ADMINISTRATIVE RULES SUBCOMMITTEE
OF THE
ARKANSAS LEGISLATIVE COUNCIL

Wednesday, December 15, 2021
9:00 a.m.
Room A, MAC
Little Rock, Arkansas

A. Call to Order.

B. Reports of the Executive Subcommittee.

C. Report of the State Board of Physical Therapy, Pursuant to Act 932 of 2021. (Ms. Nancy Worthen, Mr. Matt Gilmore)

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

1. <u>DEPARTMENT OF COMMERCE, DIVISION OF WORKFORCE SERVICES, ARKANSAS REHABILITATION SERVICES</u> (Mr. Charles Lyford, Ms. Christy Lamas)

a. <u>SUBJECT</u>: Forgiveness of Student Loan Program Rules

<u>DESCRIPTION</u>: The Department of Commerce, Division of Workforce Services, Arkansas Rehabilitation Services proposes amendments to its Rules for Administration of the Arkansas Rehabilitation Services Forgiveness of Student Loan Program. These amendments replace the current rules, which were last updated in 2007. Since that time, statutes affecting the Program have been enacted, such as the Transformation and Efficiencies Act of 2019 and Act 282 of 2021, which changed the timing of loan-forgiveness payments for eligible employees.

<u>PUBLIC COMMENT</u>: A public hearing was held on October 6, 2021. The public comment period expired on October 25, 2021. ARS provided the following summary of any comments received and its responses thereto:

Commenter's Name: Henry Washington
Commenter's Business/Agency: Arkansas Rehabilitation Services
Summary of Comments: There was a clerical error in the rules' introduction as to the effective date of Act 282 of 2021. The rules reference "full time" employees in the eligibility section, but Act 282

refers simply to "employees" of ARS. The rules also reference a twelve-month probationary period before some employees become eligible, while Act 282 refers only to a six-month probationary period. There is inconsistency between the rules and Act 282 regarding "payments" versus "installments" under the program. And the "Eligibility Under Prior Law" section of the rules appears unnecessary, given that Act 282 has taken effect.
Agency's Response to Comments and Any Changes Made: The effective date of Act 282 of 2021 has been added. The reference to "full time" employees has been removed. The reference to a twelve-month probationary period was removed. The rules now refer uniformly to "installments," consistent with Act 282. The "Eligibility Under Prior Law" section has been stricken.

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

(1) *Introduction* – It appears that the first sentence is lacking the specific date that Act 282 became effective. **RESPONSE:** The effective date of July 28, 2021 will be added.

(2) *Eligibility, 1.* – In this section, the rules will require that an individual be a full-time employee with ARS to be eligible for the Program; however, Ark. Code Ann. § 25-30-206(c), as amended by Act 282 of 2021, § 1, does not appear to include this requirement for eligibility. This requirement is also referenced in *Program Payments, 3.* Is ARS comfortable including this requirement not contained in the statute? **RESPONSE:** A probationary period is only required of full-time employees under ARS personnel policies, which is why the rules use this language. But for the same reason, simply stating "employee" in the rules along with the probationary requirement would be enough to exclude part-time or extra-help staff.

(3) *Eligibility, 2.* – In this section, the rules appear to include the possibility of an extended probationary period of 12 months, where Ark. Code Ann. § 25-30-206(c)(1), as amended by Act 282, § 1, simply references a 6 month probationary period, also included in the revised rules. What is the basis for the inclusion of a possible extended probationary period and is the ARS comfortable including it when it is not contained in the statute? **RESPONSE:** This is another personnel-policy matter—supervisors can request one additional six-month probationary period. However, the rules can be changed to match the statute, especially where installments won't be paid until there are two full years of service.

(4) *Program Payments, 2., 3., and 4.* – Ark. Code Ann. § 25-30-206(d)(1), as amended by Act 282, § 1, provides that "[a] payment shall be issued in

installments not to exceed two thousand dollars ($2,000)." (Emphasis added.) It then continues to reference "installment(s)." Should the term "payment," as used in Subsections 2., 3., in both sentences, and 4., be "installment(s)" to be consistent with the statute? **RESPONSE:** Yes, "installment" can be used in these subsections for consistency with the statute.

(5) *Eligibility Under Prior Law* – This section appears to apply to those persons determined eligible for the Program prior to the effective date of Act 282, permits those persons to submit one additional application for consideration beginning July 1, 2021, and requires that any additional applications under the prior Act, Act 1275 of 2007, be received before the effective date of Act 282. However, the effective date of Act 282 appears to be July 28, 2021, as it lacks an emergency clause or specified effective date. *See* Ark. Atty. Gen. Op. No. 2021-029. Because the July 1, 2021 and July 28, 2021 dates have passed and these rules will not become effective until well after the latter date, is this section still applicable? **RESPONSE:** Practically speaking, no. The Eligibility Under Prior Law section can be deleted.

The proposed effective date is January 1, 2022.

FINANCIAL IMPACT: The agency states that the amended rules have no financial impact.

LEGAL AUTHORIZATION: The proposed amendments include changes made in light of Act 282 of 2021, sponsored by Representative Julie Mayberry, which amended the Arkansas Rehabilitation Services Forgiveness of Student Loan Program and clarified requirements for eligibility. Pursuant to Arkansas Code Annotated § 25-30-206(b)(2), Arkansas Rehabilitation Services shall promulgate rules regarding eligibility, payment, and program management consistent with the statute, concerning the Arkansas Rehabilitation Services Forgiveness of Student Loan Program.

b. SUBJECT: Telecommunications Access Program Rules

DESCRIPTION: The Department of Commerce, Division of Workforce Services, Arkansas Rehabilitation Services proposes amendments to its Rules for the Telecommunications Access Program. This Program, known as the Telecommunications Access Program or "TAP," provides phone-related equipment to eligible applicants with disabilities. The current TAP rules have been in place since 2007. Since that time, statutes affecting TAP have been enacted, such as the Transformation and Efficiencies Act of 2019 and Act 263 of 2021, which changed end-of-year accounting procedures for TAP staff.

PUBLIC COMMENT: A public hearing was held on October 6, 2021. The public comment period expired on October 25, 2021. ARS provided the following summary of any comments received and its responses thereto:

Commenter's Name: Tammy Hamilton
Commenter's Business/Agency: Arkansas Rehabilitation Services
Summary of Comments: The rules have an internal inconsistency as to whether suspensions and ineligibility determinations are final, or whether they are appealable. The rules are inconsistent with Act 263 of 2021 in that the Act states that a petition to cease collection of program surcharges must be filed if expenditures from the past fiscal year, times three, is less than or equal to surcharge revenue from the same year. But the rules state that the petition will be filed if three times the amount of expenditures is less than the amount of surcharge revenue. And while Act 263 states that ARS can file a petition requesting that surcharge collections cease, the rules state that a petition may be filed requesting to cease collection or reduce the amount of the surcharge.
Agency's Response to Comments and Any Changes Made: The rules governing suspensions and ineligibility have been changed to state that these determinations are appealable, without reference to being final. The rules as to program expenditures and revenues have been changed such that a petition must be filed if expenditures from the past fiscal year, times three, is less than or equal to surcharge revenue from the same year. The rules were also changed to state that the petition may only request that surcharge collections cease, consistent with Act 263.

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

(1) Section 6(d) – This section provides that all determinations as to suspension and permanent ineligibility are final; however, Section 7 of the rules provides that the suspension of an individual and a determination that an individual is permanently ineligible may be appealed to the ARS Commissioner. Are these determinations final or are they appealable? **RESPONSE:** The intent was for both to apply—the determinations can be appealed because they are final. To avoid confusion, however, the sentence in subsection 6(d) about finality can be deleted.

(2) Section 6(d) – This section also provides that ARS reserves the right to pursue civil or criminal action against individuals who are suspended or determined permanently ineligible. What kinds of civil or criminal action are contemplated? **RESPONSE:** Depending on why the individual is suspended or terminated, civil actions could involve conversion, fraud as

to a publicly-financed program, etc. Criminal actions would likely involve theft.

(3) Section 8(c)(iii, iv) – Ark. Code Ann. § 23-17-119(d)(1), as amended by Act 263 of 2021, § 1, provides that at the close of the fiscal year, a determination shall be made as to whether the amount of revenues collected under the statute "is equal to or exceeds three (3) times the annual expenditures of the equipment distribution program." The statute further provides that "[i]f the amount of revenues . . . is determined to be *at least* three (3) times the annual expenditures . . ., then a petition to cease collection of the surcharge shall be filed with the [Arkansas Public Service C]ommission." Ark. Code Ann. § 23-17-119(d)(2)(A), as amended by Act 263, § 1 (emphasis added). However, the rules provide that "[i]f three times the amount of expenditures is equal to, or greater than, the amount of surcharge revenues, no further action will be taken" and "[i]f three times the amount of expenditures is less than the amount of surcharge revenues, ARS will petition the Arkansas Public Service Commission to pause collection of the surcharge or reduce the surcharge to $.01."

(a) Does the rule differ from the statute, in that "at least" seems to suggest that if the revenues are (1) equal to, or (2) greater, than three times the expenditures, action should be taken, yet the rules seem to provide for action only if the revenues are greater than three times the expenditures? **RESPONSE:** Yes. The petition should be filed if revenues are equal to three times the expenditures, as well as if revenues are greater than three times the expenditures. Subsections 8(c)(iii) and (iv) will be modified.

(b) The action contemplated by the statute appears to be solely a "petition to cease collection of the surcharge"; however, the rules appear to provide that either a "petition to pause collection" or a petition to "reduce the surcharge" could be filed. Is there a reason that the rules differ from the statute? **RESPONSE:** Yes, in that historically ARS has petitioned the PSC to cease collection or to raise or lower the surcharge, within the statutory $.02. However, subsections 8(c)(iv) and (v) can be modified to reflect that the initial petition must be to cease collection.

(4) Section 8(v) – The rules appear to define "surplus" as "the TAP surcharge revenues." Does this mean that expenditures, or three times the expenditures, will not be taken into account in determining "surplus"? **RESPONSE:** Correct. The surplus to be spent down is the funding on hand at the end of a given fiscal year, i.e. program revenue from the surcharges.

The proposed effective date is January 1, 2022.

FINANCIAL IMPACT: The agency states that the amended rules have no financial impact.

LEGAL AUTHORIZATION: The proposed amendments include changes made in light of Act 263 of 2021, sponsored by Representative Julie Mayberry, which modified the procedure for collection of surcharges to fund the Telecommunications Equipment Fund. Arkansas Code Annotated § 20-79-401(a)(1) directs Arkansas Rehabilitation Services ("ARS") to establish, administer, staff, and promote a statewide program to provide access to public telecommunications services by residents of Arkansas who are deaf, hard of hearing, deaf and blind, severely speech-impaired, or who have other disabilities that impair their ability to effectively access the telecommunications network. This program will enable these individuals to access specialized devices or services for telecommunications network access that is functionally equivalent to that enjoyed by individuals without disabilities. Pursuant to Ark. Code Ann. § 20-79-401(a)(2)(B), this program shall include, but is not limited to, the promulgation of procedures, rules, and criteria necessary to implement and administer this program, including accountability measures that utilize consumer participation in the selection and evaluation of equipment and the eligibility of applicants.

In order for a person to be eligible for the equipment distribution program, a person shall be certified as deaf, hard of hearing, deaf and blind, speech-impaired, or having another disability that impairs the individual's ability to effectively access the telecommunications network by a licensed physician, audiologist, or speech pathologist or by any other method recognized by ARS. *See* Ark. Code Ann. § 20-79-402(a). ARS shall also consider financial need and, in so doing, shall take into account financial need standards or other means tests applicable to other programs administered by ARS when promulgating procedures, rules, and criteria necessary to implement and administer the program. *See* Ark. Code Ann. § 20-79-402(b)(1).

2. DEPARTMENT OF CORRECTIONS, ARKANSAS SENTENCING COMMISSION (Ms. Lindsay Wallace)

a. SUBJECT: Sentencing Standards Grid & Seriousness Reference Table

DESCRIPTION: The Arkansas Sentencing Commission proposes amendments to its Arkansas Sentencing Standards Grid and Seriousness Reference Table. Pursuant to Arkansas Code Annotated § 16-90-803, the Arkansas Sentencing Standards Seriousness Reference Table (the "Table")

represents the vertical axis of the Sentencing Standards Grid. The horizontal axis of the grid is represented by the offender's prior criminal history. Offenses are ranked with a seriousness level between one and ten, with ten being the most serious.

In many cases, the seriousness ranking of an offense determines the percentage of an offender's sentence, which must be served prior to becoming eligible for transfer to community supervision. This proposed amendment will add the rankings of offenses created or modified by the 93rd General Assembly to the Table. This amendment also clarifies policy statements regarding statutory overrides.

PUBLIC COMMENT: No public hearing was held. The public comment period expired on November 7, 2021. The Commission received no comments.

The proposed effective date is January 1, 2022.

FINANCIAL IMPACT: The agency states that the amended rules have no financial impact.

LEGAL AUTHORIZATION: Pursuant to Arkansas Code Annotated § 16-90-802(d)(2)(A), the Arkansas Sentencing Commission shall periodically review and may revise the sentencing standards. Any revision of the standards shall be in compliance with provisions applicable to rule making contained in the Arkansas Administrative Procedure Act, § 25-15-201 et seq. *See* Ark. Code Ann. § 16-90-802(d)(2)(B).

3. DEPARTMENT OF HEALTH, ARKANSAS SOCIAL WORK LICENSING BOARD (Ms. Ruthie Bain, Mr. Matt Gilmore)

a. SUBJECT: Rules II, VII, IX, and XIV

DESCRIPTION: The Arkansas Social Work Licensing Board proposes amending the following rules under one or more of the following chapters or sections of the Arkansas Code: Ark. Code Ann. § 17-103-101 et seq. and the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-204:

- Changes to Rule II: amends the Board's current language regarding Military personnel licensure. The language is taken directly from Act 135; removes reference to permanently disqualifying offenses in regard to background checks as required by Act 748; and adds language regarding applicants with "work permits" in accordance with Act 746.

- Changes to Rule VII: adds the waiver of initial license fee for those individuals listed in Act 725.

- Changes to Rule IX: adds volunteer services provided under the Volunteer Healthcare Act to the Board's existing continuing education criteria in accordance with Act 968.

- Changes to Rule XIV: revises the definition of "originating site" to include the home of the patient for telemedicine purposes and adds language regarding the use of telemedicine for group therapy in accordance with Act 767; and revises the definition of "professional relationship" to remove audio only communication for telemedicine purposes in accordance with Act 829.

PUBLIC COMMENT: No public hearing was held. The public comment period expired on November 12, 2021. The Board received no comments.

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

(1) Section II.G.2.c.(1) – The proposed rule references "B (1) or (2) above." Is the reference to the provisions of G.2.a. or b. above? **RESPONSE:** Changed to G.2. a. or b.

(2) Section XIV.G.10. – The proposed change appears to stem from Ark. Code Ann. § 17-80-404(f), as amended by Act 767 of 2021, § 2. The statute uses the term "shall not" in reference to telemedicine use for group therapy provided to a child eighteen or younger; however, the rule uses "may not." Is there a reason for the difference in term? **RESPONSE:** Changed to "shall not."

The proposed effective date is January 1, 2022.

FINANCIAL IMPACT: The agency states that the amended rules have a financial impact. The Board estimates the total cost to state, county, and municipal government to implement the rules will be $26,700 for the current fiscal year and $53,500 for the next fiscal year, explaining:

The proposed rule in response to Act 725 of 2021 may have a financial impact on state government and the above numbers are the most extreme numbers. Act 725 requires the waiver of the initial licensing fee for individuals who meet certain criteria, i.e. receives SNAP benefits or other state aid; been on unemployment or are below the federal poverty line.

This criteria could potentially be met by all new licensees considering the number of new college graduates that make up the total for new licensure each year. The above numbers are based on the average number of new applicants each year and the cost of the license fee that could be waived. As the Board has no true way of knowing just how many applicants will avail themselves to the waiver, there is no true way of knowing at this time just what the financial impact will actually be or if there will be one. For the current fiscal year the average number of new applicants was cut in half since the rule would not be applicable until January 1, 2022.

LEGAL AUTHORIZATION: Pursuant to Arkansas Code Annotated § 17-103-203, the Arkansas Social Work Licensing Board shall, among other things, establish the criteria and process for licensure through endorsement; make rules consistent with law as may be necessary to regulate its proceedings; establish rules defining unprofessional conduct; and establish continuing education requirements and notify the applicants for licensing of the requirement. *See* Ark. Code Ann. § 17-103-203(b)(1), (4), (6), and (8). The Board shall further adopt the necessary rules to fully implement the provisions of Ark. Code Ann. § 17-103-307, concerning criminal background checks. *See* Ark. Code Ann. § 17-103-307(i). Additionally, the provision of social work services to a client within this state through any means, including without limitation electronic means or by telephone, regardless of the location of the social worker, constitutes the practice of social work and is subject to Title 17, Chapter 103, of the Arkansas Code, concerning social workers, and to rules adopted under the chapter. *See* Ark. Code Ann. § 17-103-309.

The proposed changes include those made in light of the following acts:

Act 135 of 2021, sponsored by Senator Ricky Hill, which established the Arkansas Occupational Licensing of Uniformed Service Members, Veterans, and Spouses Act of 2021 and modified the automatic occupational licensure requirements for uniformed services members, returning uniformed services veterans, and their spouses;

Act 725 of 2021, sponsored by Senator Ben Gilmore, which created the Workforce Expansion Act of 2021;

Act 746 of 2021, sponsored by Representative Clint Penzo, which authorized occupational or professional licensure for certain individuals;

Act 748 of 2021, sponsored by Representative Bruce Cozart, which amended occupational criminal background checks;

Act 767 of 2021, sponsored by Representative Aaron Pilkington, which clarified the Telemedicine Act; specified that the home of a patient may be

an originating site for telemedicine and that group meetings may be performed via telemedicine; and clarified reimbursement of telemedicine services;

Act 829 of 2021, sponsored by Representative Jim Dotson, which amended the Telemedicine Act and authorized additional reimbursement for telemedicine via telephone; and

Act 968 of 2021, also sponsored by Representative Aaron Pilkington, which updated the Volunteer Health Care Act; included therapists, addiction specialists, and counselors in the Volunteer Healthcare Program; and increased continuing education credits under the Volunteer Health Care Act.

4. <u>STATE HIGHWAY COMMISSION</u> (Mr. Gill Rogers)

a. <u>SUBJECT</u>: Amendment to Autonomous Vehicle Program

<u>DESCRIPTION</u>: Pursuant to Ark. Code Ann. § 27-51-2002(d), the Arkansas Highway Commission proposes to amend the Autonomous Vehicle Pilot Program Rules. This amendment will remove limitations that currently exist within the 'Pilot' program and set out the process for the public to apply for and obtain approval to operate autonomous vehicles pursuant to the requirements of Arkansas law.

The rules currently define terms used in the law, such as "automated driving system" or "dynamic driving task," and set out the information required to be submitted or acknowledged as part of the application process. The proposed amendment will define terms used in the law such as "human operator," "on-demand driverless capable vehicle network" and "remote operator." The amendment also changes requirements such that autonomous vehicles must comply with the minimum liability insurance coverage requirements for a motor carrier of property under 49 C.F.R. § 387.9 as it existed on January 1, 2021.

The proposed amendment requires that the autonomous vehicle or fully autonomous vehicle meets Federal Motor Vehicle Safety Standards and Regulations, 49 C.F.R. Part 571, as it existed on January 1, 2021, for the vehicle's model year, except to the extent an exemption has been granted under applicable federal law, and all other applicable safety standards and performance requirements stated in state and federal law and rules adopted by the commission.

In addition, the proposed amendment requires autonomous vehicles or fully autonomous vehicles to be registered and titled as required under the

Motor Vehicle Administration, Certificate of Title, and Antitheft Act, § 27-14-101 et seq.

The proposed amendment will also allow a person to operate an on-demand driverless capable vehicle network in the state.

PUBLIC COMMENT: A public hearing was held on this rule on October 26, 2021. The public comment period expired on October 26, 2021. The agency indicated that it received no public comments.

The proposed effective date is January 3, 2022.

FINANCIAL IMPACT: The agency indicated that this rule does not have a financial impact.

LEGAL AUTHORIZATION: These rules implement Act 619 of 2021. The Act, sponsored by Representative Austin McCollum, amended the law concerning autonomous vehicles. Under the Act, the State Highway Commission is responsible for implementing Ark. Code Ann. §§ 27-51-2000 to -2006, addressing autonomous vehicles, and "shall adopt rules necessary for the implementation of this subchapter." Ark. Code Ann. § 27-51-2005(b), *as created by* Act 619.

5. DEPARTMENT OF HUMAN SERVICES, DIVISION OF AGING, ADULT & BEHAVIORAL HEALTH SERVICES (Mr. Mark White, Mr. Jay Hill, Ms. Patricia Gann)

a. SUBJECT: Division of Aging, Adult, and Behavioral Health Services (DAABHS) Manual Extension

DESCRIPTION:

Statement of Necessity

The rule was initially promulgated to sunset on December 31, 2021; however, the public health emergency is ongoing, therefore DAABHS amends the termination date to extend the sunset date to the end of the federal public health emergency, including any extensions.

