not result in PCP refusal to refer for needed services? It reminds of the early 90's HMOs and I feel like Arkansas has taken a giant leap backwards with this. I see some wording where DHS is trying to cover themselves when the PASSES start punishing physicians for referring when needed, but I don't believe it's enough and I believe this whole situation where providers' "Value Based Payments" are allowed will do nothing short of promote unethical denial of needed services. This is not acceptable.

PASSE Equity Partners

An organization or individual that is a member of or has an ownership interest in a PASSE and delivers healthcare services to beneficiaries attributed to a PASSE.
Value-based Payments
Payments made by a PASSE to its providers to promote efficiency and effectiveness of services, improve quality of care, improve patient experience and access to care, and promote most appropriate utilization in the most appropriate setting. Such payments may be made as part of a PASSE's Quality Assessment and Performance Improvement (QAPI) strategy.

221.200 Covered Services
The PASSE cannot provide an incentive, monetary or otherwise, to Provider for withholding medically necessary services. With the exception of flexible services, all services provided to PASSE members must be medically necessary for each member. The PASSE must ensure that services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.
The PASSE may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of the enrollee. The PASSE may place appropriate limits on a service for utilization control, provided the services furnished can reasonably achieve their purpose.
The PASSE is responsible for the provision of services (except as excluded below) as described in each specific programmatic Medicaid Manual located at https://medicaid.mmis.arkansas.gov/Provider/Docs/Docs.aspx. All services described in Section II of the manuals must be made accessible to PASSE members if medically necessary.
245.100 Value-Based Payments 1-1-19
Payments made by a PASSE to its providers to promote efficiency and effectiveness of services, improve quality of care, and promote most appropriate utilization in the most appropriate setting. Such payments may be made as part of a PASSE's Quality Assessment and Performance Improvement (QAPI) strategy.
Provider incentives based on value are allowed and encouraged. Payments based on volume to increase inappropriate utilization (including denial of services) will not be permitted.
The PASSE must disclose any value-based payment arrangement with AID.
Response: Qualifications for therapy are not outlined in the documents currently running through public comment. The

established medically necessary criteria for any needed therapy paid by Medicaid is available in the therapy manuals. Additionally, a workgroup of private therapist assists DHS with needed amendments. We do appreciate your comment and will bring it up with the workgroup.

Thomas Nichols

Comment:

1. For the benefit of the beneficiaries & providers who read the rule similarly, can you please explain how the language does not represent a gap for individuals who might have mild behavioral health needs, but require developmental disabilities waiver services?
2. Would the same issue be present for an individual who requires Tier II or Tier III behavioral health services, but who is only eligible for Tier DD Services?
3. What is the timeline for committee consideration?
4. Is this a precursor of a rule that DHS plans to expand?
5. If so, what will be done for dually diagnosed individuals between January 01, 2019 and when the rule regarding the committee is implemented?

Response: Individuals that are currently receiving DD waiver services have been mandatorily attributed to a PASSE. Once assigned to a PASSE, the PASSE will be responsible for all medical care. Individuals with a dual diagnosis have already been enrolled into a PASSE and therefore there will not be a gap in services. These timelines and processes are currently being established by DHS.

Sherri Norwood

Comment: I am writing to comment on the Proposed PASSE-1-18 Provider Manual Update. I am the parent of a ten-year-old child with spina bifida. She currently receives services under DDS Waiver.

Overall, I'm excited about the flexibility the PASSE system hopes to provide and think the care coordination will be helpful.

One thing I am concerned about in this manual is potential conflict of interest for providers who are equity owners in a PASSE. Section 222.000 mentions conflict of interest, but it doesn't address this particular issue. I think that equity owner providers in a PASSE should be mandated to join the all the other PASSEs as a network provider. I've heard about people being told that they must become a member of their particular PASSE or they would no longer receive services from the equity owner provider. This is

wrong and a conflict of interest. PASSEs should not require people to become members of their PASSE because the equity owners won't join another PASSE. This is unfair.
Thank you for your hard work on this. I am optimistic.
Response: The number of PASSEs a provider wishes to join is up to them. Additionally, every member has 90 days to switch their PASSE if they so choose.

Charles and Brenda Jamison
Comment: We are grandparents of a 25-year-old severe-profound beautiful young man with autism.
He was denied speech and language therapy at age 10 because his IQ was lower than his speech-language standard scores.
We worked with our daughter, family members, and friends to try to fill in the gaps in his therapy until he was 14 when his mother found someone who dared to help him. We see him advancing in speech and he has a clearer understanding of the world around him. Looking back, we realize that those years are lost forever, and we hold Medicaid to blame.
The decisions made, at this time, will not help our grandson, but it will affect many people in our state.
Response: Qualifications for therapy are not outlined in the documents currently running through public comment. The established medically necessary criteria for any needed therapy paid by Medicaid is available in the therapy manuals. Additionally, a workgroup of private therapist assists DHS with needed amendments. We do appreciate your comment and will bring it up with the workgroup.

Dawn Nichols
Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one our providers.
Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Sarah Jennings
Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating

provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.
Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Carlos Casas
Comment: Hello there,
I'm the step father of a wonderful young man with Autism who was denied for services when he was 10 years of age because of his IQ, I believe that our country, as well with the senate and legislators need to care more for the citizens without a voice, I strongly encourage MEDICAID to re think that IQs shouldn't be more important than language scores. Hope this get to be heard. Thank you and have a blessed day!
Response: Qualifications for therapy are not outlined in the documents currently running through public comment. The established medically necessary criteria for any needed therapy paid by Medicaid is available in the therapy manuals. Additionally, a workgroup of private therapist assists DHS with needed amendments. We do appreciate your comment and will bring it up with the workgroup.

Jennifer McWhorter
Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.
Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Lacey Aimee-Lee Burris
Comment: I am a sibling of an adult with a nonverbal autism. My older brother, who does not communicate through spoken words like most of the general public, has benefitted greatly from the language services he has received in the past. Through speech and occupational therapies, my brother has found new ways of letting others know of his wants and needs, as any individual has a right to. He is now able to find ways to communicate as we all do - like placing an order at a restaurant, tell his family what movie he wants to watch, and ask for help if something is wrong. He has not always had access to these beneficial services, however. When he

turned ten almost sixteen years ago, he was denied language therapies because his IQ could not be proven to be higher than his language scores. Let me reiterate on that: his IQ could not be PROVEN to be higher. With scientific information regarding intelligence and behavior always changing and expanding, how are we to know if it is the child's IQ that isn't high enough or if it is that our testing of that child's IQ isn't adequate enough? Without the language therapy that my brother [eventually] received, he would not be able to ask for the essentials such as food, water, or the location of the bathroom. Just because he was assigned an ambiguous number that determined his intelligence, he was almost completely denied the human need for communication. Before you decide that this policy should remain in effect, imagine living in a life where you were not given the gift of words. Everything you can do right now - making a phone call to your spouse, ordering chocolate ice cream instead of strawberry, crying for help if you are in pain or injured - would not be possible without some help from a speech language pathologists and other speech therapists. Thank you for your time.
Response: Qualifications for therapy are not outlined in the documents currently running through public comment. The established medically necessary criteria for any needed therapy paid by Medicaid is available in the therapy manuals. Additionally, a workgroup of private therapist assists DHS with needed amendments. We do appreciate your comment and will bring it up with the workgroup.

Cristina Mendez
Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.
Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Stacy Levering
Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.

Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Suzette Manen
Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.
Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Ashley Knowlton
Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers
Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Jessica Hayes
Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our provider.
Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Diane Fowler
Comment: 3 sons that have Medicaid waiver and in a PASSE. It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.
Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Kluane Billings
Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.
Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Kim Warren
Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.
Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Kimberly Bruyere
Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers. Please do not limit more of our choices.
Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Nurse Betsey
Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.
Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Stacey Torell

Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.

Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Krista Price

Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.

Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Caroline Dockery

Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.

Thank you for your attention to this matter.

Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Megge Woolbright

Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.

Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Regan Schooler

Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE

groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers
Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Lacy Biram
Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.
Our special needs children rely on us to be their voice!!! Please help!
Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Lisa Michelson-Wilburn
Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.
Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Chelsey Bingham
Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.
Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary

Yolanda Whitmore
Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating

provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.
Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Lindsey Sabatini
Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.
Thank you
Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Abigail Bell
Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.
Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Shannon McIvor
Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups, then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.
Thank-you for giving this consideration!
Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Teresa Pratt
Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.

Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Kelley Grandy
Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.
Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Jacqueline Ernst
Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.
Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Kimberly Cook
Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to their PASSE only if they ate one of our providers.
I'm the mother of a special needs child that requires total care.
Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Megan Phillips
Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.
Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Susan Roberts
Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.
Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Nicole Ramirez
Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.
Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Larry and Kendra Pliler
Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.
Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Shella Beccard
Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers
Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Loretta Cochran
Comment: From: Proposed PASSE-1-18 Provider Manual Update

PASSE Equity Partners that are also Providers must be held to a high standard. Medicaid block grant funds have been given to behavioral health providers for decades and any entity, but especially direct and indirect equity partners, MUST be required to participate in ALL of the PASSE organizations. Those Block Grant dollars were given to organizations to provide services to our most vulnerable groups. It is offensive to learn that now some providers are threating clients with denial of services if they do not join particular PASSES (I'm talking to you EMPOWER and SUMMIT). By Indirect Equity Partners, I mean all the member organizations that belong to Equity Partners like the DDPA that are attempting to hide their ownership. Sunshine laws in Arkansas are obviously not strong enough to compel full disclosure – but the PASSE manual should do this. The language for sanctions against providers and PASSEs that directly market to members of other PASSEs is too weak. There need to be mandatory sanctions and punishments sufficient to stop the bad behaviors that are already taking place.

The PASSE needs to have a way to appeal to DHS/Medicaid for non-preferred drugs so that when clients need drugs that are not on the Arkansas Preferred Drug List. Right now, it is a nightmare and I have to beg Dr. Larry Miller for help with a DD client needs a non-formulary drug. The appeal and approval process is so onerous that I maintain private health insurance on my son just to pay for the medication he needs that Medicaid will not cover.

Care coordinators must follow up with members within seven (7) business days of visit to Emergency Room or Urgent Care Clinic, or discharge from Hospital or In-Patient Psychiatric Unit/Facility. Care coordinators should be contacting the client or the family WHILE the client is in the ER or in the Hospital. A week after discharge is waaay too late.

284.005 Consultation – Peer/Family Support should be here as a licensed/certified service as well as Dr. Ross Greene's Live in the Balance/Collaborative Problem Solving Consulting. I am very encouraged to see Peer and Family Support provided for in the PASSE manual. These are tremendous opportunities to improve quality of life of clients as well as their health outcomes.

Response: There are multiple sanctions that may be imposed upon the PASSE entity itself as well as against individual providers as all providers must be enrolled in Arkansas Medicaid. Each PASSE must disclose ownership to the Arkansas Insurance Department as well as to Arkansas Medicaid when enrolling as a PASSE provider.

The PASSE will be responsible for reviewing and approving non-preferred drugs based on medical necessity. They will also have an appeal process. The prior authorization criteria cannot be more stringent than the State but can be less stringent.
Seven (7) business is the high end of the limit. The PASSE has the ability to conduct follow up visits/contacts in a shorter time frame. Thank you for your comment.

Mardee Clive
Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.
Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Shannon Torell
Comment: It is important that parents and clients have a choice in their PASSE. In order to be able to choose from all 4 PASSE groups then equity partners must be made to be a participating provider in all 4 PASSEs. It is not fair if our choice is limited to only their PASSE if they are one of our providers.
Response: The number of PASSEs a provider wishes to join is up to them. Therefore, DHS does not believe changes to the manual are necessary.

Robert Baratta and Bill Philips
Comment: The Department of Human Resources, Division of Medical Services, has proposed a new rule to update its PASSE Manual that includes a faulty definition of telemedicine that does not follow the current statute. Note the highlighted section below in the definition section. Act 203 of the 2017 Regular Session amended the previous telemedicine statute. The definition of the telemedicine included in the proposed rule tracks with the current statute in § 17-80-402(7)(A) & (B). However, the prohibitions listed apply only to the establishment of a professional relationship and not telemedicine in general. § 17-80-403(c) states that "Professional relationship" does not include a relationship between a healthcare professional and a patient established only by the following: (1) An internet questionnaire; (2) An email message; (3) Patient-generated medical history; (4) Audio-only communication,

including without limitation interactive audio; (5) Text messaging; (6) A facsimile machine; or (7) Any combination thereof;

The Department is confused. In its proposed rule it is mixing what are acceptable technologies to diagnose and treat with those acceptable to establish the professional relationship (or first virtual visit).

Moreover, the current statute at § 17-80-404(a)(2) states "Once a professional relationship is established, a healthcare professional may provide healthcare services through telemedicine, including interactive audio, if the healthcare services are within the scope of practice for which the healthcare professional is licensed or certified and the healthcare services otherwise meet the requirements of this subchapter."

Accordingly, the proposed rule will put in place regulations on telemedicine for this state program that are more restrictive than both the current state telemedicine statute and governing Board of Medicine regulations.

While this proposed regulation is for a line of business we do not yet participate in, Teladoc Health should at a minimum raise the issue with of statutory conflict with the Department. Comments?

Response: Exclusion from reimbursement in Act 203 does not prevent the PASSE from using those methods of communication, but it is not considered a medical service delivered via telemedicine.

Mark George

Comment:

200.000 Definitions

1. Adverse Decision/Adverse Action. This is not exactly the best recitation of the Medicaid definition of what constitutes an adverse action. In any event, the second sentence should probably read, "... receipt of OR payment for claims OR services...." A denial of a request for a service is an adverse action whether or not it has been received, paid for, or a claim for payment has been made. I would suggest incorporating the definitions found in 42 CFR 438.400(b). The examples of "including but not limited to decisions or findings related to" can be included in a separate section.

2. Independent Assessment. The first paragraph references a "Tier 2" or a "Tier III" level of care. The Tiers should be presented consistently ... either as Tier I, 2 or 3, or as Tier I, II or III. This lack of consistency is evident in all of the various documents being submitted for comment.

3. 211.200.H

The use of the word “and” at the beginning of the sentence and at the end of the sentence above is redundant.

4. 212.000

To be consistent with how citations are presented elsewhere in the document, “42 CFR” should be included before each citation to a specific section in the federal rules.

5. 212.000E

This sentence does not read smoothly. Even correcting the “for” to “from” in the part of the sentence that reads, “... cross-subsidized by payments for any other rate cell” doesn’t make the sentence any clearer.

6. 221.200 Covered services CES waiver services is not a term previously defined.

7. 221.540 and 221.600

Both end with the same paragraph. It appears that it is applicable only to Section 221.600

8. 221.700 Transitioning to Different PASSE

Subsection A. Although 42 CFR 438.56 speaks of “disenrollment,” I can see where disenrollment from one PASSE will be needed before enrolling in a new PASSE. As such, “the member moves out of state” is wrong. If a member moves out of state, they are no longer eligible for Arkansas Medicaid, making PASSE disenrollment automatic. What the rigs reference is when a member moves to an area of the state not covered by a PASSE. Since every PASSE covers the entire state, this section is not applicable, and should be deleted.

Subsections A through D purport to list the reasons why a member can request a transition. The reasons are specified in 42 CFR 438.56(d)(2). This list in this document is not inclusive, and should be amended to include each rationale specified in the regulations.

9. 247.000 PASSE Grievance System

42 CFR 438.400 to 438.424 covers managed care grievances and appeals. Within the regs, there are different definitions for grievances and appeals. This section in the document appears to treat them as the same, or as being interchangeable. For grievances, 438.402(c)(2)(i) says a “grievance may be filed at any time, and must be resolved with 90 days. For appeals, 438.402(c)(2)(ii) states that appeals be filed with 60 days (not 45), with a resolution within 30 days. This entire section needs to be rewritten. There should be one section covering grievances, with the applicable, procedures and resolution timeframe, including information on how to appeal an unfavorable decision. There should be a separate section covering appeals and state fair hearing requests, with the applicable timeframes and procedures.

10. 247.200.D

This section is generally correct but is incomplete. It should be made clear that, pursuant to 42 CFR 438.420(c), benefits will be continued if the member requests a state fair hearing and continuation of benefits within 10 days of a notice of an adverse resolution by the PASSE. Failure by this section to track, and incorporate, the specific requirements in 438.420 will likely lead to inconsistent provisions within the member handbooks of the different PASSEs, resulting in violations by a PASSE in complying with a member's due process rights.

Subsection D.3 is not an "unless" condition. It should be a separate subsection. How will the PASSE determine what "the cost of any services furnished the member" were? Will it be based on specifically identified charges, or a part of the capitation payment received? Under a Medicaid FFS system, a provider might be required to repay Medicaid for payments received during the pendency of an appeal that is upheld against the client. In such a case, seeking recoupment from the client might make sense. In a managed care system, the PASSE will receive the same payment per member per month, regardless of services being actually furnished or paid for. As such, neither the PASSE nor the provider are out any money, and the client should not have to repay the cost of services received. Given the critical importance of services provided to the PASSE members, and the fact that members are essentially indigent to start with, recoveries should be waived as a matter of policy. In addition, if an adverse action involves the termination, suspension or reduction of a previously authorized service, the PASSE should be required to document that such termination, suspension or reduction in a service will not have a negative impact on the current, or future, health and safety of the member.

