ADMINISTRATIVE RULES SUBCOMMITTEE
OF THE
ARKANSAS LEGISLATIVE COUNCIL

Thursday, December 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. <u>ARKANSAS PUBLIC SERVICE COMMISSION</u> (Angela Sartori, Michael Brechlin)

a. <u>SUBJECT</u>: Amendments to the Arkansas Gas Pipeline Code

<u>DESCRIPTION</u>: The Arkansas Public Service Commission proposes amendments to its rules concerning the Arkansas Gas Pipeline Code, pursuant to its authority under Ark. Code Ann. § 23-15-205(a) to promulgate, amend, enforce, waive, and repeal minimum safety standards for the transportation of gas and pipeline facilities. Ark. Code Ann. § 23-15-205(d) further requires that safety regulations promulgated for gas pipeline facilities or the transportation of gas shall be consistent with federal law and with rules and regulations promulgated under authority of the Natural Gas Pipeline Safety Act of 1968, Pub. L. No. 90-481, as amended.

The Pipeline and Hazardous Materials Safety Administration ("PHMSA") of the U.S. Department of Transportation has authority to promulgate federal rules concerning gas pipeline safety. The proposed amendments to the Arkansas Gas Pipeline Code mirror the changes proposed by PHMSA in 49 C.F.R. 191, 192, and 199. Notable areas of change include:

- PHMSA amended the Federal Pipeline Safety Regulations that govern the use of plastic piping systems in the transportation of natural gas. This revision is comprised of amendments that will improve safety and allow for expanded use of plastic pipe

products. These measures have the potential to improve pipeline safety and integrity.

- *Pipeline Safety: Safety of Gas Transmission Pipelines: MAOP Reconfirmation, Expansion of Assessment Requirements, and Other Related Amendments.* This amendment revises the Federal Pipeline Safety Regulations to improve the safety of onshore gas transmission pipelines. These amendments address integrity management requirements and focus on the actions an operator must take to reconfirm the maximum allowable operating pressure ("MAOP") of previously untested natural gas transmission pipelines and pipelines lacking certain material or operational records, the periodic assessment of pipeline in populated areas not designated as "high consequence areas," the reporting of exceedances of MAOP, the consideration of seismicity as a risk factor in integrity management, safety features on in-line inspection launchers and receivers, a 6-month grace period for 7-calendar-year integrity management reassessment intervals, and related recordkeeping provisions.
- *Pipeline Safety: Gas Pipeline Regulatory Reform.* This amendment eases the regulatory burdens on construction, operation, and maintenance of gas transmission, distributions, and gathering pipeline systems without adversely affecting safety.

Following the public comment period, the following changes were made to the proposed rule:

On page 5, the second instance of "192.204" was stricken and replaced with "192.205". This corresponds with the table of contents entry "Records: Pipeline Components." On page 87, the second instance of "192.204" was stricken and replaced with "192.205". This corresponds with the entry titled "Records: Pipeline Components." On page 92, section 192.281(b)(2), after the text "ASTM D2564-12," insert the words "for PVC."
On page 114, section 192.481(a)(3), in the right column of the table, the number "39" was stricken and replaced with the number "15."

PUBLIC COMMENT: A public hearing was held on July 28, 2022. The public comment period expired on July 28, 2022. The Commission indicated that it received no public comments.

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

(1) The term "Outer Continental Shelf" is defined in the federal regulations (§ 191.3) but is not defined within the Arkansas Gas Pipeline Code, though it is referenced in § 199.2. Is there a reason the definition for

this term is not supplied within the proposed Arkansas rules? **RESPONSE:** Outer Continental Shelf includes land under the sea. Arkansas is landlocked, and does not have any land area that would fall under this definition. Additionally, Section 199.2 refers to the federal definition contained in 43 U.S.C. 1331, which matches the definition contained in 49 C.F.R. 191.3.

(2) Section 192.204 appears twice in the proposed Arkansas Gas Pipeline Code. The latter of the two appears to track federal regulation § 192.205 "Records: Pipeline Components." Should this section be labeled § 192.205 in the proposed Arkansas rules as opposed to § 192.204, as it is in the federal regulations? **RESPONSE:** Yes. The second section labeled 192.204, in both the body and the table of contents, should be 192.205.

(3) Section 192.281(b)(1) of the Arkansas Gas Pipeline Code appears to track, in part, federal regulation § 192.281(b)(2), which states "The solvent cement must conform to ASTM D2564-12 *for PVC*." (emphasis added) Is there a reason that this section of the Arkansas Gas Pipeline Code omits the words "for PVC" as it appears in the federal regulations? **RESPONSE:** No. It is an oversight, and should be corrected to include "for PVC."

(4) Section 192.281(c) of the Arkansas Gas Pipeline Code appears to track § 192.281(c) of the federal regulations but omits the words "or an alternative written procedure that has been demonstrated to provide an equivalent or superior level of safety and has been proven by test or experience to produce strong gastight joints". Is there a reason why this language appears in the federal regulations but not in the Arkansas rules? **RESPONSE:** Yes. The rules are amended to conform to federal amendments with a time delay. The change that added the quoted terms above was made March 12, 2021, and delayed to October 1, 2021. The change that includes the language above will be in another future rule filing, along with other changes made recently.

(5) Is there a reason why § 192.321 of the Arkansas Gas Pipeline Code does not mirror § 192.321 of the federal regulations? **RESPONSE:** In several locations, Arkansas code is more restrictive than Federal code. This is one of those instances. The federal changes were integrated into the state version in a way that made sense. The order and language of the federal provisions will not match the order and language of the state provisions in this instance.

FOLLOW UP QUESTION: Is the Commission satisfied that the more restrictive provisions "are consistent with federal law and with rules and regulations promulgated under authority of the Natural Gas Pipeline

Safety Act. . . " pursuant to the provisions of Ark. Code Ann. § 23-15-205(d)? **RESPONSE:** Yes.

(6) Section 192.481(a)(3) of the Arkansas Gas Pipeline Code appears to track § 192.481(a)(3) of the federal regulations. Is there a reason that the interval for Offshore monitoring in Arkansas is not to exceed 39 months when the federal regulations impose an interval not to exceed 15 months? **RESPONSE:** That is an oversight. It should be corrected to read "15 months."

The proposed effective date is pending legislative review and approval.

FINANCIAL IMPACT: The Commission indicates that the amended rules have no financial impact, stating: "No additional legal cost due to State rules because Federal law and rules already required these changes. The industry is also regulated by Federal law and Rules."

LEGAL AUTHORIZATION: Pursuant to Arkansas Code Annotated § 23-15-205(a), the Arkansas Public Service Commission by order may promulgate, amend, enforce, waive, and repeal minimum safety standards for the transportation of gas and pipeline facilities. These standards may apply to the design, installation, inspection, testing, construction, extension, operation, replacement, and maintenance of pipeline facilities and shall be practicable and designed to meet the needs for pipeline safety. *See* Ark. Code Ann. § 23-15-205(b). Safety regulations promulgated for gas pipeline facilities or the transportation of gas shall be consistent with federal law and with rules and regulations promulgated under authority of the Natural Gas Pipeline Safety Act of 1968, Pub. L. No. 90-481, as amended. *See* Ark. Code Ann. § 23-15-205(d).

Per the agency, these rules are required to comply with the federal Natural Gas Pipeline Safety Act of 1968, Pub. L. No. 90-481, as amended, 49 CFR 191, 49 CFR 192, and 49 CFR 199.

2. DEPARTMENT OF AGRICULTURE, ARKANSAS NATURAL RESOURCES COMMISSION (Chris Colclasure, Tate Wentz, Wade Hodge)

a. SUBJECT: Title 10: Water Resource Agricultural Cost-Share Program Rules

DESCRIPTION: The Department of Agriculture's Arkansas Natural Resources Commission ("Commission") proposes changes to its Rules Governing the Arkansas Water Resource Agricultural Cost-Share Program (Title 10).

The Cost-Share Program was established in 1994 and is regulated under the Commission's Title 10 rules. The Cost-Share Program is funded by the United States Environmental Protection Agency Section 319(h) Nonpoint Source Pollution Grant. Arkansas is typically awarded $3.3 million annually to administer the Arkansas Nonpoint Source Pollution Program.

The Department's Natural Resources Division (NRD) does not set aside any 319(h) funds directly for the Cost-Share Program but administers the program by providing grant awards to partners to implement conservation practices, education and outreach, or water quality monitoring. Grant awards are selected through ranking of workplan proposals. The proposals that rank highest are those that work to implement conservation practices in designated nonpoint priority watersheds or watersheds with EPA accepted Nine Element Watershed Plans.

On August 11, 2022, the Commission voted to proceed with adoption of the proposed amendments to Title 10 to increase the incentives available under the Cost-Share Program to increase Program participation.

Key Points
• The Cost-Share Program has suffered from low participation by conservation districts, with only 15% of districts participating in the Program over the last ten years.
• The proposed amendment includes increasing the landowner project cap from $2,500 or $7,500 per three-year cycle to $5,000 annually or $15,000 per three-cycle.
• The proposed amendment also revises the cost-share percentage to align with current federal nonpoint source pollution program requirements of 60% federal funds and 40% non-federal sponsor funds. The current rule requires a 60% non-federal sponsor to implement cost-share projects.

Under Title 10, the Commission delegates the authority for administration of the Cost-Share Program to conservation districts, including identifying eligible landowners, developing farm plans for conservation practices, and ensuring implementation aligns with NRCS national conservation practice standards. Over the last ten years, NRD has only had 11 of 75 (15%) conservation districts participate in funding $1,670,009 worth of conservation practices. The Cost-Share Program has also been used to purchase equipment for Conservation Districts to rent to landowners to help subsidize their local budgets and staffing.

Finally, due to the Bureau of Legislative Research's ongoing Code of Arkansas Rules Project, the proposed amendment also contains many stylistic changes that are non-substantive to bring the rule into compliance with the new style guide for rules.

Following the public comment period, the Commission removed the line striking through the word "department" in Section 1006.1.

PUBLIC COMMENT: A public hearing was held on October 12, 2022. The public comment period expired on November 5, 2022. The Commission indicated that it received no public comments.

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

(1) What was the reason for changing the definition of "Executive Director"? From what source is the new proposed definition taken? **RESPONSE**: Act 910 of 2019, the Transformation and Efficiencies Act, transferred the Arkansas Natural Resources Commission to the Department of Agriculture. The position of "Executive Director" of the Arkansas Natural Resources Commission became "Director". See Ark. Code Ann. § 15-20-205. The Director of the Natural Resources Commission is also the Director of the Department's Natural Resources Division.

(2) Ark. Code. Ann. § 15-22-904(11) authorizes the Arkansas Natural Resources Commission to "provide cost share assistance from the Arkansas Water Development Fund not to exceed forty percent (40%) to persons for the installation of approved water conservation and development practices." Is the proposed rule governed by this provision and, if so, does the proposed rule comply with its limitations? **RESPONSE**: This provision does not apply to the cost-share program rules. The money used as match under this program is all federally funded and does not come from the Water Development Fund.

(3) Section 1006.1 – Should both "Commission" and "department" be crossed out? **RESPONSE**: No—this should say "department." The line across department was an embedded line from when the document was converted from a PDF to a word document. That has been corrected.

FINANCIAL IMPACT: The Commission states that the amended rule has no financial impact. However, with respect to the total estimated cost by fiscal year to any private individual, entity, or business, the Commission states that the proposed rule is currently funded under existing US Environmental Protection Agency Section 319(h) administered by ADA-NRD Nonpoint Source Pollution program. This rule change will reduce cost to private individuals by reducing the participants' cost share percentage from 60% to 40%. Regarding the total estimated cost by fiscal year to state, county, or municipal government to implement this rule, the Commission states that the cost for this cost-share program is shared between the United State Environmental Protection

Agency and the individual landowner. There is no anticipated increased cost to state, county, or municipal government due to this proposed rule change.

LEGAL AUTHORIZATION: For the purpose of carrying out its functions, the Arkansas Natural Resources Commission shall have authority to make and amend and enforce all necessary or desirable rules and orders not inconsistent with law. *See* Ark. Code Ann. § 15-20-206(a).

b. SUBJECT: Rules Governing the Tax Credit Program for the Creation, Restoration, and Conservation of Private Wetland and Riparian Zones

DESCRIPTION: The Department of Agriculture's Arkansas Natural Resources Commission ("Commission") proposes amendments to its Rules Governing the Tax Credit Program for the Creation, Restoration, and Conservation of Private Wetland and Riparian Zones (Title 13). In 1995, the Arkansas Legislature passed Act 561, the Arkansas Private Wetland and Riparian Zone Creation and Restoration Incentive Act ("Act") of 1995, which allows for tax credits for qualifying projects that restore and enhance existing wetlands and riparian zones, create new wetlands and riparian zones, or donate wetland and riparian qualified real property interests. Title 13 governs that Tax Credit Program.

The Private Wetlands and Riparian Zone Creation, Restoration, and Conservation Committee ("Committee") members from Arkansas Game and Fish Commission and Arkansas Parks, Heritage, and Tourism requested an amendment to the Title 13 rules to clarify that, for a project to qualify for a tax credit, the project must include activities that reduce sediment inputs—something that is intended by the Tax Credit Program but not clearly stated in the current version of the rules. On August 11, 2022, the Commission voted to move forward with an amendment to clarify that point.

Key Points:
• The Committee provides recommendations on which projects are eligible to receive tax credits.
• The Committee is comprised of the Arkansas Forestry Division, Arkansas Game and Fish Commission, Arkansas Department of Finance and Administration, Arkansas Parks, Heritage, and Tourism, Arkansas Division of Energy and Environment, and two public members appointed by the Commission.
• In 2021, Committee members from the Arkansas Game and Fish Commission and Arkansas Parks, Heritage, and Tourism began verbally requesting Commission staff amend the rule to clarify that tax credit-eligible projects must include activities that reduce sediment inputs.

• The Commission proposes to amend the Title 13 rule to clarify that requirement.
• The proposed amendment also includes stylistic changes to conform to the new Code of Arkansas Rules project style guidelines.

PUBLIC COMMENT: A public hearing was held on October 12, 2022. The public comment period expired on November 5, 2022. The Commission indicated that it received no public comments.

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

(1) Section 1301.3 I – What is the authority for changing "Arkansas Natural Resources Commission" to "Arkansas Department of Agriculture's Natural Resources Division", particularly in light of Arkansas Code Annotated § 26-51-1503(2)? **RESPONSE**: In Act 910 of 2019, the Transformation and Efficiencies Act, the Arkansas Natural Resources Commission was transferred to the Department of Agriculture. Act 910 made it clear that all administrative functions of the Commission were transferred to the Department. The Director of the Natural Resources Commission also serves as the Director of the Department's Natural Resources Division, which administers the rules of the Commission.

(2) Section 1301.5 B and C – What was the impetus behind changing the fee payee from the Commission to the Department of Agriculture, particularly in light of Ark. Code Ann. § 26-51-1506(c)(1)? **RESPONSE**: As previously noted, under the Transformation Act, all administrative functions of the Commission were transferred to the Department. Although the Commission is authorized by statute to promulgate the rule and set the fee by rule, the Department administers the rule, including collection of the fee.