Rule Summary

The Director of the Division of Aging, Adult, and Behavioral Health amends the COVID-19 Response Manual to extend the sunset date of three provisions from December 31, 2021 to the end of the federal public health emergency, including any extensions. DAABHS continues to

suspend the 365-day expiration date requirement for Person-Centered Service Plans for ARChoices. Also suspended are the rules for the periodic Independent Assessment and annual Division of County Operations level of care predetermination as well as the DHS RN annual evaluation to determine whether a nursing home intermediate level of care is still appropriate. PACE involuntary dismissal rules are suspended as well as the semi-annual and annual requirements. These suspensions allow beneficiaries to remain eligible for ARChoices, Living Choices, and PACE programs even though they do not have timely evaluations. The Living Choices Assisted Living Facilities rate will be maintained at the current rate pending approval for permanency by CMS.

PUBLIC COMMENT: No public hearing was held on this proposed rule. The public comment period expired on November 8, 2021. The agency indicated that it received no public comments.

The proposed effective date is January 1, 2022.

FINANCIAL IMPACT: The agency indicated that this rule has a financial impact.

Per the agency, the total cost to implement this rule is $769,969 for the current fiscal year ($218,517 in general revenue and $551,452 in federal funds) and $1,539,938 for the next fiscal year ($437,034 in general revenue and $1,102,903 in federal funds). The total estimated cost by fiscal year to state, county, and municipal government to implement this rule is $218,517 for the current fiscal year and $437,034 for the next fiscal year.

The agency indicated that there is 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. Accordingly, the agency provided the following written findings.

(1) a statement of the rule's basis and purpose;

Due to the COVID-19 pandemic, DAABHS made revisions to rules to ensure continuity of services for clients.

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

DAABHS nurses will complete an evaluation of the beneficiary's current needs and will extend the dates for qualifying beneficiaries, ensuring continued eligibility for services. DAABHS suspended a rule to allow

members who do not receive a timely evaluation to remain eligible for ARChoices, Living Choices and PACE.

(3) a description of the factual evidence that:
(a) justifies the agency's need for the proposed rule; and
(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

DAABHS nurses will complete an evaluation of the beneficiary's current needs and will extend the dates for qualifying beneficiaries, ensuring continued eligibility for services. DAABHS suspended a rule to allow members who do not receive a timely evaluation to remain eligible for ARChoices, Living Choices and PACE.

(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;

None.

(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;

None at this time.

(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

N/A

(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 Agency monitors State and Federal rules and policies for opportunities to reduce and control costs.

LEGAL AUTHORIZATION: The Department of Human Services has the responsibility to administer assigned forms of public assistance and is specifically authorized to maintain an indigent medical care program (Arkansas Medicaid). *See* Ark. Code Ann. §§ 20-76-201(1), 20-77-107(a)(1). The Department has the authority to make rules that are necessary or desirable to carry out its public assistance duties. Ark. Code Ann. § 20-76-201(12); *see also* Ark. Code Ann § 20-10-203(b). The Department and its divisions also have the authority to promulgate rules as necessary to conform their programs to federal law and receive federal funding. Ark. Code Ann. § 25-10-129(b).

6. DEPARTMENT OF HUMAN SERVICES, DIVISION OF COUNTY OPERATIONS (Mr. Mark White, Ms. Mary Franklin)

a. SUBJECT: Updates to TEA Policy 2000-2013

DESCRIPTION:

Statement of Necessity

This change is necessary to update the Transitional Unemployment Assistance (TEA) Policy Manual due to changes in the application process for TEA, including how interviews will be conducted. Business process language has been removed in the sections. Sections of policy on Diversion Assistance have been removed as the applications for Diversion Assistance will be processed by the Department of Workforce Services beginning January 1, 2022.

Rule Summary

The TEA Policy Manual is revised as follows:

- TEA 2003 – Updated the application number and name. Removed language that is no longer needed about online applications.
- TEA 2004 – Removed languages no longer needed about face-to-face interviews because the majority of interviews will be conducted via telephone. The section was removed from the online application.
- TEA 2004.1 – Removed the language concerning submitting the PRA to the county office or agreeing to the provisions on the online application with the electronic signature.
- TEA 2005 – Updated the language from county office to the eligibility worker to comply with the universal caseload. Removed the DCO-81, Consent of Release of Information, due to this information having been embedded in the DCO-0004, Application for SNAP, Health Care, and TEA/RCA Benefits.

- TEA 2010 – Removed language concerning the specifics of Diversion Assistance, due to the Department of Workforce Services processing these applications (effective January 2022).
- TEA 2011 – Removed the section on Authorizing the Diversion Assistance Payments, due to the Department of Workforce Services processing these applications (effective January 2022).
- TEA 2012 – Removed the section on Deleting a Diversion Payment, due to the Department of Workforce Services processing these applications (effective January 2022).
- TEA 2013 – Removed the section on Deleting a Diversion Payment, due to the Department of Workforce Services processing these applications (effective January 2022).

PUBLIC COMMENT: No public hearing was held on this proposed rule. The public comment period expired on November 8, 2021. The agency indicated that it received no public comments.

The proposed effective date is January 1, 2022.

FINANCIAL IMPACT: The agency indicated that this proposed rule does not have a financial impact.

LEGAL AUTHORIZATION: The Department of Human Services has the responsibility to administer assigned forms of public assistance. *See* Ark. Code Ann. §§ 20-76-201(1), 20-77-107(a)(1). The Department has the authority to make rules that are necessary or desirable to carry out its public assistance duties, *see* Ark. Code Ann. § 20-76-201(12), and it has the specific authority to "promulgate rules to determine resource eligibility and benefit levels for" Transitional Employment Assistance Program eligibility. Ark. Code Ann. § 20-76-401(c). The Department and its divisions also have the authority to promulgate rules as necessary to conform their programs to federal law and receive federal funding. Ark. Code Ann. § 25-10-129(b).

b. SUBJECT: SNAP 9000 Expedited Case Actions

DESCRIPTION:

Statement of Necessity

The current SNAP Expedited Services policy places undue hardship on SNAP clients, which negatively affects county offices' productivity. The mandated applications, interviews, and verifications can often cause a client's service to be interrupted, which, in turn, increases the workload of the county office staff. The Food and Nutrition Service (FNS) has advised the agency that the current SNAP policy did not comply with federal

SNAP regulations. Streamlining the expedited services process will provide timely and improved services to our clients.

Rule Summary

Households granted expedited service will receive the most appropriate certification period for their household if all eligibility requirements are met at initial interview.

All other households will be certified for one or two months determined by their application date and verification will be postponed. Verification that was postponed must be returned by the end of the certification period or within thirty days of the end of the certification period to be recertified for additional benefits.

The proposed rule requires all reasonable efforts be made to verify all eligibility requirements during the expedited interview.

There are no limits on the number of times Expedited Services are requested. If verification was postponed by not returned, the household must return the verification before receiving expedited services again. However, if it has been twelve months or more since the household last received expedited services, the household may receive expedited services.

Finally, some business processes and examples are removed from the rule.

PUBLIC COMMENT: No public hearing was held on this proposed rule. The public comment period expired on November 8, 2021. The agency indicated that it did not receive any public comments.

The proposed effective date is April 1, 2022.

FINANCIAL IMPACT: The agency indicated that this rule does not have a financial impact.

LEGAL AUTHORIZATION: The Department of Human Services has the responsibility to administer assigned forms of public assistance and is specifically authorized to maintain an indigent medical care program (Arkansas Medicaid). *See* Ark. Code Ann. §§ 20-76-201(1), 20-77-107(a)(1). The Department may make rules that are necessary or desirable to carry out its public assistance duties. Ark. Code Ann. § 20-76-201(12); *see also* Ark. Code Ann § 20-10-203(b).

The Department and its divisions also have the authority to promulgate rules as necessary to conform their programs to federal law and receive

federal funding. Ark. Code Ann. § 25-10-129(b). This rule implements 7 C.F.R. § 273.2(i), which addresses expedited processing of SNAP applications.

c. SUBJECT: ARHOME Integration

DESCRIPTION:

Statement of Necessity

With the implementation of Arkansas Health and Opportunity for Me (ARHOME) and the implementation of the new integrated system, it has become necessary to update the Medical Services Policy. The Medical Services Policy is being updated to reflect the replacement of ARWorks, the addition of new programs provided through ARHOME, and the removal of business processes. This will allow the business process to change independently of the Policy Manual.

Rule Summary

Policy section A-210 has been included to revise the date for retroactive coverage, change "Medicaid" to "Health Care" and "caseworker" to "eligibility worker".

The following are changes to Policy B:

1. Global Change- "Medicaid" changed to "Health Care" Program. This has been changed throughout the entire document.
2. Global Change- "ARWorks" changed to "ARHome".
3. Global Change- "Assisted Living" changed to "Living Choices".
4. Global Change- Updated headers to singular header listing main Policy name.
5. Removal of MS Manual updated dates. Changed to 01/01/2022.
6. Removal of information out of Policy is reflected in the Business Process Manual.
7. Overall editing for grammar and style.
8. B-100 Eligibility Groups:
    a. Changed "Medicaid" to "Health Care".
9. B-200 Families and Individuals Group (MAGI):
    a. Updated grammatical error for consistency throughout policy;
    b. Removed "pin" bullet from "NOTE" to have consistency throughout policy; and
    c. Changed "Medicaid" to "Health Care".
10. B-220 Newborns:
    a. Changed "Medicaid to "Health Care".
11. B-230 Parents/Caretaker Relatives:

a. Removed “s” from Parents; and

b. Removed “pin” bullet from “NOTE” to have consistency throughout policy.

12. B-240 Pregnant Women:
    a. Changed “Medicaid” to “Health Care”.
13. B-250 Unborn Child (Pregnant Woman):
    a. Changed “Medicaid” to “Health Care”; and
    b. Corrected grammatical errors.
14. B-260 Former Foster Care Adults:
    a. Changed “Medicaid” to “Health Care”.
15. B-270 Adult Expansion Group (Arkansas Works Program):
    a. Title Changed to from (Arkansas Works Program) to (ARHOME);
    b. Removed wording that explained ARWorks;
    c. Added wording to explain ARWorks becoming ARHome;
    d. Updated the date to reflect when ARHome will take effect;
    e. Corrected grammatical errors for consistency throughout policy;
    f. Changed “Arkansas Works” to “ARHome”;
    g. Removed “pin” bullet from “NOTE” to have consistency throughout policy;
    h. Removed language about requirements for ARWorks;
    i. Added language about Medically Frail, American Indian (AI)/Alaskan Native (AN), and Mandatory enrollment in a PASSE;
    j. Added language about QHP enrollees; and
    k. Expanded acronym for ABP for easy reading.
16. B-310 Long Term Services and Supports:
    a. Corrected grammatical errors to have consistency throughout policy.
17. B-311 Nursing Facility:
    a. Added Note to refer to for Policy for spousal rules;
    b. Added Note about uncompensated transfers; and
    c. Changed “Medicaid” to “Health Care”.
18. B-312 Assisted Living Facilities:
    a. Changed “Assisted Living Facilities” to “Living Choices”; and
    b. Removed “ALF” from policy.
19. B-313 AR Choices in Homecare:
    a. Removed business processes;
    b. Added language “Refer to Health Care Procedures Manual for more information”; and
    c. Updated “Medicaid” to “Health Care”.
20. B-315 TEFRA:
    a. Updated “Medicaid” to “Health Care”.
21. B-316 Autism Waiver:
    a. Updated “Medicaid” to “Health Care”.
22. B-318 PACE- Program of All Inclusive Care for the Elderly:
    a. Updated grammatical error.

23. B-320 Medicare Savings Programs (MSP):
    a. Updated “Medicaid” to “Health Care”.
24. B-321 ARSeniors:
    a. Updated “Medicaid” to “Health Care”.
25. B-326 Medicare Savings Programs- Comparison Chart:
    a. Removed business process ; and
    b. Added “Refer to health Care Procedures Manual for more information”.
26. B-330 Workers with Disabilities:
    a. Updated “Medicaid” to “Health Care”.
27. B-340 Supplemental Security Income (SSI)/SSI Related Groups:
    a. Corrected grammatical error.
28. B-341 Supplemental Security Income (SSI) Cash Eligibles:
    a. Updated “Medicaid” to “Health Care”.
29. B-342 Eligible Due to Disregard of Social Security cost of Living Adjustment (COLA) Increases (Pickle):
    a. Updated “Medicaid” to “Health Care”.
30. B-343 Medicaid for Widows and Widowers with Disabilities (COBRA):
    a. Updated “Medicaid” to “Health Care”.
31. B-344 Widows and Widowers with Disabilities:
    a. Updated “Medicaid” to “Health Care”.
32. B-345 Medicaid for Widows, Widowers with a Disability and Surviving Divorced Spouses with a Disability (OBRA 90):
    a. Updated “Medicaid” to “Health Care”.
33. B-346 Disabled Adult Children (DAC):
    a. Updated “Medicaid” to “Health Care”; and
    b. Corrected grammatical error.
34. B-400 Foster Care Medicaid:
    a. Updated “Medicaid” to “Health Care”.
35. B-500 Emergency Medicaid Services for Aliens:
    a. Updated “Medicaid” to “Health Care”;
    b. Added “Refer to Health Care Procedures Manual for more information”;
    c. Removed “pin” bullet from “NOTE” to have consistency throughout policy; and
    d. Removed business processes.

The following are changes to Policy G:

1. Global Change- “Medicaid” changed to “Health Care” Program. This has been changed throughout the entire document.
2. Global Change- “ARWorks” changed to “ARHome”.
3. Global Change- “Assisted Living” changed to “Living Choices”.
4. Global Change- Updated headers to singular header listing main Policy name.

5. Removal of MS Manual updated dates. Changed to 01/01/2022.
6. Removal of information out of Policy is reflected in the Business Process Manual.
7. Overall editing for grammar and style according to the Code of Arkansas Rules Style Guide.
8. G-100 Verification Standards:
    a. Updated “Medicaid” to “Health Care”.
9. G-111 Eligibility Factors That Require Verification:
    a. Updated “Medicaid” to “Health Care”; and
    b. Removed “pin” bullet from “NOTE” to have consistency throughout policy.
10. G-113 Verification Sources:
    a. Removed language about sunset systems.
11. G-114 Reasonable Opportunity for Providing Verification:
    a. Corrected grammatical errors.
12. G-115 Self Declaration:
    a. Updated “caseworker” to “eligibility worker”.
13. G-120 Verifying the Social Security Number:
    a. Removed language referring to business process from Sunset systems.
14. G-130 Verifying Citizenship:
    a. Updated “Medicaid” to “Health Care”.
15. G-131 Methods of Citizenship Verification:
    a. Condensed verbiage about citizenship verification; and
    b. Removed “pin” bullet from “NOTE” to have consistency throughout policy.
16. G-132 Reasonable Opportunity for Verifying Citizenship:
    a. Removed “pin” bullets from “NOTE” to have consistency throughout policy;
    b. Corrected grammatical errors; and
    c. Updated “caseworker” to “eligibility worker”.
17. G-134 subsequent Citizenship Verification:
    a. Updated “Medicaid” to “Health Care”; and
    b. Corrected grammatical errors.
18. G-140 Alien Status Verification Requirements:
    a. Removed old business process from sunset systems;
    b. Corrected pronoun and subject tense;
    c. Corrected grammatical errors;
    d. Removed information about USDHS and chart; and
    e. Updated “Medicaid” to “Health Care”.
19. G-141 Reasonable Opportunity for Verifying Alien Status:
    a. Corrected grammatical error;
    b. Removed “pin” bullets from “NOTE” to have consistency throughout policy;
    c. Updated “Medicaid” to “Health Care”; and
    d. Updated “caseworker” to “eligibility worker”.

20. G-150 Income Verification:
    a. Updated language to remove old business process regarding ARFinds:
        i. Updated to more general information (i.e. electronic verification, data matches).
21. G-151 Reasonable compatibility Standards for Electronic Data Sources:
    a. Corrected grammatical errors.
22. G-152 Reasonable Compatibility of Income Does Not Exist:
    a. Updated "caseworker" to "eligibility worker"; and
    b. Updated grammatical errors.
23. G-160 Age/Date of Birth:
    a. Updated "caseworker" to "eligibility worker".
24. G-181 Verification of Resources using the Asset Verification System:
    a. Changed "Long Term Care Aged, Blind Long Term Care, Long Term Care Disabled" to "Nursing Facility";
    b. Expanded and added acronyms for clarity;
    c. Corrected grammatical errors;
    d. Updated "Aged, QMB Blind, and QMB Disabled" to "Qualified Medicare Beneficiary";
    e. Removed some text about AVS to allow a briefer description of its purpose; and
    f. Language clarification for AVS process.
25. G-190 Verification of the Adult Expansion Group Work and Community Engagement
Requirement:
    a. Removed entire section:
        i. Work requirement is no longer a requirement.

The following are changes to the F Policy:

1. Overall editing for grammar and style according to the Code of Arkansas Rules Style Guide.
2. F-110 Age and Relationship:
    a. Updated "Medicaid" to "Health Care".
3. F-120 Blindness and Disability:
    a. Corrected grammatical errors; and
    b. Updated "Medicaid" to "Health Care".
4. F-121 Social Security Administration:
    a. Corrected grammatical errors; and
    b. Updated "Medicaid" to "Health Care".
5. F-122 Medical Review Team (MRT):
    a. Updated "Medicaid" to "Health Care"; and
    b. Removed "pin" bullets from "NOTE" to have consistency throughout policy.
6. F-123 Dual Applications:

a. Updated “Medicaid” to “Health Care”; and
b. Corrected grammatical errors.
7. F-130 Child Support Enforcement Services:
a. Updated “Medicaid” to “Health Care”; and
b. Removed “pin” bullets from “NOTE” to have consistency throughout policy.
8. F-150 Establishing Categorical Eligibility for Long-Term Services and Supports (LTSS):
a. Corrected grammatical errors;
b. Removed hyphen out of the title to be consistent throughout policy;
c. Updated “Medicaid” to “Health Care”; and
d. Removed “pin” bullets from “NOTE” to have consistency throughout policy.
9. F-155 Functional Need Criteria:
a. Corrected grammatical errors; and
b. Updated “ALF” to “Living Choices”.
10. F-160 Primary Care Physician Requirements:
a. Updated “Medicaid” to “Health Care”.
11. F-161 Primary Care Physician Managed Care Program:
a. Updated “Medicaid” to “Health Care”.
12. F-171 Determining Monthly Premiums:
a. Removal of date from Policy to prevent updating this date every change; and
b. Removed “pin” bullets from “NOTE” to have consistency throughout policy.
13. F-180 Other Health Insurance Coverage:
a. Updated “Medicaid” to “Health Care”;
b. Corrected grammatical errors; and
c. Removed “pin” bullets from “NOTE” to have consistency throughout policy.
14. F-190 Medicare Entitlement Requirements for Medicare Savings Programs (MSP) Eligibility Groups:
a. Updated “Medicaid” to “Health Care”; and
b. Expanded acronyms for clarity.
15. F-191 Medicare Part A Entitlement:
a. Corrected grammatical errors; and
b. Updated “Medicaid” to “Health Care”.
16. F-193 Initial Enrollment Period and General Enrollment Period for Medicare Part A:
a. Corrected grammatical errors.

PUBLIC COMMENT: No public hearing was held on this rule. The public comment period expired on November 11, 2021. The agency indicated that it received no public comments.

The proposed effective date is January 1, 2022.

FINANCIAL IMPACT: The agency indicated that this rule has a financial impact.

Per the agency, the total additional cost of this rule is estimated at $1,133,055 for the current fiscal year ($113,306 in general revenue and $1,019,750 in federal funds) and $0 for the next fiscal year. The total estimated cost by fiscal year to state, county, and municipal government to implement this rule is $113,306 for the current fiscal year and $0 for the next fiscal year.

The agency indicated that there is 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, local government, or to two or more of those entities combined. Accordingly, the agency provided the following written findings:

(1) a statement of the rule's basis and purpose;

With the implementation of Arkansas Health and Opportunity for Me (ARHOME) and the implementation of the new integrated system it has become necessary to update the Medical Services Policy. The Medical Services Policy is being updated to reflect the replacement of ARWorks, the addition of new programs provided through ARHOME, and the removal of business processes. This will allow the business process to change independently of the Policy Manual. The Director of the Division of County Operations (DCO) amends the Medical Services Policy Manual, Sections A-210, B, G, & F. The implementation of ARHome as well as a new integrated system necessitates the changes.

DCO also makes technical and grammatical corrections and removes business processes that do not meet the statutory definition of a rule. DCO changes income verification concerning information received from the Asset Verification System.

