ADMINISTRATIVE RULES SUBCOMMITTEE
OF THE
ARKANSAS LEGISLATIVE COUNCIL

Thursday, September 15, 2022
9:00 a.m.
Room A, MAC
Little Rock, Arkansas

A. Call to Order

B. Reports from the Executive Subcommittee Concerning Emergency Rules

C. Reports from ALC Subcommittees Concerning the Review of Rules

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

1. **DEPARTMENT OF AGRICULTURE, COMMISSION ON WATER WELL CONSTRUCTION (Chris Colclasure; Wade Hodge)**

   a. **SUBJECT: Supervision Rule**

   DESCRIPTION: The Department of Agriculture's Water Well Construction Commission ("AWWCC") proposes changes to its Supervision Rule, requiring on-site supervision of all water well construction, installation, or repair activities ("Proposed Rule"). Currently, AWWCC Rule 3.2 provides the following: "*3.2 Supervision.* During the construction, alteration, or repair of a water well, or installation or repair of pumping equipment there must be, within a two-hour drive, a person who has obtained a registration certificate and has been certified in the type of construction engaged. The person who has obtained a registration certificate or an apprentice with proper supervision as defined by Rule 3.10.1.1 shall remain informed and have knowledge of the status of the work being accomplished."

   AWWCC has traditionally interpreted AWWCC Rule 3.2 to require either an AWWCC-certified person or an apprentice to be on-site during water well construction, alteration, and repair or water pump installation. However, upon further review it has been determined that the current rule can be interpreted to only require an AWWCC-certified person or apprentice be within two hours' drive of the site. Therefore, AWWCC voted at its regular meeting on April 2, 2021, to initiate rulemaking to clarify the Proposed Rule.

Changes to the rule include the following:

- The Proposed Rule requires an AWWCC-certified person or apprentice to be on-site at all times during the construction, alteration, or repair of a water well.
- On-site apprentices must remain under the personal supervision of an AWWCC-certified person, meaning the AWWCC-certified supervisor must be at the job site with the apprentice or within two hours' traveling distance of the apprentice whenever the apprentice is working in well construction or pump installation.
- When the apprentice's supervisor is not on-site, he or she must be aware at all times of the progress of the work being performed and reachable by wireless phone or radio.

PUBLIC COMMENT: No public hearing was held. The public comment period expired on July 16, 2021. The Commission received no public comments. At the September 14, 2021 meeting of the Administrative Rules Subcommittee, this rule was deferred by the Subcommittee for consideration by the Legislative Council; however, the Commission pulled the rule from consideration at the Council's September 17, 2021 meeting. On April 30, 2022, the Commission notified Bureau Staff that it had recently voted to go forward with the rule, and it requested placement on the Subcommittee's agenda for legislative review and approval. Following receipt of the request, Rebecca Miller-Rice, an attorney for the Bureau of Legislative Research, asked the following question:

No additional changes were made? **RESPONSE:** Correct.

At its June 16, 2022 meeting, the Subcommittee held the rule for consideration at its September meeting. The Commission confirmed that no changes had been made to the rule since last submitted.

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: Pursuant to Arkansas Code Annotated § 17-50-204(a), the Commission on Water Well Construction shall be responsible for the administration of Title 17, Chapter 50 of the Arkansas Code, concerning water well constructors, and shall adopt, and from time to time amend or repeal, necessary rules governing the installation, construction, repair, and abandonment of water wells and pumping equipment. The Commission may further adopt, and from time to time amend or repeal, rules governing applications for water well contractor licenses. *See* Ark. Code Ann. § 17-50-305(a)(1).

2. **<u>DEPARTMENT OF COMMERCE, STATE INSURANCE DEPARTMENT</u> (Booth Rand)**

a. **<u>SUBJECT</u>: Rule 123: 340B Drug Program Nondiscrimination Requirements**

<u>DESCRIPTION</u>: The State Insurance Department ("SID") is issuing this rule pursuant to Ark. Code Ann. § 23-92-606 ("Act 1103 of 2021"), which mandates that the Insurance Commissioner ("Commissioner") shall promulgate rules to implement the 340B Drug Pricing Nondiscrimination Act ("Act 1103"). The purpose of this Rule is to help reduce or remove federal commerce clause and preemption claims against Act 1103 of 2021, which have been raised in Federal District Court by supplying new definitions not in the Act, and to add penalties for violations of the Act not supplied in the Act.

AID is re-noticing this earlier proposed rule. A brief background or explanation about why the Department is re-noticing this rule is important. On or about February 22, 2022, following approval by the Department of Commerce and the Governor's office allowing promulgation of the rule, the Department filed a proposed draft rule, Rule 123 "340b Drug Program Nondiscrimination Requirements." Following filing of the proposed rule at BLR/ALC, the Department held a hearing on the proposed draft rule on April 14, 2022. The Department received significant opposition to the proposed rule from the Arkansas Hospital Association and area hospitals, primarily on the proposed rule's requirements which: (1) required arbitration of complaints with the Federal agency, HRSA, before applying state law enforcement, and (2) the Department limited jurisdiction of the Rule to 340b hospital covered entities which had a direct contract with the pharmaceutical manufacturers. The reason for the proposed limitations were due to concerns over federal pre-emption and federal commerce clause infringement claims derived from Act 1103 itself. The Department and the AG's office are currently in litigation in federal court against PHARMA which has raised these concerns.

Following the hearing, AID met with the AG's office and interveners and the hospital association related to the Department's proposed language. AID agreed to remove the arbitration and direct contracting limitations. AID also agreed to supply different definition language to help reduce the federal preemption and commerce clause claims raised against Act 1103. Out of an abundance of caution, the Department has re-filed the proposed rule and re-noticed the public because we believe we may be making a material change to the earlier filed rule. The proposed rule accomplished the following:

- Removes any arbitration requirement with HRSA before beginning state enforcement in order to help reduce hospital objections or concerns;
- Removes the direct contracting language between pharmaceutical manufacturers and covered entity hospitals as to the application of Act 1103 in order to help reduce hospital objections or concerns;
- Supplies a definition of "Arkansas-based community pharmacy," to mean a pharmacy licensed and located in this State in order to help reduce commerce clause infringement claims;
- Supplies a definition of "340B drug pricing" to mean "acquisition and delivery of 340B-priced drugs," as established under section 602 of the Veterans Health Care Act of 1992, Pub. L. No. 102-585, in order to help reduce federal pre-emption claims by explaining that the Department is not regulating "pricing" of the drugs; and
- Supplies a penalties and fines provision not supplied in Act 1103.

PUBLIC COMMENT: A public hearing was held in this matter on August 8, 2022. The public comment period expired on August 8, 2022. The agency provided the following summary of comments received and its responses thereto:

Commenter: Powers Law Firm
Comment Summary: Strike subsection (c) in Section IV which states that the prohibitions in this subsection shall only apply to direct drug pricing contract pharmacy arrangements between a pharmaceutical manufacturer and a covered entity located and conducting business in Arkansas. This is because contract arrangements are with pharmacies; secondly, there is a risk that the word, "direct," could be construed to limit relief to direct sales by manufacturers rather than through wholesalers; third: manufacturers might interpret the statement as excluding them from the scope of the Act on the grounds that their conduct occurs exclusively outside the State of Arkansas, whereas the reality is that, through wholesalers sales representatives and other means, they are conducting business within the State.
SID Response: We agree and have removed that limited language.

Commenter: Powers Law Firm
Comment Summary: Please strike the language limiting 23-92-604(c) to "340b drug pricing contract pharmacy transactions pertaining to a patient of a covered entity. Manufacturers are already protected under the federal 340b statute from diversion of 340b drugs to non-patients.
SID Response: We agree and have removed that limited language.

Commenter: Powers Law Firm
Comment Summary: Section II of the Re-proposed Rule, definition of covered entity, we suggest removing the phrase, "to participate," will make the definition read more smoothly and less subject to confusion.
SID Response: We agree and have removed that phrase.

Commenters: Community Clinic, River Valley Primary Care, East Arkansas Family Health Center, Boston Mountain Rural Health Care Center, Mid Delta Health Systems, Cabun Rural Health Services, Jefferson Comprehensive Case System Inc., First Choice Healthcare
Comment Summary: AID received a number of form letter responses from various Community hospitals. The letter thanked AID for making bulk changes in the re-proposed rule, and suggested AID accept the additional changes advised by the Powers Law Firm.
SID Response: We have agreed with all additional changes by the Powers Law Firm.

Commenter: PHARMA (Pharmaceutical Research and Manufacturers of America)
Comment Summary: Provisions of Act 1103 on the pharmaceutical manufacturer specific provisions, violate Supremacy Clause and Commerce Clause. PHARMA also submitted its Motion for Summary Judgment and Brief into the administrative record, recently filed in Arkansas Federal District Court. AID and the Arkansas Attorney General are being sued by PHARMA in federal district court over federal pre-emption and commerce clause alleged infringements over the Act 1103 of 2021 pharmaceutical manufacturer specific prohibitions or limitations.
SID Response: AID disagrees with PHARMA and will be submitting its response to the Motion and Brief in the federal litigation.

Suba Desikan, an attorney with the Bureau of Legislative Research, asked the following question and received the following response thereto:

Q. Are the definitions of "covered entity and "Arkansas-based community pharmacy" taken from a particular source? If so, where?
RESPONSE: We had to add those ourselves. We supplied the definitions and language restricting it to Arkansas-only based transactions because the Act did not, and this will help to reduce commerce clause infringement.

<u>FINANCIAL IMPACT</u>: The agency indicated that the proposed rules do not have a financial impact.