(3) Section 1303.8 A – What was the impetus behind changing the minimum width desired for a riparian zone, from thirty to fifty feet? **RESPONSE**: The increase from 30 to 50 feet was proposed to increase water quality benefits (i.e. sediment reduction, bank stabilization, and nutrient reduction) by increasing the total riparian corridor buffering capacity, as recommended by the EPA. *See* Mayer, P.M., S.K. Reynolds, M.D. McCutchen, and T.J. Canfield. *Riparian buffer width, vegetative cover, and nitrogen removal effectiveness: A review of current science and regulations. EPA/600/R-05/118*. Cincinnati, OH, U.S. Environmental Protection Agency, 2006 (recommending increased buffer widths to improve water quality benefits).

(4) Did the full Riparian Zone Creation, Restoration, and Conservation Committee have an opportunity to provide comments on the rule changes? **RESPONSE**: Yes, the committee members not only reviewed the final product, but some of the proposed changes actually came from members of the committee.

FINANCIAL IMPACT: The Commission submits that the proposed rules have no financial impact.

Per the Commission, the proposed rule change just adds clarification on what projects are eligible for a tax credit, but the change does not affect the current practice for selection of projects. The Commission states that there is no anticipated cost to private individuals, entities, or businesses. It further states that there is no anticipated cost to state, county, or municipal government to implement this rule.

LEGAL AUTHORIZATION: Ark. Code Ann. § 26-51-1506(b)(1) charges the Commission with the responsibility of promulgating and administering rules related to the creation, restoration, and conservation of wetlands and riparian zones with the intent of qualifying for the tax credits provided for in the Arkansas Private Wetland and Riparian Zone Creation, Restoration, and Conservation Tax Credits Act, codified at Ark. Code Ann. § 26-51-1501 et seq. Prior to adoption of any rules under this Act, the Arkansas Natural Resources Commission shall obtain comments on the proposed rules from the Private Wetland and Riparian Zone Creation, Restoration, and Conservation Committee. *See* Ark. Code Ann. § 26-51-1506(b)(2). The Commission is also authorized to charge a reasonable application fee for the processing of tax credit applications. *See* Ark. Code Ann. § 26-51-1506(c)(1).

3. DEPARTMENT OF FINANCE AND ADMINISTRATION, MEDICAL MARIJUANA COMMISSION (Doralee Chandler)

a. SUBJECT: Rules Governing the Licensure of Medical Marijuana Cultivation Facilities, Processors, and Dispensaries (Section VII-Section IX)

DESCRIPTION: The Department of Finance and Administration's Medical Marijuana Commission proposes its Rules Governing the Licensure of Medical Marijuana Cultivation Facilities, Processors, and Dispensaries (Section VII-Section IX). Amendment 98 of the Arkansas Constitution provides authority for the Arkansas Medical Marijuana Commission to promulgate rules pursuant to §§ 8 and 24. The Medical Marijuana Commission must follow the procedural requirements of the Arkansas Administration Procedure Act and those applicable requirements

are set out in these proposed Rules Governing the Licensure of Medical Marijuana Cultivation Facilities, Processors, and Dispensaries. These changes provide guidance to the public as to rulemaking procedures, declaratory orders, and adjudication hearings.

After the public comment period, only renumbering changes were made.

PUBLIC COMMENT: A public hearing was held on this rule on October 6, 2022. The public comment period expired on October 6, 2022. The agency received no 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: The Medical Marijuana Commission has authority to license medical marijuana cultivation facilities, processors, and dispensaries. Ark. Const. amend. 98, §§ 8(a)(1), 24(a)(1). The Commission may promulgate rules relating to its licensure responsibilities. Ark. Const. amend. 98, §§ 8(d), 24(h).

The Administrative Procedure Act requires all agencies to "adopt rules of practice setting forth the nature and requirements of all formal and informal procedures available," in addition to other rulemaking requirements. Ark. Code Ann. § 25-15-203(a)(2). Agencies "created after August 13, 2001, shall adopt," when practicable, model rules of procedure published by the Arkansas Attorney General. *See* Ark. Code Ann. § 25-15-215. These rules include model rule language from the Attorney General.

4. DEPARTMENT OF HEALTH, ARKANSAS STATE BOARD OF PHARMACY (John Kirtley, Matt Gilmore)

a. SUBJECT: Rule 7 – Drug Products/Prescriptions

DESCRIPTION: The Arkansas State Board of Pharmacy seeks review and approval of changes to its Rule 7 concerning drug products and prescriptions. Proposed changes will update language to allow pharmacists in a Class A pharmacy or FDA-registered and Arkansas-permitted 503b outsourcing facility to compound office use products for veterinarians as allowed under new FDA Guidance.

PUBLIC COMMENT: A public hearing was held on October 19, 2022. The public comment period expired on October 19, 2022. The agency

provided the following summary of comments it received and its responses thereto:

Arkansas Veterinary Medical Association: Dr. Paul Jenkins, DVM, Regulatory Chair of AVMA, Vilonia Arkansas – in addition to the letter of support supplied prior to the public hearing, Dr. Jenkins answered a couple of questions from the Board regarding if he thought that a 7 day supply of medications would be sufficient for their needs at this time to dispense to patients which he verified would be appropriate for their needs and was preferred rather than the 5 day supply that had been discussed previously. Dr. Jenkins thanked the Board for working with AVMA on this proposed rule change and was fully supportive of the language presented. Rodney Baker, AVMA added comments in addition to Dr. Jenkins thanking the Board for working with AVMA on this issue.
Agency Response: The Board accepted the AVMA letter and thanked Dr. Jenkins and Mr. Baker for working with our agency in this process.

Wedgewood Pharmacy, Swedesboro, New Jersey: Michael Blaire, RPh, Vice-President – Government and Regulatory Affairs, Wedgewood Pharmacy, Swedesboro, New Jersey – submitted a letter with his comments prior to speaking with the Board. Mr. Blaire gave verbal comments mostly in favor of the proposed rule with exception that their preference would be to not add language regarding the FDA Regulations or Guidance to be added into the Statutes for Arkansas. In his comments Mr. Blaire stated that his company does not think that the FDA has any authority over veterinary compounding but is working with FDA on some aspects of this issue.
Agency Response: The Board accepted Wedgewood's letter and Mr. Blaire's comments and pointed out that this is a rule promulgation and would not add any language to Arkansas Statutes. The Board had a substantial discussion regarding the pros and cons and potential implications of whether to include the language regarding FDA Regulations and Guidance in the rule as it had been approved for filing and public comment. Board staff would also point out that if this requested language was removed, the resultant rule would allow for compounding that would be federally illegal as it would not recognize federal restrictions on the compounding for food producing animals or the use of banned products and ingredients which could adversely impact Arkansas industry and businesses. The Board did not vote to make any changes in regard to these comments.

The proposed effective date is December 31, 2022.

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

LEGAL AUTHORIZATION: The Arkansas State Board of Pharmacy has authority to make reasonable rules, not inconsistent with law, to carry out the purposes and intentions of Title 17, Chapter 92 of the Arkansas Code (concerning pharmacists and pharmacies) and the pharmacy laws of this state that the board deems necessary to preserve and protect the public health. *See* Ark. Code Ann. § 17-92-205(a)(1).

5. DEPARTMENT OF HEALTH, STATE BOARD OF EXAMINERS OF ALCOHOLISM AND DRUG ABUSE COUNSELORS (Matt Gilmore, Pam Fite, Carol Moore)

a. SUBJECT: Rules Governing Alcoholism and Drug Abuse Counselors

DESCRIPTION: The State Board of Examiners of Alcoholism and Drug Abuse Counselors seeks review and approval of amendments to its rules concerning continuing education requirements for licensed alcohol and drug abuse counselors. The proposed amendments:

- Change the continuing education requirement from 40 continuing education hours per licensure cycle to 30 continuing education hours per licensure cycle;
- Amend the present continuing education credits earned to include attending workshops, presenting at workshops, publishing a journal article or book, and/or serving in a relevant professional leadership role; and
- Add continuing education hours earned for each hour of college coursework.

PUBLIC COMMENT: A public hearing was not held in this matter. The public comment period expired on October 20, 2022. The agency indicated that it received no comments.

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

Q. The rules provide that "fifteen (15) of the clock hours must support the intent of the license." What does this mean? **RESPONSE:** It means that 15 of those hours have to be about substance use disorder. We are a Drug & Alcohol Board and have many licensed mental health counselors. The Board wants to make sure that they also have experience in drug/alcohol training.

The proposed effective date is pending legislative review and approval.

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

LEGAL AUTHORIZATION: The State Board of Examiners of Alcoholism and Drug Abuse Counselors shall administer and enforce the provisions of Title 17, Chapter 27, Subchapter 4 concerning licensing alcoholism and drug abuse counselors, and shall adopt rules consistent with its provisions, including a code of ethical practice. *See* Ark. Code Ann. 17-27-406(a). The board, at its discretion, may require continuing education as a condition of license or certificate renewal. *See* Ark. Code Ann. 17-27-413(c).

6. DEPARTMENT OF HUMAN SERVICES, DIVISION OF AGING, ADULT, AND BEHAVIORAL HEALTH SERVICES (Jay Hill, John Finkbeiner)

~~**a. SUBJECT: Amendment to ARChoices to Allow Inpatient Attendant Care**~~

b. SUBJECT: Procedures for Name Removal from Arkansas Adult Maltreatment Registry

DESCRIPTION:

Statement of Necessity

DHS currently has a rule in place to process name removal from the Child Maltreatment Registry. DHS does not have a corresponding rule in place to process name removal from the Adult Maltreatment Registry. This rule equalizes the process between the two registries.

Rule Summary

Arkansas Adult Protective Services is establishing a process for adult maltreatment offenders to request consideration to have their name removed from the Arkansas Adult Maltreatment Registry under certain circumstances.

PUBLIC COMMENT: No public hearing was held on this rule. The public comment period expired on November 11, 2022. The agency provided the following summary of the public comments it received and its responses to those comments:

Commenter's Name: Catherine Burks RN, Compliance Officer, Absolute Care Management Corporation

COMMENT: My question is whether there will possibly be a proposal related to names on the Child Maltreatment Registry as well. We have had

numerous employees come up on the child maltreatment report. By and large, I would say almost 100% of these have been able to get their name removed once they were able to get a hearing scheduled. However, the turnaround time for someone to get their appeal request in the system and get a hearing scheduled is far too long, often two or three months out. This is hindering these individuals from being able to work and provide much needed services for Arkansans. I want to add the fact that a lot of these findings are 10+ years old and once they get a hearing there are not even any records on file of the original complaint that was called in.
RESPONSE: Thank you for your response. The child maltreatment registry is managed by the Division of Children and Family Services. Your comment has been relayed to the DCFS division director.

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

1. *Consideration for Removal by Review Team.* What are the qualifications (education, experience, e.g.) for those who will be considered for the Adult Maltreatment Registry Review Team? **RESPONSE:** The review team will be comprised of APS supervisory staff or APS team members with at least five (5) years of experience. Additionally, a DHS attorney from the Office of Chief Counsel will be included to provide counsel.

2. *Name Request Removal.* We propose adding the underlined language and part C below.

> An offender may request his or her name be removed from the Adult Maltreatment Registry when:
> A. The individual has not had a subsequent true report for one (1) year; and,
> B. More than (1) year has passed since the offender's name was placed on the Adult Maltreatment Registry; and
> C. More than (1) year has passed from the completion of any court-imposed sentence.

RESPONSE: Thank you for your response. We agree to your recommendation regarding part (c) and have updated the rule accordingly.

3. We propose adding the underlined language below.

> However, the offender may not request removal from the Adult Maltreatment Registry if any of the following apply:
> A. The offender was placed into the Adult Maltreatment Registry for any type of maltreatment that resulted in a fatality as a direct result of the offender's act or omission;
> B. The offender is still involved in an open criminal court case based on the same underlying facts for which he or she was placed

onto the Adult Maltreatment Registry; or has not completed the terms and conditions of any sentence arising from a conviction based on the same underlying facts for which he or she was placed onto the Adult Maltreatment Registry.

RESPONSE: Thank you for your response. We agree to your recommendation to add the additional language and have updated the rule accordingly.

4. We propose adding the underlined language below.

C. The offender was placed onto the Adult Maltreatment Registry for any of the maltreatment types or type involving any of the injury characteristics or details listed below:

We propose adding the following maltreatment types to the list:

a. Sexual Violence

b. Restraint of the liberty of another involving threats or violence

c. Human trafficking

RESPONSE: Thank you for your response. We agree to your recommendation to add the offenses listed and have updated the rule accordingly.

5. *Application Format for an Offender*. As to A.2., we propose adding the underlined language: Arkansas Adult Maltreatment Registry results free from a true finding of the same maltreatment type for the preceding year, or for one year following the completion of any court-ordered sentence, if applicable. **RESPONSE:** Thank you for your response. We agree to your recommendation to add the additional language and have updated the rule accordingly.

6. As to A.3., we propose adding the underlined language: Adult Maltreatment Registry results from the offender's current state of residence and any state in which the offender has resided in the preceding year free from a true finding of the same maltreatment type for the preceding year, or for one year following the completion of any court-ordered sentence, if applicable. **RESPONSE:** Thank you for your response. We agree to your recommendation to add the additional language and have updated the rule accordingly.

7. As to A.4., we propose deleting the stricken language and adding the underlined language: Arkansas Crime Information Center (ACIC) background check and an adult maltreatment related check that is free from disqualifying offenses for ~~the preceding one (1) year;~~ one (1) year prior to the date of the application. **RESPONSE:** Thank you for your

response. We agree to your recommendation to add the additional language and have updated the rule accordingly.

8. As to A.5., we propose deleting the stricken language and adding the underlined language State background check results from the offender's current state of residence and any state in which the offender has resided in the preceding year free from adult maltreatment-related offenses for ~~the preceding one (1) year;~~ one (1) year prior to the date of the application. **RESPONSE:** Thank you for your response. We agree to your recommendation to add the additional language and have updated the rule accordingly.

9. *Notice.* In addition to the above, we propose that notice of the petition for removal be given to the Medicaid Fraud Control Unit (the Unit) of the Arkansas Attorney General's Office if the underlying conduct resulted in a criminal prosecution and if one of its attorneys represented the State of Arkansas in the proceeding, and that the Unit's prosecutor be given the opportunity to provide a response/recommendation. **RESPONSE:** Thank you for your response. We agree to notify the Medicaid Fraud Control Unit (the Unit) of the Arkansas Attorney General's Office if the underlying conduct resulted in a criminal prosecution and if one of its attorneys represented the State of Arkansas in the proceeding. The Unit's prosecutor may also provide a response to the petition. We have updated the rule accordingly.

10. *Determination of Name Removal Request by an Offender.* We propose adding the underlined language:

> The Adult Maltreatment Registry Review Team will consider requests for removal of names from the Registry. In determining whether to remove an offender from the Adult Maltreatment Registry the Review Team shall consider any relevant evidence, which may include without limitation the following:
>
> The list should include input from any victim, or surviving family member of a victim, of the underlying facts for which the offender/petitioner was placed onto the Adult Maltreatment Registry.

RESPONSE: Thank you for your response. We agree to your recommendation to add the additional language and have updated the rule accordingly.

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

Q. Where does the list of excluded injury characteristics on page 2 of the proposed rule come from? **A.** We obtained this list from the name removal policy for the child maltreatment registry that is already in place and wished to be as consistent as possible between the two registries.

The proposed effective date is January 1, 2023.

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

Per the agency, the total estimated cost to implement this rule is $0 for the current fiscal year and $580 for the next fiscal year. The agency indicated that this number represents increased mailing costs.

LEGAL AUTHORIZATION: The Adult and Long-Term Care Facility Resident Maltreatment Act establishes a statewide Adult and Long-Term Care Facility Resident Maltreatment Central Registry within the Department of Human Services. Ark. Code Ann. § 12-12-1716(a)(1). The Department may promulgate rules to implement the Act. Ark. Code Ann. § 12-12-1723.