11. 283.003 Planned Respite

In that Section 211.000.C references services are to be provided in the least restrictive setting, should an HOC be an approved respite care provider?

Responses:

1. Adverse action is defined within existing Medicaid Manuals (Section 190.002). The PASSE manual utilizes the same definition to ensure consistency.
2. This will be corrected.
3. This will be corrected.
4. This will be corrected.
5. This language is taken directly from 42 CFR § 438.4.
6. CES will be clarified in this section of the manual.

7. For purposes of the PASSE manual, the sentence "The PASSE cannot transition any assigned member and is responsible for all eligible services provided to that member during the time the member is eligible and a member of that PASSE." applies to both enrollment discrimination protection as well as disenrollment limitations.
8. All federal requirements must be met and are incorporated by reference. Therefore, DHS does not believe changes to the manual are necessary.
9. Section 247.000 is for Grievances, Section 247.100 is for DHS Appeal Rights, and Section 247.200 is for PASSE Appeal rights. All federal requirements must be met and are incorporated by reference. Therefore, DHS does not believe changes to the manual are necessary.
10. Section 247.200.D does make it clear that the member can appeal within 10 days (before the date of the action on a 10-day notice) and request that services continue pending the outcome of the appeal. Part D.3 will be renumbered. The rule cited (42 CFR § 438.20) is from those governing managed care, so any arguments that unless you're in a FFS system you cannot determine the price of a service to then recover from the member who lost an appeal are misplaced. Most (virtually all) managed care systems use capitated payments; that's where the element of risk comes in.
11. An HDC can be considered "a least restrictive setting" if in fact, it is so.

Gabe Freyaldenhoven

Comment: As we are approaching the final rules being put into place for Arkansas Medicaid PASSE providers, I would like to express my concern for the lack of an Any Willing Provider provision in the manual.

Throughout the legislative process of creating Act 775, legislative intent was expressed to make sure that patients could keep their providers of choice and that patients would not be forced to change providers.

As Phase I of this program has rolled out, there have been many instances of individual PASSEs encouraging their equity owner providers not to sign with other PASSEs. This atmosphere of exclusion has the potential for PASSEs to close their networks once network adequacy standards have been met, preventing Medicaid patients from seeing the very providers they wish to see. This atmosphere will only be made worse moving forward without an Any Willing Provider provision to protect providers seeking to join a PASSE and support access to care.

Without an Any Willing Provider provision, patients will struggle with access to care provided by the license professionals that these patients are comfortable working with. This will allow a PASSE to exclude providers when the provider is willing to accept the standard contract. This creates a one-sided negotiation if the proposed rule for an out of network provider receiving 80% of the allowable also goes into effect.
I appreciate having had the opportunity to provide my comments and am asking to see protections consistent with Arkansas' Any Willing Provider statute. This would include a regulation that does not give exclusions based on network adequacy.
Response: PASSEs must comply with all applicable federal, state regulations including any willing provider act as DHS has consistently indicated throughout the development of the PASSE program.

Seth Coulter
Comment: Including Any Willing Provider provisions in the final rules for PASSE Providers:
"I appreciate having the opportunity to provide comments and am asking for protections consistent with Arkansas Willing Provider Statute. This would provide regulation that does not give exclusions based on network adequacy"
Response: PASSEs must comply with all applicable federal, state regulations including any willing provider act as DHS has consistently indicated throughout the development of the PASSE program.

Melissa Foster
Comment: My name is Melissa Foster. I am an occupational therapist in Fayetteville, Arkansas. My primary focus for the past 14 years of practice has been children with Autism, whom I love, and think of as "my babies" as well as my own biological children. Though I realize that there are a variety of PASSE concerns from both parents and practitioners, pertaining to individuals with a variety of disabilities, I will focus my comments on my concerns for children with Autism as well as my own practice.
1. Eliminate the IQ test for Speech Therapy services for clients over 10 years old. Many times it takes a child/therapists years of trial and error to determine a communication alternative for a client that will be successful. Combine this with the delayed ability we have here in the state of Arkansas for a child to be identified as needing services, this need for trial & error, and resulting progress can occur much past the 10-year mark. As long as a child is

making documentable and meaningful progress past the age of 10, he/she should be allowed to continue to benefit from these services. In addition, I typically specialize in behavior problems among individuals with Autism. The hallmark of working on these "bad" behaviors is to replace them with more appropriate means for communication. When a child is deprived of the collaborative effects of a caring OT & ST combination, it forces me, the OT, to try to pretend to be a speech therapist in our sessions in order to best serve the needs of my client. This is definitely not where my training lies, therefore, not making the most effective use of taxpayer dollars.

2. Reduce payment time for services provided. From what I am reading, it may take 30-45 days for reimbursement. Therapy providers are largely NOT associated with huge medical systems. We are overwhelmingly small business owners of 3-10 employees. Expecting such small businesses to consistently wait 1-2 months for reimbursement will create undue hardship on these tiny organizations that are simply trying to help kids and stay afloat.

3. Transparency for reimbursement. Again, the therapy community as a whole is made of small business owners, with limited reimbursement opportunities. The vast majority of our clients depend on Medicaid, and therefore, we therapists also depend on Medicaid in order to best serve or clients. It is impossible for these small businesses to budget for the upcoming year when we have no idea what reimbursement rates will be, and the time frame in which we will be reimbursed. We therapists are in this business because we LOVE to serve our clients, but we must also serve our own families/children and stick to our own family & clinic budgets. Again, it is impossible to create responsible family/clinic budgets if we are kept in the dark as to reimbursement rates.

I thank you for taking the time to take public comments, and to read this letter.

Best regards,

Occupational Therapist

Response:

1. Rules surrounding the medically necessary criteria to determine the need for therapy services is not in this public comment period.
2. This issue is between the provider and the PASSE.
3. Reimbursement is handled contractually between the PASSE and the Provider.

Bo Renshaw

Comment: Without the Any Willing Provider provision, patients will have limited access to care provided by licensed healthcare professionals of their choice. This will give a PASSE entity the ability to intently exclude providers despite their willingness to agree to the PASSE contract. This creates a one-sided negotiation if the proposed rule for an out of network provider receiving 80% of the allowable also goes into effect.

Response: PASSEs must comply with all applicable federal, state regulations including the "Any Willing Provider" Act as DHS has consistently indicated throughout the development of the PASSE program.

Arkansas Hospital Association

Comment: We offer our comments to these existing manual provisions in order to highlight a fundamental problem with the approach DHS has taken to implementing the PASSE initiative. In its original 2017 promulgation, DHS focused primarily on nonhospital outpatient care. In this manual, we expected to see reflected a comprehensive managed care program, which must include both inpatient and outpatient care (including emergency department care) at hospitals. It is imperative to ensure access to and availability of hospital care in the implementation of a managed care program because hospital services are essential for good patient care for this and every patient population.

Response: DHS agrees with the comments that all hospital-based services are critical to the PASSE model and are essential for good patient care and for every patient population. Hospitals are represented on every PASSE board because of their special role in providing care.

Comment: Across Arkansas, hospitals are the constant in our communities. Our facilities and care teams are the foundation of the healthcare system, and in fact, for many rural areas, hospitals are the sole available provider of care for all patients. Given the complexities of care for the vulnerable patient population being served by the PASSEs, hospitals, as the backbone of the Arkansas healthcare system, should not only be included as essential providers, but they also should play a central role in the new program's implementation.

Response: DHS agrees with the comments and fully understands the essential roles that hospitals provide care to our most vulnerable populations.

Comment: We applaud DHS for recognizing that hospitals must be part of the governance structure of a successful PASSE; however, representation in the boardroom alone is not enough. The hands-on patient care that our hospital personnel provide day-to-day is crucial and must be recognized in the rulemaking and expressly protected in this new system.
Response: DHS appreciates the support expressed in the comment. We understand that the essential role of hospital personnel runs throughout the fabric of the PASSE Program. We will ensure that the access to quality hospital services are maintained through our monitoring processes and therefore do not believe additional changes to the manual itself are necessary.

Comment: Virtual and Home Visit Provider Services
Virtual and Home Visit Provider Services are defined as "telemedicine, telehealth, e-consulting, and provider home visits" that include "clinical provider care, behavioral health therapies, and treatment provided to an individual at their residence." AHA requests that this definition specifically include speech, occupational, and physical therapy services, which are important components of many care plans. In-home and virtual therapy services are extremely useful, especially for rural, remote, and mobility-impaired participants who may otherwise lack access; therefore, they should be allowed and encouraged.
Response: DHS agrees, and we are making this change.