<u>LEGAL AUTHORIZATION</u>: Act 1103 of 2021, which was sponsored by Representative Michelle Gray, established the 340B Drug Pricing Nondiscrimination Act. Pursuant to the Act, the Insurance Commissioner

shall promulgate rules to implement the 340B Drug Pricing Nondiscrimination Act. *See* Ark. Code Ann. § 23-92-606, *as created by* Act 1103 of 2021.

b. **<u>SUBJECT</u>: Rule 118: Pharmacy Benefit Managers Regulation**

<u>DESCRIPTION</u>: The State Insurance Department seeks review and approval of amendments to Rule 118 concerning pharmacy benefits manager ("PBM") regulation. This rule was filed, both as an emergency rule and as a permanent rule. This proposed rule implements Act 665 of 2021 pertaining to the Pharmacy Benefits Manager Licensure Act. The proposed rule applies the Act to self-funded employer plans and all healthcare payors related to maximum allowable costs laws, consistent with court rulings. The proposed rule accomplishes the following:

- Implements Act 665 of 2021 applying our PBM laws related to maximum allowable cost to self-funded employer plans, consistent with the supreme court decision in Rutledge vs. PCMA;
- Restates and applies the Pharmacy Audit Bill of Rights from Act 665 to protect pharmacies from arbitrary PBM audits;
- Establishes PBM compensation review if pharmacies are impacted by reimbursement when 10% are reduced in participation;
- Cleans up obsolete language no longer necessary in the rule;
- Adopts recently issued bulletins, which improve invoice processing in maximum allowable cost appeals; and
- Adopts the Act 665 of 2021 network adequacy standards for pharmacies.

<u>PUBLIC COMMENT</u>: This rule was filed on an emergency basis and was reviewed and approved by the Executive Subcommittee at its meeting on June 14, 2022. The agency now seeks permanent promulgation of the rule. A public hearing was held in this matter on July 19, 2022. The public comment period expired on July 22, 2022. The agency provided the following summary of comments it received and its responses thereto:

Commenter: Pharmaceutical Care Management Association (PCMA)
Comment Summary: Changes or amendments from Act 665 of 2021 which are reflected in the proposed rule, were enacted due to the Rutledge vs. PCMA decision, and PCMA maintains that the ERISA preemption exception was only intended to apply to mandated "pharmacy reimbursement controls," and not to the other sections of the Act or Rule.
SID Response: PCMA has not identified which other sections in the proposed Rule do not fall under the exceptions under the Rutledge decision. We read the Rutledge decision to apply to any network plan activities dealing with compensation in general. That includes Network Adequacy and contract prohibitions, and fee restrictions, sections in the

proposed Rule. Finally, ERISA has always permitted state regulators to impose licensing standards on PBMs/or TPAs, without offending ERISA.

Commenter: Pharmaceutical Care Management Association (PCMA)
Comment Summary: Section 1 definition of "adverse impact" should apply to pharmacies and not pharmacists.
SID Response: We agree and amended the rule to reflect that.

Commenter: Pharmaceutical Care Management Association (PCMA)
Comment Summary: The Subsection 9 definition of "pass through pricing," is not from a statute.
SID Response: We agree, but believe under broad and substantial rulemaking authority we can define models of compensation offered by PBMs to make the rule more easily understood.

Commenter: Pharmaceutical Care Management Association (PCMA)
Comment Summary: The subsection 21 definition of "spread pricing," added language to include administrative fees not in the statute; suggest removing and following the statute.
SID Response: We agree, and have removed the administrative fee clause.

Commenter: Pharmaceutical Care Management Association (PCMA)
Comment Summary: Subsection A.15 allows licensing termination for acts of "dishonesty," which is too broad a misconduct standard, suggest deleting this description.
SID Response: We have removed that reference.

The proposed effective date is pending legislative review and approval.

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

LEGAL AUTHORIZATION: The amended rule implements Act 665 of 2021, sponsored by Representative Brian Evans, which amended the Arkansas Pharmacy Audit Bill of Rights and amended the Arkansas Pharmacy Benefits Manager Licensure Act.

Concerning the Pharmacy Audit Bill of Rights, the Insurance Commissioner shall administer and enforce it, and also, promulgate rules to implements its purposes and requirements. *See* Ark. Code Ann. § 17-92-1201(h).

Concerning the rules for the Arkansas Pharmacy Benefits Manager Licensure Act, the Insurance Commissioner may adopt rules regulating pharmacy benefits managers that are not inconsistent with the Act,

including without limitation rules related to: licensing, application fees, financial solvency requirements, pharmacy benefits manager network adequacy, prohibited market conduct practices, data reporting requirements under § 4-88-803, compliance and enforcement requirements under § 17-92-507 concerning maximum allowable cost lists, rebates, compensation, and lists of health benefit plans administered by a pharmacy benefits manager in this state. *See* Ark. Code Ann. § 23-92-509(a). Rules adopted shall set penalties or fines, including without limitation monetary fines, suspension of licensure, and revocation of licensure for violations of the Act and rules adopted. *See* Ark. Code Ann. § 23-92-509(b)(1). Furthermore, the Commissioner shall adopt rules relating to a pharmacy benefits manager's network adequacy that shall require that an individual covered by a health benefit plan have access to a community pharmacy at a standard no less strict than the federal standards established under Tricare or Medicare Part D, 42 U.S.C. §§ 1395w-101 – 1395w-154, as it existed on January 1, 2021, if that standard requires, on average:
(i) At least ninety percent (90%) of individuals covered by a health benefit plan in an urban area served by the health benefit plan to live within two (2) miles of a network pharmacy that is a retail community pharmacy;
(ii) At least ninety percent (90%) of individuals covered by a health benefit plan in suburban areas served by the health benefit plan to live within five (5) miles of a network pharmacy that is a retail community pharmacy; and
(iii) At least seventy percent (70%) of individuals covered by a health benefit plan in a rural area served by the health benefit plan to live within fifteen (15) miles of a network pharmacy that is a retail community pharmacy.
See Ark. Code Ann. § 23-92-509(b)(2), *as amended by* Act 665 of 2021.

3. <u>DEPARTMENT OF EDUCATION, DIVISION OF HIGHER EDUCATION</u> (Whitney James)

a. <u>SUBJECT</u>: Rules Governing the Governor's Higher Education Transition Scholarship Program

<u>DESCRIPTION</u>: The Department of Education's Division of Higher Education proposes its Rules Governing the Governor's Higher Education Transition Scholarship Program. The rules were created per Act 215 of 2022 to outline the administration of the program eligibility criteria, scholarship amounts, and payment of scholarships. The rules also outline the responsibilities of qualifying institutions and the responsibilities of recipients.

Following the public comment period, the word “regulations” was changed to “rules” in Section 8.01 and Section 8.07. Additionally, spelling errors were corrected in the titles of Sections 4.00 and 8.00.

PUBLIC COMMENT: A public hearing was held on June 13, 2022. The public comment period expired on June 22, 2022. The Division provided the following summary of the comments that it received and its responses thereto:

Commenter’s Name: Lucas Harder

1. 4.00: “Eligibility” is missing the second “i”. **RESPONSE:** Comment considered. Non-substantive change made.

2. 8.00: The “i” is missing from between the “l” and “t” in “responsibilities”. **RESPONSE:** Comment considered. Non-substantive change made.

Jason Kearney, an attorney with the Bureau of Legislative Research, asked the following questions:

(1) Section 3.02 – Is there a reason that the application periods and deadlines are not set forth in the rules? **RESPONSE:** We avoid setting deadlines in rules to give us flexibility to adjust without a rule change. Most years we publish a deadline but end up pushing it for various reasons (late ACT testing dates, weekends, Covid, etc.). This scholarship is a little different in that students must be accepted into a qualifying program before applying and that can happen through the first few weeks of the term.

(2) Sections 8.01 and 8.07 – Is there a reason that the rules reference regulations, in light of Act 315 of 2019, § 3204? **RESPONSE:** We will delete the word “regulations” from these sections.

The proposed effective date is pending legislative review and approval.

FINANCIAL IMPACT: The Division states that the proposed rules have no financial impact.

LEGAL AUTHORIZATION: Pursuant to Act 215 of 2022, § 51, the Department of Education’s Division of Higher Education shall provide for the administration of the “Governor’s Higher Education Transition Scholarship Program” as appropriated in the Student Assistance Grants and Various Scholarships Appropriation section of Act 215 to assist students accepted into transitional programs for students with intellectual and/or developmental disabilities at state institutions of higher education

and shall promulgate rules for the implementation of the program and for the disbursement of scholarships to eligible students. The provisions of Act 215, § 51, shall be in effect only from July 1, 2022 through June 30, 2023. Further authority for the rulemaking can be found in Arkansas Code Annotated § 6-82-105(1), which provides that the Division of Higher Education shall administer all state college financial assistance programs provided by legislation or by law and in so doing shall have the authority and responsibility with respect to state college financial assistance programs provided by legislation or by law to adopt such rules as the division shall deem necessary or appropriate to carry out the purposes of Title 6, Chapter 82, Subchapter 1 of the Arkansas Code, concerning general provisions relating to scholarships.

4. DEPARTMENT OF FINANCE AND ADMINISTRATION, REVENUE DIVISION (Paul Gehring)

a. SUBJECT: 2022-4: Sales and Use Tax Exemption for Water Used for Commercial Production of Poultry

DESCRIPTION: This rule provides clarification of the methodology for claiming the tax exemption for the purchase of water used exclusively in the commercial production of poultry, instructs water providers on their requirements when a poultry farmer claims this exemption, and promulgates the certificate to be used certifying entitlement to the exemption as contemplated in Ark. Code Ann. § 26-52-453(d).