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

With the implementation of Arkansas Health and Opportunity for Me (ARHOME) and the implementation of the new integrated system it has become necessary to update the Medical Services Policy. The Medical Services Policy is being updated to reflect the replacement of ARWorks, the addition of new programs provided through ARHOME, and the removal of business processes. This will allow the business process to change independently of the Policy Manual. The Director of the Division

of County Operations (DCO) amends the Medical Services Policy Manual, Sections A-210, B, G, & F. The implementation of ARHome as well as a new integrated system necessitates the changes. DCO also makes technical and grammatical corrections and removes business processes that do not meet the statutory definition of a rule. DCO changes income verification concerning information received from the Asset Verification System.

This is required by statute.

(3) a description of the factual evidence that:
(a) justifies the agency's need for the proposed rule; and

This system change is required for the implementation of AR Home.

(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

This system change is required for the implementation of AR Home.

(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;

None

(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;

None

(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

N/A

(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.

1115 Waivers require renewal and review every five years.

LEGAL AUTHORIZATION: This rule implements Act 530 of 2021, sponsored by Senator Missy Irvin. The Act created the Arkansas Health and Opportunity for Me Act of 2021 and the Arkansas Health and Opportunity for Me Program, effective January 1, 2022. *See* Act 530, § 9. "The Department of Human Services shall adopt rules necessary to implement" the Health and Opportunity for Me Act. *See* Ark. Code Ann. § 23-61-1012, *as created by* Act 530.

7. DEPARTMENT OF HUMAN SERVICES, DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES (Mr. Mark White, Ms. Melissa Stone)

a. SUBJECT: Occupational Therapy, Physical Therapy, and Speech-Language Pathology Medicaid Manual

DESCRIPTION:

Statement of Necessity

This amendment to the Occupational Therapy, Physical Therapy, and Speech-Language Pathology Medicaid manual clarifies and removes duplication from the current version of the manual and includes the requirements and parameters surrounding delivery of Occupational Therapy, Physical Therapy, and Speech-Language Pathology services through telemedicine. Department rule promulgation authority is also provided under A.C.A. § 20-76-201(12) which directs the Department to make rules that are necessary to provide public assistance. The 93rd General Assembly enacted Acts 767 and 829 amending the Telemedicine Act. These rule changes are in response to those amendments.

Rule Summary

- Reorganizes the manual into the following structure: provider credentialing and operational requirements, client eligibility, covered services and benefit limits, extension of benefits and prior authorizations, and retrospective review.
- Updates the table of contents to reflect new structure and organization.
- Adds hyperlinks for the list of accepted evaluation instruments and applicable procedure codes and descriptions.
- Removes duplication and includes clarifying language throughout the current version of manual.

- Updates retrospective review section.
- Includes the option of delivery of Occupational Therapy, Physical Therapy, and Speech-Language Pathology services through telemedicine and sets out those parameters and requirements.

PUBLIC COMMENT: A public hearing was held on this rule on October 28, 2021. The public comment period expired on November 8, 2021. The agency provided the following summary of the public comments it received and its responses to those comments:

Commenter's Name: Grace Velte, Graduate Assistant at the University of Central Arkansas, on behalf of Professor Lynne Hollaway, MS, OTR/L

COMMENT: Hi, I'm Grace Velte. I am a graduate assistant at UCA, and I'm here on the behalf of Ms. Hollaway. She's a pediatric professor here at the university, and we wanted to make a few changes to this new proposal. We would like to remove The Adaptive Behavior Scale-School Edition, as it is outdated and is no lover being published. We would also like to remove the Bruininks-Oseretsky Test of Motor Proficiency, as there is an updated version of this, a new edition. We would also like to add a few standardized assessments that would address areas that are not currently addressed in the assessments on the list. These are the Weekly Calendar Planning Activity; Behavior Rating Inventory of Executive Function, the second Edition; the Roll Evaluation of Activities of Life; and the Goal-Oriented Assessment of Lifeskills. Thank you.

Yes, so those are specifically for occupational therapy.

RESPONSE: Thank you for your comment. The list of accepted evaluation instruments for each discipline is not included within the proposed Occupational Therapy, Physical Therapy, and Speech-Language Pathology Medicaid Manual, but a hyperlink to the accepted evaluation instruments for each discipline will be imbedded within the electronic version of the proposed Medicaid Manual. The complete list of the accepted evaluation instruments for each discipline will also be available online.

Commenter's Name: Elizabeth Cleveland, PhD, CCC-SLP, Assistant Professor, Dept. of Communication Sciences and Disorders, University of Central Arkansas

COMMENT: The American Speech-Language-Hearing Association (ASHA) indicates nine areas of practice for speech-language pathologists, more commonly known as "ASHA's Big Nine Areas" (see The Big Nine under this website: https://www.asha.org/events/slp-summit-glossary/). These nine areas include:

1. Articulation
2. Fluency
3. Voice and Resonance (including respiration and phonation)
4. Receptive and Expressive Language
5. Hearing (including the impact on speech and language)
6. Swallowing (oral, pharyngeal, esophageal, and related functions, including oral function for feeding and orofacial myofunction)
7. Cognitive Aspects of Communication (attention, memory, sequencing, problem-solving, executive functioning)
8. Social Aspects of Communication (challenging behavior, ineffective social skills, lack of communication opportunities)
9. Communication Modalities (including oral, manual, augmentative and alternative communication techniques, and assistive technologies)

The Arkansas Medicaid Manual for occupational therapy, physical therapy, and speech-language pathology section 212.420, Part B states:

212.420 Speech-Language Pathology Comprehensive Assessments 1-1-22

B. Depending on the type of communication disorder suspected, the following are required to be included as part of a comprehensive assessment used to establish medical necessity:

1. Language Disorder: a comprehensive measure of language must be included for initial
eligibility purposes. Use of one-word vocabulary tests alone will not be accepted;

2. Speech Production Disorder: a comprehensive measure with all errors specific to the type of speech production disorder reported (for example, positions, processes, and motor patterns);

3. Voice Disorder: a medical evaluation to determine the presence or absence of a physical etiology is required as part of the comprehensive assessment; and

4. Oral Motor, Swallowing, or Feeding Disorder: if swallowing problems or signs of aspiration are noted, then a referral for a video fluoroscopic swallow study must be made and documented as part of the comprehensive assessment.

Likewise, section 212.520 states:

212.520 Speech-Language Pathology Standardized Evaluations 1-1-22

A. The standardized evaluation(s) and required scoring to establish medical necessity for speech-language pathology services varies depending on the suspected communication disorder.

1. Language Disorder: impaired comprehension or use of spoken language, written, or other symbol systems. A language disorder may involve one (1) or any combination of the following components: phonology, morphology, syntax, semantics, prosody, and pragmatics.

a. Children birth to three (3) years of age: a score on a standardized evaluation performed within the past six (6) months that indicates a composite or quotient score of at least one point five (1.5) standard deviations below the mean, along with corroborating data from a second criterion referenced evaluation.

b. Children three (3) to twenty-one (21) years of age: a score on two (2) standardized evaluations performed within the past six (6) months that both result in a composite or quotient score of at least one point five (1.5) standard deviations below the mean.

c. If both evaluations do not agree or do not indicate a composite or quotient score on a of at least one point five (1.5) standard deviations below the mean, then a third evaluation may be used to demonstrate medical necessity; however, for a client from three (3) to twenty-one (21) years of age, the third evaluation must be a norm-referenced, standardized evaluation that results in a composite or quotient score on a of at least one point five (1.5) standard deviations below the mean.

2. Speech Production (Articulation, Phonological, and Apraxia): a score on two (2) standardized evaluations performed within the past six (6) months that both result in standard scores of at least one point five (1.5) standard deviations below the mean. If only one (1) evaluation results in a standard score of at least one point five (1.5) standard deviations below the mean, then corroborating data from clinical analysis procedures can be used as a substitute for a second evaluation.

3. Voice Disorder: a detailed functional profile of voice parameters that indicate a moderate or severe voice deficit or disorder.

4. Fluency: a standardized evaluation and at least one (1) supplemental tool to address affective components each performed within the last six (6) months. The results of the standardized evaluation and supplemental tool must establish one of the following:

a. The client is within three (3) years of stuttering onset and exhibits significant risk factors for persistent developmental stuttering;

b. The client has a persistent stutter and a score on a standardized evaluation within one (1.0) standard deviation from the mean or greater during functional speaking tasks; or

c. A score on a standardized evaluation that indicates either:
i. A standard score within one (1.0) standard deviation from the mean or greater; or
ii. An index score of at one point five (1.5) standard deviations below the mean when comparing beneficiaries who stutter to individuals who do not stutter.

5. Oral Motor, Swallowing, or Feeding Disorder: an in-depth functional profile of oral motor structures and function using a comprehensive checklist or profile protocol that indicates a moderate or severe oral motor, swallowing, or feeding deficit or disorder.

The areas addressed in these sections incorporate all of ASHA's Big Nine Areas except for cognition. Pediatric cognition is an area that falls well within a speech-language pathologist's scope of practice (1, 2, 3), and yet it has always been omitted from the Arkansas Medicaid manuals. Individuals who experience cognitive impairments have diagnoses such as autism spectrum disorder, Down syndrome, cerebral palsy, premature birth, pediatric traumatic brain injury, attention deficit/hyperactivity disorder, fetal alcohol spectrum disorders, and other neurodevelopmental disabilities (1, 2). Cognitive communication impairments have even frequently been documented in pediatric COVID-19 patients (2, 3). Speech-language pathology intervention (i.e., speech therapy) for cognitive impairments have been shown to increase cognitive skills levels, academic performance, quality of life, and success during the transition from pediatric to adulthood (1).

Because of these reasons, I recommend adding Cognitive Disorder to the speech-language pathologist's list of billable evaluation and treatment services as mentioned in sections 212.520, 212.420, There are standardized and norm-referenced cognitive assessments that should follow the same requirements as found under "Language Disorders" in section 212.520.

Following the format introduced in section 212.520, please see a proposed addition to the Arkansas Medicaid manual for occupational therapy, physical therapy, and speech language pathology:

6. (following oral motor, swallowing, or feeding disorder) Cognitive Disorder: impaired cognition as characterized by one or more of the

following areas: attention, memory, sequencing, problem-solving, executive functioning.

a. Children birth to three (3) years of age: a score on a standardized evaluation performed within the past six (6) months that indicates a composite or quotient score of at least one point five (1.5) standard deviations below the mean, along with corroborating data from a second criterion referenced evaluation.

b. Children three (3) to twenty-one (21) years of age: a score on two (2) standardized evaluations performed within the past six (6) months that both result in a composite or quotient score of at least one point five (1.5) standard deviations below the mean.

c. If both evaluations do not agree or do not indicate a composite or quotient score on a of at least one point five (1.5) standard deviations below the mean, then a third evaluation may be used to demonstrate medical necessity; however, for a client from three (3) to twenty-one (21) years of age, the third evaluation must be a norm-referenced, standardized evaluation that results in a composite or quotient score on a of at least one point five (1.5) standard deviations below the mean.

Finally, please consider the addition of Cognitive Disorders to the following billing code (revisions have been added to this example):

92523 UA Evaluation of Speech Production (e.g., articulation, phonological process, apraxia, dysarthria) with Evaluation of Language Comprehension and Expression (e.g., receptive and expressive language) and Evaluation of Cognition (e.g. attention deficits, memory deficits, executive dysfunction)

1 unit equals 30 minutes; maximum of 4 units per state fiscal year

RESPONSE: Thank you for your comment. The proposed Medicaid Manual is only intending to simplify, organize, and clarify the existing eligibility and assessment criteria under the current Occupational Therapy, Physical Therapy, and Speech-Language Pathology Medicaid Manual. Adding cognitive disorder would create an expansion of the current eligibility criteria, which was not under consideration for this amendment. This comment will be considered for potential inclusion in any future revisions to the Manual.

Commenter's Name: Hannah Richesin, DPT

1. I have a bit of feedback I'd like considered regarding the proposed manual update.

In Section 201.300 C – "… (an EIDT program may elect to employ or contract with therapists…" But, then in Section 203.000 A – "A supervising therapist must be a paid employee of the Arkansas Medicaid provider that is filing claims". The first item states therapists working at an EIDT program may be contracted or self-employed. The second doesn't explicitly agree, only mentioning employees. Maybe 203.000 A could be updated to include language "paid employee OR CONTRACTOR OF…"?

Response: Thank you for your comment. Section 203.000(A) will be removed in its entirety, and Section 203.000 subsections B, C, and D will be changed to subsections A, B, and C, respectively.

2. When can we expect to see an updated fee schedule considering the recent rate reviews
recommendations? Thank you! **RESPONSE:** Thank you for your comment. An approximate date is not known at this time.

3. I have a comment/question regarding: 251.000 Method of Reimbursement 1-1-22 A.

Occupational therapy, physical therapy, and speech-language pathology services use fee schedule reimbursement methodology. Under the fee schedule methodology, reimbursement is made at the lower of the billed charge for the service or maximum allowable reimbursement for the service under the Arkansas Medicaid Program.

1. A full unit of service must be rendered in order to bill a unit of service.

2. Partial units of service may not be rounded up and are not reimbursable.

Does Arkansas Medicaid honor the CMS rule which most other payors use? I I.E. "The 8-minute rule" in therapies? I would assume yes but nothing is explicitly stated. If not, what constitutes a full unit? Is it truly all or nothing?

Here is an example where all or nothing methodology is highly problematic:

Imagine an EIDT center utilizes a computer-based system. The computer logs a child out for therapy at 8:00 am and returned at 8:45 am. Now, it will reasonably take the therapist a matter of seconds, up to a minute or two, to retrieve the next child from a separate classroom. Say the next child is logged out 8:46 am to 9:30 am. Would the therapist lose a unit? This would happen between most children transitioning. That's very

inefficient. Even if the therapist attempted to keep the child until 9:31 am, to make whole units - there is always something going on. The computer log in takes a few seconds longer,
etc. - any number of things. It is very, very difficult to make a whole exact unit each time, down to the second (or even minute). Working with other disciplines, if every child is returned at an odd time, it throws everyone's day off. A pad of even 5 minutes on a unit works so much better in reality.

Then, let's assume this ideology is carried over to other Medicaid services like dayhab in EIDT. The units are 1 hour. I am aware of no other setting where providers are expected to render a service for 59 minutes for free, if the system logged a child in at 8:01 am. I would really love to have something firm in the manual regarding this topic. I might suggest that at least 75% of a unit should be rendered to count as a whole unit.

Percentages can be problematic, but something like:
At least 10 minutes of a 15-minute unit
At least 45 minutes of an hour unit

Or, just do what CMS and most other payors have done for many years setting a standard in therapy as:

8 – 22 minutes	1 unit
23 – 37 minutes	2 units
38 – 52 minutes	3 units
53 – 67 minutes	4 units
68 – 82 minutes	5 units
83 minutes	6 units

Thank you for the consideration!

RESPONSE: Thank you for your comment. All billable units of service under the proposed Occupational Therapy, Physical Therapy, and Speech-Language Pathology Medicaid Manual are for fifteen (15) minutes except Occupational Therapy, Physical Therapy, and Speech-Language Pathology Evaluation and Treatment Planning services which are reimbursed on a per unit basis based on complexity. See the memo dated 12/30/2020 for guidance on Evaluation and Treatment Planning complexity codes attached. A full fifteen (15) minutes of service must be rendered to be reimbursable under the proposed manual. Partial units of service may not be rounded up and are not reimbursable.

Commenter's Name: Martha McKenzie Hill, Mitchell, Williams, Selig, Gates & Woodyard, P.L.L.C., on behalf of The CHMS Providers' Association

1. Ladies and Gentlemen: On behalf of the CHMS Providers' Association, please see the following comments on the proposed rules for the revised Occupational Therapy, Physical Therapy, and Speech-Language Pathology Manual.

Specifically regarding Proposed Rules 201.200, 212.50 and 212.520: There appears to be an inconsistency between 204.200 requiring referral and prescription for a 12-month period and 212.510 and 212.520 which relies on evaluations every six months. CHMS Providers Association members urge and prefer a 12-month period for referral and prescription in order to demonstrate certain gains of children over a 12-month period.

RESPONSE: Thank you for your comment. The intent of the language in 212.520 is not to require evaluations every 6 months, but the language seems to be causing confusion. The language in 212.510(A), 212.520(A)(1)(a-b), 212.520(A)(2), and 212.520(A)(4) will be changed from "six (6) months" to "twelve (12) months" to alleviate any confusion.

2. Specifically regarding Proposed Rules 206.00 and 207.00:

Section 206 and 207 require every therapist to refer. We believe that it is in the best interest of all involved that referrals should be streamlined. Current EIDT rules require facility referrals. The CHMS Providers' Association urges streamlined referrals in accordance with EIDT rules to insure efficiencies with regard to each recipient. The rules as currently proposed could cause up to four referrals per child if these rules are not adjusted and redrafted.

RESPONSE: Thank you for your comment. Occupational therapists, Physical Therapists, and Speech-Language pathologists are primary referral sources under the Individual with Disabilities Education Act (IDEA) and 34 CFR § 303.303(c). While the current language may result in multiple referrals for the same child, inclusion as drafted is the only way to ensure State of Arkansas compliance with IDEA child find requirements.

3. Specifically regarding Proposed Rule 214.100D:

"The billable unit includes time spent administering and scoring a standardized evaluation, clinical observation, administering supplemental tests and tools, writing an evaluation report and comprehensive assessment along with time spent developing the treatment plan."

Please be more specific about the administrative time needed in drafting and revising reports. Substantial time is spent drafting and revising

reports concerning patients. We need to insure that time expended is billable.

Thank you in advance for your consideration of these comments. If you have any questions, do not hesitate to contact me.

RESPONSE: Thank you for your comment. Please see the memo dated 12/30/2020 for guidance on Occupational Therapy, Physical Therapy, and Speech-Language Pathology Evaluation and Treatment Planning complexity codes, attached.

The proposed effective date is January 1, 2022.

FINANCIAL IMPACT: The agency indicated that this rule does not have a financial impact.

LEGAL AUTHORIZATION: The Department of Human Services has the responsibility to administer assigned forms of public assistance and is specifically authorized to maintain an indigent medical care program (Arkansas Medicaid). *See* Ark. Code Ann. §§ 20-76-201(1), 20-77-107(a)(1). The Department has the authority to make rules that are necessary or desirable to carry out its public assistance duties. Ark. Code Ann. § 20-76-201(12). The Department and its divisions also have the authority to promulgate rules as necessary to conform their programs to federal law and receive federal funding. Ark. Code Ann. § 25-10-129(b).

Per the agency, this rule was promulgated, in part, to implement Acts 767 and 829 of 2021. Act 767, sponsored by Representative Aaron Pilkington, clarified the Telemedicine Act, specified that the home of a patient may be an originating site for telemedicine and that group meetings may be performed via telemedicine, and clarified reimbursement of telemedicine services. Act 829, sponsored by Representative Jim Dotson, amended the Telemedicine Act and authorized additional reimbursement for telemedicine via telephone.

b. SUBJECT: Division of Developmental Disabilities Services (DDS) Manual Extension

DESCRIPTION:

Statement of Necessity

The rule was initially promulgated to sunset on December 31, 2021; however, the public health emergency is ongoing, therefore the Division of Developmental Disabilities Services amends the termination date to

extend the sunset date to the end of the federal public health emergency, including any extensions.

Rule Summary

The Director of the Division of Developmental Disabilities Services (DDS) amends the COVID-19 Response Manual to extend the sunset date of three provisions from December 31, 2021 to the end of the federal public health emergency, including any extensions. The suspension of rules for the Adult Developmental Day Treatment and Early Intervention Day Treatment concerning attendance payments is extended. The community and employment support waiver rules that are suspended temporarily modify provider types to all Qualified Behavioral Health Paraprofessionals employed by Outpatient Behavioral Health Service Agencies to provide Supportive Living Services, including Supplemental Supports to PASSE members. Also, the suspended rules allow an extension for reassessments and reevaluations for up to one year past the due date as well as allow the planning meeting to occur virtually/remotely and allow an electronic method of sign-off on required documents.

DDS allows the suspended rules concerning Well Checks to end on December 31, 2021. Lastly, the suspension on prohibition of using nursing services provided outside an Early Intervention Day Treatment Clinic and an Adult Developmental Day Treatment Clinic and the expansion of allowable services to be done in a home setting will end on December 31, 2021.

PUBLIC COMMENT: No public hearing was held on this proposed rule. The public comment period expired on November 8, 2021. The agency indicated that it received no public comments.

The proposed effective date is January 1, 2022.

FINANCIAL IMPACT: The agency indicated that this rule does not have a financial impact.

LEGAL AUTHORIZATION: The Department of Human Services has the responsibility to administer assigned forms of public assistance and is specifically authorized to maintain an indigent medical care program (Arkansas Medicaid). *See* Ark. Code Ann. §§ 20-76-201(1), 20-77-107(a)(1). The Department has the authority to make rules that are necessary or desirable to carry out its public assistance duties. Ark. Code Ann. § 20-76-201(12); *see also* Ark. Code Ann § 20-10-203(b). The Department and its divisions also have the authority to promulgate rules as necessary to conform their programs to federal law and receive federal funding. Ark. Code Ann. § 25-10-129(b).

8. DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL SERVICES (Mr. Mark White, Ms. Elizabeth Pitman)

a. SUBJECT: Outpatient Acute Crisis Unit

DESCRIPTION:

Statement of Necessity

Arkansas Medicaid is clarifying the Arkansas Medicaid Hospital Provider Manual to define the operation of Outpatient Acute Crisis Units. This change is necessary to fill gaps and improve continuity of behavioral health services in Arkansas. A State Plan Amendment is being submitted to expand ACUs into hospital outpatient settings and increase the rate for freestanding ACUs operated outside of a hospital. These changes will allow for hospitals without psychiatric units to receive reimbursement for crisis services while also helping to divert people from Emergency Departments and local jails. The rate was implemented on July 1, 2021, at a rate of $572.00 per day.

Rule Summary

- Section 218.400 is revised to recognize Outpatient Hospital Acute Crisis Units and provide hyperlinks to extension of benefits and billing information.
-Medicaid State Plan 3.1-A, page dd; 3.1-B, page 2 dd; 4.19-B, page 1aa(1); and 4.19-B, page 5aa are revised to add outpatient hospital acute crisis units; update rate methodology for Outpatient Behavioral Health Services acute crisis units, and add the same rate methodology for Outpatient Hospital Acute Crisis Units.

PUBLIC COMMENT: A public hearing was held on this rule on October 13, 2021. The public comment period expired October 30, 2021. The agency indicated that it received no public comments.

The proposed effective date is January 1, 2022, with retroactive rate change to July 1, 2021.

FINANCIAL IMPACT: The agency indicated that this proposed rule has a financial impact.

Per the agency, the additional cost to implement this rule is estimated at $953,534 for the current fiscal year ($271,543 in general revenue and $681,992 in federal funds) and $953,534 for the next fiscal year ($270,613

in general revenue and $682,921 in federal funds). The total estimated cost by fiscal year to state, county, and municipal government to implement this rule is $271,543 for the current fiscal year and $270,613 for the next fiscal year.

The agency indicated that this rule will result in 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, local government, or to two or more of those entities combined. Accordingly, the agency provided the following written findings:

(1) a statement of the rule's basis and purpose;

Arkansas Medicaid is seeking to increase access to outpatient acute crisis unit services as a diversion to use of Emergency Rooms and Hospital Inpatient Admissions for psychiatric and substance use disorder diagnoses and disease process when the person's life or another's life is not in jeopardy.

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

Create access to Behavioral Health and Substance Use Disorder Services in the proper settings and locations and in the process improve access to existing acute hospital beds for those who need a higher level of care.

(3) a description of the factual evidence that:
(a) justifies the agency's need for the proposed rule; and
(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

Arkansas has seen a rise in Behavioral Health and Substance Use Disorders in the state recently. Together with the onslaught of COVID-19 and a prevalence of other chronic diseases leading to increased need for hospital beds, the state is seeking evidence-based, less costly alternatives for those who can be treated successfully in other settings, while improving access to hospital beds for those in need of a higher level of care.

(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;

No less costly alternatives have been identified.

(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 alternatives have been suggested at this time.

(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 existing rules have been identified.

(7) an agency plan for review of the rule no less than every ten 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 Agency monitors State and Federal rules and regulations for opportunities to reduce and control cost.

LEGAL AUTHORIZATION: The Department of Human Services has the responsibility to administer assigned forms of public assistance and is specifically authorized to maintain an indigent medical care program (Arkansas Medicaid). *See* Ark. Code Ann. §§ 20-76-201(1), 20-77-107(a)(1). The Department has the authority to make rules that are necessary or desirable to carry out its public assistance duties. Ark. Code Ann. § 20-76-201(12). The Department and its divisions also have the authority to promulgate rules as necessary to conform their programs to federal law and receive federal funding. Ark. Code Ann. § 25-10-129(b).

b. SUBJECT: Arkansas Medicaid Procedure Code Linking Table Project

DESCRIPTION:

Statement of Necessity

The purpose of the rule is to bring all procedure codes currently contained in designated Arkansas Medicaid Provider Manuals up to date. The codes will be replaced with hyperlinks to a consistently maintained list of codes.

Procedure codes and the related billing requirements must be added, deleted, or modified often and under several circumstances. For example, procedure code conversions and updates are issued regularly by the Physician's Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) oversight organizations.

The procedure codes are being removed from the manual as codes are not Rules (see Ark. Code Ann. §25-15-202(9)(B)(iv)). The change will allow for contemporaneous and efficient updates when national procedure codes and billing criteria change. (In future updates, any necessary corrections to language will be made.)

The proposed revision is necessary to:

1) Bring components of the Division of Medical Services (DMS) payment policy processes up to date with the fully-implemented interChange (iC) system (iC replaced MMIS (Medicaid Management Information System)); and

2) Implement changes to the procedure code update process that can be leveraged to ensure timely compliance with all mandatory updates.

Rule Summary

Effective January 1, 2022, procedure codes are being removed from the text of the following Provider Manuals: Adult Behavioral Health, ARKids First-B, Certified Nurse Midwife, Child Health Services/EPSDT, Children's Services Targeted Case Management, Chiropractic, Dental, Federally-Qualified Health Center, Hearing, Home Health, Hospital, Hyperalimentation, Nurse Practitioner, Outpatient Behavioral Health, Physician, Podiatrist, Portable X-Ray, Private Duty Nursing, Prosthetics, Rehabilitative Hospital, Rural Health Clinic, School-Based Mental Health, Transportation, Ventilator Equipment, and Vision.

Procedure codes in these manuals are being replaced with a hyperlink to a Procedure Code Linking Table or to another subsection of the manual that contains a hyperlink to a Table.

PUBLIC COMMENT: A public hearing was held on this rule on October 21, 2021. The public comment period expired November 8, 2021. The agency indicated that it received no public comments.

The proposed effective date is January 1, 2022.

FINANCIAL IMPACT: The agency indicated that this rule does not have a financial impact.

LEGAL AUTHORIZATION: The Department of Human Services has the responsibility to administer assigned forms of public assistance and is specifically authorized to maintain an indigent medical care program (Arkansas Medicaid). *See* Ark. Code Ann. §§ 20-76-201(1), 20-77-107(a)(1). The Department has the authority to make rules that are necessary or desirable to carry out its public assistance duties. Ark. Code Ann. § 20-76-201(12). The Department and its divisions also have the authority to promulgate rules as necessary to conform their programs to federal law and receive federal funding. Ark. Code Ann. § 25-10-129(b).

"A medical code within the Arkansas Medicaid Program that is issued by the Centers for Medicare and Medicaid Services" is not considered a "rule" under the Arkansas Administrative Procedure Act. *See* Ark. Code Ann. § 25-15-202(9)(B)(iv).

c. SUBJECT: SPA 21-0011; FQHC 2-21; FQHC Mental Health Clinicians Added

DESCRIPTION:

Statement of Necessity

Act 764 of the 2021 Legislative Session requires the Arkansas Department of Human Services, Division of Medical Services to apply for a State Plan Amendment and revise Medicaid rules to allow four (4) additional types of professionally licensed clinicians to provide core services in Federally Qualified Health Centers (FQHCs).

Rule Summary

To comply with Act 764, Arkansas must submit a Medicaid State Plan amendment by revising Attachment 3.1-A page 1eee and Attachment 3.1-B page 2eee to include
- Licensed certified social worker.
- Licensed professional counselor.
- Licensed mental health counselor.
- Licensed marriage and family therapist.

The FQHC provider manual has been updated to include these licensed professionals in Sections 212.200 and 214.100. Also, four (4) new sections have been added to the manual to instruct each type of clinician regarding the services and incidental supplies and services covered for them. Those sections are 212.260, 212.270, 212.280, and 212.290.

PUBLIC COMMENT: A public hearing was held on this rule on October 20, 2021. The public comment period expired November 8, 2021. The agency provided the following summary of the public comments it received and its responses to those comments:

Commenter's Name: Joel P. Landreneau, Esq., Interim Executive Director, on behalf of the Mental Health Council of Arkansas

COMMENT: I write to you on behalf of the Mental Health Council of Arkansas and the Behavioral Health Providers' Association of Arkansas concerning SPA 21-0011 and FQHC 2-21 rule promulgations for which public comment ends today.

I realize that this promulgation merely implements Act 764 of the 93rd General Assembly which requires DMS to add certain behavioral health practitioners to the list of core services for Federally Qualified Health Clinics, but I have concerns about the impact this may have on other types of behavioral health providers.
Under this revision, the Medicaid Manual for FQHC's will read: "The services of licensed professional counselors working within the scope of their state licenses are covered if the services would be covered when furnished by a physician or incidental to a physician's services."

This appears to mean that the services of an LPC in an FQHC would be covered by Medicaid if ordered by or accompanying the services of a physician. This provision makes no distinction between those services provided to Medicaid-only recipients and those services provided to Medicaid beneficiaries who are also Medicare beneficiaries. This just says that services are covered.

This is not presently the case regarding LPC services rendered by OBHA's to Medicare/Medicaid dual eligibles. At present, if an LPC serves a Medicare patient who is Medicaid eligible as well, Medicare does not cover the service because LPC's are not authorized Medicare performing providers, and Medicaid also does not cover the service, even at the Medicare rate, because reasons. This appears to give FQHC's a means to obtain reimbursement using LPC's and LMFT's on some patients that Outpatient Behavioral Health Agencies do not also have. Once upon a time, Medicaid did pay for LPC's to see Medicare/Medicaid dual eligibles, and it appears that, under this rule, those days have returned, but only for FQHC's. Besides basic fairness, not paying OBHA's to have LPC's see dual eligibles is creating very real access barriers in some parts of the state where it is difficult to hire LCSW's.

If my reading of this is incorrect, please explain how that is. If my reading is correct, this uneven playing field needs to be corrected through the

adoption of rules that allow for Medicare/Medicaid dual eligibles to be cared for by LPC's and LMFT's who work for OBHA's, CMHC's and CCBHC's and paid by Medicaid when Medicare does not pay. Please accept this as a rule promulgation request pursuant to Ark. Code Ann. § 25-15-204(d), which states:

(d)(1) A person may petition an agency for the issuance, amendment, or repeal of a rule.
(2) Within thirty (30) days after submission of a petition, the agency shall:
(A) Deny the petition, stating in writing its reasons for the denial; or
(B) Initiate rule-making proceedings.

RESPONSE: Act 764 of 2021 requires DMS to add certain behavioral health practitioners to the list of core services for Federally Qualified Health Clinic. It does not require DMS to change rules or criteria related to the practice of these individuals, nor does it change any rules, regulations, or criteria related to billing Medicaid secondary to Medicare. FQHCs must continue to follow the same rules, regulations, and criteria related to these practitioners in the same manner as they would for any other licensed practitioner. If the client has Medicare, it is expected that the FQHC follow primary Medicare billing regulations for that client.

We accept your public comment as a petition for the agency to issue, amend, or repeal a rule as permitted under 25-14-204(d). The agency will review your petition and respond timely, as required by law.

Commenter's Name: David Ivers, J.D., VP for External Affairs & General Counsel, on behalf of Easterseals Arkansas

COMMENT: Easterseals provides services to a number of individuals who are dually diagnosed with both developmental disability and mental health conditions. Can you please clarify if this proposed rule will allow FQHCs to bill Medicaid for services of certain licensed mental health clinicians who are not reimbursed by Medicare, such as LPCs, LMSWs, etc.? Medicare allows only the following:

- Psychiatrist or other doctor.
- Clinical psychologist.
- Clinical social worker.
- Clinical nurse specialist.
- Nurse practitioner.
- Physician assistant.

However, there is a severe shortage of these practitioners, which is why Medicaid traditionally reimbursed for other types, including those listed in the proposed rule. Due to a change in policy several years ago, Medicaid stopped reimbursing for other practitioners when the service is provided to

an individual who is dually eligible (Medicare and Medicaid). This has created a severe access issue. We have a number of clients who are going without needed mental health care because of it. Will FQHCs now be allowed to bill Medicaid for services by the practitioners being added in the proposed rule who are serving dual eligible individuals?

While we support such a rule change, we support it for ALL Medicaid providers. This rule will create an unfair, unlevel playing field if not applied across the board. Also, failure to do so will not resolve the access issue since many of the individuals we and various other providers serve do not utilize FQHCs.

RESPONSE: Act 764 of 2021 requires DMS to add certain behavioral health practitioners to the list of core services for Federally Qualified Health Clinic. It does not require DMS to change rules or criteria related to the practice of these individuals, nor does it change any rules, regulations, or criteria related to billing Medicaid secondary to Medicare. FQHCs must continue to follow the same rules, regulations, and criteria related to these practitioners in the same manner as they would for any other licensed practitioner. If the client has Medicare, it is expected that the FQHC follow primary Medicare billing regulations for that client.

The proposed effective date is January 1, 2022.

FINANCIAL IMPACT: The agency indicated that this rule does not have a financial impact.

LEGAL AUTHORIZATION: The Department of Human Services has the responsibility to administer assigned forms of public assistance and is specifically authorized to maintain an indigent medical care program (Arkansas Medicaid). *See* Ark. Code Ann. §§ 20-76-201(1), 20-77-107(a)(1). The Department has the authority to make rules that are necessary or desirable to carry out its public assistance duties. Ark. Code Ann. § 20-76-201(12). The Department and its divisions also have the authority to promulgate rules as necessary to conform their programs to federal law and receive federal funding. Ark. Code Ann. § 25-10-129(b).

This proposed rule implements Act 764 of 2021, sponsored by Representative Clint Penzo. The Act ensured reimbursement of all healthcare providers for behavioral health services by the Arkansas Medicaid Program. Per the Act, "[t]he Department of Human Services shall apply for any . . . Medicaid state plan amendments . . . necessary to implement this section." Act 764, § 1(b), *codified at* Ark. Code Ann. § 20-77-144(b).

d. **SUBJECT: Pharmacy 2-21 and Medicaid State Plan Amendment (SPA) 2021-0009, Based on Act 758**

DESCRIPTION:

Statement of Necessity

The 93rd General Assembly enacted Act 758. Act 758 allows six (6) prescription refills per month for adult Medicaid clients. In addition, the act includes additions to the list of prescription medications that do not count against the monthly prescription benefit cap. The medications added include prescriptions for high blood pressure, hypercholesterolemia, blood modifiers, diabetes, or respiratory inhalers. The Division of Medical Services is revising Section II of the Pharmacy Provider Manual as well as updating the Medicaid State Plan Amendment (SPA) to reflect the changes in Act 758.

Rule Summary

Pharmacy Provider Manual Section II: Replaced the term "beneficiary" with "client" identified in each revised section.

Section 213.100 Monthly Prescription Limits (B)
• Replaced three (3) with six (6)
• Added, "6. Prescriptions for the treatment of high blood pressure."
• Added, "7. Prescriptions for the treatment of hypercholesterolemia."
• Added, "8. Blood modifier medications.'"
• Added, "9. Prescriptions for the treatment of diabetes."
• Added, "10. Inhalers to treat respiratory illness."
• Added, "C. Living Choices Assisted Living Program clients are eligible for up to nine (9) medically necessary prescriptions per month."
• Added, "D. After the client has received the maximum monthly benefit or the maximum monthly extended benefit, they will be responsible for paying for their own medications for the remainder of the month."

Deleted Section 213.110 - Extension of Benefits

Section 213.200 - Prescription Refill Limit
• Added, "Refills shall be in accordance with federal and state laws."
• Deleted, "In no event is any prescription to be refilled more than five (5) times or beyond six (6) months after the date of the original issue, whichever comes first. Renewals or continuation of drug therapy beyond five refills or six months requires a new, original prescription."

Section 215.000 – Child Health Services/Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program

• Deleted, "B. No refills are reimbursable after the five (5) refills or the six month period specified in Section 213.200 of this manual."

Section 216.201 – Prescription Benefits for Hospice Patients in Long-Term Care Facilities
• Added, "Please refer to section 213.100 for monthly prescription limits."
• Deleted, "These beneficiaries are only allowed three (3) prescriptions per month. If additional prescriptions are needed, an extension of drug benefits may be requested for up to a total of six (6) maintenance medications per month."

Section 216.202 – Regulations governing Cycle-Fill and Pharmacy Notifications for Long-Term Care Facilities
• Deleted, "Per Section 213.200, the six (6) month prescription renewal is required for LTC eligible beneficiaries residing in LTC facilities. However, for those drugs that can be cycle filled as stated above, the file (5) refill limit does not apply."

Arkansas Medicaid State Plan

SPA page 31A5a – Categorically Needy
• Deleted, "The first three (3) prescriptions do not require prior authorization. The three (3) additional prescriptions must be prior authorized."
• Added, "…, EPSDT, high blood pressure, hypercholesterolemia, blood modifiers, diabetes, and respiratory illness inhaler…"

SPA page 31B4g - Medically Needy
• Deleted, "The first three (3) prescriptions do not require prior authorization. The three (3) additional prescriptions must be prior authorized."
• Added, "…, EPSDT, high blood pressure, hypercholesterolemia, blood modifiers, diabetes, and respiratory illness inhaler…"

PUBLIC COMMENT: A public hearing was held on this rule on October 20, 2021. The public comment period expired on November 8, 2021. The agency indicated that it received no public comments.

The proposed effective date is January 1, 2022.

FINANCIAL IMPACT: The agency indicated that this rule has a financial impact. Per the agency, the total cost to implement this rule is $30,537,600 for the current fiscal year ($8,666,571 in general revenue and $21,871,029 in federal funds) and $61,075,200 for the next fiscal year ($17,333,142 in general revenue and $43,742,058 in federal funds). The total estimated cost to state, county, and municipal government to

implement this rule is $8,666,571 for the current fiscal year and $17,333,142 for the next fiscal year.

The agency indicated that there is 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. Accordingly, the agency provided the following written findings:

(1) a statement of the rule's basis and purpose;

The 93rd General Assembly enacted Act 758. Act 758 allows six (6) prescription refills per month for adult Medicaid clients. In addition, the Act includes additional medications to the list of prescriptions that do not count against the monthly prescription benefit cap. The medications added include prescriptions for high blood pressure, hypercholesteriolemia, blood modifiers, diabetes, or respiratory inhalers. The Division of Medical Services is revising Section II of the Pharmacy Provider Manual as well as updating the Medicaid State Plan Amendment (SPA) to reflect the changes in Act 758.

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

We are making this change to align the State Plan with Act 758.

(3) a description of the factual evidence that:
(a) justifies the agency's need for the proposed rule; and
(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

We are making this change to align the State Plan with Act 758.
(3) 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;

We are making this change to align the State Plan with Act 758.

(4) 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;

We are making this change to align the State Plan with Act 758.

(5) 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

We are making this change to align the State Plan with Act 758.

(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.

We are making this change to align the State Plan with Act 758.

LEGAL AUTHORIZATION: The Department of Human Services has the responsibility to administer assigned forms of public assistance and is specifically authorized to maintain an indigent medical care program (Arkansas Medicaid). *See* Ark. Code Ann. §§ 20-76-201(1), 20-77-107(a)(1). The Department has the authority to make rules that are necessary or desirable to carry out its public assistance duties. Ark. Code Ann. § 20-76-201(12). The Department and its divisions also have the authority to promulgate rules as necessary to conform their programs to federal law and receive federal funding. Ark. Code Ann. § 25-10-129(b).

These rules implement Act 758 of 2021. The Act, sponsored by Representative Lee Johnson, clarified and expanded the prescription limitations in the Arkansas Medicaid Program and exempted long-term medication from being counted towards a prescription limit in the Arkansas Medicaid Program. Per the Act, "[o]n or before January 1, 2022, the Department of Human Services shall submit and apply for any federal waivers, Medicaid state plan amendments, or other authority necessary to implement this section." Act 758, § 1(d), *codified at* Ark. Code Ann. § 20-77-406(d).

e. SUBJECT: Section I 1-21 – Telemedicine

DESCRIPTION:

Statement of Necessity

The 93rd General Assembly enacted Act 767 and Act 829. Act 767 amends the Telemedicine Act to allow the originating site to include the home of the client. Act 829 amends the Telemedicine Act to allow

provider reimbursement for telemedicine provided via telephone. The Division of Medical Services is revising Section I of the General Provider Manual to reflect the changes in these two (2) acts.