7. DEPARTMENT OF HUMAN SERVICES, DIVISION OF COUNTY OPERATIONS (Mary Franklin, items a-e; Larry Crutchfield, items a-d; Rosaura Page, items a-d; Phil Harris, item c; Tammy Hull-Richardson, item c; Derwin Taylor, item c; Elizabeth Pitman, item e)

a. SUBJECT: SNAP and Medicaid – Office of Child Support Enforcement Related Changes

DESCRIPTION:

Statement of Necessity

Medical Services Policy and the Supplemental Nutrition Assistance Program (SNAP) Manual are being updated to streamline the process for providing accurate information to the Office of Child Support Enforcement (OCSE) regarding the absent parent(s) for a Medicaid or SNAP applicant or recipient.

For Medicaid, the rule needs to be updated to reflect the change that, if an absent parent is determined to exist and a valid good cause reason is not verified or the caretaker relative voluntarily requests a referral to be made, they are to be referred to OCSE for child support services during initial approval. If the applicant or recipient refuses to comply during any case

action, a non-compliance sanction can be applied by the DHS Eligibility Worker.

For SNAP, any parent (custodial, teen, or non-custodial) who states a refusal to cooperate with the OCSE requirement will not be eligible to participate in SNAP. Custodial and non-custodial parents will be disqualified from receiving SNAP benefits if they fail to cooperate with OCSE.

Technical language and grammar are corrected throughout all sections.

Rule Summary

Medical Services Policy F-130 – Clarifies that OCSE referrals will be made at initial approval for Medicaid. States that if a parent or another legally responsible person states that they refuse to cooperate with OCSE during any case action, the DHS Eligibility worker may apply the sanction.

Medical Services Policy G-111 – Notes that if a parent fails to provide absent parent information for their children, they will not be eligible for Medicaid coverage. Also removes absent parent information from eligibility factors that must require verification.

SNAP 1623.3 – Adds the clarification that any parent may be disqualified from receiving SNAP benefits if they fail to cooperate with OCSE.

SNAP 1623.3.1 – removes the word "guardian."

SNAP 1623.3.3 – States that, if a parent declares a refusal to cooperate with OCSE at application, the parent is ineligible to participate in SNAP.

SNAP 1623.3.4 – Clarifies that parents must cooperate with OCSE rather than the agency and adds rules for disqualifying the parent for non-cooperation.

PUBLIC COMMENT: No public hearing was held on this rule. The public comment period expired on October 24, 2022. The agency indicated that it received no public comments.

The proposed effective date is March 27, 2023.

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

Per the agency, this rule will result in a cost reduction of $50,712 for the current fiscal year ($14,392 in general revenue and $36,320 in federal funds) and $202,849 for the next fiscal year ($57,569 in general revenue and $145,280 in federal funds). The total estimated reduction in cost to state, county, and local government as a result of this rule is $14,392 for the current fiscal year and $57,569 for the next fiscal year.

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: SUPPORT Act Changes for Former Foster Care Youth

DESCRIPTION:

Statement of Necessity

With the new federal requirements from the Children's Bureau, Former Foster Care coverage should be available to individuals that age out of foster care in one state and move to another. This only applies to youth who reach eighteen (18) years of age on or after January 01, 2023 (and meet all other eligibility requirements). The Medical Services Policy is being updated to reflect these changes.

Rule Summary

The following are changes to Policy B-260:
1. Updated MS Manual date to 01/01/23; and
2. Added note: If an individual has aged out of foster care in one state, and they move to another state, they are eligible for Former Foster Coverage if all other general Health Care eligibility requirements are met. This applies only to youth who reach eighteen (18) years of age on or after January 01, 2023.

PUBLIC COMMENT: No public hearing was held on this rule. The public comment period expired on October 31, 2022. The agency indicated that it received no public comments.

The proposed effective date is January 1, 2023.

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

Per the agency, this rule implements a federal rule or regulation. The total estimated cost to implement the federal rule or regulation is $39,195 for the current fiscal year ($11,124 in general revenue and $28,072 in federal funds) and $78,390 for the next fiscal year ($22,247 in general revenue and $56,143 in federal funds). The total estimated cost by fiscal year to state, county, and municipal government as a result of this rule is $11,124 for the current fiscal year and $22,247 for the next fiscal year.

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

This rule implements the federal SUPPORT Act, which requires states to make medical assistance available to certain individuals under age 26 who "were in foster care under the responsibility of a State on the date of attaining 18 years of age or such higher age as the State has elected[.]" 42 U.S.C. § 1396a(a)(10)(A)(i)(IX).

c. SUBJECT: TEA Income Limit Increase

DESCRIPTION:

Statement of Necessity

The Department of Human Services and the Department of Commerce's Division of Workforce Services, which jointly administer the TEA program, submit a proposal to support Arkansas's maternal health initiative. DHS raises the net income limit standard from $223.00 to $513.00 monthly. The TEA Policy Manual has also been updated with the new eligibility system's language and procedures.

Rule Summary

- TEA 2101 – Updated the income eligibility limit from $223 to $513.
- TEA 2351 – Updated language, minimum wage information, and income eligibility limit.

- TEA 2353 – Updated language, minimum wage information, and income eligibility limit.
- TEA 2362 – Added numbers, updated income limit, and updated language.
- TEA 4120.1 – Updated income and examples.
- TEA 4120.2 – Updated income and examples.
- TEA 9041.1 – Updated income.
- Glossary – Updated income (G).

PUBLIC COMMENT: No public hearing was held on this rule. The public comment period expired on November 7, 2022. The agency indicated that it received no public comments.

The proposed effective date is January 1, 2023.

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

Per the agency, the total estimated cost to implement this rule is $8,026,871 for the current fiscal year ($909,974 in general revenue and $7,116,896 in federal funds) and $16,053,742 for the next fiscal year ($1,819,949 in general revenue and $14,233,793 in federal funds). The total estimated cost by fiscal year to state, county, and municipal government to implement this rule is $909,974 for the current fiscal year and $1,819,949 for the next fiscal year.

The agency indicated that there is a new or increased cost or obligation of at least $100,000 per year to a private individual, private entity, private business, state government, county government, municipal government, or to two or more of those entities combined. Accordingly, the agency provided the following written findings:

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

The Department of Human Services and the Department of Commerce's Division of Workforce Services who jointly administer the TEA program submitted a proposal to support Arkansas's maternal health initiative. DHS is raising the income limit that has been approved to raise the net income standards from $223.00 to $513.00 monthly. Policy manual has also been updated in accordance with the new eligibility system's language and procedures.

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

The Department of Human Services and the Department of Commerce's Division of Workforce Services who jointly administer the TEA program submitted a proposal to support Arkansas's maternal health initiative. DHS is raising the income limit that has been approved to raise the net income standards from $223.00 to $513.00 monthly. Policy manual has also been updated in accordance with the new eligibility system's language and procedures.

(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;

The Department of Human Services and the Department of Commerce's Division of Workforce Services who jointly administer the TEA program submitted a proposal to support Arkansas's maternal health initiative. DHS is raising the income limit that has been approved to raise the net income standards from $223.00 to $513.00 monthly. Policy manual has also been updated in accordance with the new eligibility system's language and procedures.

(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;

N/A

(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, including, along with the Division of Workforce Services, the Transitional Employment Assistance Program. *See* Ark. Code Ann. §§ 20-76-201(1), 20-77-401(a)(2)(A). 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: Adding Unborn Child to Pregnant Woman Need Standard

DESCRIPTION:

Statement of Necessity

When the rule was converted to a new format, the clarification regarding the unborn child being counted in the need standard for the pregnant woman was not included in the text of the rule. It is necessary that this clarification be added to the current rule. In addition, universal changes should be updated for conciseness throughout the rule.

Rule Summary

The following are changes to Section O of the Medical Services Policy Manual:

1. Global Change – changing "Medicaid" to "Health Care" in sections -422, -430, and -451;

2. O-422 Deprivation Due to Unemployment of the Principal Wage Earner:
    a. Corrected grammar and formatting;
    b. Removal of "pin" graphic at Note;

3. O-430 Medically Needy Pregnant Women Categories:
    a. Added clarification that the unborn child is counted in the need standard for the pregnant woman;

b. Corrected grammar and formatting;

4. O-451 Medically Needy – Foster Care: corrected grammar and formatting.

PUBLIC COMMENT: No public hearing was held on this rule. The public comment period expired on November 12, 2022. The agency indicated that it received no public comments.

The proposed effective date is January 1, 2023.

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).

e. SUBJECT: Expansion of Pregnant Women Medicaid

DESCRIPTION:

Statement of Necessity

To support Arkansas's maternal health initiative, DHS is raising the income limit of the Pregnant Women full coverage category to 209% of the federal poverty level and eliminating the limited benefit Pregnant Women category. To implement these changes, it is necessary to update the Medical Services Policy and various sections of the Medicaid Provider Manual.

Rule Summary

Removes "Pregnant Women Limited" from the Beneficiary Aid Category List. Updates CMS Medicaid Eligibility S28 in the State Plan concerning mandatory coverage for pregnant women.

Medical Services Policy

- A-217 Retroactive Eligibility- Pregnant Woman
  - Remove information regarding Limited Pregnant Woman

- Delete pin from "NOTE" to be consistent with policy formatting
- Update formatting to reflect the numeric word preceding the number to be consistent with policy formatting
- Change format from "i.e.," to "for example"

- C-205 Pregnant Woman (PW) Period of Eligibility
  - Remove information regarding Limited Pregnant Woman
  - Update formatting to reflect the numeric word preceding the number to be consistent with policy formatting
- E-110 Income and Resource Limits for MAGI and Non-MAGI Groups
  - Remove Limited Pregnant Woman information
  - Update the income limit of Full Pregnant Woman
- F-130 Child Support Enforcement Services
  - Remove information regarding Limited Pregnant Woman
  - Correct a grammatical error of making the word medical lower case
  - Update Appendix F of the Medical Services Policy Manual with current federal Poverty Levels
  - Changes to ensure consistent terminology and updated effective dates are made throughout

Medicaid Provider Manuals

- Section I of the Provider Manual
  - Section 124.130
    - Outline the services eligible for Women in Aid Category 61 (PW)
    - Clarify that Aid Category 61 PW Unborn Child does not include family planning benefits
- Section II of the Nurse Practitioner Provider Manual:
  - Section 214.321
    - Clarify that Aid Category 61 PW Unborn Child does not include family planning benefits
    - Change "beneficiaries" to "clients," as well as grammar changes in Sections 203.500, 214.321, and 214.600
- Section II of the Physicians Provider Manual:
  - Section 247.100
    - Outline the services Women in Aid Category 61 (PW) are eligible
    - Clarify that Aid Category 61 PW Unborn Child does not include family planning benefits
    - Change "beneficiaries" to "clients," as well as grammar changes in Sections 203.140, 243.200, and 247.100
- Section II of the ARKids First B Provider Manual:
  - Change "beneficiaries" to "clients", as well as grammar changes in Section 200.110
- Section II of the Hospital/Critical Access Hospital/ESRD Provider Manual:

    - Change “beneficiaries” to “clients,” as well as grammar changes in Section 216.100
    - Removes Pregnant Woman Poverty Level and information regarding additional aid categories in Section 216.100
    - Removes limitation of Medicaid-covered family planning services to Pregnant Woman Poverty Level and adds Pregnant Women in Section 216.510
- Section II of the Certified Nurse Midwife Manual:
    - Section 215.260
        - Outline the services Women in Aid Category 61 (PW) are eligible
        - Clarify that Aid Category 61 PW Unborn Child does not include family planning benefits
        - Removes requirement that the beneficiary is responsible for payment of services not covered under the PW categories
        - Update information for verifying client’s eligibility by removing internal system processes and removing some coverage restrictions for temporary Aid Category 62, Pregnant Woman – Presumptive Eligibility (PW-PE)
    - Change “beneficiaries” to “clients,” as well as grammar changes in Sections 215.220 and 215.260

PUBLIC COMMENT: No public hearing was held on this rule. The public comment period expired on November 12, 2022. The agency indicated that it received no public comments.

The proposed effective date is January 1, 2023.

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

Per the agency, the total estimated cost to implement this rule is $615,853 for the current fiscal year ($174,779 in general revenue and $441,074 in federal funds) and $1,231,707 for the next fiscal year ($349,558 in general revenue and $882,148 in federal funds). The total estimated cost by fiscal year to state, county, and municipal government to implement this rule is $174,779 for the current fiscal year and $349,558 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;

To support Arkansas's maternal health initiative, DHS is raising the income limit of the Pregnant Women full coverage category to 209% of the federal poverty level and eliminating the limited benefit Pregnant Women category. To implement these changes, it is necessary to update the Medical Services Policy.

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

To support Arkansas's maternal health initiative, DHS is raising the income limit of the Pregnant Women full coverage category to 209% of the federal poverty level and eliminating the limited benefit Pregnant Women category. To implement these changes, it is necessary to update the Medical Services Policy.

(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;

To support Arkansas's maternal health initiative, DHS is raising the income limit of the Pregnant Women full coverage category to 209% of the federal poverty level and eliminating the limited benefit Pregnant Women category. To implement these changes, it is necessary to update the Medical Services Policy.

(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;

N/A

(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, DIVISION OF MEDICAL SERVICES (Elizabeth Pitman, items a-e, g-l; Paula Stone, Melissa Weatherton, Patricia Gann, items a, k; Cynthia Neuhofel, items b, e, i; Jay Hill, John Finkbeiner, item f)

a. SUBJECT: Arkansas Independent Assessment (ARIA) Manual, 1915(i)

DESCRIPTION:

Statement of Necessity

The Department of Human Services (DHS) recently sought approval from the Centers of Medicare and Medicaid Services (CMS)for its Home and Community Based Services (HCBS) 1915(c) Community and Employment Supports (CES) waiver and the Provider-Led Arkansas Shared Savings Entity (PASSE) 1915(b) waiver. Both were approved Spring 2022 and are in final stages of promulgation.

DHS now submits a State Plan Amendment to its 1915(i) plan related to the PASSE and the Adult Behavioral Health Services for Community Independence (ABSCI) program and revises the Arkansas Independent Assessment provider manual. The updates make the 1915(i) and manual

consistent with the waiver renewals, while also incorporating the following:

- The Division of Medical Services (DMS) is restructuring its client appeal process to allow services to continue during the time between an adverse decision and an appeal or fair hearing being resolved. This rule helps ensure client services are not disrupted prior to due process being exhausted. The Notice of Action fully explains the client may be liable for cost of continued services should he or she lose their appeal and gives the client right of refusal for the services.
- DMS now will allow the independent reassessment to be conducted in person or through the use of interactive video that is recorded with the permission of the client or telephonically that is recorded with the permission of the client and the approval of the respective DHS program staff, for behavioral health and developmental disabilities PASSE tiering, to help address access issues and help deter disruption of services.
- DMS is revising the Level 1 and Level II Therapeutic Community (a 1915(i) service) rates to account for differences between costs and current rate per recommendation during recent analysis of the services provided.
- Additionally, DMS is adding Assertive Community Treatment (ACT) as a service bundle available to clients who receive services through the 1915(i) state plans.