PUBLIC COMMENT: A public hearing was held on this rule on July 15, 2022. The public comment period expired on July 18, 2022. The agency indicated that it received no public comments.

The proposed effective date is October 1, 2022.

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

LEGAL AUTHORIZATION: This rule implements Act 970 of 2021. The Act, sponsored by Representative Craig Christiansen, provided a sales and use tax exemption for water used by a poultry farm and required the adoption of related rules. The Secretary of the Department of Finance and Administration shall promulgate rules for the administration of Ark. Code Ann. § 26-52-453, regarding water used in poultry farming. Ark. Code Ann. § 26-52-453(e), *as created by* Act 970.

5. **<u>DEPARTMENT OF HEALTH, ARKANSAS STATE MEDICAL BOARD</u> (Amy Embry; Matt Gilmore)**

a. **<u>SUBJECT</u>: Rule No. 2.8: Requiring Minimum Standards for Establishing Provider/Patient Relationships**

<u>DESCRIPTION</u>: The Arkansas State Medical Board is seeking review and approval of a proposed amendment to Rule 2.8, concerning minimum standards for establishing provider/patient relationships, to comply with Act 829 of 2021.

<u>PUBLIC COMMENT</u>: A public hearing was held on March 22, 2022. The public comment period expired on March 22, 2022. The agency provided the following summary of comments received and its responses thereto:

Commenter: Claudia Tucker, Senior Vice President of Government Affairs and Public Policy, Teladoc Heath, Inc.
Summary: Submitted a letter dated February 25, 2022 and expressed support of proposed rule 2.8 in establishing a provider/patient relationship. Ms. Tucker stated that adopting proposed rule 2.8 will complete the telemedicine policy work already accomplished in Arkansas to maximize access to healthcare across the state.
Response: The Board accepted the public comments.

Commenter: Kyle Zebley, Executive Director, ATA Action
Summary: Submitted a letter dated February 28, 2022 and expressed support of proposed rule 2.8 in establishing a provider/patient relationship. Mr. Zebley also stated the rule will serve as a step forward for Arkansas's state telemedicine regulation and the rule would enable providers to establish provider-patient relationships so long as they have access to the patient's personal health record, records which may be created through the use of telemedicine technologies, and uses any technology deemed appropriate by the provider.
Response: The Board accepted the public comments.

Commenter: David Wroten, Executive Vice President, Arkansas Medical Society
Summary: Submitted a letter dated March 11, 2022. These comments requested that the Board consider changing "provider" to "health care professional," provide a clear definition of personal health record, and adding 17-80-403(c) which prohibits the establishment of a professional relationship using only an internet questionnaire, email, patient-generated medical history, text messaging, facsimile machine, or any combination thereof.
Response: The Board added 17-80-403(c) to section B of the rule.

Commenter: Nicole Gillum, General Counsel, Capitol Advisors Group on behalf of Teledoc Health
Summary: Submitted an e-mail dated June 29, 2022 requesting that the word "only" be added to 17-80-403(c). This word was inadvertently omitted when added to the rule.
Response: The Board accepted the comments and made the change.

Commenter: Dr. Robert King
Summary: Provided verbal comments on March 22, 2022 requesting that the Board allow the VA to use virtual care visits for established patients on long term opiate therapy.
Response: The Board accepted the comments, however did not amend regarding long-term opiate therapy. Dr. Tina McClain, M.D., Chief of Staff of the Central Arkansas Health Care System did speak with the Board about this issue at the August 2022 Board meeting.

The proposed effective date is pending legislative review and approval.

FINANCIAL IMPACT: The agency indicated that the proposed rules do not have a financial impact.

LEGAL AUTHORIZATION: The Arkansas State Medical Board has authority to make and adopt all rules and bylaws not inconsistent with the laws of this state or of the United States and necessary or convenient to perform the duties and to transact the business required by law. *See* Ark. Code Ann. § 17-95-303(1). In addition, the board has authority to promulgate and put into effect such rules as are necessary to carry out the purposes of the Arkansas Medical Practices Act, § 17-95-201 et seq., § 17-95-301 et seq., and § 17-95-401 et seq., and the intentions expressed therein. *See* Ark. Code Ann. § 17-95-303(2).

Pursuant to Arkansas Code Annotated § 17-80-406, state licensing and certification boards for a healthcare professional shall amend their rules where necessary to comply with the Telemedicine Act. The proposed rule amendments implement Act 829 of 2021, sponsored by Representative Jim Dotson, which amended the Telemedicine Act, authorized additional reimbursement for telemedicine via telephone, and declared an emergency.

6. **<u>DEPARTMENT OF HUMAN SERVICES, DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES</u> (Mark White; Melissa Weatherton; Elizabeth Pitman)**

a. **<u>SUBJECT</u>: CES Waiver Slot Increase**

<u>DESCRIPTION</u>:

<u>Statement of Necessity</u>

The Community and Employment Supports (CES) 1915(c) home and community-based services waiver is being submitted to CMS for its required five (5) year renewal.

<u>Rule Summary</u>

Changes to the rule include the following:

- Clarification that certification is the responsibility of DHS and MCO credentialing is the responsibility of the PASSEs. Clarified the role of DDS, DMS and DCO in the approval process.
- Removed Crisis Intervention because it is a service available under the PASSE program to all members and was duplicative.
- Streamlined "crisis plans, safety plans, behavioral support plans" to use consistent language across the PASSE program.
- Using the terminology Behavioral Prevention and Intervention Plans and clarifying that they are the responsibility of the Supportive Living providers.
- Added Treatment Plans under Consultation to clarify that providers need to provide and can bill for service Treatment Plans that will be incorporated into the member's PCSP.
- Clean up on Consultation service to clarify what type of clinician can provide what task.
- Adding two new services: HCBS Monitoring and Supervision and HCBS Enabling Technology.
- Removed restrictive language on who can receive Respite and where.
- Removed prescriptive language under Supported Employment and replaced with examples.
- Clarified who can be paid staff under the waiver.
- Increased the Group Home bed capacity from 4 to 8 to address trends in institutionalization we are seeing due to pandemic and workforce shortage.
- Added sufficient number of waiver slots over the next three (3) years to serve an additional 3,204 people.
- Added 200 more slots for children in foster care.

- Clarified that assisting clients with some medications is not "administration."
- Corrected requirements for Care Coordinator qualifications.
- Permanently adding training requirements for direct support professionals, that are currently in place in an Appendix K, in lieu of one year experience.

PUBLIC COMMENT: A public hearing was held on this rule on May 10, 2022. The public comment period expired May 29, 2022. Due to its length, the public comment summary is provided separately.

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 $53,785,000 for the current fiscal year ($13,919,558 in general revenue, $38,520,817 in federal funds, and $1,344,625 in PASSE premium taxes) and $131,665,680 for the next fiscal year ($34,075,078 in general revenue, $94,298,960 in federal funds, and $3,291,642 in PASSE premium taxes). The total estimated cost by fiscal year to state, county, and municipal government to implement this rule is $13,919,558 for the current fiscal year and $34,075,078 for the next fiscal year.

The total estimated cost by fiscal year to any private individual, entity, and business subject to the proposed rule is $1,344,625 for the current fiscal year and $3,291,642 for the next fiscal year. The agency indicated that this additional cost is due to the premium tax paid by the PASSEs.

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;

This rule is part of the Governor's commitment to reduce the Community and Employment Supports (CES), 1915(c) Home and Community-Based Services Waiver waitlist as it stood on December 1, 2021. 1915(c) waivers require approval from the Centers for Medicare & Medicaid Services. Formal approval will affect the date of this initiative; however, DDS has committed to reducing the CES waitlist within a three (3) year period.

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

This rule is part of the Governor's commitment to reduce the Community and Employment Supports (CES), 1915(c) Home and Community-Based Services Waiver waitlist as it stood on December 1, 2021.

(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;

This rule is part of the Governor's commitment to reduce the Community and Employment Supports (CES), 1915(c) Home and Community-Based Services Waiver waitlist as it stood on December 1, 2021.

(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;

There are no less costly alternatives.

(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;

N/A

(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 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). The Department is tasked with applying for "any federal waivers, federal authority, or state plan amendments necessary to implement" the Medicaid Provider-Led Organized Care Act, and it may promulgate rules as necessary to implement the Act. Ark. Code Ann. § 20-77-2708.

7. DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL SERVICES (Mark White, items a-d; Melissa Weatherton, item a; Elizabeth Pitman, items a-d; Jay Hill, items c-d)

a. SUBJECT: HCBS and PASSE Waivers

DESCRIPTION:

Statement of Necessity

The Department of Human Services (DHS) must renew its Home and Community-Based Services (HCBS) C waiver and its Provider-Led Arkansas Shared Savings Entity (PASSE) B waiver with CMS.