Rule Summary

Section I- General

Section 105.190 (Telemedicine)
• Replaced the word "patient" with "client" throughout the section.
• Added, "An originating site includes the home of a client."
• Added, "Any other originating sites are not eligible to bill a facility fee."
• In number three (#3) on the first page, added the word "…professional…"
• Added, "6. The healthcare professional who is licensed in Arkansas has access to a client's personal health record maintained by a healthcare professional and uses any technology deemed appropriate by the healthcare professional, including the telephone, with a client located in Arkansas to diagnose, treat, and if clinically appropriate, prescribe a noncontrolled drug to the client."
• Added, "A health record is created with the use of telemedicine, consists of relevant clinical information required to treat a client, and is reviewed by the healthcare professional who meets the same standard of care for a telemedicine visit as an in-person visit."
• Deleted, "4. Audio only communication, including without limitation interactive audio;"
• Deleted, "The use of interactive audio is not reimbursable under Arkansas Medicaid."
• In the 'Telemedicine with a Minor' section, the word "client" follows the word "minor" throughout the section.
o Replaced "individual" with "provider."
• Added, "Telemedicine Exclusions" section:
"Telemedicine does not include the use of:
1. Audio-only communication unless the audio-only communication is in real-time, is interactive, and substantially meets the requirements for a health care service that would otherwise be covered by the health benefit plan:
a. Documentation of the engagement between patient and provider via audio-only communication shall be placed in the medical record addressing the problem, content of the conversation, medical decision-making, and plan of care after the contact.
b. Medical documentation is subject to the same audit and review process required by payers and governmental agencies when requesting documentation of other care delivery such as in-office or face-to-face visits.
2. A facsimile machine;

3. Text messaging; or
4. Email."

PUBLIC COMMENT: A public hearing was held on this proposed rule on October 19, 2021. The public comment period expired November 8, 2021. The agency provided the following summary of the single public comment it received and its response to that comment:

Commenter's Name: Joel Landreneau, Executive Director, Behavioral Health Providers Association; Interim Executive Director, Mental Health Council

COMMENT: My name is Joel Landreneau. I am Executive Director of Behavioral Health Providers Association, and I'm also Interim Executive Director of the Mental Health Council, and I wanted to speak briefly today about this Section 100 rule promulgation, which appears to be a verbatim restatement of Act 829 in particular, which is the section that I'm focused on.

The Telemedicine exclusions, where it says that Telemedicine does not include the use of audio-only unless the communication is in real time, is interactive, and substantially meets the requirements for a healthcare service that would otherwise be covered by the health plan.

This rule, unless there's another promulgation coming in Section 200 that would be provider type specific, then this doesn't answer the questions that I get frequently about which services are permitted to be audio-only, when it's interactive and real time, and which are not.

The way I read this provision of Act 829, it sounds to me as though the payor has some discretion deciding whose requirements are sought to be met to satisfy this requirement, - "substantially meets the requirements for health care service". It doesn't say whose requirements, but the way I read this, it sounds as though the payor has some discretion in deciding where the requirements are met for that service and where they are not met.
So, this rule promulgation provides no guidance on whether or not it is each and every service that is available through audio-only, when it's interactive and in real time, or if there are some that are allowed and some that not allowed.

I'm thinking, for example, individual psychotherapy has traditionally been allowed for telemedicine, and it would make sense that audio-only would also be allowed, but for a group therapy session audio-only doesn't sound like that might be something that would work very well.
And so, unless there's another promulgation coming in the Section 200 Manual for Outpatient Behavioral Health, this needs to be clarified so that

it's clear to the providers which billing codes are allowable to be billed audio-only and which are not. And that concludes my remarks.

RESPONSE: Telemedicine rules in Section I of the General Provider Manual of the Division of Medical Services (DMS) references that definitions are found in the Arkansas State Medical Board (ASMB) or licensing or certification board for other healthcare providers (if no less restrictive than ASMB). Standards of care and safeguards established by the healthcare professional's licensing board should be utilized in decision making regarding use of audio-only communication for service provision.

Lacey Johnson, an attorney with the Bureau of Legislative Research, asked the following question and received the following response:

Q. In § 105.190, under the heading "Professional Relationship" after the numbered list, the proposed rules state, "A health record *is* created with the use of telemedicine…" However, Act 829 states that "a health record *may be* created with the use of telemedicine…" Is there a reason the proposed rules use "is created" rather than "may be created"?

RESPONSE: Division of Medical Services uses the term, "A health record is created with the use of telemedicine" for this rule to ensure providers of telemedicine understand that a health record is necessary for reimbursement of Medicaid treatment services regardless of method or location of service delivery. While the Act provides for the health record to be optional, Division of Medical Services requires documentation of all services provided as proof of service delivery and reimbursement.

The proposed effective date is January 1, 2022.

FINANCIAL IMPACT: The agency indicated that this rule does not have a financial impact.

LEGAL AUTHORIZATION: The Department of Human Services has the responsibility to administer assigned forms of public assistance and is specifically authorized to maintain an indigent medical care program (Arkansas Medicaid). *See* Ark. Code Ann. §§ 20-76-201(1), 20-77-107(a)(1). The Department has the authority to make rules that are necessary or desirable to carry out its public assistance duties. Ark. Code Ann. § 20-76-201(12). The Department and its divisions also have the authority to promulgate rules as necessary to conform their programs to federal law and receive federal funding. Ark. Code Ann. § 25-10-129(b).

These proposed rules implement Acts 767 and 829 of 2021. Act 767, sponsored by Representative Aaron Pilkington, clarified the Telemedicine Act, specified that the home of a patient may be the originating site for

telemedicine and that group meetings may be performed by telemedicine, and clarified reimbursement of telemedicine services. Act 829, sponsored by Representative Jim Dotson, amended the Telemedicine Act and authorized additional reimbursement for telemedicine via telephone.

f. **SUBJECT: Division of Medical Services (DMS) Manual Extension**

DESCRIPTION:

Statement of Necessity

The rule was initially promulgated to sunset on December 31, 2021; however, the public health emergency is ongoing, therefore the Division of Medical Services (DMS) amends the termination date.

Rule Summary

The Director of the Division of Medical Services (DMS) amends the COVID-19 Response Manual to extend the sunset date from December 31, 2021 to the end of the federal public health emergency, including any extensions.

The proposed rule amends the termination date from December 31, 2021 to "the termination of the federal public health emergency, including any extensions" for:
- Fingerprint submission requirements,
- The definition of Ambulatory Surgical Center concerning temporary enrollment as a hospital,
- The temporary use of phone assessments and the suspension of timeliness for reassessments,
- The prohibition of coverage of swing bed services,
- Private authorization requirements related to Medicaid Utilization Management Program review,
- Annual review and renewal of personal care service plans,
- The coverage of administration of monoclonal antibodies,
- Limitations on outpatient laboratory services for COVID-19 and:
- COVID-19 antigen laboratory testing with procedure code 87426,
- COVID-19 laboratory testing with codes U0001, U0002, U0003, and U0004,
- Annual limitations for physician and outpatient hospital visits for:
- Treatment of COVID-19 by COVID-19 diagnosis codes, and
- Physician and nurse practitioner visits to patients in skilled nursing facilities,
- Places of delivery of services provided by physicians, and advanced practice registered nurses and hospitals,

- Pick-up and delivery locations and physician certifications prior to transport by non-emergency ground ambulances.

PUBLIC COMMENT: No public hearing was held on this proposed rule. The public comment period expired on November 8, 2021. The agency provided the following summary of the single public comment it received and its response to that comment:

Commenter's Name: Wendy Funk Schrag, LMSW, ACSW, Vice President State Government Affairs, on behalf of Fresenius Medical Care North America

COMMENT: Fresenius Medical Care operates 12 dialysis clinics in Arkansas serving over 960 people with End Stage Renal Disease.

Regarding the proposed changes for non-emergency ambulance services in Sections 204.00 and 205.00, it appears the proposed rule removes the usual requirements around medical necessity forms being completed in emergencies, which we support.

Currently, the manual does not include any coverage of non-emergency ambulance trips to or from dialysis clinics that we see; however, the proposed rule highlighted below mentions dialysis services. We hope these proposed changes in Section 213.00 do apply to dialysis facilities so that anywhere a patient is located, the patient can receive ambulance non-emergency transportation if necessary to get to their dialysis treatments. We support this change.

A. Section 213.000 of the Medicaid Provider Manual for Transportation:
1. Ground transportation trips by Ambulance providers may be made to any destination that is able to provide treatment to the patient in a manner consistent with state and local Emergency Medical Services (EMS) protocols in use where the services are being furnished. These destinations may include, but are not limited to:
a. Any location that is an alternative site determined to be part of a hospital, Critical Access Hospitals (CAH) or Skilled Nursing Facilities (SNF), community mental health centers federally qualified health centers (FQHCs), physician's offices, urgent care facilities, ambulatory surgery centers (ASCs), and any other location furnishing dialysis services outside of the ESRD facility.

Thank you for the opportunity to submit these comments.

RESPONSE: This rule pertains to the COVID-19 Public Health Emergency exceptions to existing policy. It is being promulgated to remove the sunset clause of 12/31/2021 and will remain in effect until the

end of the Federal Public Health Emergency. The rule referenced in Section 213.000 of the Transportation manual will revert back to its previous language at the end of the Federal Public Health Emergency.

The proposed effective date is January 1, 2022.

FINANCIAL IMPACT: The agency indicated that this rule has a financial impact.

Per the agency, the total cost to implement this rule is $584,549 for the current fiscal year ($165,895 in general revenue and $418,654 in federal funds) and $1.169.097 for the next fiscal year ($331,790 in general revenue and $837,307 in federal funds). The total estimated cost by fiscal year to state, county, and municipal government to implement this rule is $165,895 for the current fiscal year and $331,790 for the next fiscal year.

The agency indicated that there is 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. Accordingly, the agency provided the following written findings:

(1) a statement of the rule's basis and purpose;

- Due to the COVID-19 pandemic, DMS made revisions to rules to ensure continuity of services for clients.

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

- Due to the COVID-19 pandemic, DMS made revisions to rules to ensure continuity of services for clients.

(3) a description of the factual evidence that:
(a) justifies the agency's need for the proposed rule; and
(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

- Due to the COVID-19 pandemic, DMS made revisions to rules to ensure continuity of services for clients.

(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;
- None

(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;

- None at this time.

(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

- N/A

(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 Agency monitors State and Federal rules and policies for opportunities to reduce and control costs.

LEGAL AUTHORIZATION: The Department of Human Services has the responsibility to administer assigned forms of public assistance and is specifically authorized to maintain an indigent medical care program (Arkansas Medicaid). *See* Ark. Code Ann. §§ 20-76-201(1), 20-77-107(a)(1). The Department has the authority to make rules that are necessary or desirable to carry out its public assistance duties. Ark. Code Ann. § 20-76-201(12); *see also* Ark. Code Ann § 20-10-203(b). The Department and its divisions also have the authority to promulgate rules as necessary to conform their programs to federal law and receive federal funding. Ark. Code Ann. § 25-10-129(b).

g. SUBJECT: Continuous Glucose Monitors

DESCRIPTION:

Statement of Necessity

The purpose of this Rule is to implement the requirements of Act 643 of 2021. Act 643 requires that Continuous Glucose Monitors (CGM) and related supplies be covered by Arkansas Medicaid. The Act defines a

CGM, and the criteria for coverage. A Prior Authorization (PA) will be required.

Additionally, the procedure codes will be updated to the National procedure codes used by Medicare, and Medicaid will pay the Medicare rates, according to established State Plan reimbursement methodology. See the attached CGM Fact Sheet for additional information about the rates and procedure codes.

Rule Summary

Medicaid is updating a provider manual and amending the Medicaid State Plan coverage pages to comply with Act 643.

The Provider Manual is the Prosthetic/DME (Durable Medical Equipment) Provider Manual. Two (2) new sections will be added to the provider manual to include the information listed above. A link will allow providers to view or print the authorized procedure codes.

Finally, the SPA will be updated to include the coverage criteria (amount, duration, and scope).

PUBLIC COMMENT: A public hearing was held on this rule on October 20, 2021. The public comment period expired on November 11, 2021. The agency provided the following summary of the public comments it received and its responses to those comments:

Commenter's Name: Erika Gee, Attorney, on behalf of Wright, Lindsey & Jennings LLP

1. Thank you. We will be submitting a written comment as well, but I would like to take this opportunity to briefly give this comment during the hearing regarding the proposed rule. It our position that this rule does not appropriately implement Act 643, because the Act that was passed by the legislature broadly defines the types of CGMs which shall be covered by the program, but this proposal instead limits the types of CGMs that the program will cover to the procedure codes used by Medicare. That is in conflict with the requirements of Act 643, which does not reference or limit CGM coverage to the Medicare program or to align with the Medicare program. It is our request that this rule will be modified to actually implement the requirements of Act 643. Thank you.

RESPONSE: Arkansas Medicaid follows the Medicare program codes and rates for DME whenever available. Division of Medical Services is in the process of reviewing all DME products to ensure consistency with the Medicare rates. The absence of specific language related to how Medicaid

is to cover continuous glucose monitors in Act 643 does not preclude Arkansas Medicaid from following its own rules and regulations for how it covers DME products.

2. Please accept this as a public comment on the proposed rule regarding Continuous Glucose Monitors (CGM), which was released for public comment on October 11, 2021.

This rule has been drafted with the intent of implementing the provisions of Act 643 of 2021, which became effective on July 28, 2021. Act 643 directs the Arkansas Medicaid program to provide coverage for CGMs for certain individuals with diabetes and broadly defines the types of CGMs which shall be covered by the program. See Act 643 §1, codified at Ark. Code Ann. § 20-7-141(a).

However, the proposed rule does not implement Act 643. Instead, it limits the types of CGMs that the program will cover to "align with procedure codes used by Medicare." See Proposed Rule, Attachment 4.19B, at p. 2g. This language is in conflict with the requirements of Act 643, which does not reference Medicare or limit CGM coverage to "align with" the Medicare program. Instead, the provisions of Act 643 broadly cover CGMs which meet certain criteria, which would encompass not only procedure codes K0553 and K04554 as proposed, but also A9276 and A9277.

We request that the rule be modified to fully implement Act 643 by adding the additional procedure codes for qualifying CGM devices. I have also enclosed a redlined version of the proposed rule with our requested change.

Thank you for your consideration of this matter.

RESPONSE: Arkansas Medicaid follows the Medicare program codes and rates for DME whenever available. Division of Medical Services is in the process of reviewing all DME products to ensure consistency with the Medicare rates. The absence of specific language related to how Medicaid is to cover continuous glucose monitors in Act 643 does not preclude Arkansas Medicaid from following its own rules and regulations for how it covers DME products. Please note that HCPCS and other codes are not published within the State Plan.

Commenter's Name: Dee Ann Stahly, Director, State Government Affairs, on behalf of Dexcom, Inc.

COMMENT: First, we would like to thank the Arkansas Department of Human Services for its considerations, analysis, and the opportunity to

provide comments on the proposed rule draft for Continuous Glucose Monitoring Coverage for Medicaid beneficiaries with diabetes. Founded in 1999, Dexcom, Inc. is the market leader in transforming diabetes care and management by providing superior continuous glucose monitoring (CGM) technology to help patients and healthcare professionals better manage diabetes.

Since our inception, we have focused on better outcomes for patients, caregivers, and clinicians by delivering solutions that are best in class – while empowering our community to take control of diabetes. We believe that this policy will provide tremendous benefit to patients with diabetes and their caregivers in Arkansas and we would like to comment on a few specific areas in which we believe that it could be strengthened.

The proposed rule provides coverage for a CGM if the client has a presence of type 1 diabetes or any other type of diabetes with the use of insulin more than two (2) times daily. We encourage DHS to explicitly include language that also includes coverage for a client that is using an insulin pump. Insulin pumps are frequently used by people with many forms of diabetes that require exogenous, injected insulin and specifically noting this in the rule is of utmost importance to guarantee access for these populations.
While it is common to require a Prior Authorization (PA) for CGM coverage in Medicaid programs, we encourage DHS to ensure that patient access is not comprised by a burdensome PA review process that could result in the delay of a patient receiving a CGM. This is especially important for reauthorization of a CGM. A patient must remain on a CGM and be guaranteed continuation of care to receive the full benefits of the technology.

Finally, the most cost-effective channel for Medicaid patients to receive a CGM is through the pharmacy. Costs to the state for the CGM systems can be up to 50% lower if they choose to manage CGM as a pharmacy benefit and receive rebates.

Currently, 21 state Medicaid programs manage CGM through the pharmacy channel with more agencies moving to this model in 2022. Additionally, most commercial plans also offer CGM through the pharmacy. This is the most convenient way for patients to access their CGM, as they can pick up their supplies while also picking up their insulin, and it saves the state money. We encourage DHS to consider moving CGM to a pharmacy benefit.

We applaud the Department’s commitment to Medicaid patients with this proposed rule, and we urge you to make that access even stronger with these minor changes to the policy. Patients with better management of

their diabetes have better health outcomes, a higher quality of life, and cost significantly less to the state.

Thank you for reviewing our comments. We hope that you will take them under consideration. We look forward to working with you to help ensure that the most vulnerable populations have access to the technologies they need to successfully manage their diabetes while reducing costs for the state. Please contact me if you have any questions or need more information.
RESPONSE: 1. Requests for those who use an insulin pump would meet the more than 2 times per day criteria already. The use of an insulin pump indicates medical need for insulin more frequently than two times per day. We will add language to clarify that use of an insulin pump meets the qualifications.

2. PA process- The current PA process is streamlined and may be submitted via portal. If a provider has questions, we can have their provider representative do onsite education or education over the phone/zoom/teams meeting. The provider must complete the request and submit the required documents for the review to be completed.

3. Continuous Glucose Monitors are not a drug, rather a device, so they have been historically billed as a medical professional claim. Any changes to move them from a medical or DME type claim to a pharmacy claim would require large changes to both the medical and pharmacy systems.

Commenter's Name: Joseph Henske, MD, FACE, Associate Professor of Medicine, Director of the UAMS Diabetes Center, University of Arkansas for Medical Sciences, Division of Endocrinology and Metabolism

COMMENT: I am writing to comment on the updated changes to the Prosthetic/DME Provider Manual and Medicaid State Plan to include coverage for Continuous Glucose Monitors (CGM) as required by Act 643 of the 93rd General Assembly, effective 1/1/22. I am sincerely appreciative of the efforts of all who have worked to pass this bill into law. I am grateful for the opportunity to provide further comment at this stage.

I have several points of emphasis that I would like to make with respect to the current language:

1. Who is qualified. Under section 1(a.), this should more explicitly include language to include coverage for both type 1 or type 2 diabetes not only using insulin injections but also for those using an insulin pump. This may not be clear from the current language as written "with use of insulin

more than two times daily" that use of insulin pump would also meet criteria.

2. The PA process. I understand that prior authorization may be needed to verify that the patient meets the above criteria and ongoing reauthorization at regular intervals. I want to be sure that this prior authorization/review process should be:

a. Streamlined (i.e. minimal burden to clinical staff) with use of simple check boxes that can be easily completed by clinic staff using office visit notes every 6 months indicating persistent diabetes, ongoing use of insulin or ongoing risk of sever hypoglycemic events, and compliance with routine follow up, etc.

b. Efficient so as to not delay reauthorization/reapproval of refills, particularly when patient continues to meet criteria which are most likely lifelong in nature after being first qualified.
3. Pharmacy Channel. Opportunity to fill CGM as a pharmacy benefit would be most efficient for patients (who can pick up Rx with the rest of their medications and insulin) and would be a up to 50% cost savings to the state. Most commercial plans use the pharmacy channel for CGM distribution as well as >21 states include this in their Medicaid plans. Solely distributing via a DME (durable medical equipment) pathway would create unnecessary complexity, increase delays in care, and increase unnecessary costs to the system. It should be noted that CGM prescription should not require use of a Medicaid "slot", similar to how it is handled for refills of other diabetes testing and insulin pump supplies.

Please carefully consider these recommendations. As director of the Diabetes Center at UAMS, I lead a large team of providers taking care of the most challenging cases of diabetes in the state. I appreciate that we now will be able to use continuous glucose monitoring to assist in our care of Medicaid patients, and want to ensure that the process to obtain these much-needed devices is streamlined and efficient to maximize the benefit for the individuals and minimize the costs to the program.

RESPONSE: 1. Requests for those who use an insulin pump would meet the more than 2 times per day criteria already. The use of an insulin pump indicates medical need for insulin more frequently than two times per day. We will add language to clarify that use of an insulin pump meets the qualifications.

2. PA process- The current PA process is streamlined and may be submitted via portal. If a provider has questions, we can have their provider representative do onsite education or education over the

phone/zoom/teams meeting. The provider must complete the request and submit the required documents for the review to be completed.

3. Continuous Glucose Monitors are not a drug, rather a device, so they have been historically billed as a medical professional claim. Any changes to move them from a medical or DME type claim to a pharmacy claim would require large changes to both the medical and pharmacy systems.

Commenter's Name: C. Rachel Kilpatrick, MD, Washington Regional Endocrinology

COMMENT: Regarding the changes for Medicaid diabetes patients as it relates to continuous glucose monitoring systems, I would like to encourage our lawmakers to ensure that these devices are made available through pharmacies (rather than through durable medical equipment). The ability to go through pharmacy reduces the paperwork burden to obtain the devices and ensures a consistent supply in patients who are prescribed these devices. Thank you for your consideration.

RESPONSE: Continuous Glucose Monitors are not a drug, rather a device, so they have been historically billed as a medical professional claim. Any changes to move them from a medical or DME type claim to a pharmacy claim would require large changes to both the medical and pharmacy systems.