Rule Summary

ARIA Manual Amendments

- Adds Early Intervention Day Treatment (EIDT) services to the ARIA system overview (section 201.000)
- Adds the statement that "for clients seeking services under ARChoices and Living Choices waivers and the PACE program who are not eligible at the time of application, the independent assessment is used, along with financial eligibility, as part of the determination for Medicaid eligibility." (section 201.000)
- Allows reassessments to be conducted in person or through the use of interactive video that is recorded with the permission of the client or telephonically that is recorded with the permission of the client and the approval of the respective DHS program staff
- Deletes description of EIDT in Developmental Screen Overview (201.100)
- Adds Division of Aging, Adult, and Behavioral Health Services to referral process (210.100) for behavioral health assessments
- Revises tiering definitions and logic (210.300 and 220.300)
- Makes grammatical changes to Independent Assessment Referral Process (220.100) and Possible Outcomes (220.400)

- Adds new sections to reflect the above changes (220.500, 220.510, 230.000, 230.400, 250.000, 260.000, and 270.000)
- Adds program qualification requirements including referral process, assessor qualifications, and tiering definitions
- Adds new sections reflective of the updates to the SPA amendments, and the recently approved CES and PASSE Waiver renewals

1915(i) State Plan Amendments

- Corrects and changes service name from Supported to Supportive for Supportive Employment
- Formally identifies Division of Aging, Adult, and Behavioral Health Services (DAABHS) as the Operating Agency and corrects who carries out HCBS Operational and Administrative Functions
- Allows reassessments to be conducted in person or through the use of interactive video that is recorded with the permission of the client or telephonically that is recorded with the permission of the client and the approval of the respective DHS program staff
- Updates projected number of unduplicated participants for the new Year 1 of the plan to reflect enrollment of the ARHOME medically frail population into the PASSE
- Identifies who is responsible for performing client evaluations and reevaluations
- Clarifies the process for performing client evaluation/reevaluation
- Makes grammatical changes to numbers 5, 6, 7 of Evaluation/Reevaluation of Eligibility section
- Makes technical changes to Home and Community-Based Settings section and adds DAABHS to number 8 explanation
- Clarifies the names and definitions of Supportive Employment, Adult Rehabilitation Day Treatment, Peer Support, Therapeutic Communities, Aftercare Recovery Support, Partial Hospitalization, Supportive Housing, under Services Section and changes division responsible for verification of provider qualifications for some services
- Adds Community Support System Provider (CSSP) as providers of all 1915(i) services
- Deletes the reference to typical number of days for detox services
- Makes technical changes to clarify Quality Improvement Strategy Section to include changing the Requirements table, adding External Quality Review Organization (EQRO) and DAABHS, and adding the sample size specificity; changing frequency of monitoring to quarterly, and ensuring all monitoring activities are consistent in both the ABSCI and PASSE 1915(i)

- Adds criteria for when Person-Centered Service Plans should be updated to number 8 of Person-Centered Planning and Service Delivery and number 1 in the Quality Improvement Strategy
- Revises the name of the Master Treatment Plan to PCSP/Treatment Plan throughout the document
- Adds Assertive Community Treatment (ACT) and Crisis Stabilization Intervention as services
- Removes Mobile Crisis Intervention as a service

State Plan Pages 4.19 B 19 and 20

- Adds Therapeutic Communities information to the Methods and Standards for Establishing Payment Rates

The following changes were made after the public comment period closed:

Global Changes

- Updated effective dates
- Changed "Supportive Employment" back to "Supported Employment" as it currently appears in the State Plan

Attachment 3.1-i PASSE Section

- Edits for typographical errors and consistency
- Updated process for performing evaluation/reevaluation
- Updated Needs-based HCBS Eligibility Criteria (SPA 3.1-i, page 7)
- Added the following language to SPA 3.1-i, page 13: "The State Medicaid Agency (SMA) approves the processes and templates related to PCSPs and conducts a retrospective review of a sample of PCSPs annually."
- Updated the following service descriptions
    - Adult Rehabilitation Day Treatment
    - Therapeutic Communities
    - Aftercare Recovery Support
- Added the underlined language to "Policies Concerning Payment for State Plan CHBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians":

    All relatives who are paid to provide the services must meet the minimum qualifications set forth ~~in this Waiver~~ <u>in the state's certification policy which include a minimum of a high school diploma, background checks and training specific to the population and service provided</u> and may not be involved in the development of the Person Centered Service Plan (PCSP).
- Updated language in Discovery Evidence sections under Requirements 2, 4, 5, 6, and 7

Attachment 3.1-i ABSCI section

- Edits for clarity and consistency
- Updated Process for Performing Evaluation/Reevaluation to indicate that clients who meet eligibility criteria are referred for independent assessment
- Added explanation of evaluation tool to Needs-based HCBS Eligibility Criteria section
- Updated Crisis Stabilization Intervention service definition
- Added categorically needy limits to Assertive Community Treatment
- Updated language in Discovery Evidence sections under Requirements 1, 2, 4, 5, 6, and 7

PUBLIC COMMENT: A public hearing was held on this rule on August 16, 2022. The public comment period expired on September 3, 2022. The agency provided the following summary of the public comments it received and its responses to those comments:

Commenter's Name: Luke Mattingly

COMMENT: I also have just lately learned of the document being posted. I would like some explanation in the public comment of on page 92 while the projected number of cases is going from 2000 down to 500.
RESPONSE: This number reflects the estimated population of those individuals who qualify for Medicaid under the Spenddown category. Approximately fifteen hundred (1,500) individuals who qualified for Medicaid under the Medically Frail Medicaid category were enrolled in the PASSE program in July and August of 2022.

Commenter's Name: David Ivers, J.D., VP for External Affairs and General Counsel, Easterseals Arkansas

1. We appreciate the efforts DHS is making to improve both ARIA and 1915(i). In particular, 1915(i) holds great potential that is underutilized due in large part to confusion about eligibility, services, and licensure requirements.

ARIA-We support the flexibility added for reassessments. This should help expedite and make it easier to coordinate for the parties to be present. For individuals with both behavioral health and IDD needs, can the assessments be combined? They contain similar questions and are lengthy. To require separate assessments seems an unnecessary burden on individuals and their caregivers.

RESPONSE: Oftentimes, the Department nor the PASSE is aware of a dual diagnosis or complex care need when the member initially enters the

PASSE program. For this reason, we will continue to either assess the member with a BH Independent Assessment or an IDD Independent Assessment based on the member's diagnosis. Once the member is in the PASSE, services are approved based on their functional need and if a dual diagnosis or complex care need is suspected, the member will be assessed with the Complex Care Independent Assessment and can be awarded a Tier 4 designation. The Tier only sets the PASSE's per member per month payment and should not drive any available services.

2. *1915(i) General Comments*: Throughout the proposed rules, "HCBS Provider for Services for Persons with Developmental Disabilities and Behavioral Health Diagnoses" has been removed and "Community Support System Provider" (CSSP) inserted. It is a problem from a practical standpoint for HCBS CES Waiver providers to become CSSP providers if the licensure rules for CSSP and the Waiver are not in alignment. More specifically, if providers have some individuals who should be served under traditional CES Waiver and some in 1915(i) through CSSP, it will make it difficult administratively if the Waiver and CSSP licensure standards are significantly different. At the least, providers should be able to meet heightened CSSP requirements through criteria that are "add-ons" to the basic Waiver standards. We realize these are not the licensure rules, but we did want to point out that ongoing problem. A similar concern is present with regard to the qualifications of staff who can provide Waiver vs. 1915(i) services, as addressed more specifically below. Is there a minimum or standard fee schedule for these services?

RESPONSE: Thank you for this question, but it is a question for another policy packet running in public comment at this time.

3. In 3.1-I, Page 6 for Needs-Based HCBS Eligibility Criteria: It is unclear exactly which individuals are eligible for 1915(i) services as opposed to the CES Waiver. The 1915(i) explanation reads:

> After medical eligibility has been determined through diagnosis, the following needs-based criteria is used:
>
> The member must receive a minimum of a Tier 2 on the independent functional assessment for HCBS behavioral health services. To meet a Tier 2, the member must have difficulties with certain behaviors that require a full array of services to help with functioning in home and community-based settings and moving towards recovery and is not a harm to his or herself or others. Behaviors assessed include manic, psychotic, aggressive, destructive, and other socially unacceptable behaviors. Measurement is completed through an assessment of functional deficits through an evaluation of the member and caregiver report. The assessment measures the member's behavior in psychosocial

sub-domains and intervention domain that evaluates the level of intervention necessary to manage behaviors as well as required supports to maintain the member in home and community settings. 1915(i) services must be appropriate to address the member's identified functional deficits due to their behavioral health diagnosis.

These criteria are heavily laden with behavioral health terminology and do not speak well to the IDD population. Many individuals with IDD have not been formally diagnosed with a BH condition but have challenging behaviors or otherwise complex conditions that make serving them extremely time-consuming and resource-intensive. Can the wording be revised to address this population more accurately?

RESPONSE: All services under the PASSE model are available to a PASSE member regardless of their diagnosis. Home and Community based services under the 1915c and the 1915i are approved based on the member's functional need, not diagnosis. The 1915(i) services must be used to address behavioral needs of individuals.

4. *Page 7, Target Groups* – This part mentions an income cap of 133% FPL for ARHOME Medically Frail. But the description of BH and IDD does not explain the different income cap of 150% FPL. **RESPONSE:** This has to do with how a person is eligible for Medicaid. Members in the PASSE are in multiple Medicaid eligibility categories. The 1915i outlines services about to Medicaid recipients once they attributed to a PASSE regardless of their Medicaid eligibility category.

5. *Page 11, item 6*, *Supporting the Participant in Development of Person-Centered Service Plan*: 60 days is often too long to begin care. Even if every element of the PCSP listed is not completed, there should be a minimum requirement for when care must begin, and oftentimes 60 days is too long. The client may rapidly deteriorate and end up in a hospital, HDC or other institutional setting. Please establish a shorter period for when actual care must begin. **RESPONSE:** This is a maximum date requirement. Members may receive care prior to.

6. *Pages 12-13, Informed Choice of Providers*: We have concerns that the members and their families do not have an accurate picture of the services that will be available to them when selecting a PASSE. At the very least, families should be told each PASSE's standard rates paid to providers for 1:1 care and shared staff, along with restrictions such as benefit limits or exclusions. **RESPONSE:** We disagree that a parent should be told what a provider will be paid for a particular service. A family should be concerned about the services being offered to their loved one.

7. *Page 14, Supportive Employment*: What is the difference between this service in 1915(i) and Supported Employment in the CES Waiver? If providers have some individuals who should be served under traditional CES Waiver and some in 1915(i), it will make it difficult administratively if the service descriptions are not aligned with any differences clearly stated and supported by rationale. **RESPONSE:** These are different services with different service descriptions. Providers, if licensed, can decide which service to provide.

8. *Page 16, Behavior Assistance*: This sounds like it is written only for individuals with "behavioral health treatment plans," as opposed to a "Behavior Prevention and Intervention Plan" mentioned in the DD Waiver. Individuals whose primary diagnoses is IDD need terminology that is IDD-focused and that speaks to Waiver staff who can deliver the service. **RESPONSE:** We are using the terminology of both currently, but plan to amend to make the language consistent in the future.

9. *Page 18, Adult Day Rehabilitation Day Treatment*: Traditionally, this service has been for individuals with chronic mental illness, and the wording still reflects that. Is there a comparable service for individuals with intellectual and developmental disabilities who have complex, higher needs that cannot be met easily in the traditional waiver HCBS setting? **RESPONSE:** Adult Developmental Day Treatment is the equivalent service for adults with intellectual and developmental disabilities.

10. *Page 20, Peer Support*: Is this service for BH clients only? Can we use it for IDD clients to allow peers to demonstrate how they overcame barriers and navigate various systems to live independently, to illustrate self-advocacy, to provide ongoing encouragement and support, etc.? **RESPONSE:** Peers must be certified and the only way to be certified is to have lived behavioral health or substance use. If those requirements are met, the service is available to all PASSE members.

11. *Page 22, Family Support Partners*: Is this service for caregivers of children with BH diagnoses only? This could be a valuable service for parents/caregivers of children with IDD, but it would have to be reworded to include them. **RESPONSE:** All services under the PASSE model are available to all PASSE members if they are on the PCSP and approved by the PASSE.

12. *Page 25, Supportive Life Skills Development*: Thank you for including "habilitation" in the description. **RESPONSE:** You are welcome.

13. *Page 27, Child and Youth Support*: This service also seems written to address BH without IDD in mind. Along with "symptoms of illness" we would suggest adding "challenging behaviors" or words to that effect.

RESPONSE: This service is defined to treat behavioral needs of children and youth and their families. Symptoms of a mental health condition include behaviors that can be addressed through this service. This service can be delivered to individuals who have a diagnosis of IDD and symptoms or behaviors that can respond to this treatment service.

14. *Page 28, Therapeutic Communities*: This also seems written more for individuals whose primary diagnosis is BH. Also, what is the basis for less than 16 beds? The federal institutions for mental disease (IMD) rules is 16 beds or less. **RESPONSE:** All services under the PASSE model are available to all PASSE members if they are on the PCSP and approved by the PASSE. That said, the member must be exhibiting significant behavioral health needs. The bed count was established to avoid the IMD rule.

15. *Page 30, Residential Community Integration*: Can this be revised to better accommodate individuals with IDD. For instance, the first sentence says it is an intermediate level of care between inpatient psychiatric care and outpatient behavioral health services. **RESPONSE:** This service is to address the needs of youth that have significant behaviors that do not allow them to be treated in their homes. In most instances, those youth have received inpatient psychiatric services and are not ready to move into home environments. They can also be used to prevent required treatment in inpatient psychiatric settings. Currently, many youths with IDD who have significant behavioral health symptoms are being treated in inpatient psychiatric settings and can benefit from treatment in Residential Community Reintegration as well.

16. *Page 33, Assertive Community Treatment*: The last sentence says this service is typically for individuals with serious mental illness or co-occurring disorders. However, there are a number of individuals whose primary diagnosis is IDD who have very serious needs as well and who need intensive intervention. **RESPONSE:** We agree that individuals with IDD have behavioral needs that can respond to services delivered in home and community settings and ACT is an EBP developed to treat individuals with SMI.

17. *Page 41, Partial Hospitalization*: Again, the service description, especially with its emphasis on mandatory individual and group therapy and psychoeducation, appears to be geared toward individuals whose primary diagnosis is BH. **RESPONSE:** That interpretation is correct.

18. *SERVICES*: For each service, for CSSP it states: "All performing providers must successfully complete and document courses of initial training and annual re-training sufficient to perform all tasks assigned by the mental health professional." Can you explain more specifically as to

what the training or credentials of the direct caregivers will need to be to satisfy this requirement? We are interested particularly in understanding how much additional training our IDD staff will have to obtain to perform these services. **RESPONSE:** The certification for Intensive CSSP requires professional oversight of the services being delivered. The services address behavioral health symptoms, and the delivery of these services must be overseen by a professional that has a license to guide direct care staff in addressing behavioral health symptoms. The services goal is to resolve behavior issues. All training should support staff in being part of a team and provide behavioral interventions developed to meet the individual needs identified by the professional.

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 estimated cost to implement this rule is $4,337,577 for the current fiscal year ($1,231,004 in general revenue and $3,106,573 in federal funds) and $6,506,366 for the next fiscal year ($1,846,507 in general revenue and $4,659,859 in federal funds). The total estimated cost by fiscal year to state, county, and municipal government to implement this rule is $1,231,004 for the current fiscal year and $1,846,507 for the next fiscal year.