Rule Summary

HCBS C Waiver – Renewal only, no significant changes

PASSE B Waiver – Renewal with following updates:

- Clarifies that PASSE clients may not enroll in the PCCM program
- Clarifies the names of the PASSE entities currently participating in the state, by removing Forevercare and adding CareSource
- Places the dually diagnosed in a fourth tier
- Provides for inclusion of individuals who are eligible under ARHOME and are designated as Medically Frail
- Clarifies care coordinator responsibilities
- Clarifies that care coordination services must be available seven (7) days a week
- Clarifies that transplants are on the list of excluded services which are carved out of PASSE and paid for by FFS Medicaid
- Clarifies the state's quality assurance strategies
- Clarifies scope of marketing

- Adds a requirement that marketing materials must also be translated into Marshallese
- Clarifies that DHS may delegate enrollee assistance to a designated vendor, if necessary
- Deletes stakeholder information no longer in effect
- Clarifies that the contracted enrollment broker contract must be conflict free
- Outlines new implementation schedule for adding individuals eligible under ARHOME
- Removes option for enrollee to submit disenrollment request to MCO/PIHP/PAHP/PCCM entity and requires the request be submitted to DHS
- Clarifies auto assignment methodology is random assignment
- Clarifies that the PASSE is responsible for informing clients of their appeal rights
- Updates the following monitoring activities to clarify who performs and the sample size: data analysis, enrollee hotlines, focused studies, geographic mapping, independent assessment, network adequacy assurance by plan, on-site review, provider self-report data, test 24/7 PCP availability (removes), utilization review, and other (reduces other activity detail designations)
- Summarizes results or findings of each activity conducted during previous waiver cycle
- Outlines new fiscal impact for the next Waiver cycle

PUBLIC COMMENT: A public hearing was held on this rule on November 18, 2021. The public comment period expired on November 29, 2021. Due to its length, the public comment summary is provided separately.

The proposed effective date is pending legislative review and approval.

FINANCIAL IMPACT: The agency indicated that these rules have a financial impact.

Per the agency, the total cost to implement this rule is $17,006,500 for the current fiscal year ($4,826,445 in general revenue and $12,180,055 in federal funds) and $51,019,500 for the next fiscal year ($14,479,334 in general revenue and $36,540,166 in federal funds).

The total estimated cost to state, county, and municipal government as a result of this rule is $4,826,445 for the current fiscal year and $14,479,334 for the next fiscal year. The agency stated that this represents the state share for the 4.3% increase in the rate paid by DHS to the PASSEs per beneficiary. Although this increase does reflect expected increases due to inflation and nationwide increases in healthcare costs, it also reflects

increased services that will be available to PASSE beneficiaries, such as new placements to assist those with complex needs and those with both developmental disabilities and significant behavioral health needs.

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;

DHS must renew its Home and Community Based Services (HCBS) C waiver and its Provider-Led Arkansas Shared Savings Entity (PASSE) B waiver with CMS.

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

Department of Human Services (DHS) must renew its Home and Community Based Services (HCBS) C waiver and its Provider-Led Arkansas Shared Savings Entity (PASSE) B waiver with CMS.

This rule is required by statute.
(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;

Department of Human Services (DHS) must renew its Home and Community Based Services (HCBS) C waiver and its Provider-Led Arkansas Shared Savings Entity (PASSE) B waiver with CMS.

(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) 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.

DMS reviews all rules periodically.

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: Acute Crisis Units – Hospital Provider Manual

DESCRIPTION:

Statement of Necessity

This rule helps to address access issues and provides appropriate clinical treatment to children and adolescents presenting to or admitted to emergency rooms. Currently there are no Acute Crisis Units available to

provide stabilization and treatment for children and youth as an alternative to acute inpatient hospitalization.

Rule Summary

The Acute Crisis Units section of the Hospital Provider Manual is being revised to change age nineteen (19) to age four (4) for treatment services, while implementing safeguards based on age.

PUBLIC COMMENT: A public hearing was held on this rule on July 13, 2022. The public comment period expired on July 23, 2022. The agency indicated that it received no public comments.

This rule was filed on an emergency basis and was reviewed and approved by the Executive Subcommittee on June 17, 2022. The proposed effective date for permanent promulgation is October 1, 2022.

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

Per the agency, the total estimated cost to implement this rule is $217,479 for the current fiscal year ($61,721 in general revenue and $155,759 in federal funds) and $5,219,500 for the next fiscal year ($1,481,294 in general revenue and $3,738,206 in federal funds). The total estimated cost by fiscal year to state, county, and municipal government to implement this rule is $61,721 for the current fiscal year and $1,481,294 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;

This rule helps to address access issues and provides appropriate clinical treatment to children and adolescents presenting to or admitted to emergency rooms. Currently there are no Acute Crisis Units available to provide stabilization and treatment for children and youth as an alternative to acute inpatient hospitalization.

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

This rule helps to address access issues and provides appropriate clinical treatment to children and adolescents presenting to or admitted to emergency rooms. Currently there are no Acute Crisis Units available to provide stabilization and treatment for children and youth as an alternative to acute inpatient hospitalization.

(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;

This rule helps to address access issues and provides appropriate clinical treatment to children and adolescents presenting to or admitted to emergency rooms. Currently there are no Acute Crisis Units available to provide stabilization and treatment for children and youth as an alternative to acute inpatient hospitalization.

(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;

There are no less costly alternatives.

(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;

N/A

(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). 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).

c. **SUBJECT: Living Choices Assisted Living Facility Waiver Renewal; LCAL 2-20**

DESCRIPTION:

Statement of Necessity

CMS approves HCBS waivers for a period of 5 years. The Living Choices Assisted Living waiver expired January 31, 2021, but continued operating under a temporary extension. DHS proposed a waiver renewal with the Centers for Medicare and Medicaid Services (CMS) and filed a proposed rule in April 2021. The extension also allowed DHS to align the waiver start date with the beginning of the state's fiscal year of 07/01/2021, a date CMS expressed interest in establishing as well.

The proposed rule went through a public comment process. A public hearing was held on April 16, 2021. DHS received no public comments during the initial public comment period. The rule proceeded to review in June 2021 before the Committees on Public Health, Welfare and Labor; the Administrative Rules Subcommittee; and the Arkansas Legislative Council, and the rule received review and approval. At that time, DHS stated it would resubmit the rule for review if CMS required changes necessitating such. The rule was not final-filed following legislative review as it was not yet approved by CMS.

CMS conducted a lengthy review of the Waiver renewal. CMS approved the Living Choices Assisted Living waiver on January 19, 2022, but required changes from the proposed rule that had been adopted during legislative review; accordingly, the rule proceeded to a second public comment period and will again be presented for legislative review.

Rule Summary

With this renewal cycle, the roles and responsibilities of the operating agencies (DMS, DAABHS, DPSQA, & DCO) are clarified. In addition, the appeals process is changing to an automatic continuation of benefits during the appeal process unless the waiver beneficiary opts out. Rates for services are updated for the next 5 years. The roles of the DHS Nurses and Eligibility Nurses are clarified. Reporting requirements are clarified, and the Provisional Service Plan option is removed.

PUBLIC COMMENT: A public hearing was held on this rule on April 16, 2021. The public comment period expired on May 13, 2021. The agency indicated that it received no public comments. The rule was reviewed and approved by the Administrative Rules Subcommittee on June 16, 2021. After ALC review and approval but before final filing, CMS required changes to the proposed rule. The agency implemented these changes and opened a second public comment period. The second public comment period expired on August 14, 2022. The agency provided the following summary of the public comments it received and its responses to those comments:

Commenter's Name: Todd Hightower, Healthmark Services, Inc.

COMMENT: Please find my comments on the language for the living choices waiver renewal below. In my experience with HUD funding, we were paying in excess of $7,500 to $8,000 per year to have an independent audit of financials performed. Under HUD guidelines we refinanced placing the single asset building into an S corp and leasing it to our operating company. This allowed the required independent audit to reflect the 12 monthly lease payments versus every line item from operations and not only lowered our cost to something affordable but reduced the time of our independent auditors from 3 weeks to 3 days. I say this to comment that an arbitrary number of $100k per year in revenue would require living choices waiver providers who provide care for an average of 3 Medicaid residents per year (assuming SSI residents with little to no share of cost) to perform an independent audit at cost approaching 10% of the revenue per year? This seems overly burdensome, and I feel will reduce yet further, those willing to accept Medicaid in our assisted living communities.

In addition, this would make the Living Choices Waiver program to provide independent audits while all other HCBS settings are not required to do so?

I am asking this be removed from the language, or at least make the requirement match the federal limit of $750k in revenues, which would increase those required to audit be a facility with average Medicaid census

closer to 21 per year, or just over 50% of the census in a full 40 bed facility, our POA threshold.

RESPONSE: Thank you for your comment. DHS will take your comment under advisement and further research and consider the audit issues you raise.

Commenter's Name: Phyllis Bell, ARALA Executive Director

COMMENT: Living Choices Assisted Living (LCAL) waiver providers are mostly small business owners who provide essential health services to Arkansans, allowing clients to remain in their homes and local communities. The Living Choices Assisted Living (LCAL) waiver provides financial safeguards that protect the program's integrity. Some of the safeguards in place are pre-payment financial checks through the MMIS system and random quality assurance checks provided by the contracted fiscal agent. There are also post-payment integrity safeguards administered by DHS-DAABS, DMS, The Centers for Medicare and Medicaid Services (CMS), Arkansas Legislative Audit, and the Office of Medicaid Inspector General.

On page 131 of the proposed changes, LCAL providers will be mandated to provide and finance an independent audit with numerous already established safeguards. This requirement seems onerous and redundant. More importantly, it seems disproportionate to the requirements of other health services providers, and more specifically other home and community-based services (HCBS) providers. The independent audit will create an undue burden on an essential provider group that has been negatively impacted financially over the last several years with declining Medicaid reimbursement rates. The current CMS-approved LCAL Medicaid reimbursement is $67.25. Due to the current reduced rate and the decline in access for vulnerable Arkansans to assisted living services under the LCAL, the Arkansas Department of Human Services (DHS) recently authorized a new rate review by Myers and Stauffer which considers current data from providers and proposes a more sustainable rate. This report will be submitted to CMS for consideration.