Commenter's Name: John Vinson, Pharm.D., Chief Executive Officer & Executive Vice-President, on behalf of the Arkansas Pharmacists Association

COMMENT: The Arkansas Pharmacists Association appreciates the opportunity to provide feedback on the proposed rules on coverage of continuous glucose monitors for patients with diabetes in Arkansas Medicaid, dated 10/13/2021 to 11/11/2021 related to Arkansas Act 643 of 2021. Access and coverage of continuous glucose monitoring for many patients with diabetes can save lives and reduce disease complications from a very difficult disease to treat and manage.

Patients with diabetes that use insulin and are Medicaid beneficiaries often visit their local Arkansas community pharmacist more than 30 times a year. These local pharmacists have trusted relationships with these patients and are accessible in all 75 counties. Arkansas community pharmacists will be more likely to provide this service to Arkansas Medicaid beneficiaries if Arkansas Medicaid would amend the current proposed rule to also provide coverage for continuous glucose monitoring products through the pharmacy benefits (Magellan).

In addition, the available continuous glucose monitoring products are eligible products for significant rebates and substantial financial savings to taxpayers and the program if covered through the Medicaid pharmacy benefit rather than the medical benefit. A significant number of state Medicaid programs around the country are either already covering these products through the pharmacy benefit or will in the near future because of the costs savings and increased access through pharmacy benefits.

The Arkansas state employees and public-school employees program, Employee Benefits Division (EBD), recently moved coverage of these continuous glucose monitoring products to the pharmacy benefit with pharmacy claims processed by MedImpact because of similar reasons as stated above. Their policy decision has improved access, improved patient care, and resulted in significant cost savings to the state through rebate negotiations with 100% pass through discounts from the manufacturers to the state. The Arkansas Medicaid program would likely benefit to an even greater degree financially than the Employee Benefits Division because of the deep discounts available for covered National Drug Codes (NDCs) required under the Medicaid Drug Rebate Program in federal law or Section 1927 of the Social Security Act.

Thank you for your consideration and we look forward to further discussion with your team about these suggested enhancements to the proposed rule.

RESPONSE: Continuous Glucose Monitors are not a drug, rather a device, so they have been historically billed as a medical professional claim. Any changes to move them from a medical or DME type claim to a pharmacy claim would require large changes to both the medical and pharmacy systems.

Commenter's Name: Jennifer O'Donnell

COMMENT: I have two questions on this proposal:

1. The link to the pricing does not work. Can you please advice the proposed reimbursements?

2. Are there any brick-and-mortar requirements by Arkansas Medicaid? Or can out-of-state durable medical equipment providers provide these items to members?

Thank you.

Response: 1. The link will not be activated until after the rule has been completely promulgated and the effective date has arrived. In the meantime, the proposed rates are:

Code	Modifier	Description	Rate	Notes
K0553		Supply allowance for therapeutic continuous glucose monitor (CGM), includes all supplies and accessories, 1 month supply = 1 unit of service Class II system	$222.77	The supply allowance for supplies used with a therapeutic CGM system encompasses all items necessary for the use of the device and includes, but is not limited to: CGM sensor, CGM transmitter, home BGM and related BGM supplies (test strips, lancets, lancing device, calibration solutions) and batteries. Supplies or accessories billed separately will be denied as unbundling
K0553	KF	Supply allowance for therapeutic continuous glucose monitor (CGM), includes all supplies and accessories, 1 month supply = 1 unit of service Class III system	$259.20	The supply allowance for supplies used with a therapeutic CGM system encompasses all items necessary for the use of the device and includes, but is not limited to: CGM sensor, CGM transmitter, home BGM and related BGM supplies (test strips, lancets, lancing device, calibration solutions) and batteries. Supplies or accessories billed separately will be denied as unbundling
K0554		Receiver (monitor), dedicated, for use with therapeutic glucose continuous monitor system Class II system	$243.30	Purchased device and limit of 1 per 12 months
K0554	KF	Receiver (monitor), dedicated, for use with therapeutic glucose continuous monitor system Class III system	$270.14	Purchased device and limit of 1 per 12 months

2. Out of state providers may participate. The provider must enroll and have an active Arkansas Medicaid provider ID to participate.

Commenter's Name: Veronica De La Garza, Director, State Government Affairs, on behalf of American Diabetes Association
COMMENT: I am writing on behalf of the American Diabetes Association (ADA), the nation's largest voluntary health organization concerned with the health of people with diabetes. An estimated 34 million Americans and 378,000 Arkansans have diabetes, a chronic illness that requires continuing medical care and ongoing patient self-management to prevent acute complications and reduce the risk of long-term complications, such as blindness, amputation, kidney failure, heart attack, and stroke.

Advances in treatments, including continuous glucose monitoring (CGM), have been shown to be effective tools in diabetes management and the prevention of complications associated with the disease. ADA's 2021 Standards of Medical Care in Diabetes (Standards), which is updated annually by a committee of U.S. experts in diabetes care, provides that the use of professional CGM and/or intermittent real-time or intermittently scanned CGM can be helpful in identifying and correcting patterns of hyper-and hypoglycemia and improving A1C levels in people with diabetes on noninsulin as well as basal insulin regimens.[1]

Unfortunately, there continue to be gaps in access to CGM and other technologies among under-served populations, including – and perhaps most acutely – in the Medicaid population. ADA applauds the Arkansas legislature for enacting legislation to address coverage of continuous glucose monitors to further broaden access for people with diabetes to these technologies that will enable them to better manage their diabetes, and which may result in fewer adverse health outcomes or even premature deaths.

ADA respectfully submits the recommendations below regarding the CGM proposed rule. These recommendations broadly reflect our support for measures that will expand access to CGM technology for Arkansas Medicaid beneficiaries with diabetes. Eliminating burdensome requirements for access to diabetes management technologies is vital to reducing disparities in utilization particularly among under-served people with diabetes.

- Eliminate prior authorization as a barrier

Prior authorization requirements can present barriers that delay timely access to devices, medications, or therapies. Such barriers, which include step therapy protocols, frequently override what a provider believes to be in his or her patient's best clinical interest. ADA recommends that Arkansas Medicaid ensure that coverage and formulary decisions be based on clinical evidence and the direction of health care providers. Additionally, there must be a clear and timely appeals process for denials of coverage.

- Broaden Channels of Access to CGM

ADA also recommends that CGM be made available through as many channels as possible including both mail-order and local pharmacies to

[1] American Diabetes Association: Standards of Medical Care in Diabetes 2021, Diabetes Care 44: Supp. 1, p.S88 (January 2021).

increase access for the diverse population that can benefit from the devices.

- Ensure patient- and provider-centered choices for CGM devices

We respectfully urge that Arkansas Medicaid take extra care to avoid making choices that would limit access for people with diabetes to CGM or any technology that those individuals and their doctors believe is most appropriate to manage their diabetes. ADA's 2021 Standards provide that the choice of technology should be individualized based on patient's needs, desires, skill level, and availability of devices. These are determinations that should be made by a patient in conjunction with their health care provider.

Additionally, individuals who have been successfully using CGM should be able to continue to have access to that device across health care payers to avoid interruption in access that may result from the need for new training and education or lack of supplies and equipment. If coverage changes must occur, ADA recommends steps be taken to ensure a smooth transition process. At minimum, Arkansas Medicaid should adopt a transition period coupled with an exceptions process, enabling beneficiaries currently successfully using a CGM to continue to use that item and its associated supplies regardless of new limitations or exclusions.

The American Diabetes Association appreciates the opportunity to submit these recommendations for your consideration and looks forward to working with you to implement measures aimed at increasing access to CGMs to Arkansas Medicaid beneficiaries. Should you have any questions regarding these comments, please contact me at vdelagarza@diabetes.org.

RESPONSE: 1. PA process- The current PA process is streamlined and may be submitted via portal. If a provider has questions, we can have their provider representative do onsite education or education over the phone/zoom/teams meeting. The provider must complete the request and submit the required documents for the review to be completed.

2. Continuous Glucose Monitors are not a drug, rather a device, so they have been historically billed as a medical professional claim. Any changes to move them from a medical or DME type claim to a pharmacy claim would require large changes to both the medical and pharmacy systems.

3. AR Medicaid does not contract with one specific name brand. If a transition to a new product is required a provider may request a prior authorization with documented appropriate medical necessity.

Commenters' Names: Paul E. Valentin-Stone, M.D., Ann D. Layton, M.D., Ashley Poppy, APRN, CHI St. Vincent

COMMENT: Arkansas Department of Human Services, Division of Medical Services has issued a proposed rule for Medicaid coverage for Continuous Glucose Monitoring (CGM) systems, effective 1/1/2022. We are an Internal Medicine clinic that sees a high volume of patients with diabetes, so this bill will directly impact the ease of care for these patients to control their diabetes. It should keep them from utilizing the ER or hospitals by keeping their blood sugars regulated. The following are a few points that we hope you will consider with this new rule:

• The proposed rule provides coverage for the CGM if the client "has a presence of type 1 diabetes or any other type of diabetes with the use of insulin more than two times daily." We encourage DHS to explicitly include language for type 1 or type 2 patients on insulin and that also includes coverage for a client that is using an insulin pump.

• While it is common to require a prior authorization (PA) for CGM coverage in Medicaid programs, we encourage DHS to ensure that patient access is not compromised by a burdensome PA review process that could delay a patient receiving a CGM. This is especially important for reauthorization of CGM. A patient must remain on CGM to receive the full benefits of this technology.

• The most cost-effective channel for Medicaid patients to receive a CGM is through the pharmacy. Costs to the state for the CGM systems can be up to 50% lower if they choose to manage CGM as a pharmacy benefit and receive rebates. 21 state Medicaid programs manage CGM through the pharmacy channel and several more will be doing so, or are considering that products are readily available at the pharmacy. Additionally, CGM systems are now much easier to use so there is no need for a training visit to start a patient on CGM. A patient can receive his/her CGM supplies at the pharmacy while also picking up insulin.

Thank you for your consideration of these recommendations and we are very appreciative of the time and effort spent on this bill. We are excited to see our patients' care being a primary focus. We have seen the benefits of CGM use and are sure this will be a step forward in the care of these diabetic patients.

RESPONSE: 1. Requests for those who use an insulin pump would meet the more than 2 times per day criteria already. The use of an insulin pump indicates medical need for insulin more frequently than two times per day. We will add language to clarify that use of an insulin pump meets the qualifications.

2. PA process- The current PA process is streamlined and may be submitted via portal. If a provider has questions, we can have their provider representative do onsite education or education over the phone/zoom/teams meeting. The provider must complete the request and submit the required documents for the review to be completed.

3. Continuous Glucose Monitors are not a drug, rather a device, so they have been historically billed as a medical professional claim. Any changes to move them from a medical or DME type claim to a pharmacy claim would require large changes to both the medical and pharmacy systems.

Commenters' Names: Lauren Fields, MBA, BSN, RN, Chief Nursing Officer, Anna Hall, MS, RDN, LD, CDCES, Clinical Director of Coordinated Care, Lydia Sartain, MS, RDN, LD, CDCES, Director of Diabetes and Nutrition, Shelby Roberson, MS, RDN, LD, CDCES, Registered Dietitian, ARcare

COMMENT: We are writing to you today as healthcare providers who are seeking the best possible outcomes and improved quality of life for our patients, family, and friends. Within ARcare, we are privileged to serve a wide variety of patients with more than fifty clinics across the state of Arkansas. We service rural areas, as well as the metro, but regardless of geographical location, one thing is consistent- we take care of many patients with Medicaid insurance. We are excited about the pending changes to come with Arkansas Medicaid providing coverage for continuous glucose monitor (CGM) use.

As diabetes educators, we can take numbers and information and provide the patient with the knowledge and skill set to better self-manage their diabetes diagnosis, but the use of CGM's and technology within the scope of diabetes care is incomparable. It takes numbers and information and converts it into a tangible and tactical tool that our patients are able to use. Per the Standards of Care, written by the American Diabetes Association, "major clinical trials of insulin-treated patients have included self-monitoring of blood glucose (SMBG) as part of multifactorial interventions to demonstrate the benefit of intensive glycemic control on diabetes complications. Glucose monitoring allows patients to evaluate their individual response to therapy and assess whether glycemic targets are being safely achieved. Integrating results into diabetes management can be a useful tool for guiding medical nutrition therapy and physical activity, preventing hypoglycemia, or adjusting medications ... " (7. Diabetes Technology: Standards of medical care in diabetes-2021. (2020). Diabetes Care, 44 (Supplement 1), S77-S97. https://doi.org/10.2337/dc21-s007).

In conclusion, there is proven research that continuous glucose monitoring is useful for reducing Hemoglobin A 1 c levels, as well as a decrease in hypoglycemic events, in both Type 1 and Type 2 children and adults, alike.

We are appreciative of the actions taken thus far to better meet the needs of our Medicaid patient population. We do ask that a few minor adjustments are made to the verbiage in the proposed rule to ensure ease and timeliness for our patients to obtain their CGM systems, such as follows:

We encourage DHS to explicitly include language for T1 or T2 patients on MDI or utilizing an insulin pump.

We encourage DHS to ensure that patient access is not compromised by a burdensome PA review process that could delay our patients receiving a CGM. This could be the difference between life and death for a patient who is struggling with frequent hypoglycemic events or hypoglycemia unawareness.

Finally, we ask that DHS recognize the most cost-effective channel for Medicaid patients to receive a CGM is through the pharmacy. CGM systems can be up to 50% lower for the state, if CGM's are included as a pharmacy benefit. At ARcare, our team of clinical pharmacists, nurses, and dietitians are committed to ensuring our patients can utilize the device and take advantage of remote technology used to provide excellent patient care, even if patients are hesitant to come into the clinic for routine care and education, especially in these unprecedented times of COVID-19.

Again, we appreciate the action that has already taken place to improve the diabetes epidemic in Arkansas by use of CGM technology within our state and ask that you would consider these additional updates to the Arkansas Medicaid proposed rule for CGM coverage.

RESPONSE: 1. Requests for those who use an insulin pump would meet the more than 2 times per day criteria already. The use of an insulin pump indicates medical need for insulin more frequently than two times per day. We will add language to clarify that use of an insulin pump meets the qualifications.

2. PA process- The current PA process is streamlined and may be submitted via portal. If a provider has questions, we can have their provider representative do onsite education or education over the phone/zoom/teams meeting. The provider must complete the request and submit the required documents for the review to be completed.

3. Continuous Glucose Monitors are not a drug, rather a device, so they have been historically billed as a medical professional claim. Any changes to move them from a medical or DME type claim to a pharmacy claim would require large changes to both the medical and pharmacy systems.

The proposed effective date is January 1, 2022.

FINANCIAL IMPACT: The agency indicated that this rule has a financial impact.

Per the agency, the total cost to implement this rule is $2,093,399 for the current fiscal year ($594,107 in general revenue and $1,499,293 in federal funds) and $4,186,799 for the next fiscal year ($1,188,213 in general revenue and $2,998,585 in federal funds). The total estimated cost by fiscal year to state, county, and municipal government as a result of this rule is $594,107 for the current fiscal year and $1,188,213 for the next fiscal year.

The agency indicated that there is 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. Accordingly, the agency provided the following written findings:

(1) a statement of the rule's basis and purpose;

The purpose of this Rule is to implement the requirements of Arkansas Act 643 of 2021.

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

Act 643 of 2021 requires that Continuous Glucose Monitors (CGM) and related supplies be covered by Arkansas Medicaid. The Act defines a CGM, and the criteria for coverage.

(3) a description of the factual evidence that:
(a) justifies the agency's need for the proposed rule; and
(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

Continuous Glucose Monitors provide safe and effective monitoring of glucose levels for those who require multiple measurements throughout the day and will help qualifying clients to control their diabetes in a manner that will prevent more costly treatments.

(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;

No less costly alternatives were identified.

(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 alternatives are proposed at this time.

(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

Not applicable

(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 Agency monitors State and Federal rules and regulations for opportunities to reduce and control cost.

LEGAL AUTHORIZATION: The Department of Human Services has the responsibility to administer assigned forms of public assistance and is specifically authorized to maintain an indigent medical care program (Arkansas Medicaid). *See* Ark. Code Ann. §§ 20-76-201(1), 20-77-107(a)(1). The Department has the authority to make rules that are necessary or desirable to carry out its public assistance duties. Ark. Code Ann. § 20-76-201(12). The Department and its divisions also have the authority to promulgate rules as necessary to conform their programs to federal law and receive federal funding. Ark. Code Ann. § 25-10-129(b).

This rule implements Act 643 of 2021. The Act, sponsored by Senator Breanne Davis, mandated that the Arkansas Medicaid Program cover a continuous glucose monitor for an individual with diabetes.

h. SUBJECT: ARHOME Cost Sharing; SPA 21-0010, Section I 3-21

DESCRIPTION:

Statement of Necessity

The State of Arkansas submitted a new Section 1115 Demonstration Waiver which will replace the current ARWorks program. The ARHOME aid category covers individuals ages 19-64 who earn up to 138% of the poverty level. Beneficiaries with household income above 20% of the federal poverty level will be responsible for cost sharing for listed services in calendar year 2022.

Beneficiaries at or below 20% FPL, individuals who are medically frail, and individuals identified as American Indian or Alaskan Native (AI/AN) are not subject to cost sharing.

Beneficiaries with household incomes above 100% of the federal poverty level who are enrolled in a qualified health plan will be subject to a monthly premium.

Rule Summary

State Plan, Sections ABP2a and ABP4

ABP2a
• Added language regarding individuals identified as American Indian or Alaskan Native
(AI/AN)

ABP4
• Added language outlining cost-sharing parameters and exclusions

Provider Manual, Section I – General
Added a new section (124.240)

124.240 - Arkansas Health and Opportunity for Me Program (ARHOME)
• Distinguishes the amount of copayment and cost sharing, if any, attributed to each
beneficiary household based on federal poverty level percentages.

Section 133.100 - Inpatient Hospital Coinsurance Charge for Medicaid Beneficiaries With Medicare
• Added reference to section 124.240 (above) in this section (133.100)

Section 133.400 – Co-payment on Prescription Drugs

• Added reference to section 124.240 (above) in this section (133.400)

PUBLIC COMMENT: A public hearing was held on this rule on October 27, 2021. The public comment period expired November 12, 2021. The agency indicated that it received no public comments.

The proposed effective date is January 1, 2022.

FINANCIAL IMPACT: The agency indicated that this rule has a financial impact.

Per the agency, this rule will reduce governmental costs by $7,399,800 for the current fiscal year ($739,980 in general revenue and $6,659,820 in federal funds) and $14,799,600 for the next fiscal year ($1,479,960 in general revenue and $13,319,640 in federal funds).

The agency stated that the QHPs will now be responsible for collecting cost sharing from the members. In the past, unpaid cost share has been a debt to the State and it will now be a debt to the QHPs. The total estimated cost to these entities is $7,399,800 for the current fiscal year and $14,799,600 for the next fiscal year.

The agency indicated that there is a new or increased cost of 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. Accordingly, the agency provided the following written findings:

(1) a statement of the rule's basis and purpose;

The State of Arkansas submitted a new Section 1115 Demonstration Waiver which will replace the current ARWorks program. The ARHOME aid category covers individuals ages 19-64 who earn up to 138% of the poverty level. Beneficiaries with household income above 20% of the federal poverty level will be responsible for cost sharing for listed services in calendar year 2022.

Beneficiaries at or below 20% FPL, individuals who are medically frail, and individuals identified as American Indian or Alaskan Native (AI/AN) are not subject to cost sharing.

Beneficiaries with household incomes above 100% of the federal poverty level who are enrolled in a qualified health plan will be subject to a monthly premium.

The ARHOME program will become effective January 1, 2022.

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

This is to implement a cost sharing requirement for beneficiaries as defined above.

(3) a description of the factual evidence that:
(a) justifies the agency's need for the proposed rule; and
(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

Beneficiaries with household income above 20% of the federal poverty level will be responsible for cost sharing for listed services in calendar year 2022.

(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;

None

(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;

None

(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 State of Arkansas submitted a new Section 1115 Demonstration Waiver which will replace the current ARWorks program. The ARHOME aid category covers individuals ages 19-64 who earn up to 138% of the poverty level. Beneficiaries with household income above 20% of the federal poverty level will be responsible for cost sharing for listed services in calendar year 2022.

(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 Agency monitors State and Federal rules and policies for opportunities to reduce and control costs.~~

~~**LEGAL AUTHORIZATION:** This rule implements Act 530 of 2021, sponsored by Senator Missy Irvin. The Act created the Arkansas Health and Opportunity for Me Act of 2021 and the Arkansas Health and Opportunity for Me Program, effective January 1, 2022. *See* Act 530, § 9. "The Department of Human Services shall adopt rules necessary to implement" the Health and Opportunity for Me Act. *See* Ark. Code Ann. § 23-61-1012, *as created by* Act 530.~~

9. DEPARTMENT OF HUMAN SERVICES, DIVISION OF PROVIDER SERVICES & QUALITY ASSURANCE (Mr. Mark White, Ms. Martina Smith)

a. SUBJECT: Direct Care Staffing Requirements Update Pursuant to Act 715 of 2021

DESCRIPTION:

Statement of Necessity

Section 520 of the Rules for Nursing Homes is being updated to reflect changes due to Act 715 of 2021. Section 520 covers Minimum Direct-care Staffing requirements. Act 715 of 2021 changes staffing standards and reporting requirements for nursing facilities.