The agency indicated that there is a new or increased cost or obligation of at least $100,000 per year to a private individual, private entity, private business, state government, county government, municipal government, or to two or more of those entities combined. Accordingly, the agency provided the following written findings:

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

The State is submitting a State Plan Amendment to its 1915i plan related to the PASSE Independent Assessment and the Adult Behavioral Health Services for Community Independence (ABSCI) program and revising its Independent Assessment manual. The rule also updates rates for adult behavioral health services and allows reassessments to be conducted in person or through interactive video or telephonically.

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

There is no statute that requires the specific elements of the proposed rule.

(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 would decrease the time required to complete a reassessment.

A rate analysis of facility-based adult behavioral health provider services was conducted in the fall of 2021, and it was determined at that time that the current therapeutic communities' rates were not sufficient to reimburse providers for the cost of providing the service.

The other updates included in the rule are needed to adapt and evolve the agency's HCBS operations to improve service delivery.

(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).

b. SUBJECT: Pharmacy (1-22) Provider Manual Change for Combining the DUR Board and DRC

DESCRIPTION:

Statement of Necessity

Combining the Drug Utilization Review (DUR) Board and the Drug Review Committee (DRC) will streamline the Arkansas Medicaid drug review process. Currently, the DUR Board reviews new drugs to the market and drug classes for implementing clinical criteria for point-of-sale claim adjudication and for prior authorization review by the Arkansas Medicaid pharmacy program and the pharmacy vendor staff. The DRC reviews drug classes to be included in the preferred drug list with preferred and non-preferred options recommended based on clinical safety and efficacy information.

The combined board will continue to be known as the DUR Board.

Many of the topics discussed during the DUR Board meeting are also discussed during the DRC meeting. Sometimes, this confuses Medicaid staff and the board or committee members. Criteria decided during the DUR Board meeting will sometimes not be applicable when the preferred drug list is recommended in the DRC meeting. Combining the DUR and DRC allows for criteria discussion at the same time as preferred drug list placement. Combining the committees also will decrease some of the confusion and make for a more efficient process. The Pharmacy Provider Manual is being revised to reflect this change.

Rule Summary

Pharmacy Provider Manual
Section 240.000 - Prior Authorization

- Replaced Drug Review Committee (DRC) with Drug Utilization Review (DUR) Board;
- Revised language from “once” to “one (1) time” when discussing frequency of emergency override.

PUBLIC COMMENT: A public hearing was held on this rule on October 5, 2022. The public comment period expired on October 24, 2022. The agency indicated that it received no public comments.

The proposed effective date is January 1, 2023.

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).

c. Prosthetics Rate Review – State Plan Amendment (SPA) and Prosthetics Provider Manual

DESCRIPTION:

Statement of Necessity

Current procedure code and rate review were requested by the Division of Medical Services (DMS). The review reflected outdated procedure codes and rates for reimbursement. The purpose of the revisions to the Prosthetics Provider Manual and the State Plan Amendment (SPA) is to improve alignment of Prosthetic and Orthotic supplies with current Medicare codes and rates for reimbursement, and to update the SPA to align with provider manuals. Medicaid will reimburse ninety percent (90%) of the current Arkansas Medicare non-rural rate. A rural rate will not be applied. Codes that do not have a Medicare comparable code or rate will be reimbursed at eighty percent (80%) of the Arkansas Blue Cross/Blue Shield (BCBS) rate unless manual pricing is otherwise documented using the provider invoice. The changes will allow an update of rates and align with Medicare codes to improve Medicare crossover billing.

Rule Summary

The State Plan Amendment (SPA) revisions are:

- Attachment 3.1-A Page 3c -For Specialized Wheelchairs provided to eligible recipients replaced “of all ages” with “two (2) years of age and older”;

- Attachment 3.1-A Page 5c:
    - (5) – Added “Services for recipients who are under twenty-one (21) years of age do not require prior authorization” for orthotic appliances;
        - Replaced “age” with “years of age”; and
        - Added “…in the Procedure Code Table Link in Section II …”;
    - (6) – Added “Services for recipients who are under twenty-one (21) years of age do not require prior authorization” for prosthetic devices;
        - Replaced “age” with “years of age”;
        - Replaced “twenty thousand dollars ($20,000)” with “sixty thousand dollars ($60,000)”;
        - Added “…in the Procedure Code Table Link in Section II …”; and
        - Added a hyper link to the Procedure Code Table in Section II;
- Attachment 3.1-B Page 3e - For Specialized Wheelchairs provided to eligible recipients replaced “of all ages”, with “two (2) years of age and older”;
- Attachment 3.1-B Page 5b:
    - (5) - Added “Services for recipients who are under twenty-one (21) years of age do not require prior authorization” for orthotic appliances;
        - Replaced “age” with “years of age”;
        - Added “…in the Procedure Code Table Link in Section II …”;
    - (6) - Added “Services for recipients who are under twenty-one (21) years of age do not require prior authorization” for prosthetic devices;
        - Replaced “age” with “years of age”;
        - Replaced “twenty thousand dollars ($20,000)” with “sixty thousand dollars ($60,000)”;
        - Added “…in the Procedure Code Table Link in Section II …”; and
        - Added a hyper link to the Procedure Code Table in Section II;
- Attachment 4.19-B Page 4c:
    - Added “Effective for dates of service on or after January 1, 2023, reimbursement rate maximums for orthotic appliances and prosthetic devices will be set at ninety percent (90%) of the January 1, 2022, Medicare non-rural rate for the State of

Arkansas. For orthotic and prosthetic codes not listed on the Medicare fee schedule, reimbursement rate maximums for dates of service on or after January 1, 2023, will be set at eighty percent (80%) of the January 1, 2022, Arkansas Blue Cross/Blue Shield rate, or manually priced";
    - Added a hyperlink to the Medicaid Fee Schedules provider list; and
- Prosthetics Provider Manual
    - Updated Table of Contents – 212.212 and 212.213.
    - Section 212.212 Replaced "All ages" with "two (2) years of age and older"; and
    - Section 212.213 Replaced "Age two (2) through adulthood" with "two (2) years of age and older".
- Updated stylistic formatting of age and numerical references throughout all pages.

PUBLIC COMMENT: A public hearing was held on this rule on October 5, 2022. The public comment period expired on October 24, 2022. The agency provided the following summary of the public comments it received and its responses to those comments:

Commenter's Name: David Chandler, Senior Director of Payer Relations, American Association for Homecare

COMMENT: The American Association for Homecare (AAHomecare) is writing to provide comment regarding the Prosthetics Rate Review and related rate reductions for enteral formula products. Generally, we do not support rate reductions below Medicare published rates by geographic region, especially in this current market environment. This is also a critical time for Medicaid recipients who may have difficulty accessing enteral formula products. There have been recent changes in the enteral formula market due to (1) the current COVID-19 public health emergency (PHE), (2) the recall of a major manufacturer's enteral formulas, and (3) well-documented supply chain challenges. As is the case with most health care providers during the current pandemic, providers of enteral formulas have experienced significantly increased costs of doing business. Therefore, it is critically important that access is not further reduced or eliminated due to unsustainable rate reductions.

AAHomecare is the national association representing durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) suppliers, manufacturers, and other stakeholders in the homecare community. Our members are proud to be part of the continuum of care that assures that the families and individuals you cover receive cost effective, safe, and reliable homecare products and services. Our members supply home nutrition products (including tube feedings and primary or exclusive sources of

nutrition), oxygen therapy, positive airway pressure devices, ventilator services, complex rehabilitation technology (CRT) and many other medically necessary home medical equipment (HME) items and services that allow patients to be discharged from hospitals, nursing homes and other health care facilities to continue their care in the home setting.

The changes in availability of enteral nutrition formulas, combined with increased cost of goods, labor, and shipping continue to impact patient access to care in the home. Current reimbursement levels are no longer sustainable in today's market environment and any reduction to rates could eliminate access to vital products and services in the home altogether. On behalf of our members who are providing enteral formula to patients in Arkansas, we are requesting that you halt any rate reductions for enteral formula and consider adjusting reimbursement to accommodate inflation, added costs of multiple shipments for a bulky heavy liquid nutrition product, and other supply chain-related cost increases.

As has been the case for other parts of the health care sector, the PHE has contributed to the substantial cost increases HME suppliers have incurred. Enteral equipment, formula, and supply acquisition costs have risen dramatically due to reduced product availability. In addition, supply chain disruptions now require additional deliveries and shipping to provide patients with 30-day supply. The cost for personal protective equipment (PPE), vital to protecting patients and employees while providing services in a home-based setting, has also increased significantly. A tight job market has increased staffing costs; many suppliers have had to employ contract staffing and pay retention bonuses to keep existing employees, including Clinical Dietitians and Technicians who may provide direct patient care in the home.

In February 2022, a major formula manufacturer announced a voluntary recall and subsequently ceased production of formula in one of their plants in Michigan. The manufacturer produced a range of formulas, notably formulas used for infants and children with severe allergies, renal failure, intestinal failure, and various metabolic disorders. According to The American Journal of Clinical Nutrition, many of these formulas had limited alternatives or a limited supply, which was rapidly depleted following a surge in demand. *(1)* This impacted the already strained supply chain and exacerbated shortages in the market.

Increased costs are impacting access to these products due to limited availability for raw materials and ingredients that manufacturers require to produce these formulas, along with product containers. The COVID-19 pandemic has also affected manufacturers' workforces and their ability to sustain unexpected increases in production due to a major enteral nutrition manufacturer's extended plant closure. *(2)* Unfortunately, many other

industries use the same ingredients to manufacture their products. While other industries can pass along those added costs to the end user/consumer, enteral nutrition suppliers are limited to receiving fixed payment rates set by Arkansas Medicaid.

With further rate reductions, it may become extremely difficult for suppliers to continue providing life-sustaining enteral nutrition and supplies to those who need them to safely manage their medical conditions. A disruption in access could lead to adverse health outcomes and increase overall costs of care. To mitigate enteral nutrition access issues, we ask that Arkansas Medicaid halt any rate reductions.

AAHomecare and our HME supplier members share your goal of providing quality and timely products and services to Medicaid recipients and improving patient outcomes while lowering overall health care expenses. Our members are happy to work with you to help determine optimal solutions for patients and HME providers alike. Please let us know if you would like further information about the current HME market situation. We are available to discuss and provide additional details as needed.

References:

(1) "Infant and child formula shortages: now is the time to prevent recurrences" – American Journal of Clinical Nutrition – May 17, 2022 – https://academic.oup.com/ajcn/advance-article/doi/10.1093/ajcn/nqac149/6587046

(2) "A break in the baby formula supply chain" – Georgia Tech – May, 27, 2022 https://news.gatech.edu/news/2022/05/27/break-baby-formula-supply-chain

RESPONSE: Enteral Products are not included these rate adjustments.

Commenter's Name: Robert Rankin, Executive Director, Healthcare Nutrition Council

COMMENT: The Healthcare Nutrition Council (HNC) is providing comments on the Prosthetics Rate Review and related rate reductions for enteral formula products. HNC is an association representing manufacturers (*1)* of enteral nutrition (EN) formulas and oral nutrition supplements (ONS), including those categorized as medical foods, and parenteral nutrition (PN). Our mission is to improve patient outcomes by advancing nutrition policies and actions that raise awareness and optimize access of essential nutrition support therapies across the continuum of care.

It is widely recognized that nutritional status plays a significant role in health outcomes and healthcare costs. Addressing malnutrition is essential

to improving overall healthcare and may ultimately reduce the economic burden incurred when caring for the oldest and sickest Americans. Disease-related malnutrition can manifest in patients across all spectrums of body mass index, ranging from under to overweight individuals. Malnutrition often is associated with acute and chronic diseases and injury, such as cancer, stroke, infection, trauma, and surgical procedures. Large-scale studies have shown that as many as half of hospitalized patients and 35% to 85% of older age long-term care residents are undernourished.(*2,3,4,5)*

HNC is requesting that you halt any rate reductions for enteral formula and consider adjusting reimbursement to accommodate inflation, added costs of multiple shipments for a bulky heavy liquid nutrition product, and other supply chain cost increases.

The changes in availability of enteral nutrition formulas, combined with increased cost of goods, labor, and shipping, continue to impact patient access to these life-supporting nutrition formulas. Current reimbursement levels are no longer sustainable in today's market environment and any reduction to rates could eliminate access to vital products and services for patients who have no other nutrition alternatives.

As has been the case for other parts of the health care sector, cost increases have been exacerbated by the Public Health Emergency (PHE). Enteral equipment, formula, and supply acquisition costs have risen dramatically due to reduced product availability. In addition, supply chain disruptions now require additional deliveries and shipping to provide patients with a 30-day supply. Increased costs are impacting access to these products due to limited availability of raw materials and ingredients that manufacturers require to produce these formulas, along with product containers. Unfortunately, many other industries use the same ingredients to manufacture their products. While other industries can pass along those added costs to the end user/consumer, enteral nutrition suppliers are limited to receiving fixed payment rates set by Arkansas Medicaid. Our ultimate goal is to make sure patients continue to have access to nutrition products they need.

With further rate reductions, it may become extremely difficult for suppliers to continue to provide life-sustaining enteral nutrition and supplies to those who need them to safely manage their medical conditions. A disruption in access could lead to adverse health outcomes and increase overall costs of care and place patients at nutrition risk.

To mitigate enteral nutrition access issues, we ask that Arkansas Medicaid halt any rate reductions.

Malnutrition continues to be a crucial component in reducing hospital-acquired conditions, lowering healthcare costs and improving the health and well-being of vulnerable Medicare beneficiaries. HNC urges you to halt any rate reductions for enteral formula and consider adjusting reimbursement to accommodate inflation, added costs of multiple shipments for a bulky heavy liquid nutrition product, and other supply chain cost increases. HNC stands ready to work with the Arkansas Division of Medical Services to address these policies as one means to improve the public health system. If you have any questions or would like additional information, please contact Justine Coffey, JD, LLM, Healthcare Nutrition Council, at jcoffey@healthcarenutrition.org or 202-207-1109.

References:
1 HNC members are Abbott Nutrition, Nestle Healthcare Nutrition, and Nutricia North America.
2 Robinson MK, Trujillo EB, Mogensen KM, et al: Improving nutritional screening of hospitalized patients: The role of prealbumin. JPEN J Parenter Enteral Nutr. 2003 27:389-395.
3 Chima CS, Barco K, Dewitt MLA, et al: Relationship of nutritional status to length of stay, hospital costs, discharge status of patients hospitalized in the medicine service. J Am Diet Assoc 1997 97:975-978.
4 Braunschweig C, Gomez S, Sheean PM: Impact of declines in nutritional status on outcomes in adult patients hospitalized for more than 7 days. J Am Diet Assoc 2000 100:1316-1322.
5 Crogan NL, Pasvogel A: The influence of protein-calorie malnutrition on quality of life in nursing homes. J Geronotol A Biol Sci Med Sci 2003 58A(2):159-164.

RESPONSE: Enteral Products are not included in these rate adjustments.

Commenter's Name: Billi Graham, Med South Medical Inc d/b/a Family Choice Nutrition

COMMENT: Med South Medical Inc d/b/a Family Choice Nutrition is writing to provide comment regarding the Prosthetics Rate Review and related rate reductions for enteral formula products. This is a difficult time for Medicaid recipients who may have difficulty accessing enteral formula products. There have been recent changes in the enteral formula market;
(1) the recall of a major manufacturer's enteral formulas
(2) the current COVID-19 Public Health Emergency
(3) the well-documented supply chain challenges

As is the case with most health care providers during the pandemic, providers of enteral formulas have experienced substantially increased costs of doing business. Consequently, it is crucial that access is not further reduced or eliminated due to unsustainable rate reductions.