Clarification on who employs the RN referenced on page 53 paragraph 4 would be beneficial.

RESPONSE: Thank you for your comment. As noted above, DHS will take your comment under advisement and further research and consider the audit issues you raise. You are correct that the Living Choices program is currently the subject of a rate review process to be made part of a Waiver Amendment to CMS. Any Amendment will be open to further public comment.

Commenter's Name: Ed Holman, President, Retirement Services of Arkansas, LLC

1. I want to make my opposition very clear on a section of Appendix I: Financial Accountability. Because of the confusion with the page numbering and the references, I am including the paragraph in question below:

> All Living Choices Waiver providers who are paid a total of $100,000 or more during a year by the State of Arkansas are required to submit an independent audit of its financial statements for that year in accordance with the Government Auditing Standards. Living Choices Waiver providers who are paid more than $750,000 in federal funds during a year must have an independent single audit conducted for that year in accordance with OMB Circular A-133. All required Living Choices Waiver service provider audits are submitted to and reviewed by the DHS Office of Payment Integrity and Audit (OPIA) for compliance with audit requirements. The purpose of the OPIA reviews of provider financial audits is to notify the Division of any deficiencies identified by that provider's CPA. DAABHS is notified of any deficiencies via e-mailed letter upon completion of the review. No CAPs are required and individual claims are not reviewed in the process. If during review of an audit issues are discovered, then OPIA is responsible for notifying DMS for recoupment or other appropriate action. Reviews are consistent across all providers and provider types.

Assisted living II providers are coming off of their worst five years since the program was enacted. Ten providers have shut their doors and even more are struggling and nearing bankruptcy. Probably twenty facilities are in default on their loans, either financially, or technically, by not meeting the debt service coverage requirements of their loan provisions. We have had to cut staff and services just to stay open. We have had to endure six minimum wage hikes, plus had to comply with the insurance requirements to provide health insurance to our staff under the provisions of Obamacare. At the same time our rates were cut 20% from their highest level. We are grateful that we have benefited from some Federal and State aid, but this was only a Band-Aid fix. Our recent Appendix K was also a help, but still will not get most providers out of technical default on their loans. The intent of the waiver program was to provide for payments that are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough assisted living providers, as required under 42 U.S.C. 1396a(a)30 (A). Our recent rate study and resulting recommendations will go a long way to helping the program back on its

feet. But, then along comes this requirement for audited financials for even our smallest providers. An audit may cost up to $8,000. Is DHS going to reimburse this payment? We had eight small providers doing between $91,000 and $130,000 last year and taking $8,000 out of that revenue stream will erase any profit that they may have made, if the audit cost is not reimbursed. This does not encourage participation and may actually encourage providers to limit waiver residents, or even drop out of the program.

RESPONSE: Thank you for your comment. As noted above, DHS will take your comment under advisement and further research and consider the audit issues you raise.

2. My next question, or concern is why is AL II being singled out for an audit? Nursing homes easily do ten times the Medicaid revenues that ALs do and they are not subject to this requirement. The largest user does roughly $11.5 million and it is not subject to an audit, yet an AL doing $100,000 would be required to provide an audit. They do have to do cost reports for both Medicaid and Medicare, but this can be done in-house and the only audit on their figures is when State comes out to do a Medicaid audit. As a plus for the cost reports, their rates are determined by this process guaranteeing that nursing home reimbursement is a reflection of their costs. I do not believe any home health programs have this requirement, nor do assisted living level 1, or residential care facilities and I am not aware of any other HCBS program that is subject to these stringent audit requirements. I would urge that this section of Appendix I be dropped. If DHS is intent on wanting financial information from providers they should implement a cost report system that would adjust our rates annually in order to keep up with rising labor rates and inflation.

RESPONSE: Thank you for your comment. As noted above, DHS will take your comment under advisement and further research and consider the audit issues you raise. Additionally, DHS will take your comments regarding a cost report system into consideration.

The proposed effective date is October 1, 2022.

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

d. **SUBJECT: AR Choices in Homecare Renewal**

DESCRIPTION:

Statement of Necessity

The Center for Medicare and Medicaid Services approves Home & Community Based Services waivers for a period of five years. The AR Choices in Homecare waiver expired January 31, 2021, but continued operating under a temporary extension. DHS proposed a waiver renewal with the Centers for Medicare and Medicaid Services (CMS) and filed a proposed rule in July 2021. The extension also allowed DHS to align the waiver start date with the beginning of the state's fiscal year of 07/01/2021, a date CMS expressed interest in establishing as well.

The proposed rule went through a public comment process. A public hearing was held on July 13, 2021. DHS received public comments, and revisions to the rule resulted. The rule proceeded to review in September 2021 before the Committees on Public Health, Welfare and Labor; the Administrative Rules Subcommittee; and the Arkansas Legislative Council, all of which reviewed and approved. At that time, DHS stated it would resubmit the rule for review if CMS required changes necessitating such. The rule was not final filed following legislative review as it was not yet approved by CMS.

CMS conducted a lengthy review of the Waiver renewal. CMS approved the AR Choices in Homecare waiver on March 10, 2022, but required changes from the proposed rule that had been adopted during legislative review; accordingly, the rule proceeded to a second public comment period and will again be presented for legislative review.

Rule Summary

The roles and responsibilities of the operating agencies (Division of Medical Services, Division of Aging, Adult, & Behavioral Health Services, Division of Provider Services and Quality Assurance, and Division of County Offices) are clarified with this waiver renewal. The AR Choices Manual reflects the functional eligibility determinations and evaluations listed in the AR Choices waiver. The Personal Care Manual has been updated to remove duplication of AR Choices rules and references AR Choices Manual. The appeals process language is updated throughout as necessary to reflect the automatic continuation of benefits

during the appeal process unless the waiver beneficiary opts out. Rates for services are updated for the next five years and additional waiver slots are added. The Service Budget Limits are updated, and the Provisional Service Plan option is removed. The waiver renewal updates Service Budget Limits, Established Change of Condition Processes and a Process for Granting and Exception to the maximum SBL. The financial impact is $12,992,412 for State Fiscal Year (SFY) 2022 and $13,615,716 for SFY 2023.

The state share of increasing the Attendant Care and In-Home Respite Care rates is $3,699,914 for SFY 2022 and $3,864,140 for SFY 2023.

PUBLIC COMMENT: A public hearing was held on this rule on July 13, 2021. The initial public comment period expired on August 2, 2021. The agency provided the public comment summary for the initial public comment period:

Commenter's Name: Luke Mattingly, CEO/President, on behalf of CareLink

1: ARChoices Section 212.000(D) – Refers readers to the approved assessment manual. When reviewing this current on-line manual, there is no mention of ARChoices or how the tiers for LTSS are established and applied. Also, the eligibility rules have been red-lined and the rules only now reference the State Administrative Rule for level of care. This revision lacks transparency within the waiver for how the eligibility process is established, changed, and controlled. **RESPONSE:** Thank you for your comment. The approved assessment tool manual is referenced to provide transparency in relation to the tool. Notwithstanding the final tier determination, the Level of Care eligibility is made by the Division of County Operation. The assessment of functional need is used as part of the process to determine medical eligibility and in the development of the PCSP. We have included reference to the State Administrative Rule to avoid possible incongruence should there be future rule change.

2: ARChoices Section 240.000 Prior Authorization – There is very little detail in this section. It needs to be changed to reflect the same language as the Personal Care Manual. **RESPONSE:** Thank you for your comment. DHS will update this section to clarify that the authorization mechanism for the ARChoices program is the Person-Centered Service Plan. Additionally, sections 212.320 and 212.323 include language that the PCSP serves as the authorization for ARChoices waiver services.

3: ARChoices Section 262.300 Billing Instructions – The requirement for providers to supply the documentation proving that services were rendered at a time before or after the hospital discharge occurred has always been

administratively burdensome. Medicaid has the information as a payor and has access to admission and discharge data. Unskilled home health providers do not have direct access to the information being requested. It requires significant administrative effort to obtain the required documentation.

With the implementation of state-wide requirement for Electronic Visit Verification systems, Medicaid has access to all information required to compare data and verify that services occurred before admission or after discharge without additional provider input.

This section needs to be revised to eliminate the provider requirement and to reflect that Medicaid will verify that services have been provided before admission or after discharge. All information to verify this is within state data systems available to Medicaid.

RESPONSE: Thank you for your comment. It is the provider's responsibility to develop and maintain sufficient written documentation to support each service for which billing is made.

4: Methods for Remediation / Fixing Individual Problems – References an Intra-agency agreement between AADHS and DMS. What are the parameters of this agreement and where can this agreement be reviewed?
RESPONSE: Thank you for your comment. Providers may request a copy of this agreement through the Freedom of Information process.

5: Appendix J Cost Neutrality – It is interesting to note that the state projects a 2.5% annual inflationary factor for SNF's in factor D derivation. The state makes no such annual inflationary consideration for ARChoices providers. There are always several years between rate changes for ARChoices services. This 2.5% annual inflationary consideration is not applied to ARChoices waiver provider operational inflationary costs/expense, however the 2.5% increase for SNF's is directly applies to inflationary expenses related to operations. This is yet another inequity between SNF's and HCBS. **RESPONSE:** Thank you for your comment.

6: Rate for service – While the rate increase in the waiver is desperately needed, the rate setting methodology for In-home services is derived from "what is the minimum Medicaid can pay for this service" resulting in low wages and minimal benefits for workers. The rate setting process does not provide the opportunity to build a career ladder for in-home Aides nor does it focus on paying a wage that attracts high quality candidates. The rate is such that providers can only offer minimum wage or close to minimum wage pay. This is not conducive to providing high quality services and results in high turnover rate for this occupation, which is detrimental to participant care.