Rule Summary

DPSQA amends Section 520 of the Rules for Nursing Homes. The new Section 520 changes the rules and reporting requirements to comply with Act 715. This rule provides guidance to nursing home facilities as to how reporting should be conducted, when reporting should be made to DHS, requirements for waivers and variances, and how facilities should respond to the law.

Act 715 directs that the Rules for Nursing Homes, as applied to Medicare and Medicaid certified nursing facilities, be consistent with federal staffing and data reporting requirements. DPSQA changes the staff to resident ratios and eliminates the penalties associated with those standards.

DPSQA also amends the reporting requirements for actual average direct care hours per resident.

PUBLIC COMMENT: No public hearing was held on this proposed rule. The public comment period expired on October 18, 2021. The agency provided the following summary of the public comments it received and its responses to those comments:

Commenter's Name: Holly Johnson, Senior Assistant Attorney General, Office of Arkansas Attorney General Leslie Rutledge, Medicaid Fraud Control Unit

1. Pursuant to the directions outlined for public comments in the September 17, 2021, Memorandum (Direct Care Staffing Requirements update pursuant to Act 715 of 2021), please find the following:

520.1 Definitions: Under parts (c) and (d), the word "skilled" is added to "nursing facilities" with respect to "direct care services" and "direct care staff" but does not appear in Act 715.

RESPONSE: Correct. The State of Arkansas has both skilled nursing facilities and nursing facilities; thus, it is appropriate to use nursing facilities to include all facilities.

2. Under part (h), "as existing on January 1, 2021" is not included.
RESPONSE: This can be added.

3. This section does not include definitions for "nurse aide", "nursing facility", and "nursing staff". **RESPONSE:** Definitions will be updated at the beginning of the manual.

4. 520.4 Average Direct Care Hours Per Resident Day: Certified Nursing Facilities: Under part (c), what states that the facility shall file an amended monthly report with the department within fifteen (15) days of the federal direct care data system reporting deadline for the quarter?

RESPONSE: DHS and AHCA agreed to fifteen days, as the Act used the word "promptly." This was an attempt to define the word "promptly." The language in the Act states: "When necessary to correct monthly report data following quarterly data validation and based on the final staffing data reported in the federal direct care data system for the applicable quarter, a certified nursing facility shall promptly file an amended monthly report with the department."

5. 520.6 Certified Medication Assistants: Under part (b), will the person be able to perform both functions during the same shift, a different shift, or in what manner?
RESPONSE: Yes.

6. 520.9 Waivers and Variances: Under part (a), the word "certified" is left out. **RESPONSE:** This can be added.

7. Under part (c), is there a time frame in which a request should be made?
RESPONSE: No, because it can vary.

Lacey Johnson, an attorney with the Bureau of Legislative Research, asked the following questions and received the following responses:

1. Section 520.9(a) states that, in certain scenarios, "the department may temporarily waive the average direct care hours per resident day standard or reporting requirements." I see that Act 715 provides that the Department may temporarily waive the average direct care hours per resident day standard. What is the authority for temporarily waiving reporting requirements?

RESPONSE: We agree with this assessment. We cannot waive the reporting requirements. This should be changed. [The agency provided an updated version of the rule.]

2. Is there specific authority for the provisions of § 520.9(b)(1), regarding temporary waivers/variances of rules during specific emergency scenarios? **RESPONSE:** No.

This rule was filed on an emergency basis and was reviewed and approved by the Executive Subcommittee on September 16, 2021. The proposed effective date for permanent promulgation is January 1, 2022.

FINANCIAL IMPACT: The agency indicated that this proposed rule has a financial impact.

Per the agency, the total cost to implement this rule is $562,501 for the current fiscal year ($159,638 in general revenue and $402,863 in federal funds) and $750,001 for the next fiscal year ($212,850 in general revenue and $537,151 in federal funds). The total estimated cost to state, county, and municipal government to implement this rule is $159,638 for the current fiscal year and $212,850 for the next fiscal year.

The agency indicated that there is 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. Accordingly, the agency provided the following written findings:

(1) a statement of the rule's basis and purpose;

Act 715 changed the staffing standards that required a particular ratio of staff to residents. Act 715 also eliminated the penalties associated with such standards. Previously, if those ratios were not met, DHS could issue penalties to the facilities for a failure to meet those standards. In the previous FY, DHS collected $210,500 in penalties from nursing facilities.

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

Act 715 changed the staffing standards that required a particular ratio of staff to residents. Act 715 also eliminated the penalties associated with such standards. Previously, if those ratios were not met, DHS could issue penalties to the facilities for a failure to meet those standards. In the previous FY, DHS collected $210,500 in penalties from nursing facilities.

(3) a description of the factual evidence that:
(a) justifies the agency's need for the proposed rule; and
(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

Act 715 changed the staffing standards that required a particular ratio of staff to residents. Act 715 also eliminated the penalties associated with such standards. Previously, if those ratios were not met, DHS could issue penalties to the facilities for a failure to meet those standards. In the previous FY, DHS collected $210,500 in penalties from nursing facilities.

(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;

None.

(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;

None.

(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;

Act 715 changed the staffing standards that required a particular ratio of staff to residents. Act 715 also eliminated the penalties associated with such standards. Previously, if those ratios were not met, DHS could issue penalties to the facilities for a failure to meet those standards. In the previous FY, DHS collected $210,500 in penalties from nursing facilities.

(7) an agency plan for review of the rule no less than every ten 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.

Act 715 changed the staffing standards that required a particular ratio of staff to residents. Act 715 also eliminated the penalties associated with such standards. Previously, if those ratios were not met, DHS could issue penalties to the facilities for a failure to meet those standards. In the previous FY, DHS collected $210,500 in penalties from nursing facilities.

LEGAL AUTHORIZATION: The Department of Human Services, Office of Long-Term Care, located within the Division of Provider Services and Quality Assurance, is "the unit of state government primarily responsible for the inspection, regulation, and licensure of long-term care facilities." Ark. Code Ann. § 20-10-203. It may promulgate rules "as it shall deem necessary or desirable to" accomplish its duties. Ark. Code Ann. § 20-10-203. The Department has the general authority to make rules that are necessary or desirable to carry out its public assistance duties. Ark. Code Ann. § 20-76-201(12); *see also* Ark. Code Ann § 20-10-203(b). The Department and its divisions also have the authority to promulgate rules as necessary to conform their programs to federal law and receive federal funding. Ark. Code Ann. § 25-10-129(b).

This rule implements provisions of Act 715 of 2021. The Act, sponsored by Representative Brian Evans, modernized and strengthened nursing facility staffing standards and reporting requirements. Per the Act, "the Department shall promulgate rules as necessary to carry out the provisions of [Ark. Code Ann. § 20-10-1402]," which addresses staffing standards. *See* Ark. Code Ann. § 20-10-1402, *as amended by* Act 715.

b. **SUBJECT: Licensure Update Pursuant to Acts 135 and 746**

DESCRIPTION:

Statement of Necessity

The Director of the Division of Provider Services and Quality Assurance amends the Rules for the Arkansas Long Term Care Facility Nursing Assistant Training Program to incorporate Acts 135 and 746 of the 93rd General Assembly.

Rule Summary

The 93rd General Assembly enacted Acts 135 and 746. Act 746 directs occupational and licensing entities to grant licenses to individuals who hold a Federal Form I-766 United States Citizenship and Immigration Services-issued Employment Authorization Document, known as a "work permit," who fulfill the professional licensing requirements. Act 135 directs occupational and licensing entities to provide automatic or expedited professional licensing to uniformed service members, veterans, and their spouses. DPSQA oversees the licensing of long-term care nursing assistants. To comply with these acts, DPSQA amends the Rules for the Arkansas Long Term Care Facility Nursing Assistant Training Program to incorporate these requirements.

PUBLIC COMMENT: No public hearing was held on this proposed rule. The public comment period expired on November 8, 2021. The agency indicated that it did not receive any public comments.

Lacey Johnson, an attorney with the Bureau of Legislative Research, asked the following questions and received the following responses:

1. The citation in the last paragraph of Section D should reference A.C.A. § 17-1-110 rather than § 17-1-109. **RESPONSE:** That is correct. This has been corrected in the attached packet.

2. Section E(2) states that, in order to be eligible for automatic/expedited licensure, a uniformed service veteran must establish residence in Arkansas and make an application within one year of his/her discharge from uniformed service. However, the one-year time limit does not appear in A.C.A. § 17-4-104, which addresses applicability of the Arkansas Occupational Licensing of Uniformed Service Members, Veterans, and Spouses Act of 2021. I see a similar one-year requirement in A.C.A. § 17-4-107(2), regarding acceptance of uniformed service education, training, or service-issued credentials. Is it DHS's position that the one-year requirement in § 17-4-107(2) applies to both acceptance of

education/training/service-issued credentials and eligibility for automatic/expedited licensure, or was the requirement in the proposed rules taken from somewhere else?

RESPONSE: Section E quotes the wrong statute:

To comply with the Arkansas Occupational Licensing of Uniformed Service Members, Veterans, and Spouses Act of 2021 (Arkansas Code Annotated § 17-4-106), the following rules apply to:

Instead, it should read:

To comply with the Arkansas Occupational Licensing of Uniformed Service Members, Veterans, and Spouses Act of 2021 (Arkansas Code Annotated § 17-4-101, et seq.), the following rules apply to:

This has been corrected in the attached packet.

The proposed effective date is January 2, 2022.

FINANCIAL IMPACT: The agency indicated that this rule has no financial impact.

LEGAL AUTHORIZATION: The Office of Long-Term Care, located within the Department of Human Services, Division of Provider Services and Quality Assurance, has may promulgate rules "necessary or desirable to properly and efficiently carry out the purposes and intent of" Title 20, Chapter 10 of the Arkansas Code, addressing long-term care facilities and services. The Department also has authority to "promulgate rules necessary to implement an aide training program for all long-term care facilities in this state, to prescribe in-service training programs, and to enforce compliance with those programs." Ark. Code Ann. § 20-10-705(a). The Department and its divisions may promulgate rules as necessary to conform their programs to federal law and receive federal funding. Ark. Code Ann. § 25-10-129(b).

These rules implement Acts 135 and 746 of 2021. Act 135, sponsored by Senator Ricky Hill, established the Arkansas Occupational Licensing of Uniformed Service Members, Veterans, and Spouses Act of 2021. Under the Act, "[a]n occupational licensing entity shall grant automatic occupational licensure to" certain specified individuals. *See* Ark. Code Ann. § 17-4-105, *as created by* Act 135. Act 746, sponsored by Representative Clint Penzo, authorized occupational or professional licensure for certain individuals. Temporary language contained within Act 746 required all occupational or professional licensing entities to promulgate rules necessary to implement the Act. *See* Act 746, § 2(a).

c. SUBJECT: Division of Provider Services & Quality Assurance (DPSQA) Manual Extension

DESCRIPTION:

Statement of Necessity

The rule as initially promulgated was set to terminate on December 31, 2021; however, the public health emergency is ongoing, therefore DPSQA amends the termination date.

Rule Summary

DPSQA amends the COVID-19 Response Manual to align the termination of DPSQA's waiver of pre-admission screening for prospective nursing home residents with the termination of the 1135 waiver and continues to suspend the rules for the Therapeutic Community's level of direct care. DPSQA removes the termination date from the Pre-Admission Screening for Nursing Facility Residents Potentially MI/DD section (271.000) and aligns it with 1135 waiver termination language: "upon termination of the public health emergency, including any extensions." By continuing to suspend these rules, nursing homes are able to admit individuals with diagnoses or other indicators of mental illness or developmental disability without first getting an assessment and approval by the Division of Provider Services and Quality Assurance, Office of Long-Term Care (OLTC), clearing such individuals for placement in the facility. However, prior to admission, the facility must review the individual's information to ensure the facility can meet the individual's medical and behavioral needs.

The section waiving rules related to Therapeutic Community Direct Services Requirements (272.000) is extended to align with the termination of the public health emergency, including any extensions.

PUBLIC COMMENT: No public hearing was held on this proposed rule. The public comment period expired on November 8, 2021. The agency indicated that it received no public comments.

The proposed effective date is January 1, 2022.

FINANCIAL IMPACT: The agency indicated that this rule does not have a financial impact.

LEGAL AUTHORIZATION: The Department of Human Services has the responsibility to administer assigned forms of public assistance and is specifically authorized to maintain an indigent medical care program

(Arkansas Medicaid). *See* Ark. Code Ann. §§ 20-76-201(1), 20-77-107(a)(1). The Department has the authority to make rules that are necessary or desirable to carry out its public assistance duties. Ark. Code Ann. § 20-76-201(12); *see also* Ark. Code Ann § 20-10-203(b). The Department and its divisions also have the authority to promulgate rules as necessary to conform their programs to federal law and receive federal funding. Ark. Code Ann. § 25-10-129(b).

10. DEPARTMENT OF PUBLIC SAFETY, STATE CRIME LABORATORY (Ms. Amanda Yarbrough)

a. SUBJECT: To Establish the State Crime Laboratory Student Loan Forgiveness Program

DESCRIPTION: Act 360 of 2021 established the State Crime Laboratory Student Loan Forgiveness Program. The proposed rules are being promulgated pursuant to Act 360. The proposed rules establish eligibility criteria and requirements for the program, instructions for submitting applications, and various provisions related to the administration of the program.

PUBLIC COMMENT: No public hearing was held on these proposed rules. The public comment period expired on November 5, 2021. The agency indicated that it received no public comments.

The proposed effective date is pending legislative review and approval.

FINANCIAL IMPACT: The agency indicated that this rule has a financial impact.

Per the agency, the total cost to implement this rule is $0 for the current fiscal year and $75,000 for the next fiscal year. The total estimated cost by fiscal year to state, county, and municipal government to implement this rule is $0 for the current fiscal year and $75,000 for the next fiscal year.

LEGAL AUTHORIZATION: This rule implements Act 360 of 2021, sponsored by Representative Dwight Tosh, which established the State Crime Laboratory Student Loan Forgiveness Program. Per the Act, "[t]he State Crime Laboratory Board shall promulgate rules for determining a pathologist's eligibility for student loan forgiveness under the program[.]" Act 360, § 1(b)(2), *codified at* Ark. Code Ann. § 12-12-327(b)(2).

11. DEPARTMENT OF PUBLIC SAFETY, CRIME VICTIM REPARATIONS BOARD (Ms. Amanda Yarbrough)

a. SUBJECT: CVRB Rules

DESCRIPTION: Act 472 of 2021 made technical corrections to Arkansas Code Annotated § 12-12-401, including updating the definitions related to sexual assault reimbursement. In an effort to conform CVRB Rules to the format proposed for the Code of Arkansas Rules established by Act 662 of 2019 and to provide greater clarity regarding applicability of the board's rules, CVRB rules are being reorganized and grouped into sections: 1. General Provisions, 2. Crime Victims Reparations, and 3. Sexual Assault Reimbursement.

Rule 1. Title and Operative Date of the Act
- This rule was renumbered as Rule 1.1 and moved to Section 1 – General Provisions.
- Reference to Ark. Code Ann. § 12-12-404 (sexual assault reimbursement) was added.

Rule 2. Definitions
- This rule was renumbered as Rule 2.1 and moved to Section 2 – Crime Victims Reparations.

Rule 3. Types of Compensation Available
- This rule was renumbered as Rule 2.2 and moved to Section 2 – Crime Victims Reparations.

Rule 4. Membership and Officers of the Board
- This rule was renumbered to Rule 1.2 and moved to Section 1 – General Provisions.

Rule 5. Purpose of the Board
- This rule was renumbered to Rule 1.3 and moved to Section 1 – General Provisions.

Rule 6. Powers and Duties of the Board.
- This rule was renumbered to Rule 1.4 and moved to Section 1 – General Provisions.
- Reference to Ark. Code Ann. § 12-12-401 et seq. was added to include the board's authority to reimburse sexual assault claims.

Rule 7. Meetings of the Board
- This rule was renumbered to Rule 1.5 and moved to Section 1 – General Provisions.

Rule 8. Eligibility Criteria for Compensation
- This rule was renumbered to Rule 2.3 and moved to Section 2 – Crime Victims Reparations.

Rule 9. Unjust Enrichment
- This rule was renumbered to Rule 2.4 and moved to Section 2 – Crime Victims Reparations.

Rule 10. Maximum Compensation Amounts and Methods of Payments
- This rule was renumbered to Rule 2.5 and moved to Section 2 – Crime Victims Reparations.

Rule 11. Application Review
- This rule was renumbered to Rule 2.6 and moved to Section 2 – Crime Victims Reparations.

Rule 12. Advance (Emergency) Award of Compensation
- This rule was renumbered to Rule 2.7 and moved to Section 2 – Crime Victims Reparations.

Rule 13. Appeals Procedure
- This rule was renumbered to Rule 2.8 and moved to Section 2 – Crime Victims Reparations.

Rule 14. Penalty for False Claims
- This rule was renumbered to Rule 2.14 and moved to Section 2 – Crime Victims Reparations.

Rule 15. Board Staff
- This rule was renumbered to Rule 1.6 and moved to Section 1 – General Provisions.

Rule 16. Claims of Incompetents or Minor Children
- This rule was renumbered to Rule 2.9 and moved to Section 2 – Crime Victims Reparations.

Rule 17. Amendment to Rules and Regulations
- This rule was renumbered to Rule 1.7 and moved to Section 1 – General Provisions.

Rule 18. Cost Ceiling on Medical Bills
- This rule was renumbered to Rule 2.10 and moved to Section 2 – Crime Victims Reparations.

Rule 19. Cost Ceiling on Mental Health Bills

- This rule was renumbered to Rule 2.11 and moved to Section 2 – Crime Victims Reparations.

Rule 20. Conflict of Interest
- This rule was renumbered to Rule 1.8 and moved to Section 1 – General Provisions.

Rule 21. Supplemental Awards
- This rule was renumbered to Rule 2.12 and moved to Section 2 – Crime Victims Reparations.

Rule 22. Financial Obligation Requirement
- This rule was renumbered to Rule 2.13 and moved to Section 2 – Crime Victims Reparations.

Rule 3.1 Definitions
- This rule was created to define terms used in Section 3 – Sexual Assault Reimbursement.

Rule 3.2 Eligibility Criteria for Compensation
- This rule was created to outline the eligibility criteria for sexual assault reimbursement.

Rule 3.3 Collateral Sources
- This rule was created to ensure consistency in the requirements related to collateral sources for all claims reimbursed by the board.

Rule 3.3 Collateral Sources
- This rule was created to ensure consistency in the requirements related to collateral sources for all claims reimbursed by the board.

Rule 3.4 Maximum Payment Amounts
- This rule was created to establish, by rule, the rates that are currently being used by the board for sexual assault expense reimbursement.

PUBLIC COMMENT: No public hearing was held on this rule. The public comment period expired on November 5, 2021. The agency indicated that it received no public comments.

Lacey Johnson, an attorney with the Bureau of Legislative Research, asked the following questions and received the following responses:

1. The text added in Rule 1.4(18) states that the Board shall have the power to "reimburse any medical facility or licensed healthcare provider." However, Act 472 consolidated the definitions of "medical facility" and "licensed healthcare provider" into a single term – "licensed

healthcare provider." In light of Act 472, is there a specific reason the Board retained the term "medical facility" in this section?

RESPONSE: [The agency indicated that there was not a specific reason this language was retained. However, because the definition of "licensed healthcare provider" in the rules was updated to include a medical facility, the agency believes the proposed rules conform with Act 472.]

2. Rule 3.2 provides that billing for a medical-legal examination must be submitted to the Board within three months, except for good cause. Is there a statutory source for this three-month timeframe, or does it come from somewhere else?

RESPONSE: [The agency indicated that the Board has statutory authority under Ark. Code Ann. § 12-12-404 to prescribe minimum standards and rules necessary to implement the subchapter regarding sexual assault medical-legal examinations. Per the agency, this is the statutory authority relied upon for this provision.]

The proposed effective date is January 1, 2022.

FINANCIAL IMPACT: The agency indicated that this rule does not have a financial impact.

LEGAL AUTHORIZATION: The Crime Victims Reparations Board may prescribe rules necessary to implement the provisions of the Arkansas Crime Victims Reparations Act. *See* Ark. Code Ann. § 16-90-706(b)(2). The Board also has authority to "prescribe minimum standards and rules necessary to implement" Ark. Code Ann. §§ 12-12-401 to -406, regarding medical-legal examinations in cases of sexual assault. *See* Ark. Code Ann. § 12-12-404(b).