Med South Medical Inc d/b/a Family Choice Nutrition is part of the continuum of care that assures that families and individuals you cover receive cost effective, safe, and reliable homecare products and services. We supply home nutrition products (including tube feedings and primary or exclusive sources of nutrition), other medically necessary home medical equipment (HME) items and services that allow patients to be discharged from hospitals, and other health care facilities to continue their care in the home setting.

The changes in availability of enteral nutrition formulas, combined with increased cost of goods, labor, and shipping continue to impact patient access to care at home. Current reimbursement levels are no longer sustainable in today's market and any reduction to rates could eliminate access to vital products and services in the home all together. As a locally-owned business who provides enteral formula to patients throughout Arkansas, we are requesting that you halt any rate reductions for enteral formula and consider adjusting reimbursement to accommodate inflation, added costs of multiple shipments for a bulky heavy liquid nutrition product, and other supply chain cost increases.

With further rate reductions, it would become extremely difficult for Med South Medical Inc d/b/a Family Choice Nutrition to continue providing life-sustaining enteral nutrition and supplies to Arkansas Medicaid beneficiaries who need them to safely manage their medical conditions. A disruption in access could lead to adverse health outcomes and increase overall costs of care. To mitigate enteral nutrition access issues, we ask that Arkansas Medicaid halt any rate reductions. The current enteral nutrition market environment is severely strained due to the impacts of the pandemic, the major recall of formulas, and the global supply chain challenges.

Please let us know if you would like further information about the current DME market situation. We are available to discuss and provide additional details as needed.

RESPONSE: Enteral Products are not included in these rate adjustments.

Commenter's Name: Chuck Bari, Woodsprings Pharmacy and Home Medical

COMMENT: Woodsprings Pharmacy and Home Medical is writing to provide comment regarding the Prosthetics Rate Review and related rate reductions for enteral formula products.

This is a difficult time for Medicaid recipients who may have difficulty accessing enteral formula products. There have been recent changes in the enteral formula market;
(1) the recall of a major manufacturer's enteral formulas
(2) the current COVID-19 Public Health Emergency
(3) the well-documented supply chain challenges

As is the case with most health care providers during the pandemic, providers of enteral formulas have experienced substantially increased costs of doing business. Consequently, it is crucial that access is not further reduced or eliminated due to unsustainable rate reductions.

Woodsprings Pharmacy and Home Medical is part of the continuum of care that assures that families and individuals you cover receive cost effective, safe, and reliable homecare products and services. We supply home nutrition products (including tube feedings and primary or exclusive sources of nutrition), other medically necessary home medical equipment (HME) items and services that allow patients to be discharged from hospitals, and other health care facilities to continue their care in the home setting.

The changes in availability of enteral nutrition formulas, combined with increased cost of goods, labor, and shipping continue to impact patient access to care at home. Current reimbursement levels are no longer sustainable in today's market and any reduction to rates could eliminate access to vital products and services in the home all together. As a locally-owned business who provides enteral formula to patients throughout Arkansas, we are requesting that you halt any rate reductions for enteral formula and consider adjusting reimbursement to accommodate inflation, added costs of multiple shipments for a bulky heavy liquid nutrition product, and other supply chain cost increases.

With further rate reductions, it would become extremely difficult for Woodsprings Pharmacy and Home Medical to continue providing life-sustaining enteral nutrition and supplies to Arkansas Medicaid beneficiaries who need them to safely manage their medical conditions. A disruption in access could lead to adverse health outcomes and increase overall costs of care. To mitigate enteral nutrition access issues, we ask that Arkansas Medicaid halt any rate reductions. The current enteral nutrition market environment is severely strained due to the impacts of the pandemic, the major recall of formulas, and the global supply chain challenges.

Please let us know if you would like further information about the current DME market situation. We are available to discuss and provide additional details as needed.

RESPONSE: Enteral Products are not included in these rate adjustments.

Commenter's Name: Michelle Brooks, Office Manager, Medical Solutions of Arkansas LLC

COMMENT: Medical Solutions of Arkansas LLC is writing to provide comment regarding the Prosthetics Rate Review and related rate reductions for enteral formula products. Medical Solutions is probably the largest incontinent and boost provider in Northeast Arkansas. We absolutely do not support rate reductions, and do not support rates below Medicare published rates especially in this current market environment.

As the office manager for Medical Solutions if these changes take place, it will no longer be viable for our company to offer these supplies and could potentially close our doors. I met with our vendor in person earlier this month and was informed of a blanket price increase to our account effective 11-1-22. There will be absolutely no way we can continue to operate with these proposed reimbursements. I strongly encourage you to reach out to the major vendors in this sector to confirm price increases are indeed actively taking place. This increase in cost and decrease in reimbursement poses a real threat to our company and employees alike. On the other hand, if Medicaid is moving toward no longer "wanting" to reimburse for these services please just let that be known to the public and beneficiaries vs masking this proposal as a decrease in reimbursement so we align with other states. What we need a true picture of the current situation (2022) and an increase in reimbursement.

Current reimbursement levels are no longer sustainable in today's market environment and any reduction to rates could eliminate access to vital products and services in the home all together.

On behalf of Medical Solutions of Arkansas and suppliers, homecare, and durable medical equipment companies who are providing enteral formula to patients in Arkansas, we are requesting that you halt any rate reductions for enteral formula and consider adjusting reimbursement to accommodate inflation, added costs of multiple shipments for a bulky heavy liquid nutrition product, and other supply chain cost increases.

As we speak Vanilla Boost is on back order with an expected ETA of mid-November. As has been the case for other parts of the health care sector, the PHE has contributed to the substantial cost increases HME suppliers have incurred. Enteral equipment, formula, and supply acquisition costs have risen dramatically due to reduced product availability. In addition, supply chain disruptions now require additional deliveries and shipping to provide patients with 30-day supply. The cost for personal protective

equipment (PPE), vital to protecting patients and employees while providing services in a home-based setting, has also increased significantly. A tight job market has increased staffing costs. We are currently working with just 3 employees in the office when we had 5!!

Increased costs are impacting access to these products due to limited availability for raw materials and ingredients that manufacturers require to produce these formulas, along with product packaging. The COVID-19 pandemic has also affected manufacturers' workforces and their ability to sustain unexpected increases in production. Unfortunately, many other industries use the same ingredients to manufacture their products. While other industries can pass along those added costs to the end user/consumer, enteral nutrition suppliers are limited to receiving fixed payment rates set by Arkansas Medicaid.

In the standard formula category, B4150, this proposal would trigger a 37.7% rate reduction to rates that are lower than the neighboring states Texas and Louisiana (see chart below). A disruption in access could lead to adverse health outcomes and increase overall cost of care. To mitigate enteral nutrition access issues, we ask that Arkansas Medicaid halt any rate reductions. The current enteral nutrition market environment is severely strained due to the impacts of the PHE and the global supply chain challenges.

Nutrition

HCPCS Code	AR Avg Rate	Payment Method	Medicare Avg Rate (AR region)	Medicare % Diff	LA Avg Rate	LA % Diff	TX Avg Rate	TX % Diff
B4160¥	$1.07	Purchase			$1.68	-57.0%	$1.11	-3.7%
B4150¥	$0.77	Purchase	**$0.48**	**37.7%**	$1.00	-29.9%	$1.05	-36.4%
B4100	$0.88	Purchase			$0.93	-5.7%	$0.72	18.2%
B4161¥	$1.88	Purchase			$2.84	-51.1%	$2.93	-55.9%
		Average		**37.7%**		**-35.9%**		**-19.4%**

¥ Arkansas Medicaid covers this code for beneficiaries <21 years only
MP = Manually priced

Nutritional status plays a significant role in health outcomes and healthcare costs. Addressing the nutritional needs of beneficiaries requiring enteral nutrition is essential to improving their overall healthcare and may ultimately reduce the economic burden incurred when caring for the AR Medicaid beneficiaries.

Aligning with the recently presented National Strategy from the White House Conference on Hunger, Nutrition and Health, we share the goal of maintaining access to quality and timely nutrition products and services to Medicaid recipients and improving patient outcomes while lowering overall health care expenses using nutrition. Our goal is to improve access,

not decrease access with lower AR Medicaid rates, and promote nutrition and health by maintaining access to life-sustaining enteral nutrition which can only occur if the rates are not so low that suppliers cannot continue to maintain access to these products for AR Medicaid beneficiaries.

A reduction in reimbursement will drastically cut and potentially eliminate access in our area as Medical Solutions would not be able to offer this product category.

RESPONSE: Enteral Products are not included in these rate adjustments.

Commenter's Name: Christy Banks, RD LD

COMMENT: My name is Christy Banks, Registered Dietitian and I am a tax-paying, law-abiding concerned citizen of Little Rock, AR. I'm writing with comments regarding the Prosthetics Rate Review and related rate reductions proposed for enteral formula products. From 2007 to 2014, I worked with cardiac and pre-term patients at Arkansas Children's Hospital. During that time, I observed on a first-hand basis just how vital access to adequate nutrition is to sustain life, improve quality of life, and support brain and muscle development. Children with sufficient intake of calories, protein and fat can thrive and often overcome their serious diagnosis with consistent availability of the prescribed formulas. This is a remarkably difficult time for Arkansas Medicaid recipients who may have difficulty accessing enteral formula products. There have been recent changes in the enteral formula market such as: the recall of a major manufacturer's enteral formulas; the current COVID-19 Public Health Emergency; the well-documented supply chain challenges.

As is the case with most health care providers during the pandemic, providers of enteral formulas have experienced substantially increased costs of doing business. Consequently, it is crucial that patient's access is not further reduced or eliminated due to unsustainable rate reductions.

Local DME and Home Infusion Companies are part of the continuum of care that assures that families and individuals covered by AR Medicaid receive cost effective, safe, and reliable homecare products and services. They supply home nutrition products (including tube feedings and primary or exclusive sources of nutrition), other medically necessary home medical equipment (HME) items and services that allow patients to be discharged from hospitals and other health care facilities to continue their care in the home setting.

The changes in availability of enteral nutrition formulas, combined with increased cost of goods, labor, and shipping continue to impact patient access to care at home. Current reimbursement levels are no longer

sustainable in today's market and any reduction to rates could eliminate access to vital products and services in the home all together. On behalf of locally-owned businesses who provide enteral formula to patients throughout Arkansas, I am requesting that you cease any rate reductions for enteral formula and consider adjusting reimbursement to accommodate inflation, added costs of multiple shipments for a bulky heavy liquid nutrition product, and other supply chain cost increases.

With further rate reductions, it would become extremely difficult for DME and Home Infusion Companies to continue providing life-sustaining enteral nutrition and supplies to Arkansas Medicaid beneficiaries who need them to safely manage their medical conditions. A disruption in access would lead to adverse health outcomes and increase overall costs of care. To mitigate enteral nutrition access issues, I ask that Arkansas Medicaid halt any rate reductions. The current enteral nutrition market environment is severely strained due to the impacts of the pandemic, the major recall of formulas, and the global supply chain challenges.

AR Medicaid rates are considerably lower than rates in surrounding states, and are due for a market adjustment. For several special formulas the product costs more than the amount reimbursed by Medicaid.

Nutrition

HCPCS Code	AR Avg Rate	Payment Method	Medicare Avg Rate (AR region)	Medicare % Diff	LA Avg Rate	LA % Diff	TX Avg Rate	TX % Diff
B4160*	$1.07	Purchase			$1.68	-57.0%	$1.11	-3.7%
B4150*	$0.77	Purchase	**$0.48**	**37.7%**	$1.00	-29.9%	$1.05	-36.4%
B4161*	$1.88	Purchase			$2.84	-51.1%	$2.93	-55.9%

Please contact me if you would like further information about the current DME market situation. I am available to discuss and provide additional details as needed.

RESPONSE: Enteral Products are not included in these rate adjustments.

The proposed effective date is January 1, 2023.

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

Per the agency, the total cost to implement this rule is $1,235,000 for the current fiscal year ($350,493 in general revenue and $884,507 in federal funds) and $2,470,000 for the next fiscal year ($700,986 in general revenue and $1,769,014 in federal funds). The total estimated cost by fiscal year to state, county, and municipal government to implement this

rule is $350,493 for the current fiscal year and $700,986 for the next fiscal year.

The agency indicated that there is a new or increased cost or obligation of at least $100,000 per year to a private individual, private entity, private business, state government, county government, municipal government, or to two or more of those entities combined. Accordingly, the agency provided the following written findings:

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

The purpose of the revisions to the Prosthetics Provider Manual and the State Plan Amendment (SPA) is to improve alignment of Prosthetic/Orthotic supplies with current Medicare codes and rates for reimbursement. The changes will allow an update of rates and align with Medicare codes to assist and improve Medicare crossover billing.

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

Current procedure code and rate review were requested by the Division of Medical Services (DMS). The review reflected outdated procedure codes and rates for reimbursement. The purpose of the revisions to the Prosthetics Provider Manual and the State Plan Amendment (SPA) is to improve alignment of Prosthetic/Orthotic supplies with current Medicare codes and rates for reimbursement.

(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;

Current procedure code and rate review were requested by the Division of Medical Services (DMS). The review reflected outdated procedure codes and rates for reimbursement. The purpose of the revisions to the Prosthetics Provider Manual and the State Plan Amendment (SPA) is to improve alignment of Prosthetic/Orthotic supplies with current Medicare codes and rates for reimbursement. Medicaid will reimburse ninety (90) percent of the current Arkansas Medicare non-rural rate. A rural rate will not be applied. Codes that do not have a Medicare comparable code or rate will be reimbursed at eighty (80) percent of the Arkansas Blue Cross/Blue Shield (BCBS) rate unless manual pricing is otherwise documented using the provider invoice. The changes will allow an update of rates and align with Medicare codes to assist and improve Medicare crossover billing.

(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).

d. SUBJECT: Hospital Cost Settlement Reopening Process

DESCRIPTION:

Statement of Necessity

The Division of Medical Services seeks to ensure federal claiming can be completed within the Federal Medicaid Timeframe for reporting and claiming federal funding for hospital cost settlements. The proposed rule amendment will reduce the need to pay federal funding amounts from State General Revenue (SGR) prior to finalizing a reopened Hospital Cost Settlement Report. It also will increase efficiency by reducing the need to pay SGR for Cost Settlements that change in amount when reopened but are not completed within the timeframe.

Rule Summary

DMS adds an eighteen (18) month timeframe and a minimum of $10,000 difference in costs for Hospitals to request their cost settlement be reopened from the date the Notice of Program Reimbursement (NPR) was issued.

PUBLIC COMMENT: A public hearing was held on this rule on October 11, 2022. The public comment period expired on October 24, 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. Is the 18-month timeframe based on federal law? If so, could you provide the citation to the relevant statute/regulation? **A.** That provision is not based in federal law, but is within agency discretion. The impetus of the time frame is to ensure processing within 2 years so that the state can claim match on the appropriate reporting cycle.

The proposed effective date is January 1, 2023.

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).~~

e. **SUBJECT: National Drug Code (NDC) Billing Updates**

DESCRIPTION: The Division of Medical Services is updating several provider manuals to add modifiers to National Drug Codes (NDC). The new modifiers are:

KP = First drug of a multiple drug unit dose formulation.
KQ = Second or subsequent drug of a multiple drug unit dose formulation.
JW = Drug waste (wastage).

The KP and KQ modifiers will only apply in certain specific situations. If an electronic claim contains four (4) or more NDCs, providers will be required to file a paper claim.