Comment: Pharmacy (and Other) Requirements
Although PASSEs are designed to manage the entire healthcare and specialty needs of patients, the pharmacy requirements (and in fact, other sections of the manual) are written as if only outpatient nonhospital care will be required by the individuals whose care is being managed by the PASSEs. For example, sections 221.220 and 221.230 address only outpatient and physician-administered drugs. These sections also should specify that PASSEs must ensure that members have the same or better access to inpatient drugs as they would have under Medicaid Fee-for-Service. To safeguard continued high-quality care for participants with inpatient stays, PASSEs should be explicitly required to guarantee access to inpatient drugs at least at the level consistent with existing practice for Medicaid Fee-for-Service patients.
Response: The cost of inpatient drugs has been built into the inpatient hospital rates by the DHS actuaries. We will clarify that PASSEs must guarantee access to inpatient drugs at least at the level consistent with Medicaid fee for service.

Comment: State Monitoring
Under section 225.000 of the manual (a current manual provision), DHS will analyze timely access to care at the end of the first year and at least every three years thereafter. We applaud the Department for recognizing that timely access to care is critical; however, once again, DHS fails to recognize that access to inpatient and outpatient hospital care is essential. We anticipated that this provision would be broadened in the comprehensive PASSE manual in recognition that the PASSEs are supposed to be managing the entire continuum of care for vulnerable Arkansans. Yet the analysis in section 225.000 still addresses access to only a specific subset of providers, and hospitals are not included in the list. Hospital inpatient, emergency, and outpatient services are essential services, and access to them is absolutely necessary to guarantee the health of the PASSE populations. Therefore, we respectfully request that DHS actively monitor access to hospital services, both inpatient and outpatient.
Response: DHS agrees that hospital inpatient, outpatient and emergency services are essential services. We assure that DHS will actively monitor access to all of these critical services.

Comment: Provider Selection
We applaud DHS's statement in section 245.000 that PASSEs may not discriminate against providers who "serve high-risk populations or specialize in conditions that require costly treatment." Limiting risk avoidance on the part of the PASSEs is essential to ensuring a strong provider network and continued access to care. As well, we strongly encourage DHS to mirror similar language in section 245.100, Value-Based Payments. Adequate risk adjustment in pay-for-performance methodology may be difficult, but it is essential to avoid punishing providers serving higher-needs or disadvantaged populations.
In recognition of the state's "any willing provider" law, we also request that the Department include a requirement that no PASSE may prohibit or limit a healthcare provider that is qualified and willing to accept the plan's operating terms and conditions, schedule of fees, covered expenses, utilization regulations and quality standards from the opportunity to join the PASSE's network. Arkansas law also requires that any measures designed to maintain quality or control costs be imposed equally on all providers in the same class. This statutory provision should be reflected in the PASSE manual.

Response: DHS reiterates that the Arkansas "Any Willing Provider" laws apply in the PASSE Program and are incorporated by reference; therefore, we do not need to make additional changes to the manual.

Comment: Provider Credentialing and Re-Credentialing
The detailed provider credentialing specifications in section 248.300 do not include any information about how providers may appeal a negative credentialing decision by the PASSE. This puts patients' continuity of care at risk if a PASSE makes an unfounded or inappropriate decision and a provider is suddenly deemed out-of-network. Providers whose credentials are denied or revoked should have the opportunity to appeal their case to a committee at the PASSE and, if necessary, the DHS credentialing work group.
Response: Each PASSE must have provider appeal rights. DHS also has appeal rights as specified in the Medicaid Provider Manual.

Comment: Request for DHS Hearing for Anti-Competitive Practices-
Section 247.300 establishes procedures for providers to engage DHS if they feel a PASSE is not negotiating in good faith and is engaged in anti-competitive practices. To initiate a hearing, the provider must present evidence, which must "include upper and lower payment amounts paid for the same services, except for value-based payments, to other providers." This necessitates that providers have full knowledge of rates paid to other providers, an uncommon practice, but one which AHA welcomes.
Providers do not share their negotiated prices with one another because of the federal antitrust laws, which prohibit price fixing and other alleged conspiracies to manipulate prices. Therefore, we request that a sentence be added to this section requiring the PASSEs to make available to providers the upper and lower payment amounts being paid to other providers in their network. Without this requirement, no provider could access the protections offered in this manual section because they could not meet the initial requirement for requesting a hearing.
Further, this section also states that a PASSE "shall not be required to disclose the methodology for making value-based payments." While AHA understands that PASSEs may not wish to make legitimate trade secrets public, DHS should ensure that providers within a PASSE network have full knowledge of any and all value-based purchasing methodology, procedures and calculations, so

that hospitals may critically evaluate clinical decision-making processes with quality goals in mind.
Finally, transparency in the development of value-based purchasing methodology is especially critical given the problems inherent in the process and the lack of scientific consensus that value-based purchasing improves the patient experience. For this reason, we strongly encourage DHS to require PASSEs to disclose their proposed value-based purchasing methodology prior to its implementation and submit the proposal to a committee that includes providers who can weigh in on the potential impact of the proposal on patient care. No such proposal should be implemented without the committee's review and approval. Otherwise, we risk a managed care entity defining "value" as something other than improving the quality of care.
Response: This is a unique feature that DHS has added to encourage both Providers and PASSEs to negotiate in good faith. At this time, we do not have sufficient evidence that this is not occurring and therefore will not make changes to the manual. DHS will continue to monitor the indicators such as network adequacy to determine whether we should make provisions in the future.

Comment: Out-of-Network and Emergency Care Access-
To ensure that this vulnerable population's access to emergency care is protected, and providers adequately reimbursed for services rendered, the PASSE provider manual should be amended to explicitly guarantee coverage for emergency services provided by out-of-network hospitals. For example, the manual should mirror the language in sections I.F.1.03 - I.F.1.22 42 of the State Guide to CMS Criteria for Medicaid Managed Care Contract Review and Approval. In summary, these federal regulations state that PASSEs must:
Cover and pay for emergency services regardless of whether the provider has a contract with the PASSE;
Not deny payment when an enrollee has an emergency medical condition;
Allow enrollees to obtain emergency service outside the primary care case management system;
Not limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms;
Not refuse to cover emergency services based on the provider not notifying the enrollee's PCP, PASSE, or applicable state entity within 10 calendar days;

Cover services until the attending emergency physician or treating provider determines the enrollee is sufficiently stabilized for transfer and discharge; and
Cover post-stabilization care services within or outside the network if they are pre-approved by a PASSE plan provider or representative, or not-pre-approved but administered to maintain the enrollee's stabilized condition.
Clearly, these are fundamental, basic protections to ensure a patient's ability to receive necessary emergency care from the nearest appropriate provider.
Further, in compliance with CMS regulations and recognizing the already limited Medicaid Fee-for-Service rates, the AHA requests that DHS specify that PASSEs must pay non-contracted providers the maximum allowed by federal law for emergency care services rendered. Currently, this maximum is an amount equal to what would be paid under the Medicaid Fee-for-Service program.
Response: All federal requirements must be met and are incorporated by reference. Therefore, DHS does not believe changes to the manual are necessary.

Public Hearing Darragh Auditorium Little Rock, AR 8-20-18. Cindy Alberding

Comment: In the 1915 (c), abeyance is gone. So for individuals that –it still says that individuals must have a service every month, care coordination is no longer in there, but they must have one service at least every month. So, for people that are in jail or in the hospital, that's what abeyance was used for. So, are those individuals going to lose their waiver space? I also couldn't find any information on the 14-day absentee payments, which right now providers have in the waiver, but people are having a lot of trouble getting that to pay.
Response: Page 7 line 22-25 and page 8 line 1-5 concerning the Abeyance Process. Thank you for your comment and for bringing this to our attention. Additional research and discussion will be held around this issue.
Page 8 lines 6-10 concerning the Retainer Payment. Under the current CES Waiver, retainer payments are allowed. Processing is delayed of the expenditure as it must go through the "red" claim submission process.

DHS and the PASSEs are developing the transition of care policy plans, which must be approved by CMS prior to the implementation of Phase II.

DHS has sought approval from CMS, and formal approval is pending.

The proposed effective date of the rule is January 1, 2019.

FINANCIAL IMPACT: There will be a savings to implement this federal rule in the current fiscal year of $6,915,805 in general revenue and $16,535,552 in federal funds for a total savings of $23,451,357 in the current fiscal year. For the next fiscal year, there will be a savings of $14,177,435 in general revenue and $33,897,964 in federal funds for a total savings in the next fiscal year of $48,075,399.

In the current fiscal year, additional revenue is generated due to premium taxes from PASSE entities - $11,820,950 ($5,910,475 for use to offset general revenue of PASSE payments and $5,910,475 for use to reduce the DDS wait list. In the next fiscal year, additional revenue will be generated due to premium taxes from PASSE entities - $24,232,946 ($12,116,473 for use to offset general revenue of PASSE payments and $12,116,473 for use to reduce DDS wait list).