The state needs to engage in a more open conversation about this occupation and what skill sets would be preferable to deliver high quality customer care. This in turn would help ascertain what wage rate needs to be in place to support this high-quality care and in turn what rate would support the wage. Instead, the base assumption starting point for determining the rate is minimum wage, which here in Arkansas is $ 11.00 per hour.

RESPONSE: Thank you for your comment. Under Executive Order 19-02 rates are reviewed on a regular cycle utilizing a standard rate review methodology.

7: Removal of Provisional Plans of Service – What is the plan to make ARChoices readily available to eligible participants? SNF's have the ability to begin services and then retro bill to first day of service after deemed eligible. No such provision is in place for ARChoices. With average processing of ARChoices initial applications exceeding 45 days or more it leaves many families with no choice but to select a facility placement over HCBS. **RESPONSE:** In order to be determined eligible for the ARChoices waiver, individuals must meet both financial and medical eligibility requirements. Allowing for services to begin prior to determination of both financial and medical eligibility places both providers and individual at financial risk. Individuals with active full Medicaid benefit plans may receive services under state plan personal care until waiver services are approved.

8: Additional Requirements/Access to Services – In addition to topics already mentioned which fall into this category, the inability of DHS to issue a Prior Authorization at the same time as issuing the approved PCSP is detrimental to service providers and places participant services at risk. The prior authorization (PA) should be issued and coincide with the issuance of the PCSP. A prior authorization is required for a provider to be reimbursed for services. DHS issues the PCSP and expects providers to start services immediately upon receipt, but the Prior Authorization is not issued until a later date. **RESPONSE:** Thank you for your public comment. DHS is reviewing internal processes to improve efficiency in systems. The authorization for services continues to be the Person-Centered Service Plan which is sent to the provider by the DHS PCSP/CC nurses.

9: Service Budget Caps – Tier 1: $ 34,000; Tier 2: $ 23,000; Tier 3: $ 6,000

All service caps are set to low to ensure that participants in that particular level of care has a reasonable opportunity to remain in their homes as long

as possible. In Tier 1 allowing only $34,000 annually to someone that is totally dependent and requires extensive assistance is not sufficient to ensure Home and Community Based care will assist the individual from being institutionalized. Likewise Tier 2 participants need additional supports than the budget cap allows. However, the $ 6,000 cap for Tier 1 services is the most egregious. These individuals meet the functional needs requirements to be eligible for ARChoices. This service cap barely provides any services at all. The cap should be at least doubled to ensure a level of care that keeps participants in their home and delays progression into Tiers requiring more care or institutionalization. The service budget cap should at least be doubled to $ 12,000.

RESPONSE: The Service Budget Limit (SBL) amounts were adjusted to incorporate rate increases to ensure clients continued to receive services authorized, notwithstanding subsequent rate increases. SBL's limit the maximum dollar amount of services that may be authorized based on medical determination by the Division of County Operation. Section 212.200 outlines the process for adjustments to the SBL based on change in condition.

Commenter's Name: Jacque McDaniel, Executive Director, on behalf of East Arkansas Area Agency on Aging

1: Section 200.120-262.410 – The Personal Care policy changed "beneficiary" to "client". The ARChoices policy changed "Beneficiaries" and "individuals" to "participants". Why was different terminology utilized? **RESPONSE:** Notwithstanding any difference in the terminology the individuals referenced are the same.

2: Section 213.540 E – There are three applicable rules listed—Section 215.350, 215.351 and 262.100. Is there a Section 262.100? **RESPONSE:** Thank you for your comment. The reference to Section 262.100 has been removed.

3: Section 200.120-262.410 of the Personal Care policy changed "beneficiary" to "client". The ARChoices policy changed "Beneficiaries" and "individuals" to "participants". Why was different terminology utilized between Personal Care and ARChoices policies? **RESPONSE:** Notwithstanding any difference in the terminology the individuals referenced are the same.

4: Section 212.000 Item B – The last sentence of this paragraph may have an error with the change from 'individual' to 'participant'. **RESPONSE:** Language has been reviewed to ensure consistency in the manual.

5: Section 212.000 Item I – The policy states the "program provides for the entrance of all eligible persons on a first-come, first-served basis, once participants meet all functional and financial eligibility requirements." Should "functional" be changed to "medical"? **RESPONSE:** Thank you for your comment. The language has been updated.

6: Section 212.000 Item I states eligible persons will be served on a first-come, first-served basis. With the elderly, behavioral health (BH) and development disabled (DD) populations being combined in one waiver, should the slots be segregated to the different populations to assure availability for the elderly population? The average length of program eligibility for elderly waiver clients is much shorter than the BH and DD populations. **RESPONSE:** The ARChoices waiver is a distinct waiver and has not been combined with BH or and DD waivers. The slots available under the ARChoice waiver are available only to those beneficiaries who have been determined eligible for the ARChoices waiver.

7: Section 212.200 "Waiver Renewal Process" – Item C states "unless one of the following conditions applies:" then lists item 1, item 2, item 3 "or the participant disenrolls from the ARChoices Waiver program." Should this last item actually be numerated as item 4? **RESPONSE:** This item is listed as item 4.

8: Section 212.300 lists the acronym for person-centered service plan (PCSP) several times, but some of the listings were transposed as PCPS in Items A and C. **RESPONSE:** Thank you for your comment. The manual has been updated.

9: Section 262.300 Billing Instructions – With the detailed requirements for caregivers to utilize electronic visit verification for documenting and billing services, the policy requiring a provider to gather documentation to prove what time the participant was admitted to a facility needs to be changed. The state should have the information to determine what time the participant was admitted to a facility instead of placing another burden on the lowest paid provider to gather this information. **RESPONSE:** Thank you for your comment. It is the provider's responsibility to develop and maintain sufficient written documentation to support each service for which billing is made.

10: Appendix 1-2: Rates, Billing and Claims – Rate Determination Methods: Even though various methodologies were used for rate determination, the rate is inadequate to support the services in our state when the minimum wage increase and other costs far exceeded the percentage increase in the rate. The added stress of low unemployment rates and shortage of workers with the ever-increasing older population has seriously threatened the viability of Home and Community-Based

Services in our state. **RESPONSE:** Thank you for your comment. Under Executive Order 19-02 rates are reviewed on a regular cycle.

The rule was reviewed and approved by the Administrative Rules Subcommittee on September 17, 2021. After ALC review and approval but before final filing, CMS required changes to the proposed rule. The agency implemented these changes and opened a second public comment period. The second public comment period expired on August 14, 2022. Due to its length, the public comment summary for this second public comment period is provided separately.

The proposed effective date is October 1, 2022.

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

Per the agency, this rule implements a federal rule or regulation. The cost to implement the federal rule or regulation is $12,992,412 for the current fiscal year ($3,699,914 in general revenue and $9,292,498 in federal funds) and $13,615,716 for the next fiscal year ($3,864,140 in general revenue and $9,751,576 in federal funds). The total estimated cost to state, county, and municipal government is $3,699,914 for the current fiscal year and $3,864,140 for the next fiscal year. The agency indicated that these amounts represent the state share of increasing the Attendant Care and In-Home Respite Care rates.

Per the agency, 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, 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;

CMS approves HCBS waivers for a period of 5 years. The AR Choices in Homecare waiver expired 12/31/2020 and is currently operating under a temporary extension. This extension will allow DHS to align the waiver start date with the beginning of the state's fiscal year of 07/01/2021. The roles and responsibilities of the operating agencies (DMS, DAABHS, DPSQA, & DCO) will be clarified with this waiver renewal. The AR Choices and Personal Care Provider Manuals will now reflect the functional eligibility determinations and evaluations listed in the AR Choices waiver. In addition, the appeals process is changing to an automatic continuation of benefits during the appeal process unless the waiver beneficiary opts out. Rates for attendant care and in-home respite services are being updated to align with the personal care rate. The Service

Budget Limits are being updated and Individual Service Budgets are defined. The Provisional Service Plan option is being removed.

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

CMS approves HCBS waivers for a period of 5 years. The AR Choices in Homecare waiver expired 12/31/2020 and is currently operating under a temporary extension. This extension will allow DHS to align the waiver start date with the beginning of the state's fiscal year of 07/01/2021. The roles and responsibilities of the operating agencies (DMS, DAABHS, DPSQA, & DCO) will be clarified with this waiver renewal. The AR Choices and Personal Care Provider Manuals will now reflect the functional eligibility determinations and evaluations listed in the AR Choices waiver. In addition, the appeals process is changing to an automatic continuation of benefits during the appeal process unless the waiver beneficiary opts out. Rates for attendant care and in-home respite services are being updated to align with the personal care rate. The Service Budget Limits are being updated and Individual Service Budgets are defined. The Provisional Service Plan option is being removed.

(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;

CMS approves HCBS waivers for a period of 5 years. The AR Choices in Homecare waiver expired 12/31/2020 and is currently operating under a temporary extension. This extension will allow DHS to align the waiver start date with the beginning of the state's fiscal year of 07/01/2021. The roles and responsibilities of the operating agencies (DMS, DAABHS, DPSQA, & DCO) will be clarified with this waiver renewal. The AR Choices and Personal Care Provider Manuals will now reflect the functional eligibility determinations and evaluations listed in the AR Choices waiver. In addition, the appeals process is changing to an automatic continuation of benefits during the appeal process unless the waiver beneficiary opts out. Rates for attendant care and in-home respite services are being updated to align with the personal care rate. The Service Budget Limits are being updated and Individual Service Budgets are defined. The Provisional Service Plan option is being removed.