Portions of this rule implement Act 472 of 2021. The Act, sponsored by Senator Bob Ballinger, made technical corrections to Title 12 of the Arkansas Code concerning law enforcement agencies. These changes included updating a number of definitions related to sexual assault medical-legal examinations.

12. DEPARTMENT OF PUBLIC SAFETY, DIVISION OF LAW ENFORCEMENT STANDARDS & TRAINING (Ms. Amanda Yarbrough)

a. SUBJECT: CLEST Rules

DESCRIPTION: CLEST's proposed legislation passed the General Assembly as Act 218 of 2021. The changes to state law through Act 218

are addressed throughout the proposed rule changes. Other changes made or proposed during the 2021 session of the General Assembly are addressed in the proposed rule changes.

In an effort to conform CLEST Rules to the format proposed for the Code of Arkansas Rules established by Act 662 of 2019, technical changes are being made throughout the rules to ensure a smooth transition of rules into the new code. Examples of technical corrections include clarification of proper punctuation; merging rules containing similar content; changing "him" or "her" to "them" and "they;" ensuring proper use of defined terms; and removing unnecessary or repetitive information.

- Rule 1000
    - CLEST Rule 1024 has been incorporated into this rule.
    - Technical corrections and rule cleanup.

- Rule 1001
- Update to define "annually" as the January-December calendar year. This is relevant to CLEST Rule 1002 that requires officers to complete 24 hours of continuing education "annually." This change is to clarify confusion about whether annual means the calendar year or a rolling 12-month period.
- Technical corrections and rule cleanup.
- Deleted defined terms not used in the rule.

- Rule 1002
- Act 792 of 2021 requires law enforcement officers to complete duty-to-intervene training annually. CLEST Rule 1002 is being updated to include this requirement in minimum standards.
- 1002 is also being updated to increase the minimum hours of annual racial profiling training for law enforcement officers. This change comes following a recommendation from the Task Force to Advance the State of Law Enforcement in Arkansas to increase the required training to 4 hours annually.
-During the 2021 legislative session, House Bills 1333 and 1342 were filed to allow Marshallese citizens eligibility for certification as a law enforcement officer. Because Marshallese citizens are not eligible for United States citizenship, they are not eligible for certification under current CLEST rules. Following a partnership with local agencies and legislative sponsors, CLEST Rule 1002 is being amended to allow a narrow exception to the citizenship requirement for Marshallese citizens.
- Technical corrections and rule cleanup. (Section (7), related to failure or removal from the basic training academy, has been moved to CLEST Rule 1005.)
- All language in Rule 1006 has been incorporated into this rule.

- Rule 1003
    - Technical corrections and cleanup.

- Rule 1004
    - Repeal/reserve. All language has been moved to Rule 1009.

- Rule 1005
- CLEST Rule 1005 is being updated to clarify the requirements of a law enforcement officer following failure or dismissal from basic law enforcement training courses.
- Technical corrections and rule cleanup.

- Rule 1006
    - Repeal/reserve. All language has been moved to Rule 1002.

- Rule 1007
    - Technical corrections and rule cleanup.
    - All language in Rule 1019 has been incorporated into this rule.

- Rule 1008
    - Technical corrections and rule cleanup.

- Rule 1009
- CLEST Rule 1009 is being updated to clarify the requirements for a law enforcement officer to obtain an intermediate certificate. This is not a change required by legislation; however, recent confusion regarding requirements has necessitated a change to provide clarity going forward.
- Technical corrections and rule cleanup.
- All language in Rule 1004 has been incorporated into this rule.

- Rule 1010
    - Technical corrections and rule cleanup.

- Rule 1011
    - Technical corrections and rule cleanup.

- Rule 1012
    - Technical corrections and rule cleanup.

- Rule 1013
    - Technical corrections and rule cleanup.

- Rule 1014
- CLEST Rule 1014 is being updated following a recommendation from the Task Force to Advance the State of Law Enforcement in Arkansas. The Task Force recommended that the following criteria be included in

the training requirements for field training officer certification: Communication Skills, Implicit Bias, Ethics, Duty to Intervene, Cultural Competency, De-Escalation, and Crisis Intervention Training.
    - Technical corrections and rule cleanup.

- Rule 1015
    - Technical corrections and rule cleanup.

- Rule 1016
- CLEST Rule 1016 is being updated to allow the Commission discretion in accepting military police experience in lieu of or in addition to the law enforcement experience requirement for certification as a CLEST instructor. This is not a change required by specific legislation; however, in an ongoing effort to support the military community, CLEST believes that military police experience should be reviewed and accepted at the discretion of the Commission.
    - Technical corrections and rule cleanup.

- Rule 1017
    - Technical corrections and rule cleanup.
    - All language in Rule 1018 has been incorporated into this rule.

- Rule 1018
    - Repeal/reserve. All language has been moved to Rule 1017.

- Rule 1019
    - Repeal/reserve. All language has been moved to Rule 1007.

- Rule 1020
    - Technical corrections and rule cleanup.

- Rule 1021
    - Technical corrections and rule cleanup.

- Rule 1022
    - All language in Rule 1023 has been incorporated into this rule.
    - Technical corrections and rule cleanup.

- Rule 1023
    - Repeal/reserve. All language has been moved to Rule 1022.

- Rule 1024
    - Repeal/reserve. All language has been moved to Rule 1000.

- Rule 1025
    - Technical corrections and rule cleanup.

- Rule 1026
    - Technical corrections and rule cleanup.

- Rule 1027
    - Technical corrections and rule cleanup.

- Rule 1028
    - Technical corrections and rule cleanup.

- Rule 1032
- Updated annual training requirements to be consistent with state law and Rule 1002.
    - Technical corrections and rule cleanup.

- Rule 1033
    - Technical corrections and rule cleanup.

- Rule 1034
- CLEST Rule 1034 is being updated pursuant to Act 218 of 2021 to include updated reasons for an officer's decertification, to now include excessive force and dishonesty/untruthfulness.
    - Technical corrections and rule cleanup.

PUBLIC COMMENT: No public hearing was held on these proposed rules. The public comment period expired on November 5, 2021. The agency indicated that it received no public comments.

The proposed effective date is January 1, 2022.

FINANCIAL IMPACT: The agency indicated that this rule does not have a financial impact.

LEGAL AUTHORIZATION: The Arkansas Commission on Law Enforcement Standards (CLEST), located within the Department of Public Safety, is tasked with establishing minimum selection and training standards, courses of study, and basic training requirements for law enforcement personnel and minimum requirements for instructors. *See* Ark. Code Ann. § 12-9-104(3), (7)(B)-(D). CLEST may promulgate rules for the administration of these duties. *See* Ark. Code Ann. § 12-9-104(1)(A). These rules implement Acts 218 and 792 of 2021.

Act 218, sponsored by Representative Carol Dalby, concerned law enforcement agency organization, staffing, and personnel matters. Act 792, sponsored by Representative Justin Boyd, required training

concerning a law enforcement officer's duty to intervene when the officer observes the use of excessive force by another law enforcement officer.

13. DEPARTMENT OF TRANSFORMATION AND SHARED SERVICES, DIVISION OF INFORMATION SYSTEMS (Mr. Mitch Rouse)

a. SUBJECT: REPEAL Standard Statement – Data and System Security

DESCRIPTION: The Department of Transformation and Shared Services' Division of Information Systems ("DIS") seeks to repeal the Standard Statement – Data and System Security rule. The rule was previously promulgated by the Office of the State Executive Chief Information Officer, which was disbanded in 2007, and the rule was never officially transferred. Additionally, the content of this rule is included in an internal standards policy that has been modified many times over the years and is used internally only to the state with no public interaction. As such, the rule needs to be repealed.

PUBLIC COMMENT: A public hearing was held on October 26, 2021. The public comment period expired on November 9, 2021. The Division received no comments.

The proposed effective date is January 1, 2022.

FINANCIAL IMPACT: The agency states that the repealed rule has no financial impact.

LEGAL AUTHORIZATION: The Division of Information Systems shall be vested with all the powers and duties necessary to administer the Division and to enable it to carry out fully and effectively the rules and laws relating to the Division. *See* Ark. Code Ann. § 25-4-105(a)(1). Pursuant to Ark. Code Ann. § 25-4-105(a)(2)(G), the Division's powers and duties relate to information technology and include without limitation promulgating rules that are necessary for efficient administration and enforcement of the powers, functions, and duties of the Division as provided in Title 25, Chapter 4 of the Arkansas Code. Act 751 of 2007 dissolved and transferred the duties and responsibilities of the Executive Chief Information Officer, Chief Information Officer, and Office of Information Technology.

b. SUBJECT: REPEAL Standard Statement – Domain Name Service (DNS) Resolution

DESCRIPTION: The Department of Transformation and Shared Services' Division of Information Systems ("DIS") seeks to repeal the Standard Statement – Domain Name Services (DNS) Resolution rule. The rule is an internally used standards policy that relates to the use of domain name service resolution for entities that utilize the state network. This rule has been modified many times internally and applies only to DIS and other state entities with no public interaction. As such, the rule needs to be repealed.

PUBLIC COMMENT: A public hearing was held on October 26, 2021. The public comment period expired on November 9, 2021. The Division received no comments.

The proposed effective date is January 1, 2022.

FINANCIAL IMPACT: The agency states that the repealed rule has no financial impact.

LEGAL AUTHORIZATION: The Division of Information Systems shall be vested with all the powers and duties necessary to administer the Division and to enable it to carry out fully and effectively the rules and laws relating to the Division. *See* Ark. Code Ann. § 25-4-105(a)(1). Pursuant to Ark. Code Ann. § 25-4-105(a)(2)(G), the Division's powers and duties relate to information technology and include without limitation promulgating rules that are necessary for efficient administration and enforcement of the powers, functions, and duties of the Division as provided in Title 25, Chapter 4 of the Arkansas Code.

c. SUBJECT: REPEAL Standard Statement – Machine Readable Privacy Policy

DESCRIPTION: The Department of Transformation and Shared Services' Division of Information Systems ("DIS") seeks to repeal the Standard Statement – Machine Readable Privacy Policy. This rule was previously promulgated by the Office of the State Executive Chief Information Officer, which was disbanded in 2007, and the rule was never officially transferred to DIS. This rule is an internally used standards policy that relates to the requirement of all state entities to comply with the P3P specifications in the creation of their website machine readable privacy policies beginning July 1, 2004. This rule has been modified many times internally and applies only to DIS and other state entities with no public interaction. As such, the rule needs to be repealed.

PUBLIC COMMENT: A public hearing was held on October 26, 2021. The public comment period expired on November 9, 2021. The Division received no comments.

The proposed effective date is January 1, 2022.

FINANCIAL IMPACT: The agency states that the repealed rule has no financial impact.

LEGAL AUTHORIZATION: The Division of Information Systems shall be vested with all the powers and duties necessary to administer the Division and to enable it to carry out fully and effectively the rules and laws relating to the Division. *See* Ark. Code Ann. § 25-4-105(a)(1). Pursuant to Ark. Code Ann. § 25-4-105(a)(2)(G), the Division's powers and duties relate to information technology and include without limitation promulgating rules that are necessary for efficient administration and enforcement of the powers, functions, and duties of the Division as provided in Title 25, Chapter 4 of the Arkansas Code. Act 751 of 2007 dissolved and transferred the duties and responsibilities of the Executive Chief Information Officer, Chief Information Officer, and Office of Information Technology.

d. SUBJECT: REPEAL Standard Statement – Subdomains of Arkansas.gov and AR.gov

DESCRIPTION: The Department of Transformation and Shared Services' Division of Information Systems ("DIS") seeks to repeal the Standard Statement – Subdomains of *Arkansas.gov* and A*r.gov*. This rule was previously promulgated by the Office of the State Executive Chief Information Officer. This rule is an internally used standards policy that relates to the process and requirement for eligible entities who request to register a website under the *Arkansas.gov* or *Ar.gov* domains. This rule has been modified many times internally and applies only to DIS and other state entities, not with the public. As such, the rule needs to be repealed.

PUBLIC COMMENT: A public hearing was held on October 26, 2021. The public comment period expired on November 9, 2021. The Division received no comments.

The proposed effective date is January 1, 2022.

FINANCIAL IMPACT: The agency states that the repealed rule has no financial impact.

LEGAL AUTHORIZATION: The Division of Information Systems shall be vested with all the powers and duties necessary to administer the

Division and to enable it to carry out fully and effectively the rules and laws relating to the Division. *See* Ark. Code Ann. § 25-4-105(a)(1). Pursuant to Ark. Code Ann. § 25-4-105(a)(2)(G), the Division's powers and duties relate to information technology and include without limitation promulgating rules that are necessary for efficient administration and enforcement of the powers, functions, and duties of the Division as provided in Title 25, Chapter 4 of the Arkansas Code. Act 751 of 2007 dissolved and transferred the duties and responsibilities of the Executive Chief Information Officer, Chief Information Officer, and Office of Information Technology.

e. SUBJECT: REPEAL Standard Statement – Spyware Scanning

DESCRIPTION: The Department of Transformation and Shared Services' Division of Information Systems ("DIS") seeks to repeal the Standard Statement – Spyware Scanning rule. This rule was previously promulgated by the Office of the State Executive Chief Information Officer. This rule is an internally used standards policy that relates to the requirement for all computers attached to the state network to utilize anti-spyware software. This rule has been modified many times internally and applies only to DIS and other state entities, not with the public. As such, the rule needs to be repealed.

PUBLIC COMMENT: A public hearing was held on October 26, 2021. The public comment period expired on November 9, 2021. The Division received no comments.

The proposed effective date is January 1, 2022.

FINANCIAL IMPACT: The agency states that the repealed rule has no financial impact.

LEGAL AUTHORIZATION: The Division of Information Systems shall be vested with all the powers and duties necessary to administer the Division and to enable it to carry out fully and effectively the rules and laws relating to the Division. *See* Ark. Code Ann. § 25-4-105(a)(1). Pursuant to Ark. Code Ann. § 25-4-105(a)(2)(G), the Division's powers and duties relate to information technology and include without limitation promulgating rules that are necessary for efficient administration and enforcement of the powers, functions, and duties of the Division as provided in Title 25, Chapter 4 of the Arkansas Code. Act 751 of 2007 dissolved and transferred the duties and responsibilities of the Executive Chief Information Officer, Chief Information Officer, and Office of Information Technology.

f. **SUBJECT: REPEAL Standard Statement – Physical and Logical Security**

DESCRIPTION: The Department of Transformation and Shared Services' Division of Information Systems ("DIS") seeks to repeal the Standard Statement – Physical and Logical Security rule. This rule was previously promulgated by the Office of the State Executive Chief Information Officer, which was disbanded in 2007, and the rule was never officially transferred to DIS. This rule is an internally used standards policy that relates to the requirement of applying adequate physical and logical security to IT assets of the state. This rule has been modified many times internally and applies only to DIS and other state entities with no public interaction. As such, the rule needs to be repealed.

PUBLIC COMMENT: A public hearing was held on October 26, 2021. The public comment period expired on November 9, 2021. The Division received no comments.

The proposed effective date is January 1, 2022.

FINANCIAL IMPACT: The agency states that the repealed rule has no financial impact.

LEGAL AUTHORIZATION: The Division of Information Systems shall be vested with all the powers and duties necessary to administer the Division and to enable it to carry out fully and effectively the rules and laws relating to the Division. *See* Ark. Code Ann. § 25-4-105(a)(1). Pursuant to Ark. Code Ann. § 25-4-105(a)(2)(G), the Division's powers and duties relate to information technology and include without limitation promulgating rules that are necessary for efficient administration and enforcement of the powers, functions, and duties of the Division as provided in Title 25, Chapter 4 of the Arkansas Code. Act 751 of 2007 dissolved and transferred the duties and responsibilities of the Executive Chief Information Officer, Chief Information Officer, and Office of Information Technology.

14. **DEPARTMENT OF TRANSFORMATION AND SHARED SERVICES, OFFICE OF PERSONNEL MANAGEMENT (Mr. Mitch Rouse)**

a. **SUBJECT: REPEAL Dispute Resolution Appeal Rules**

DESCRIPTION: The Department of Transformation and Shared Services, Office of Personnel Management, seeks to repeal its Rule 2014-1 State Employee Dispute Resolution Appeal Rules and Procedures. The rule established a statewide grievance appeal process for eligible state

employees pursuant to Ark. Code Ann. § 21-1-701 et seq. In 2019, Ark. Code Ann. § 21-1-703, concerning appeals of grievance decisions of state agencies, was repealed by Act 1054 of 2019. The rule has been replaced by State Policy that establishes a grievance procedure, and the grievance procedure is a process available only to state employees and does not affect the general public.

PUBLIC COMMENT: A public hearing was held on October 26, 2021. The public comment period expired on November 9, 2021. The Office received no comments.

The proposed effective date is January 1, 2022.

FINANCIAL IMPACT: The agency states that the repealed rule has no financial impact.

LEGAL AUTHORIZATION: Arkansas Code Annotated § 21-1-703 previously required the Office of Personnel Management to promulgate rules to provide a process for appeals of the grievance decisions of state agencies and to provide a procedure for the nonbinding mediation consistent with Title 21, Chapter 1, Subchapter 7 of the Arkansas Code, concerning state employee grievances. Pursuant to Act 1054 of 2019, § 1, this section was repealed.

15. DEPARTMENT OF TRANSFORMATION AND SHARED SERVICES, OFFICE OF STATE PROCUREMENT (Mr. Mitch Rouse)

a. SUBJECT: Rule Governing Time Period for Submission of Resolution of Protested Solicitations and Awards, R2:19-11-244.3

DESCRIPTION: The Department of Transformation and Shared Services' Office of State Procurement seeks to amend its Rule Governing Time Period for Submission of Resolution of Protested Solicitations and Awards, R2:19-11-244.3. The proposed amendment to the rule establishes that protested solicitations and awards shall be submitted in writing within fourteen (14) calendar days after the calendar day on which the contract is awarded or the notice of anticipation to award the contract is posted, whichever occurs first.

PUBLIC COMMENT: A public hearing was held on October 26, 2021. The public comment period expired on November 9, 2021. The Office received no comments.

The proposed effective date is pending legislative review and approval.

FINANCIAL IMPACT: The agency states that the amended rule has no financial impact.

LEGAL AUTHORIZATION: The proposed amendments include changes made in light of Act 487 of 2021, sponsored by Senator Scott Flippo, which clarified the law concerning the time for submitting a protest under the Arkansas Procurement Law. Pursuant to Arkansas Code Annotated § 19-11-225(a)(1), the State Procurement Director shall adopt rules in accordance with the applicable provisions of the Arkansas Procurement Law, Ark. Code Ann. §§ 19-11-201 through 19-11-281, and of the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

E. Proposed Rules Recommending Expedited Process for Occupational Licensure Pursuant to Ark. Code Ann. § 17-4-109, as Amended by Act 135 of 2021.

1. DEPARTMENT OF HEALTH, ARKANSAS STATE BOARD OF NURSING (Ms. Sue Tedford)

a. Chapter Two – Licensure: RN, LPN, and LPTN

b. Chapter Three – Registered Nurse Practitioner

c. Chapter Four – Advanced Practice Registered Nurse

d. Chapter Eight – Medication Assistant-Certified

2. DEPARTMENT OF HEALTH, ARKANSAS STATE BOARD OF PHARMACY (Mr. John Kirtley)

a. Rule 1 – General Operations

3. DEPARTMENT OF LABOR AND LICENSING, DIVISION OF OCCUPATIONAL & PROFESSIONAL LICENSING BOARDS AND COMMISSIONS, STATE BOARD OF LICENSURE FOR PROFESSIONAL ENGINEERS AND PROFESSIONAL SURVEYORS (Ms. Denise Oxley, Ms. Heather Richardson)

a. Rules of the Board of Licensure for Professional Engineers and Professional Surveyors

F. Agency Updates on Delinquent Rulemaking under Act 517 of 2019.

1. Department of Agriculture, Arkansas Bureau of Standards (Act 501 of 2019) (REPORT BY LETTER PURSUANT TO MOTION ADOPTED AT JULY 22, 2020 MEETING)

G. Monthly Written Agency Updates Pursuant to Act 595 of 2021.

H. Agency Requests to Be Excluded from Act 595 Reporting Requirements.

1. Department of Commerce, State Insurance Department (Acts 965, 1103, and 1105)

2. Department of Commerce, Division of Workforce Services (Act 770)

3. Department of Education (Acts 69, 539, and 959)

4. Board of Finance (Act 1004)

5. Department of Finance and Administration, Arkansas Racing Commission (Act 682)

6. Department of Human Services (Acts 357, 651, 745, and 937)

7. Department of Labor and Licensing (Acts 746 and 811)

8. Arkansas Teacher Retirement System (Act 711)

9. Department of Transformation and Shared Services (Acts 379 and 1004)

I. Initial Rule Reports Pursuant to Act 1076 of 2021.

1. Department of Agriculture (Mr. Wade Hodge)

2. Department of Health (Mr. J. Terry Paul)

J. Adjournment.