The amounts reported for this statement are tentative pending final approval of rates for calendar year 2019 and 2020.

The total savings to the state will be $35,272,307 for the current fiscal year and $72,308,345 for the next fiscal year.

Concerning the cost to the regulated entities, the agency reports that PASSE entities will negotiate with providers to set service rates under this model. Therefore, the rule itself does not impose any specific cost on the provider.

LEGAL AUTHORIZATION: DHS is authorized to "make rules and regulations and take actions as are necessary or desirable to carry out the provisions of this chapter [Public Assistance] and that are not inconsistent therewith." Arkansas Code Annotated § 20-76-201(12). DHS may promulgate rules as necessary to conform to federal rules that affect its programs as necessary to receive any federal funds. *See* Ark. Code Ann. § 25-10-129(b).

Act 775 of 2017, sponsored by Representative Aaron Pilkington, required DHS to submit an application for any federal waivers, federal authority, or state plan amendments necessary to

implement the Medicaid Provider-Led Organized Care System. The Act authorized DHS to promulgate rules necessary to implement the system. *See* Ark. Code Ann. § 20-77-2708.

c. SUBJECT: Arkansas Independent Assessment (ARIA) New-18 Manual

DESCRIPTION: This manual accompanies the PASSE provider manual and describes the ARIA tool that will be used to assess clients for PASSE assignment, Personal Care services, HDC placement, and developmental day treatment services.

This manual more fully describes the Arkansas Independent Assessment Tool (ARIA) being used to assess behavioral health clients, developmental disability clients, and personal care clients. The manual contains tiering logic that explains how the individual domains will be scored to arrive at a tier. Additionally, the manual contains the potential outcomes of the tiering results for all clients.

This manual incorporates the conflict-free case management require in 1915(c) Home and Community Based Services waivers and 1915(i) home and community based services state plan amendments that individuals be independently assessed for services. This manual also explains how populations will be assigned to a Provider-led Arkansas Shared Savings Entity (PASSE) based on their tier results.

PUBLIC COMMENT: DHS held three public hearings, one in Little Rock on August 20, 2018, one in Monticello on September 4, 2018, and one in Hope on September 6, 2018. The public comment period ended on September 12, 2018. DHS received the following comments and provided its responses:

DHS Responses to Public Comments Regarding the Independent Assessment Manual:

ARKANSAS HOSPITAL ASSOCIATION

Comment: Comments about the Arkansas Independent Assessment (ARIA)

Arkansas patients deserve a PASSE structure based upon an appropriate standardized assessment, evidence-based tier determination, and scientifically-grounded capitation approach. The tier determination process, upon which all PASSE capitation calculations rest, is based on a scientifically untested assessment.

The assessment selected, MnCHOICES, is a state-developed tool that was created to address specific policy decisions of the Minnesota Medicaid program, rather than as a general and broadly applicable assessment. In fact, MnCHOICES was created expressly and exclusively for the elderly population of Minnesota. It was not developed for use in children, youth, or the behavioral health or developmental disabilities populations, which have clinical and functional concerns that are distinct from those experienced by elderly people with age-related disabilities. As well, after a diligent and thorough search, the AHA could find no scientific evidence of the validity of MnCHOICES – in these or even its intended target population.

The selection of tier determination criteria from the assessment instrument is similarly problematic. We are unsure of how these criteria were identified or whether there is evidence that they meaningfully differentiate between participants and provide a good explanation of the amount of overall care needed by participants. Comparing roughly aggregated averages is not a substitution for analyses of variance explanation and tests of internal and external validity. Basing capitation payments upon weak methodology increases the likelihood that capitated payments may not be sufficient to fully cover medical and supportive costs for some PASSE participants, putting their health and access to timely medical care at risk.

The AHA requests that DHS identify and implement evidence-based evaluation measures to ensure that the assessment system is accurately reflecting participant characteristics and that the tier determination methods adequately capture individual participant resource needs. The results of these evaluations should be used to guide program decisions and make changes to the assessment and tier determination process going forward. Taking these steps will help to ensure that the program's goals of managing and improving patient care are achieved to best serve the individual patients within this vulnerable population.

Response: The ARIA has now been tested for nearly a year and the accuracy of assessments are well supported by data. Of the total 36,940 independent assessments for behavioral health needs, DHS has received 139 beneficiary appeals and 100 provider appeals for tier assignment. 4 appeals went to a hearing, 2 of which the tier determination was upheld and 2 were reassessed. Capitation rates are not based on ARIA. The DHS Actuaries developed the capitation rates based on Medicaid fee for service claims data.

Unknown

Comment: MnCHOICES should not be used as an assessment in Arkansas because Minnesota has alternative programs that Arkansas does not offer for those individuals who are unable to qualify due to intellect.
All the tiers have to mental score of 2 to 4 depending on age. This is NOT consistent with definition of DD.
Arkansas law says that a developmental disability is "an impairment of general intellectual functioning or adaptive behavior" that is a "substantial handicap to the person's ability to function without appropriate support services, including, but not limited to, planned recreational activities, medical services such as physical therapy and speech therapy, and possibilities for sheltered employment or job training." It is caused by mental retardation or a closely related condition; cerebral palsy; epilepsy; autism; or dyslexia (difficulty learning to read and spell) resulting from cerebral palsy, epilepsy, or autism.* * Arkansas Code 16-123-102(3)
https://www.daas.ar.gov/pdf/daas-childguide-060407.pdf
Based solely on the proposed tier levels you would be excluding all those with closely related conditions
Please add tier levels that include those with closely related conditions or add an alternative assessment.
Response: The ARIA has been used for the DD Population since March 2018. More than 4,300 on the DD Population have been completed and 100% of those assessments resulted in a Tier II or Tier III determination.

Mark George

Comment: 201.000(B). This is not a complete sentence.
Response: This will be corrected.

Comment: 220. l 00(a)(2) Clients do not apply to be on the CES Waiver Waitlist. They apply for the Waiver and, upon being determined eligible for the Waiver, are placed on the Waitlist. This should probably be two separate sentences ... those on the Waitlist, and those applying for the CES Waiver.
Response: We will strike through the wording, "or applying."

Comment: 220. l 00(8)(2) Should read that individuals in an HDC will only be "assessed or reassessed" if they are seeking transition into the community. Current residents of an HDC will not be initially assessed, so they cannot be "reassessed."
Response: We will add the wording, "assessed or."

Public Hearing Darragh Auditorium Little Rock, AR 8-20-18
Cindy Alberding

Comment: In the Independent Assessment document, it now says, "Including 24 hours a day, seven days a week paid supports and services." "Paid" is a new word from what we used to have with pervasive and some of those others. It always just said 24 hours or as needed level of care. So, I'm hoping that "including" means up to 24 hours paid supports, but I wonder why the word "paid" is in there now, if there is another meaning behind that.

Response: Yes, "up to" 24 hours of paid support through the CES waiver program.

DHS has sought approval from CMS, and formal approval is pending.

The proposed effective date of the rule is November 1, 2018.

FINANCIAL IMPACT: There is no financial impact. The financial impact of the ARIA implementation has already been accounted for in previous rule filings regarding the personal care services and the ARIA tool. This manual expounds upon the tool itself but does not change the previous requirements to be assessed.

LEGAL AUTHORIZATION: DHS is authorized to "make rules and regulations and take actions as are necessary or desirable to carry out the provisions of this chapter [Public Assistance] and that are not inconsistent therewith." Arkansas Code Annotated § 20-76-201(12). DHS may promulgate rules as necessary to conform to federal rules that affect its programs as necessary to receive any federal funds. *See* Ark. Code Ann. § 25-10-129(b). DHS and any entity with whom it contracts may rely on official publications of the U.S. Department of Health and Human Services for the administration of the Medicaid program and other rules, regulations, standards, guidance, or information that apply to the Medicaid program by reference in statute, promulgated regulation, rule, or official federal publication. *See* Ark. Code Ann. § 20-77-107(e).

Act 775 of 2017, sponsored by Representative Aaron Pilkington, required DHS to submit an application for any federal waivers, federal authority, or state plan amendments necessary to implement the Medicaid Provider-Led Organized Care System.

The Act authorized DHS to promulgate rules necessary to implement the system. *See* Ark. Code Ann. § 20-77-2708.

Case management services are regulated by federal law. *See* 42 CFR § 440.169, and § 441.18. DHS states that the proposed rule changes in the manual incorporate the conflict-free case management requirements in waivers and state plan amendments. Federal law protects against conflicts in cases where the same entity helps individuals gain access to services and provides services to that individual. *See* 42 CFR § 441.301(c). Generally, a state must devise conflict of interest protections, which must be approved by CMS. Additionally, individuals must be provided with a clear and accessible alternative dispute resolution process. DHS has sought approval from CMS, and formal approval is pending.