(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;

There are no less costly alternatives.

(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;

N/A

(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). 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, OFFICE OF CHIEF COUNSEL**
(Mark White; Brett Hays)

a. **SUBJECT: Declaratory Orders**

DESCRIPTION:

Statement of Necessity

Ark. Code. Ann. § 25-15-206 requires that each state agency shall provide by rule for the filing and prompt disposition of petitions for declaratory orders as to the applicability of any rule, statute, or order enforced by it. DHS has not promulgated such a rule.

Summary

DHS promulgates a rule providing for the filing and prompt disposition of petitions for declaratory orders.

PUBLIC COMMENT: No public hearing was held on this rule. The public comment period expired on July 25, 2022. The agency indicated that it received no public comments.

The proposed effective date is October 1, 2022.

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

LEGAL AUTHORIZATION: "Each agency shall provide by rule for the filing and prompt disposition of petitions for declaratory orders as to the applicability of any rule, statute, or order enforced by it." Ark. Code Ann. § 25-15-206.

9. **DEPARTMENT OF LABOR AND LICENSING, DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING BOARDS AND COMMISSIONS, ARKANSAS TOWING AND RECOVERY BOARD**
(Miles Morgan; Dan Parker)

a. **SUBJECT: Rules of the Arkansas Towing and Recovery Board**

DESCRIPTION: The Arkansas Towing and Recovery Board is seeking review and approval of its amended rules. The proposed amendments would accomplish the following:

1. Amend the board's definitions and add a definition for "repossession," "commercial purpose," and "personal use."

Additionally, the definition of "consent towing was amended to conform to Act 789 of 2021;

2. Amend the board's rules to provide that the burden is on the owner of the tow vehicle to prove personal ownership of the vehicle being towed;
3. Amend the board's rules, concerning licenses and safety permits to establish the process and requirements for consent towing registration;
4. Amend rules of the board, concerning fees, to provide the registration fee for consent-only tow service businesses is $25 per Act 789 of 2021;
5. Amend the board's rule on minimum coverage of liability insurance;
6. Create a new rule, establishing the procedures and requirements for posting notices on the board's website pursuant to Act 794 of 2021; and
7. Create a new rule for development of enhanced tow vehicle license for heavy duty non-consent rotation pursuant to Act 1063 of 2019.

PUBLIC COMMENT: A public hearing was not held in this matter. The public comment period expired on August 5, 2022. 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 the amended rules have a financial impact of up to $1,000 for the current and next fiscal year to private individuals, entities, and businesses subject to the amended rule. The agency provided the following explanation of the estimated cost:

1. Enhanced Heavy Duty License – Costs to tow companies will be determined by the type of equipment and tow-vehicles they currently have and what they may need to purchase to comply with the rule.
2. The increase in license/permit fees will be minimal costing on average $78 per company, those with larger fleets will pay more.
3. There will be a modest increase for the signage on the side of the tow vehicle of less than $100.
4. Insurance costs will not be incurred by a vast majority of the tow companies, as most of the companies carry coverage in excess of the minimum standard. The increase reflects the value of the cargo towed. This was determined through a survey of current licensees.
5. Act 794 of 2021 will have some minor costs (usage fee) due to the requirement of having to post certain notices on the board's website.

LEGAL AUTHORIZATION: The Arkansas Towing and Recovery Board shall promulgate rules to carry out the intent of Title 27, Chapter 50, Subchapter 12 of the Arkansas Code, concerning removal or immobilization of unattended or abandoned vehicles, and shall regulate the towing industry and vehicle immobilization service industry, including:

1. Establishing reasonable licensing, insurance, and equipment requirements for any person engaging in towing and related services for safety purposes or vehicle immobilization services under the subchapter;
2. Establishing reasonable tow truck safety requirements for any tow vehicle as defined in the subchapter;
3. Establishing a procedure to accept and investigate complaints from a consumer who claims that he or she has been overcharged for fees related to nonconsent towing, recovery, storage, or vehicle immobilization services;
4. Determining and sanctioning excessive or unnecessary fees charged to consumers related to nonconsent towing, recovery, storage, or vehicle immobilization services;
5. Requiring all entities permitted, licensed, or regulated under the subchapter to provide to the board all documents in response to information requests by the board pursuant to the investigation of consumer complaints or board complaints against the permittee or licensee;
6. Requiring all entities permitted, licensed, or regulated under the subchapter to provide itemized billing for fees related to towing, storage, or vehicle immobilization services that explains how the charges were calculated;
7. Requiring all entities permitted, licensed, or regulated under the subchapter to maintain a copy of their current maximum rate schedule or fee schedule posted in a conspicuous place and readily accessible to the public;
8. Requiring all entities permitted, licensed, or regulated under the subchapter to allow the owner or agent of the owner of a motor vehicle removed under the subchapter or under § 27-50-1101 to use any other entity permitted, licensed, or regulated under the subchapter when reclaiming the motor vehicle from storage;
9. Requiring all entities permitted, licensed, or regulated under the subchapter to post a sign notifying customers of the consumer complaint process under § 27-50-1218. The sign shall be in a conspicuous and central location in the public area and shall be a minimum of sixteen inches by twenty inches (16″ x 20″) in size. The board may assess a fine of between fifty dollars ($50.00) and two hundred fifty dollars ($250) for failure to comply with these provisions;

10. Setting a minimum standard for the structure of the place of business and storage facility located in Arkansas and utilized for the daily operation of a towing company licensed and regulated under Ark. Code Ann. § 27-50-1203(e). The place of business shall utilize: (a) A location easily accessible by the public; (b) An appropriate and secure filing system for business records; and (c) Clear and visible signage displaying the name on the business license issued by the board that: (1) Is a minimum of four feet by six feet (4′ x 6′) in size or meets the criteria established by a municipal zoning ordinance, subdivision regulation, or building code; and (2) Displays the name, physical address, a published telephone number of the towing company, and hours of operation;
11. Adopting rules for the: registration of a person engaged in a consent-only towing business; issuance of a certificate of registration required under subdivision (f)(1)(A)(iii) of Ark. Code Ann. § 27-50-1203; and the denial, revocation, or suspension of a license or permit issued under the subchapter; and
12. Establishing a website that is sponsored and managed by the board for a towing business to post the notice required by § 27-50-1101 and the subchapter.
    See Ark. Code Ann. § 27-50-1203(e)(1).

The amended rules implement Acts 789 and 794 of 2021, which were both sponsored by Representative Craig Christiansen. Act 789 amended the law concerning the removal or immobilization of unattended or abandoned vehicles. Act 794 amended the law concerning the requirements for a tow business to give public notice in certain circumstances and allowed public notice to be given on a website.

10. <u>DEPARTMENT OF TRANSFORMATION AND SHARED SERVICES, BUILDING AUTHORITY DIVISION</u> (Lauren Ballard)

a. <u>SUBJECT</u>: Building Authority Minimum Standards and Criteria

<u>DESCRIPTION</u>: Act 440 of 2021 required changes to:

- Section 2-101(C) – increase in bidding requirement threshold for professional services agreements
- Sections 3-101, 3-201 – increase in bidding requirement threshold for capital improvements projects
- Section 3-312 – increase bid security threshold
- Section 3-202 – emergency contracting requirements

Additionally, changes from previous legislative sessions that had not yet been incorporated into the rules were made such as abolishing the Arkansas Building Authority Council via Acts 2 and 3 of 2016, the repeal

of the Arkansas Prevailing Wage Rate laws via Act 1068 of 2017, and changes to definitions regarding the sustainable energy-efficient buildings via Act 674 of 2019.

Furthermore, the following changes were made globally to the rule:

- Addition of indentations for lists
- Heading, footer, margins, and spacing made consistent
- Duplicative, confusing, and poorly worded sentences restructured for clarity, subject/verb agreement, and to reduce confusion (such as removal of terms "and/or," "and the like")
- Removal of obsolete references (i.e., the use of the telegram)
- Additions regarding modern practice (i.e., the acceptance of flash drives or other portable electronic media for drawings and designs)
- Grammatical corrections and errors (spelling errors, missing commas, etc.)
- Agency changed to Department as a result of Act 910 of 2019, in addition to updating references to other entities (i.e., Arkansas Energy Office under the Department of Energy and Environment, the Division of Services for the Blind to the Department of Commerce)
- Updated numbers, capitalization, abbreviations, and references to forms and disclosures, etc., to be consistent throughout the document.

Changes made as a result of the public comment period:

- § 2-101(G) – removed extra "dollars" after the numerical number
- § 2-407(C)(9) – corrected "Entergy" to "Energy"
- § 2-1504(B)(7) – unstruck "lots"
- § 2-1504(B)(8) – added comma before the "such as" statement
- § 3-200(A) – removed extra "the" and "from"
- § 3-200(B) – corrected Agency to Department and added missing ", and"
- § 3-200(D) – removed extra "of the"
- § 3-202(C) – corrected spelling error
- § 3-202(C)(7) – corrected spelling error
- § 3-205 – corrected agency to department
- § 3-318(I)(5)(g) – corrected plural "Projects" to singular "Project"
- § 3-319(D) – unstruck "not receipt" from original language
- § 3-326 – unstruck previously removed statement regarding initializing of changes

Upon final approval, the table of contents, page numbers, and footers will be corrected and updated accordingly.