To further facilitate Medicaid drug rebates, which are processed through the Medicaid pharmacy vendor, Magellan, the modifier for drug waste (JW) will be required in every instance drug waste occurs.

Updating the NDC claim submission process will allow for correct billing, payment, and rebates.

This update also removes outdated tables, language, and forms; updates instructions for filing claims; and removes vendor names.

PUBLIC COMMENT: A public hearing was held on this rule on October 5, 2022. The public comment period expired on October 24, 2022. The agency indicated that it received no public comments.

The proposed effective date is January 1, 2023.

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).

f. **SUBJECT: Living Choices Waiver Rate Adjustment**

DESCRIPTION:

Statement of Necessity

The Division of Medical Services is required to conduct rate reviews for every Medicaid program in a three-year cycle. DHS completed a stakeholder-involved rate review in early August of 2022. Based on the recommendations of that completed Rate Study, DHS now seeks a Waiver Amendment to increase reimbursement rates to Assisted Living Facilities.

Rule Summary

DMS proposes an increase in the rate for the Assisted Living Facilities in the Living Choices Waiver, effective January 1, 2023, from the current rate of $67.25 per person per day to $96.76 per person per day.

(Due to the ongoing public health emergency, the current interim rates are $81.59 per person per day, and $85.67 per day for rural facilities.)

PUBLIC COMMENT: A public hearing was held on this rule on October 10, 2022. The public comment period expired on October 24, 2022. The agency provided the following summary of the single public comment it received and its response to that comment:

Commenter's Name: Phyllis Bell, Executive Director, The Arkansas Residential Assisted Living Association (ARALA)

COMMENT: Living Choices Assisted Living (LCAL) waiver providers are mostly small business owners who provide essential health services to Arkansans. These services allow clients to remain in their homes and local communities. Due to the reduced reimbursement 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 considered the most current cost data from providers and proposed a more sustainable rate. The Arkansas Residential Assisted Living Association (ARALA) providers appreciated being included in and the transparency of the process during the most recent survey. Clarification is being sought on the following sections:

Appendix J-2, Table Waiver Year 1 has a rate of $75.24 and Table Waiver Year 2 has a rate of $90.00. Will the agency please explain how the rates in these tables are to be interpreted?

ARALA's understanding is that the agency is requesting the new rate of $96.76 be implemented no later than January 1, 2023. Will you please confirm this is the agency's intention?

The current Appendix K reimbursement rates, through which qualifying individuals receive necessary services, are below the cost data provided during the recent survey. The recommended rate will assist in maintaining access to quality-of-life choices for vulnerable and often elderly Arkansans.

RESPONSE: Waiver Years 1 and 2 reflect the averages of the actual rates in effect from July 1, 2021, until December 31, 2022, and include in those averages the approved Appendix K rate, as opposed to the rates listed in the approved waiver prior to this amendment.

The rate DHS is requesting of CMS for this Living Choices Waiver Rate Adjustment is ninety-six dollars and seventy-six cents ($96.76) beginning January 1, 2023.

The proposed effective date is January 1, 2023.

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

Per the agency, the total estimated cost to implement this rule is $1,956,994 for the current fiscal year ($555,395 in general revenue and $1,401,599 in federal funds) and $3,913,987 for the next fiscal year ($1,110,790 in general revenue and $2,803,198 in federal funds). The total estimated cost by fiscal year to state, county, and municipal government to implement this rule is $555,395 for the current fiscal year and $1,110,790 for the next fiscal year.

The agency indicated that there is a new or increased cost or obligation of at least $100,000 per year to a private individual, private entity, private business, state government, county government, municipal government, or to two or more of those entities combined. Accordingly, the agency provided the following written findings:

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

The Division of Medical Services is required to conduct rate reviews for every Medicaid program in a three-year cycle. Living Choices rates were reviewed in 2021 (year 3 of the cycle).

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

The Division of Medical Services is required to conduct rate reviews for every Medicaid program in a three-year cycle. Living Choices rates were reviewed in 2021 (year 3 of the cycle).

(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;

The Division of Medical Services is required to conduct rate reviews for every Medicaid program in a three-year cycle. Living Choices rates were reviewed in 2021 (year 3 of the cycle).

(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;

N/A

(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).

g. SUBJECT: Primary Care Case Management (PCCM) Reconciliation

DESCRIPTION:

Statement of Necessity

The Primary Care Case Management (PCCM) program pays a monthly case management fee to Primary Care Providers (PCP) the first week of each quarter. The payment amount is based on their caseload at that time. The reconciliation process ensures that PCPs are paid for any clients who came on or left the PCP's panel sometime during the quarter after the quarterly payment was made.

Currently the PCCM reconciliation process is executed through an annual ad-hoc manual process. Moving the PCCM Reconciliation to a quarterly automated schedule is easier to maintain operationally, assists in avoiding potential audits, and provides better service to providers as payments and adjustments will be provided on a more frequent, and timely basis.

Rule Summary

Section I – Primacy Care Case Management Fee 171.230 (I) – Sentence revised to read, "Case management fees will be reconciled at least quarterly, and may be reconciled at any time determined necessary to resolve immediate issues."

PUBLIC COMMENT: A public hearing was held on this rule on October 12, 2022. The public comment period expired on October 31, 2022. The agency indicated that it received no public comments.

The proposed effective date is January 1, 2023.

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).

h. SUBJECT: Long Acting Reversible Contraceptive Rate Increase

DESCRIPTION:

Statement of Necessity

The Division of Medical Services revises the Medicaid State Plan to update the rate methodology for long acting reversible contraceptives for family planning.

Rule Summary

The updated methodology for long acting reversible contraceptives will be based on the Wholesale Acquisition Cost plus 6%.

PUBLIC COMMENT: A public hearing was held on this rule on October 19, 2022. The public comment period expired on November 5, 2022. The agency provided the following summary of the public comments it received and its responses to those comments:

Commenter's Name: Katy Mullins, Conway Women's Health Center, PA

COMMENT: Please acknowledge this as a public comment on Arkansas Medicaid's proposed change to its Medicaid State Plan regarding updating LARC reimbursement to WAC + 6%. This will be HUGE to our practice if approved. Not only will it improve the financial health of our office, it will allow us the ability to provide uniform care to ALL of our patients. It would also be beneficial if CPT code 59400 would be considered for an allowable increase has this code pricing has not been changed in many, many years. Its current reimbursement is $1210. CPT code 59510 has not been updated either.

RESPONSE: Thank you for your comment. The intent of the proposed change is to provide additional support to Medicaid providers and optimize uniformity of care for Medicaid members. While changes to

procedure coding and specific fees are beyond the scope of this rule change, your comment is noted.

Commenter's Name: Robin Fagala, RHIA, CMPE, Practice Manager, Conway OB-GYN Clinic, Elevation Med Spa

COMMENT: I want to express my support for the efforts to make changes to the reimbursement for the long acting reversible contraceptive (LARC) devices. Although we were excited to have the cost covered with the raise in 2021, we are back in same situation as before now. I believe a re-wording of the policy would be the easiest way to keep up with this variance in the future. Reimbursement of wholesale cost plus 6% is a fair rate to pay for any LARC device. As providers we should not be expected to "fund" a portion of these devices with part of our insertion fee. I would be happy to speak with you further about this matter if you wish.

RESPONSE: Thank you for your comment. The proposed change was designed to provide added compensation to providers and maximize the use of limited resources to support Medicaid members. Your comment is noted.

The proposed effective date is January 1, 2023.

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

Per the agency, the estimated cost to implement this rule is $129,476 for the current fiscal year ($12,948 in general revenue and $116,529 in federal funds) and $258,953 for the next fiscal year ($25,895 in general revenue and $233,058 in federal funds). The total estimated cost by fiscal year to state, county, and municipal government as a result of this rule is $12,948 for the current fiscal year and $25,895 for the next fiscal year.

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).

i. SUBJECT: 340B Modifiers on Physician Administered Drugs

DESCRIPTION:

Statement of Necessity

This change is a broad scope of work along with other State agencies, including the Medicaid Fraud Control Unit (MFCU), and is necessary to ensure that 340B providers are billing the actual invoice price but no greater than the ceiling price, and to ensure that DHS is reimbursing providers no more than the ceiling price on physician administered drugs. Additionally, the CMS modifiers of "JG" and "TB" need to be promulgated to identify 340B purchased drugs. The use of these modifiers will identify any 340B purchased drug and will ensure that all other physician administered drugs without the modifiers will then be eligible for rebate invoicing.

Rule Summary

CMS approved modifiers "JG" (drug or biological acquired with 340B drug pricing program discount) and "TB" (drug or biological acquired with 340B drug pricing program discount, reported for informational purposes), will be required on provider claims by 340B providers for proper payment of the lesser of actual invoice price or the ceiling price per unit. The ceiling price for physician administered drugs will be supplied by the pharmacy vendor into MMIS.

PUBLIC COMMENT: A public hearing was held on this rule on October 19, 2022. The public comment period expired on November 6, 2022. The agency provided the following summary of the public comments it received and its responses to those comments:

Commenter's Name: Jack Geisser, Sr. Director, Healthcare Policy, Medicaid, and State Initiatives, Biotechnology Innovation Organization (BIO)

1. I am writing to submit comments on behalf of the Biotechnology Innovation Organization (BIO) regarding the Department of Medical Services' proposed rule to implement "340B Modifiers on Physician-Administered Drugs."

BIO is the world's largest trade association representing biotechnology companies, academic institutions, state biotechnology centers, and related organizations across the United States and in more than thirty other nations. BIO's members develop medical products and technologies to treat patients afflicted with serious diseases, to delay the onset of these

diseases, or to prevent them in the first place. In that way, our members' novel therapeutics, vaccines, and diagnostics yield not only improved health outcomes, but also reduced health care expenditures due to fewer physician office visits, hospitalizations, and surgical interventions.

The 340B Program is now the second largest pharmaceutical program in the federal government behind Medicare, totaling $44 billion in 2021. By some conservative estimates, duplicate discounts amount to 3% to 5% of total 340B claims. *(1)* This means that these conservative estimates indicate that duplicate discounts could total more than $1.32 Billion to $2.2 Billion. Minimizing diversion and duplicate discounts is essential to program integrity to protect against waste and abuse. While BIO strongly supports the use of 340B modifiers to identify all 340B claims, we have some concerns that part of this rule, as drafted, is confusing and should be deleted.

Specifically, in 142.200 (H), the proposed rule states,
". . . A covered outpatient drug includes outpatient drugs and drugs used in connection with an inpatient or outpatient service provided by a hospital described in subparagraph (L), (M), (N), and (O)."
BIO believes the sentence above should be deleted from the proposed rule as it is unnecessary and confusing, and more importantly is inconsistent with federal law.

Section 1927(k) of the Social Security Act defines "covered outpatient drugs," and specifically excludes, among others, drugs used in inpatient settings. Therefore, the reference to "inpatient" in the proposed rule contradicts federal law and should be removed from the proposed rule.
Reference:
1 Mundra, Ashwin, "The 340B Noncompliance Data Gap Leaves Drug Manufacturers in the Dark," The Drug Channels Institute, Blog, March 18, 2022. https://www.drugchannels.net/2022/03/the-340b-noncompliance-data-gap-leaves.html

RESPONSE: The State of Arkansas included full definitions of entities from the Federal guidance to define various facilities. However, only covered outpatient physician administered drugs will be required to be billed with the modifiers. The modifiers would not apply to inpatient drugs or per diem billing. The Arkansas 340B facilities are aware of the intent for outpatient drugs only, as they have been working with the state regularly to prepare for this change.

2. Secondly, the reference to "subparagraph (L), (M), (N), and (O)" does not appear to attach to corresponding subparagraphs in the provider manual the proposed rule is amending. These subparagraphs appear to be in reference to 340B covered entity types in the federal statute, but the

proposed rule does not indicate this, and such a reference would be inappropriate and unnecessary for the purposes of requiring modifiers on 340B-purchased physician-administered drugs. *(2)*

Notwithstanding these concerns, as noted, BIO strongly supports the use of 340B modifiers on all appropriate claims. Program integrity is of the utmost importance to BIO and its members. We believe claim modifiers are essential mechanism to reduce the incidence of duplicate discounts and diversion, which are prohibited by federal statute. Thank you for the opportunity to comment on this proposed rule.
Reference:
2 42 U.S.C § 256b(b)(2)

RESPONSE: Several Official Notices have been provided to all providers for best practices for use of the modifiers on the covered outpatient physician administered drugs. Also, the State of Arkansas has met and communicated with 340B providers regularly to make sure that covered entity billing departments are ready and understand the changes. The state also intends to hold billing clinics to help 340B providers be ready for the changes.

The proposed effective date is January 1, 2023.

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

Per the agency, the proposed rule will result in savings of $1,604,351 for the current fiscal year ($455,315 in general revenue and $1,149,036 in federal funds) and savings of $2,139,135 for the next fiscal year ($607,086 in general revenue and $1,532,048 in federal funds). The total estimated cost reduction by fiscal year to state, county, and municipal government as a result of this rule is $455,315 for the current fiscal year and $607,086 for the next fiscal year.

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).

j. SUBJECT: Life360 HOME Program

DESCRIPTION:

Statement of Necessity

DHS is creating the Life360 HOME program to contract with hospitals to provide Medicaid clients in target populations with intensive care coordination services to ensure they are connected to medical services and nonmedical supports in their communities and to address their social determinants of health (SDOH) needs. Life360s are designed to supplement not supplant existing supports and services.

Medical care will continue to be delivered and billed as it currently is. This rule is necessary to:

- Reduce the maternal and infant mortality rates in the state and reduce long-term costs;
- Reduce the additional risk for disease and premature death associated with living in a rural county;
- Strengthen financial stability of small, rural hospitals, and enhance access to medical services in rural counties;
- Fill gaps in continuum of care for individuals with serious mental illness and substance use disorders;
- Increase their engagement in educational and employment opportunities among Medicaid beneficiaries most at risk for poor health outcomes associated with poverty;
- Reduce inappropriate and preventable utilization of emergency departments and inpatient hospital settings; and
- Increase the use of preventative care and health screenings.

Rule Summary

To achieve the above, the Division of Medical Services creates the Life360 HOME Provider Manual, seeks a new 1915(b) waiver, and amends the State Plan. This rule provides for intensive care coordination services to high-risk Medicaid populations. The services include home visiting services for women with high-risk pregnancies and care coordination services for individuals in rural areas with mental illness or substance use disorder. The aim of the program is to improve maternal and child health outcomes, fill gaps in the continuum of care client with mental illness, and increase engagement in educational and employment opportunities among Medicaid clients most at risk for poor health outcomes associated with poverty. In addition, the State Plan is amended to provide women with high-risk pregnancies who are eligible for Medicaid, but are not in the New Adult Medicaid Expansion Group, can receive home-visiting services through Arkansas's Life360 HOME

program, authorized under the ARHOME Section 1115 waiver program; and allows for hospitals approved to provide Maternal Life360 HOME services can receive $300 per member per month for women enrolled in the Maternal Life360 HOME who are enrolled in an Arkansas Medicaid aid category that is not the ARHOME Medicaid aid category.

PUBLIC COMMENT: A public hearing was held on this rule on October 20, 2022. The public comment period expired on November 7, 2022. Due to its length, the public comment summary is attached separately.