9. <u>OIL AND GAS COMMISSION</u> (Shane Khoury)

a. <u>SUBJECT</u>: Rule B-3: Spacing of Wells

<u>DESCRIPTION</u>: This amendment:

(1) Corrects references to other AOGC rules that have been repealed, adopted, or amended since B-3 was last amended; and

(2) Authorizes a location exception so that Class II disposal wells (not commercial disposal wells or enhanced recover wells) may be located closer than 280 feet from a mineral lease line in old, historic production areas if the offset operator being encroached upon gives written permission and waives the requirement of a hearing before the AOGC.

<u>PUBLIC COMMENT</u>: Public hearings were held on August 7, 2018, and August 14, 2018, in Fort Smith and El Dorado, respectively. The public comment period expired on August 27, 2018. The Commission received no public comments.

The proposed effective date is pending legislative review and approval.

<u>FINANCIAL IMPACT</u>: There is no financial impact.

LEGAL AUTHORIZATION: Pursuant to Arkansas Code Annotated § 15-71-110(d)(12), the Oil and Gas Commission may make, after hearing and notice, such reasonable rules, regulations, and orders as are necessary from time to time in the proper administration and enforcement of its statutory authority, including rules, regulations, or orders for the purpose of regulating the spacing of wells and to establish drilling units.

b. SUBJECT: B-4: Application to Transfer a Well

DESCRIPTION: This rule codifies and clarifies existing administrative procedures necessary for the transfer of the operatorship of an oil, gas, or brine production well from one operator to another. The rule also requires operators to post well specific financial assurance when transferring gas wells that produce at a low volume (less than 25 MCF per day). The Commission believes this is necessary to prevent these types of wells from being transferred to entities that may not have adequate assets to properly plug and abandon these wells when they are no longer economic.

PUBLIC COMMENT: Public hearings were held on August 7, 2018, and August 14, 2018, in Fort Smith and El Dorado, respectively. The public comment period expired on August 27, 2018. The Commission received no public comments.

The proposed effective date is pending legislative review and approval.

FINANCIAL IMPACT: The cost to the regulated parties is unknown. Entities seeking to acquire operatorship of gas wells that produce at a low volume will be required to post well specific financial assurance. The Commission believes this is necessary to prevent these types of wells from being transferred to entities that may not have adequate assets to properly plug and abandon these wells when they are no longer economic. The cost of acquiring financial assurance to these operators will be dependent on the number of wells and the type of financial assurance utilized by the operator (cash, CD, letter of credit, surety bonds).

There is no cost by fiscal year to state, county, or municipal government to implement this rule.

Because there is potentially a new or increased cost or obligation of at least $100,000 per year to a private individual, private entity, private business, state government, county government, municipal government, or to two or more of those entities combined, the Commission submitted the following written findings:

(1) a statement of the rule's basis and purpose;

The purpose of the rule amendment is to provide the state with additional financial assurance for low producing gas wells which are nearing the end of the wells economic life and are being transferred to another operator. Although a marginally producing gas well is capable of continued economic production, the well may not have sufficient profitability for a new operator to pay for the plugging of the well when the well is no longer capable of economic production. Although AOGC rules will require the operator to plug the well, the operator may not have the financial ability to plug the well and should an operator go bankrupt or otherwise be unable to plug the well, the additional financial assurance required by this rule amendment will provide the necessary funds to help offset costs of plugging the well.

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

See answer to (1) above. Ark. Code Ann. § 15-71-110(d)(14), 15-72-216 and 15-72-217 require wells to be plugged. Ark. Code Ann. § 15-72-204 requires financial assurance for wells, but does not specify the amount, which has been established by rule.

(3) a description of the factual evidence that:

(a) justifies the agency's need for the proposed rule; and

Low producing gas wells which are nearing the end of the wells economic life, and covered by this rule amendment, are the most likely category of wells to not be plugged by the last operator, and eventually may become part of the AOGC abandoned well plugging program. The proposed additional well specific financial assurance requirements are designed to offset the cost of plugging those wells should they be placed into the plugging program due to insolvent or bankrupt operators. The AOGC currently has approximately 425 abandoned wells in the AOGC plugging program, which represents approximately five to seven million

dollars of cost to the AOGC plugging program. In order to limit the number of wells potentially being added to the AOGC plugging program, it is necessary to adopt well transfer rules which require additional financial assurances to cover the cost of plugging these low producing gas wells (which are nearing the end of the wells economic life) when being transferred to new operators.

(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

The purpose of the statutory requirements are to ensure that wells nearing the end of the wells economic life are properly plugged. Wells that are not plugged pose an environmental threat or negatively impact oil and gas resources. The proposed requirement for additional financial assurance being posted by the operator acquiring a low producing gas well (which is nearing or at the end of the well's productive life) ensures that new operators have the necessary resources to plug the well. Any additional cost to the new operators for providing the additional financial assurance is justified as it is the operator's responsibility to plug the well and not leave that obligation to the AOGC plugging program.

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

An alternative is to deny the transfer of low volume producing gas wells, so that they remain with the operator who derived the greatest economic benefit from the well and consequently have the funds necessary to plug the wells. However, that would inappropriately interfere with business transactions outside the jurisdiction of the AOGC. The AOGC does have the jurisdiction to establish transfer requirements and the proposed financial assurance requirements will allow for a regulatory process limiting the number of low producing natural gas wells which may become subject to being plugged by the AOGC plugging program.

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(No comments)

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

The existing rules have not created or contributed to the issue being addressed.

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

Due to the continuing changes in technology and operational advances in the oil and gas industry, the AOGC continually reviews the oil and gas rules to insure the existing rules are not impediments to developing the resources of the State. As evidence of that policy, the Commission has amended various oil and gas rules or adopted new rules over 125 times over the last 10 years to account for rapidly changing oil and gas technology. With respect to the proposed amendment, the ability of operators to plug low producing gas wells is a function of the health of the oil and gas industry and unfortunately, the proposed amendment will probably always be necessary to ensure operators have the necessary assets to offset the cost of plugging these wells. However, as with all the rules this amendment will be reviewed on a periodic basis to determine if the environmental and resource protections provided by the proposed rule remain necessary.

LEGAL AUTHORIZATION: Pursuant to Arkansas Code Annotated § 15-71-110(d), the Oil and Gas Commission may, after hearing and notice, make such reasonable rules, regulations, and orders as are necessary from time to time in the proper administration and enforcement of its statutory authority.

c. **SUBJECT: Rule B-7: When Wells Shall Be Plugged and Abandoned and Notice of Intention to Plug and Abandon Wells**

DESCRIPTION: This rule:

(1) Clarifies what wells are subject to the temporary abandonment provisions of the rule.

(2) Requires operators to post well specific financial assurance when applying for temporary abandonment status. By practice, the Commission typically imposes this requirement when granting extension of the initial three-year period of temporary abandonment after notice and a hearing. This amendment changes the timeframe so that the well specific financial assurance is required for administrative approval by the Director. The Commission believes this is necessary to encourage operators to either produce or properly plug wells nearing or at the end of its productive life.

(3) Removes AOGC witness requirement for fluid level tests and makes witnessing discretionary for AOGC in an attempt to maximize staff availability for field inspection activities.

(4) Specifies and streamlines process for operators to comply with temporary abandonment provisions upon receipt of a notice of violation.

PUBLIC COMMENT: Public hearings were held on August 7, 2018, and August 14, 2018, in Fort Smith and El Dorado, respectively. The public comment period expired on August 27, 2018. The Commission received no public comments.

The proposed effective date is pending legislative review and approval.

FINANCIAL IMPACT: The cost to the regulated parties is unknown. Entities seeking to temporarily abandon wells will be required to post well specific financial assurance at the time of initial application, as opposed to when seeking an extension at a hearing before the commission. The Commission believes this is necessary to encourage operators to either produce or properly plug wells nearing or at the end of its productive life. The rule specifies the amount of financial assurance as $35,000 for natural

gas wells and $15,000 for oil wells. The cost of acquiring financial assurance to these operators will be dependent on the number of wells and the type of financial assurance utilized by the operator (cash, CD, letter of credit, surety bonds).

There is no cost by fiscal year to state, county, or municipal government to implement this rule.