<u>PUBLIC COMMENT</u>: A public hearing was held on this rule on August 2, 2022. The public comment period expired on August 15, 2022. The agency provided the following summary of the comments it received and its responses to those comments:

<u>Commenter's Name</u>: J. Alan Rogers, BXS Insurance

COMMENT: My question; was the addition of electronic bid security discussed including the definition of electronic? **RESPONSE:** Comment considered; no changes made. Electronic bid security may be available in the future, but it is not available at this time.

<u>Commenter's Name</u>: Gib Richardson, AR ARNG/Department of the Military

COMMENT: The main change the Department of the Military would like see is the ability to use our On-Call Architects and Engineers on projects with estimated construction costs up to $3,000,000. The $1,000,000 threshold is very outdated with today's construction costs. I think we've highlighted all of the places that references this threshold. Most of our projects are 100% federally reimbursed, and we sometimes miss opportunities to receive federal money for projects because we don't have time to go through the RFQ process to select the design professional.

This is a lower priority, but we'd also like to see some exceptions on the Capital Improvements threshold that requires review by DBA. (Para 3-101) For instance, we don't think we need an A/E firm to design (and DBA review) projects like:
- painting (interior and exterior)
- floor covering replacement
- re-roofing with shingles
- siding repair/replacement

We saw that threshold was raised from $35,000 to $50,000 and that's a great improvement, but we still believe there could be some exceptions.

The Military Department greatly appreciated the opportunity to review and provide comments on this draft. We look forward to answering any questions you might have about our suggestions.

RESPONSE: Comment considered; no changes made. The $1,000,000 threshold for performance-based contracts is set by Ark. Code Ann. § 19-11-267 and the limit for capital improvement projects is set by Ark. Code Ann. § 22-9-203.

Commenter's Name: Emily Bowers, Green Building Initiative

COMMENT: My name is Emily Bowers, and I am the Director of State and Local Engagement at the Green Building Initiative (GBI). I am writing to express our appreciation for including our ANSI-accredited green building certification, Green Globes, in the Building Authority Minimum Standards and Criteria. GBI has certified over 3.7 million square feet of commercial and multifamily property in the state of Arkansas, and as the Minimum Standards and Criteria rules are amended, we wanted to offer any support needed if questions surrounding green building efforts or commissioning arise. We are passionate about mitigating climate impacts through the built environment and appreciate the strides the State of Arkansas has made for their constituents. Please let me know if we can ever be of service to the Department.

RESPONSE: Comment considered; no changes made.

Commenter's Name: Randy Stocks, Stocks-Mann Architects, PLC

COMMENT: Please consider adding the following multiplier to the Design Service Fee Schedule in Article 2-211 under 2-211(B) of the MSC:

> *6. For projects involving extensive site development requiring additional civil engineering, over and above typical site development, such as underground utility extensions to the site, complex subsurface stormwater systems and/or stormwater detention systems, roadway design to access the site, complex soil stabilization methods, etc., add a maximum of 1.0% to the fees indicated.*

Rationale: Some sites chosen by Agencies/Departments involve much more extensive site development design and engineering than other simple sites with basic pavement, surface drainage and hookup to existing utilities already on site. These more extensive sites require the architect to engage a civil engineer. Civil engineers require a 2% to 4% higher fee than the fees in the MSC Design Service Fee Schedule. In these instances, either the architect must pay for these higher fees out of their basic fees or the civil engineer has to take a reduced fee. In either case, the one or the other of the design professionals is penalized due to the nature of the site. The same building on a simple site that doesn't require civil engineering would yield a standard fee for the architect. The same building on a complex site requiring a civil engineer would yield a reduced fee for the architect, even though the architect's scope of work for the building is the same. This proposed multiplier would at least allow some recognition for complex sites and provide a means to negotiate an increase to the basic fee commensurate with the site development requirements.

If you have any questions regarding this proposal, please contact me. Thank you for your consideration.

RESPONSE: Comment considered; no changes made. Comment will be kept for review, research, and consideration for future rule updates.

Commenter's Name: Randall Palculict, Jackson Brown Palculict Architects

COMMENT: Per AIA contract documents, Civil and Landscape Architecture are not part of Basic Architectural services. For assignments that do not fall under DBA, sometimes a building owner will choose to contract separately with those disciplines at other times they are included as "additional services". I recommend removing Civil, and Landscape Architecture from list of "Basic Services" in section 2-202 (highlighted below).

2-202 ARCHITECTURAL AND BUILDING RELATED ENGINEERING SERVICES FEES (A) Fees shall be based on the Design Services Fee Schedule shown in §2-211. This fee schedule is to be used for all Architectural, Civil, Landscape Architecture, Structural, Mechanical, and Electrical Design Professional Services. These fees shall be considered part of "Basic Services" for a project as defined in §2-201.

I have copied Brent Stevenson the Executive Director of AIA Arkansas. Please let us know if you have any questions.

RESPONSE: Comment considered; no changes made.

The proposed effective date is pending legislative review and approval.

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

LEGAL AUTHORIZATION: The Building Authority Division has the power to "establish, promulgate, and enforce minimum design and construction standards and criteria for all capital improvements undertaken by any state agency, including . . . the bidding and awarding of capital improvements regarding projects under the jurisdiction of the division." Ark. Code Ann. § 22-2-108(9)(A). The Secretary of the Department of Transformation and Shared Services may promulgate reasonable rules "as may be required" for the Division "to carry out its duties, responsibilities, powers, and authorities under" the Building Authority Division Act. Ark. Code Ann. § 22-2-108(16).

This rule implements Act 440 of 2021. The Act, sponsored by Senator Ronald Caldwell, amended the award procedure for public improvement contracts.

11. DEPARTMENT OF TRANSFORMATION AND SHARED SERVICES, OFFICE OF PERSONNEL MANAGEMENT (Lauren Ballard)

a. SUBJECT: Unlawful Propagation of Divisive Concepts

DESCRIPTION: Act 1100 of 2021 requires TSS to develop rules regarding the unlawful propagation of divisive concept training. This rule prohibits state entities from training on divisive concepts and contains other state entity compliance requirements. Each state entity is required to develop a policy prohibiting divisive concept propagation and to review its training and grant programs to ensure compliance with Act 1100. The rule requires each state entity to submit a report to TSS by December 31 of each year documenting its compliance with the Act. The rule authorizes TSS to notify the Governor if a state entity fails to comply with the rule's requirements. The reporting form documenting compliance with the rule's requirements is included along with the rule.

PUBLIC COMMENT: A public hearing was held on this rule on June 29, 2022. The public comment period expired on July 18, 2022. 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 no financial impact.

LEGAL AUTHORIZATION: This rule implements Act 1100 of 2021. The Act, sponsored by Senator Trent Garner, prohibited the propagation of divisive concepts and reviewed state entity training materials. "The Secretary of the Department of Transformation and Shared Services shall develop rules for the enforcement of the provisions of" Title 25, Chapter 1, Subchapter 9 of the Arkansas Code, prohibiting the propagation of divisive concepts. *See* Ark. Code Ann. § 25-1-904(b), *as created by* Act 1100.

12. **DEPARTMENT OF TRANSFORMATION AND SHARED SERVICES, OFFICE OF STATE PROCUREMENT (Lauren Ballard)**

a. **SUBJECT: Rules Governing Mandatory Procurement Training Program**

DESCRIPTION: This three-part rule addresses the requirements contained in Ark. Code Ann. § 19-11-280 for the establishment of a mandatory training and certification program for state agency procurement personnel. The rule establishes the mandatory procurement training program, addresses documentation of compliance, addresses apparent non-compliance, and provides notice for revocation of procurement certification or delegated authority.

PUBLIC COMMENT: A public hearing was held on this rule on June 29, 2022. The public comment period expired on July 18, 2022. The agency indicated that it received no public comments.

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

Q. A.C.A. § 19-11-280(c)(2) states, "To maintain certification under this section, a state agency employee shall complete a reasonable number of hours of continuing education, as provided for by rule by the director." The proposed rules provide that the State Procurement Director "shall set the minimum number of hours of procurement training required for the following fiscal year by June 30th." Will this occur through the formal rulemaking process, or will the Director set the annual minimum through some other process? **RESPONSE:** In response to your inquiry, Secretary Rouse has advised that setting the minimum number of hours of required procurement training will occur through policy and not formal rulemaking.

The proposed effective date is pending legislative review and approval.

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

LEGAL AUTHORIZATION: This rule implements Act 419 of 2019. The Act, sponsored by Representative Jeff Wardlaw, amended the laws concerning various procurement methods, provided for the training and certification of procurement officials, and required additional legislative review of procurement rules. The Act required the State Procurement Director to "establish a training and certification program to facilitate the training, continuing education, and certification of state agency procurement personnel" and to promulgate rules regarding the procedure for revoking a state agency employee's procurement certification. Ark.

Code Ann. § 19-11-280(a), (d)(2). The Director also has authority to promulgate rules regarding the required number of continuing education hours for procurement personnel. Ark. Code Ann. § 19-11-280(c)(2).

E. Agency Updates on the Status of Outstanding Rulemaking Pursuant to Act 595 of 2021[1]

1. **Arkansas Department of Transportation, Arkansas Highway Commission**
2. **Department of Agriculture**
3. **Department of Commerce, State Insurance Department***
4. **Department of Education**
5. **Department of Finance and Administration, Revenue Division***
6. **Department of Health, Division of Health-Related Boards**
7. **Department of Health, State Board of Health**
8. **Department of Labor and Licensing***
9. **Department of Transformation and Shared Services***
10. **Office of Arkansas Lottery**

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

G. Adjournment

[1] For those items designated by an asterisk ("*"), no update may be required depending on the action taken by the Subcommittee with respect to that agency's rules under Item D.