Because there is potentially a new or increased cost or obligation of at least $100,000 per year to a private individual, private entity, private business, state government, county government, municipal government, or to two or more of those entities combined, the Commission submitted the following written findings:

(1) a statement of the rule's basis and purpose;

The purpose of the rule amendment is to provide the State with additional financial assurance for oil and gas wells which are nearing or at the end of the wells productive life. Although a non-productive well placed in temporary abandonment status may be brought back into production at a later date by the operator, temporary abandonment status is sometimes used in attempt to postpone the plugging of an oil or gas well no longer capable of economic production. Commission rules require that oil and gas wells no longer productive to be plugged, however, should an operator go bankrupt or otherwise be unable to plug the well, the financial assurances required by this rule amendment would provide necessary funds to help offset costs of plugging the well by the AOGC Abandoned and Orphaned Well Plugging Program.

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

See answer to (1) above. Ark. Code Ann. § 15-71-110(d)(14), 15-72-216 and 15-72-217 require wells to be plugged. Ark. Code Ann. § 15-72-204 requires financial assurance for wells, but does not specify the amount, which has been established by rule.

(3) a description of the factual evidence that:

(a) justifies the agency's need for the proposed rule; and

The AOGC currently administers an Abandoned and Orphaned Well Plugging Program and Fund, which was established in 2005.

The plugging program is a mechanism for the AOGC to plug abandoned oil and gas wells utilizing primarily industry fees and some forfeited bonds to fund the plugging costs for the abandoned wells from insolvent or bankrupt companies. Through FY17 the AOGC has plugged 723 abandoned oil and gas wells at a cost of $7.9 million dollars. The AOGC currently has approximately 425 abandoned wells remaining on the AOGC plugging list which represents approximately five to seven million dollars of cost to the AOGC Plugging Program. In order for the AOGC plugging program to remain viable utilizing the current funding mechanisms, it is necessary to amend the temporary abandonment rules to minimize the number of abandoned oil and gas wells added to the program without the necessary financial assurance to cover the cost of plugging the wells. The temporary abandoned wells covered by this rule amendment are the most likely category of wells to eventually be placed into the plugging program and the proposed additional financial assurance requirements are designed to offset the cost of plugging those wells should they be placed into the plugging program due to insolvent or bankrupt operators.

(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

The purpose of the statutory requirement that a well no longer productive be properly plugged by the operator is to insure abandoned wells do not pose an environmental threat or negatively impact oil and gas resources if left unplugged at the close of the well's useful life. The proposed requirement for additional financial assurance being posted by the operator on a well which is nearing or at the end of the well's productive life places the responsibility on the operator to plug the well as required by the statute. The cost to the operators for providing the additional financial assurance is justified as it is the operator's responsibility to plug the well and not leave that obligation to the AOGC plugging program.

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

An alternative is to require the operator to plug non-productive wells, which the AOGC currently does by administrative rule and order. Typical enforcement of these regulations and orders is time consuming and ineffective when an insolvent company is the

operator. The proposed financial assurance requirements will allow for a more timely and definite solution to the plugging of an abandoned well.

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(No comments)

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

The existing rules have not created or contributed to the issue being addressed.

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

Due to the continuing changes in technology and operational advances in the oil and gas industry, the AOGC continually reviews the oil and gas rules to insure the existing rules are not impediments to developing the resources of the State. As evidence of that policy, the Commission has amended various oil and gas rules or adopted new rules over 125 times over the last 10 years to account for rapidly changing oil and gas technology. With respect to the proposed amendment, the number of abandoned oil and gas wells and the number of potential abandoned wells is a function of the health of the oil and gas industry and unfortunately, the proposed amendment will probably always be necessary to offset the cost of plugging abandoned wells. However, as with all the rules this amendment will be reviewed on a periodic basis to determine if the environmental and resource protections provided by the proposed amendment remain necessary.

LEGAL AUTHORIZATION: Pursuant to Arkansas Code Annotated § 15-71-110, the Oil and Gas Commission shall have jurisdiction of and authority over all persons and property necessary to administer and enforce effectively its statutory authority relating to the exploration, production, and conservation of oil and gas, and may, after hearing and notice, make such reasonable rules, regulations, and orders as are necessary from time to time in the proper administration and enforcement of its statutory authority, including rules, regulations, or orders to require "[a] reasonable financial assurance acceptable to the commission conditioned on the performance of the duty to plug each dry or abandoned well." Ark. Code Ann. § 15-71-110(a)(1), (d)(1)(B).

d. SUBJECT: General Rule B-17: Well Drilling Pits and Completion Pits Requirements

DESCRIPTION: This rule:

(1) Clarifies when frack flow back ends and produced water begins;

(2) Allows pits designed for recycling to accept produced water, when approved by both the Director of ADEQ and AOGC (this will allow for more flexible use of available water for well completions);

(3) Affirmatively states that rainwater, and other forms of fresh water may be put into pits (this is currently done); and affirmatively states that two 20 mil liners with leak detection, as opposed to one 40 mil liner, is acceptable (this currently based on a letter approval from ADEQ/AOGC).

Overall, this amendment provides for alternative uses of produced water for well completion and reduces disposal costs for the regulated community.

PUBLIC COMMENT: Public hearings were held on August 7, 2018, and August 14, 2018, in Fort Smith and El Dorado, respectively. The public comment period expired on August 27, 2018. The Commission received no public comments.

The proposed effective date is pending legislative review and approval.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: Pursuant to Arkansas Code Annotated § 15-71-110(a)(1), (d), the Oil and Gas Commission shall have jurisdiction of and authority over all persons and property necessary to administer and enforce effectively its statutory authority relating to the exploration, production, and conservation of oil and gas and may, after hearing and notice, make such reasonable rules, regulations, and orders as are necessary from time to time in the proper administration and enforcement of its statutory authority.

10. ARKANSAS SECURITIES DEPARTMENT (David H. Smith)

a. SUBJECT: Amendments Rule 302.01 (c) and 302.02 (f) of the Rules of the Arkansas Securities Commissioner

DESCRIPTION: The proposed amended rules make changes in examination requirements for broker-dealer agents and investment adviser representatives that are needed due to changes made by FINRA and the Securities and Exchange Commission. These amendments address matters necessary for the orderly administration of laws concerning the regulation of securities activity in Arkansas.

PUBLIC COMMENT: The Department held a public hearing on September 7, 2018. The public comment period ended on September 7, 2018. The Department received no comments.

The proposed effective date of the rule is pending legislative review and approval.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: Generally, the Securities Commissioner may make, amend, and rescind any rules, forms, and orders which are necessary to carry out the provisions of Arkansas law governing securities. *See* Ark. Code Ann. § 23-42-204. In prescribing rules and forms, the Commissioner may cooperate with the Securities and Exchange Commission, and with self-regulatory organizations with a view to effectuating the policy

of Arkansas law governing securities to achieve maximum uniformity in the form and content of registration statements, applications, rules, and reports wherever practicable. *See* Ark. Code Ann. § 23-42-204. Rules and forms may govern registration statements, applications, notice filings, and reports and defining any terms, and the Commissioner may classify securities, persons, and matters within his or her jurisdiction and prescribe different requirements for different classes. *See* Ark. Code Ann. § 23-42-204.

The Financial Industry Regulatory Authority (FINRA) is a private self-regulatory organization that regulates certain aspects of the securities industry. While the Securities and Exchange Commission (SEC) is the ultimate governmental regulatory authority for the industry, FINRA protects investors by overseeing all brokerage firms and providing regulatory oversight. FINRA writes and enforces the rules governing the activities of the entire securities industry, checks for compliance with these rules, and educates investors. All brokers must be licensed by FINRA, which means passing qualification exams and completing continuing-education requirements.

This proposed FINRA registration requirement was approved by the SEC as effective on October 1, 2018.

11. DEPARTMENT OF TRANSPORTATION

a. SUBJECT: Permits for Overweight Vehicles Carrying Agronomic or Horticultural Products

DESCRIPTION: Pursuant to Act 1085 of 2017, the Arkansas Department of Transportation in cooperation with the Arkansas Department of Agriculture created Permit Rules for Overweight Vehicles Carrying Agronomic or Horticultural Products to provide a process for ARDOT and AHP to issue annual permits to allow qualified overweight agricultural trucks to carry up to 100,000 pounds.

The rules allow for a permit for one tractor and up to five identical trailers to be issued for five different origin and destination routes. Each tractor and trailer is required to undergo a safety inspection prior to issuance of the permit, and the rule calls for additional driver requirements.

Permit fees have been set at $1000.

PUBLIC COMMENT: A public hearing was held on August 16, 2018. The public comment period expired on August 13, 2018. The agency submitted the following public comment summary:

There were no commenters at the August 16, 2018 hearing. Two comments were received, only one of which was received during the comment period.

Telephone call from farmer David Brown
August 6, 2018

Mr. Brown called to inquire into the status of the proposed rules. He objected to the one thousand dollar ($1,000.00) permit fee, indicating it was too high.

RESPONSE: Mr. Brown was advised of the location on the web for copies of the proposed rules, and provided a copy of the Notice of Rulemaking via email.

Wesley W. Ward, Secretary of Agriculture
Arkansas Agriculture Department
Email Received August 24, 2018

QUESTION 1: One farmer spoke with Captain Batson yesterday morning and is frustrated that he was turned down for a permit for his cotton trailers and was told that the regulation doesn't specify cotton. He expressed his frustration because the regulation does include fiber crops in the definition of "agronomic crops."

RESPONSE 1: Cotton would certainly qualify as an "agronomic crop" under the definition. Assuming the vehicle configuration otherwise met the statutory requirements, the permit rules would apply and allow issuance of a permit for up to 100,000 pounds.

QUESTION 2: The same farmer is further frustrated because the regulation says semi-trailers (which is what he uses) but was told that he doesn't qualify because his is actually using a "pup-trailer."

RESPONSE 2: Act 1085 specifies that a permit may be issued to "a truck tractor and semi-trailer combination." The statute does not identify multiple trailers as being permissible, as the language used is singular. In addition, there are locations within the code

where the configuration of a truck tractor with multiple trailers is specifically identified. For instance, ACA § 27-35-208(c)(2)(A) states "No semitrailer or trailer operated on the highways of this state in a truck tractor-semitrailer-trailer combination shall have an overall length, unladen or with load, in excess of twenty-eight feet (28')." This is the language that would have been used had the statute meant to apply to a multiple trailer configuration.

QUESTION 3: Another concern that we are hearing is that the regulations state "each applicant may apply for up to five (5) different routes." The concern here is that the Department of Transportation is viewing this similar to other overweight permits such as having to move a combine with a lowboy trailer.

RESPONSE 3: This is an area that was much discussed during the drafting of these rules. The concern was making sure that the permit did not provide unrestricted access to all highways and bridges, as many are weight restricted. Research performed by the Department indicated that damage to the highways did not increase in a linear fashion as the load weight went up, but rather increased by an order of magnitude, such that this 18% weight increase resulted in three times as much damage to the roads. In order to protect the system and ensure the safety of people and the vehicles involved it is necessary to check and authorize each route, including an analysis of all bridges on that route, that a vehicle plans to travel.

QUESTION 4: There are also some concerns from farmers about requiring a North American Standard Level I inspection. Several of the farmers don't know what that is and were concerned that it is an attempt to further keep them from being able to get the permits.

RESPONSE 4: Any farmer that requests a permit under the rule will be provided the inspection by the Arkansas Highway Police as part of the permit process. This is not an attempt to keep farmers from obtaining the permits, but rather a way of making sure that vehicles carrying this increased load are in a condition capable of carrying the additional weight. A recent study by the Commercial Vehicle Safety Association (CVSA) found that vehicles that were overweight, both legally and illegally, had a higher instance of "out of service" violations when randomly inspected, with a predominance of findings related to the brake components. The

required inspection simply seeks to minimize the safety issues present from overweight loads.

QUESTION 5: Another concern is that the public comment period for the permanent rule apparently expired on August 16th but no one knew about it.

RESPONSE 5: As required by Arkansas law a public notice was issued in the Arkansas Democrat-Gazette and run for three days notifying the public of the opportunity to issue comments, as well as being posted on the Department's website. In addition, the permanent rule and Bureau forms, indicating the comment period, were sent to the Agriculture Department on July 16th.

QUESTION 6: Some of the farmers are citing to Louisiana's regulations which are 88,000 on the interstate and 100,000 within 100 miles of farm (non-interstate) with a cost of $100 per truck.

RESPONSE 6: Louisiana has a special permit that allows up to 100,000 pounds on state highways at the $100 per truck rate. Without being involved in the discussion that resulted in that rate, we do not know what factors were involved in determining how those permits would be charged. And, any weights on farm products on interstate highways in excess of 80,000 pounds is strictly the result of federal law which would, to apply in Arkansas, literally require an act of Congress.

In determining the $1,000 permit fee, we began by attempting to calculate an actual damage amount cause by the additional weight. We applied the formula that is used for calculating the maintenance assessment for one-time overweight permits on weight-restricted roads, but that resulted in a much higher permit fee that was not considered feasible. We believe the lower $1,000 fee is reasonable for applicants though it is still short of covering the actual damage costs. It is worth noting that the $1,000 fee for unlimited trips is less than the cost of a single overweight citation for the same weight. Both the fee and the fine go to highway maintenance.

This rule was filed as an emergency rule (with a permit fee of $333) and was reviewed and approved by the Executive Subcommittee on July 19, 2018. The proposed effective date for permanent promulgation is pending legislative review and approval.

FINANCIAL IMPACT: The cost to the regulated entity is $1000 per permit issued.

The department indicated that there is an increased cost or obligation of $100,000 per year to a private individual, private entity, private business, state government, county government, municipal government, or to two or more of these entities combined, and they submitted the following information:

(1) a statement of the rule's basis and purpose;

This rule was prompted by the passage of Act 1085 of 2017, A.C.A. § 27-35-210(q) which directs the Arkansas Department of Transportation in cooperation with the Department of Agriculture to promulgate rules allowing the Arkansas Highway Commission to issue a permit valid for one (1) year authorizing the movement of a truck tractor and semi-trailer combination with a minimum of five (5) axles hauling agronomic or horticultural crops in their natural state that exceed the maximum gross weight as provided in § 27-35-203 but do not exceed a total gross weight of one hundred thousand pounds (100,000 lbs.). A truck tractor and semi-trailer combination issued such a permit shall not exceed the height, length, or width restrictions set out in Chapter 35 of Title 27 of the Arkansas Code;

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

ARDOT drafted rules in cooperation with the Agriculture Department as directed by A.C.A. § 27-35-210(q). In so doing the Department took into consideration the objective of the legislation, to allow up to 100,000 pound loads for certain qualifying entities going from the field to point of first processing. The objective appears to be to allow those so inclined to increase efficiency by increasing possible load weight to 100,000 pounds;

(3) a description of the factual evidence that:
(a) justifies the agency's need for the proposed rule;

ARDOT drafted rules in cooperation with the Agriculture Department as directed by A.C.A. § 27-35-210(q), which

states: "The Arkansas Department of Transportation in coordination with the Arkansas Agriculture Department shall promulgate rules necessary to implement this subsection, including without limitation the criteria required to qualify for the issuance of a special permit."

and
(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

ARDOT has attempted to meet the statutory objectives by providing for permits that may only be issued to vehicles which have been inspected and pre-qualified on routes that have been determined to be safe for the traveling public and do not have any intermediate weight restricted roads or bridges.

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

The rule allows for permitted vehicles to drive upon weight restricted roads when their origin or destination is on a weight restricted road. These roads are particularly susceptible to damage from traffic that weighs in excess of the road rating. (Note, travel on weight restricted bridges or upon the interstate is still prohibited).

An analysis of the effect on roadways by the Department's System Information and Research Division determined that, at the level between the existing 85,000 pounds and the mandated 100,000 pounds, the damage to the roadway is exponential, resulting in three times the damage.

The only alternative to these situations is to not permit the activity, but to do so would make the statutorily required rule almost ineffective.

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

This is the initial submission in accord with Subcommittee Rule (d)(2); as such, public comment has not yet occurred.

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response;

No.

and

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

The Department will continually, and annually, review the rule for determination of its continued effectiveness compared to its costs and damage to the system, and attempt to make corrections and revisions as technology and funding allow.

LEGAL AUTHORIZATION: These rules implement Act 1085 of 2017, sponsored by Representative Michael John Gray, which amended the law concerning the transportation of agricultural products. The State Highway Commission may issue a special permit valid for one (1) year authorizing the movement of a truck tractor and semi-trailer combination with a minimum of five (5) axles hauling agronomic or horticultural crops in their natural state that exceed the maximum gross weight as provided in § 27-35-203 but do not exceed a total gross weight of one hundred thousand pounds (100,000 lbs.). *See* Ark. Code Ann. § 27-35-210(q)(1). The Arkansas State Highway and Transportation Department in coordination with the Arkansas Agriculture Department shall promulgate rules necessary to implement this act, including without limitation the criteria required to qualify for the issuance of a special permit. Ark. Code Ann. § 27-35-210(q)(3).

The department is authorized to "establish by properly promulgated and adopted rules reasonable fees that are necessary to carry out the powers and duties of the commission for

applications, permits, licenses, and other administrative purposes including but not limited to driveways, logos, billboards, signage, sign visibility, and weight restricted roadway maintenance to support the administration and operation of programs for which the fees are assessed." *See* Ark. Code Ann. § 27-65-107(a)(17).

E. Adjournment.