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

1. Ark. Code Ann. § 23-61-1010(b)(2)(B) states that eligible hospitals must provide "a federally recognized evidence-based home visitation model to a woman during pregnancy and to the woman and child for a period of up to twenty-four (24) months after birth." The proposed state plan states, "The services start during pregnancy and will be provided through the baby's first 12 months." Why is the timeframe in the state plan shorter than that in the statute? **RESPONSE:** DHS intends to provide Maternal Life360 HOME services to eligible women enrolled in ARHOME or any other Medicaid aid category (e.g., pregnant Woman, Parent Caretaker Relative). Women who are enrolled in ARHOME will receive Life360 services for up to 24 months after the baby's birth. Women enrolled in other Medicaid aid categories will receive services up to 12 months after the baby's birth. Ark. Code Ann. § 23-61-1010(b)(2)(B) and ARHOME's 1115 demonstration Special Terms and Conditions regulate the ARHOME program, while the state plan amendment, along with the 1915(b) waiver, will regulate the Life360 participation of women in other Medicaid aid categories.

2. As mentioned in the previous question, the proposed state plan provides for services during the first 12 months of a baby's life. Section 210.100(A)(2) of the proposed rules also provides for a 12-month timeframe. Section 203.230(A) of the proposed rules requires a Maternal Life360 to cover home visiting services for "at least the first two (2) years of the baby's life." Why are these time periods different? **RESPONSE:** Section 210.100(A)(2) provide the two time frames (24 months and 12 months) depending on whether the client is enrolled in ARHOME or in another Medicaid aid category.

2. If enrolled in ARHOME at any point during enrollment in the Maternal Life360 program, was enrolled in the Maternal Life360 while pregnant with a high-risk pregnancy and delivered the baby within the previous twenty-four (24) months

OR If enrolled in a Medicaid program that is not ARHOME for the full duration of enrollment in the Maternal Life360 program, was enrolled in the Maternal Life360 while pregnant with a high-risk pregnancy and delivered the baby within the previous twelve (12) months. High-risk pregnancy must be verified through a completed referral form from the client's physician that includes the most current clinical note.

Section 203.230(A) refers to the Life360 home visiting provider criteria. Because the Life360 HOME will serve both ARHOME clients and clients in other Medicaid aid categories, the home visiting provider must be able to serve women for 24 months. The home visiting agency will provide services to some women for only 12 months after the baby's birth, but to be eligible to partner with a Life360 HOME, the home visiting agency must be able to serve women for 24 months.

3. Section 203.230(B) of the proposed rules states that Success Life360 partners "must be experienced in working with young adults most at risk of long-term poverty." Ark. Code Ann. § 23-61-1010(a)(3) requires assistance for "young adults most at risk of poor health due to long-term poverty." What is the difference between these two categories? **RESPONSE:** There is no difference. The young adults who will be served by the Success Life360 HOME are most at-risk of long-term poverty, and, by the nature of poverty's correlation with health outcomes, at-risk of poor health.

4. (Possibly the same question as #2.) Section 220.300(A) states that services will be provided for 2 years to clients enrolled in a QHP through ARHOME and 1 year for clients enrolled in any other Medicaid category. Why are these time periods different? **RESPONSE:** DHS will be providing different service lengths to Maternal Life360 HOMEs based on the Medicaid program in which they are enrolled.

The proposed effective date is January 1, 2023.

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

Per the agency, the total estimated cost to implement this rule is $6,463,500 for the current fiscal year ($1,224,190 in general revenue and $5,239,310 in federal funds) and $16,871,000 for the next fiscal year ($3,219,284 in general revenue and $13,651,716 in federal funds). The total estimated cost by fiscal year to state, county, and municipal government to implement this rule is $1,224,190 for the current fiscal year and $3,219,284 for the next fiscal year.

The agency indicated that there is a new or increased cost or obligation of at least $100,000 per year to a private individual, private entity, private business, state government, county government, municipal government, or to two or more of those entities combined. Accordingly, the agency provided the following written findings:

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

The Director of the Division of Medical Services (DMS) creates the Life360 HOME Program to contract with hospitals to provide Medicaid clients in target populations with intensive care coordination services to ensure they are connected to medical services and nonmedical supports in their communities and to address their social determinants of health needs.

(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 necessary to:

- Reduce the maternal and infant mortality rate in the state and reduce long-term costs;
- Reduce the additional risk for disease and premature death associated with living in a rural county;
- Strengthen financial stability of small, rural hospitals and enhance access to medical services in rural counties;
- Fill gaps in continuum of care for individuals with serious mental illness and substance use disorders;
- Increase their engagement in educational and employment opportunities among Medicaid beneficiaries most at risk for poor health outcomes associated with poverty;
- Reduce inappropriate and preventable utilization of emergency departments and inpatient hospital settings; and
- Increase the use of preventative care and health screenings.

(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 necessary to:

- Reduce the maternal and infant mortality rate in the state and reduce long-term costs;
- Reduce the additional risk for disease and premature death associated with living in a rural county;
- Strengthen financial stability of small, rural hospitals and enhance access to medical services in rural counties;

- Fill gaps in continuum of care for individuals with serious mental illness and substance use disorders;
- Increase their engagement in educational and employment opportunities among Medicaid beneficiaries most at risk for poor health outcomes associated with poverty;
- Reduce inappropriate and preventable utilization of emergency departments and inpatient hospital settings; and
- Increase the use of preventative care and health screenings.

(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;

N/A

(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).

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

k. **SUBJECT: Rebalancing Services for Clients with Intellectual and Developmental Disabilities and Behavioral Health Needs**

DESCRIPTION:

Statement of Necessity

This rule includes ten (10) manuals and several accompanying State Plan pages. The manual amendments, enactments, and repeals are all focused on shifting away from a fee-for-service methodology for our clients with high needs (IDD or BH), lessening administrative burden on our providers, supporting the workforce (both paraprofessional and clinical) that are employed to provide services to IDD and BH clients, and raising the quality of the care with evidence-based and recognized service models.

Rule Summary

The following manuals are affected by this rule:

New Manuals:

- Community and Employment Support (CES) Waiver Certification Manual
    - Identifies the minimum standards for community providers delivering services to clients enrolled in the Arkansas 1915(c) home and community-based waiver number AR.0188, which is known as the Community and Employment Support Waiver (CES Waiver).

      After the public comment period, the agency removed this manual from the rule.

- Home and Community-Based Services for Clients with Intellectual Disabilities and Behavioral Health Needs Manual

  Changes based on Public Comments:

- Clarified the name of the 1915i state plan outside the PASSE program because it is no longer named the Adult Behavioral Services for Community Independence.
- Added the word Intervention to the service Crisis Stabilization Intervention because that is the actual name.
- Added Assertive Community Treatment to the 1915i state plan outside the PASSE because it was inadvertently left off of the service list.
-

- Diagnostic and Evaluation Manual
  - Sets criteria to determine eligibility for the Division of Development Disabilities Services and treatment planning and diagnostic clarification for the Division of Aging, Adult, and Behavioral Health Services.

  Changes based on Public Comments:
  - Based on public comment, language has been amended under the Autism section and under the Institutional Level of Care section to specifically ensure that the clients PCP is involved and makes the referral for the additional evaluations.
  - Under Evaluator Requirements for Autism testing, we mimicked the requirements for the other sections to allow LPEs and LPEIs, under their scope of practice, to perform the evaluations.

Amended Manuals:

- Community Support System Provider Certification Manual—Changes include:
  - Adds an Intensive Level to this provider type.
  - Adds an intermediate level between base and enhanced.
  - Adds two new services to this provider type.
  - Changes the term "beneficiary" to "client" throughout the document.
  - Changes the CSSP "licensure" to "Agency Certification" throughout the document.
  - Clarifies that the CSSP is the CSSP Agency, not the specific provider, by updating terminology.
  - Makes technical changes as necessary.

  Changes based on Public Comments:
  - Corrected formatting mistakes.
  - Minor changes to adverse action definition and appeal process based on public comment.
  - Removed definitions for which defined terms were not used elsewhere within document.
  - Several new definitions were added for clarity purposes.
  - "Employee" definition changed based on public comment.

    - Specific criminal background, maltreatment, drug screen, and registry check requirements were included in Section 302 for clarity purposes based on public comment.
    - Section 303 “Employee Training” had multiple changes based on public comment.
    - Section 305 “Client Service Records” had multiple changes based on public comment and for clarity purposes.
    - Section 309 “Emergency Plans and Drills” was moved to become the new section 501 based on public comment and for clarity purposes.
    - Section 311 “Compliance with State and Federal Laws, Rules, and Other Standards” was simplified for clarity purposes based on public comment.
    - Section 312 “Emergency Response Services” was moved to become the new Section 1003 “Behavioral Health Crisis Response Services” for clarity purposes and simplified based upon public comment.
    - The new Section 312 “General Nutrition and Food Service Requirements”, Section 313 “Medications” and Section 314 “Service Logs”, were moved from Subchapter 10 “Enhanced CSSP Agency Certification” because these standards needed to apply to Base CSSP Agency certification home and community-based service providers and not just Enhanced CSSP Agency certification providers.
    - New Section 315 “Behavioral Management Plans for IDD Clients” was added due to its unintentionally being left out of the original proposed Rule.
    - New Subchapter 5 “Settings Requirement” was added for clarity purposes based on public comment to create a standalone section applicable to home and community-based service settings. All section in this subchapter were pulled from other portions of the proposed document (primarily the former Subchapter 10 Enhanced CSSP Agency) with slight revisions based on public comment.
    - Subchapter 9 (now 10) was revised and simplified based on public comment.
    - Dozens of other minor typo corrections, terminology corrections, capitalization corrections, and changes for consistency purposes were made throughout.
- PASSE Manual—Removes home and community-based specialty services sections (This information is included in the new HCBS for Clients with IDD and BH Needs Manual).
- Physician’s Manual
    - Section 203.270 modifies PCP referral policy for some behavioral health services if place of service is not the physician’s office.

- Renames Section 205.100 as Physician's Supervision in the Provision of Behavioral Health Counseling Services, and adds Hyperlinks to the new Counseling Services provider manual and the new Diagnostic and Evaluation provider manual.
- Removes Section 248.000, Psychotherapy and Psychological Testing.
- Renames Section 292.740 Counseling Services, and modifies rule regarding who can provide these services to clients and where counseling may occur.
- Renames Section 292.741 Behavioral Health Screen, and adds screening services.
- Removes Section 292.742, Family/Group Psychotherapy.
- Updates term psychotherapy to behavioral health counseling in Sections 205.100 and 292.740.

Changes based on Public Comments:

- o 205.100—Added reference to PCCM program.
- o 292.740—Added limitations for Place of Service Codes for counseling services.
- o 292.741—Added that the emotional/behavioral assessment is "standardized".

- Outpatient Behavioral Health Services Manual is amended and will become the Counseling Services Manual
  - Updates term Outpatient Behavioral Health Services to Counseling Services throughout the manual.
  - Changes staff requirements for providers.
  - Clarifies the physician's role in the relationships with Counseling Services providers.
  - Requires prior authorization for certain counseling services for beneficiaries under the age of four (4).
  - Limits individuals solely licensed as Licensed Alcoholism and Drug Abuse Counselors (LADAC) to only provide services to individuals with a primary substance use diagnosis.
  - Adds Licensed Alcoholism and Drug Abuse Counselor Master's to allowable performing providers list for specific procedure codes.
  - Updates minimum documentation requirements for specific procedure codes.
  - Adds services, service descriptions, and minimum documentation requirements for Intensive Outpatient Substance Abuse Treatment and Crisis Stabilization Intervention.
  - Updates minimum documentation requirements for Acute Crisis Units and Substance Abuse Detoxification.

Changes Based on Public Comments:

- Section 202.200 Providers with Multiple Sites: Removed this section. No longer applicable due to end of moratorium and changes to Behavioral Health system.
- Section 211.200 Staff Requirements: Language updated to include individuals who are contracted by a certified Behavioral Health Agency or Community Support System Agency.
- Section 213.000: Order of paragraphs changed to be consistent with program entry.
- Section 217.100 Primary Care Physician (PCP) Referral: Duplicative language was removed.
- Section 224.000 Physician's Role: Clarify the responsibility of Counseling Services providers to communicate with PCPs.
- Section 226.100: Removed Item C. and edited item D.
- Section 252.121 Pharmacological Management: Removed language inconsistent with changes to delivery of services under current telemedicine policy.
- Section 255.000: Crisis Stabilization Intervention: Duplicate language removed. Staff requirements included in Section 211.200
- Section 255.001 Crisis Intervention: Added language to clarify no PCP referral is required for Crisis Intervention.
- Section 255.001 Crisis Intervention: Duplicate language removed. Staff requirements included in Section 211.200

Repealed Manuals:

- Independent Licensed Practitioner Certification Manual—The repeal will allow ILPs to enroll in Medicaid with proof of their clinical license. This is consistent with how Medicaid treats other professionals.
- School-Based Mental Health Manual and corresponding Medicaid State Plan pages— these services are contained in other programs.
- Adult Behavioral Health Services for Community Independence Manual—these services are now outlined in the new Home and Community-Based Services for Clients with Intellectual Disabilities and Behavioral Health Needs Manual.

PUBLIC COMMENT: A public hearing was held on this rule on October 27, 2022. The public comment period expired on November 13, 2022. Due to its length, the public comment summary is provided separately.

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

1. What is the statutory authority for the monetary penalties allowed by CSSP Manual § 606(a) and DDS CES Waiver Provider Manual § 806(a)?

RESPONSE: The statutory authority for imposition fines for both is derived from A.C.A. 20-48-1003(b)(1)(B)(i-iii): Administration (Community and Employment Supports Services Waiver Program Provider Fee):

> (1) In accordance with the Arkansas Administrative Procedure Act, § 25-15-201 et seq., the Division of Medical Services of the Department of Human Services shall promulgate rules and prescribe forms for:
> (A) The proper imposition and collection of the provider fee;
> (B)(i) The enforcement of this subchapter, including without limitation certification nonrenewal, letters of caution, sanctions, or fines.
> (ii) The fine for failure to comply with payment and reporting requirements shall be at least one thousand dollars ($1,000) but no more than one thousand five hundred dollars ($1,500).
> (iii) The fine and, if applicable, the outstanding balance of the provider fee shall accrue interest at the maximum rate permitted by law from the date the fine and, if applicable, the provider fee is due until payment of the outstanding balance of the fine and, if applicable, the provider fee;

2. Do the dieticians listed in the DDS CES Waiver Provider Manual § 610(b)(12) fall under one of the exemptions listed in Ark. Code Ann. § 17-83-104? If not, why does the manual not require licensure by the Arkansas Dietetics Licensing Board? **RESPONSE:** The section 610 mimics the CES waiver approved by CMS.

The proposed effective date is January 1, 2023.

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

Per the agency, the total estimated cost to implement this rule is $350,000 for the current fiscal year ($99,330 in general revenue and $250,670 in federal funds) and $700,000 for the next fiscal year ($198,660 in general revenue and $501,340 in federal funds). The total estimated cost by fiscal year to state, county, and municipal government to implement this rule is $99,330 for the current fiscal year and $198,660 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 includes ten (10) manuals and several accompanying State Plan pages. The manual amendments, enactments, and repeals are all focused on shifting away from a fee for payment methodology for our clients with high needs (IDD or BH), lessening administrative burden on our providers, supporting the workforce (both paraprofessional and clinical) that are employed to provide services to IDD and BH clients, and raising the quality of the care with evidence-based and/or recognized service models.

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

The manual amendments, enactments, and repeals are all focused on shifting away from a fee for payment methodology for our clients with high needs (IDD or BH), lessening administrative burden on our providers, supporting the workforce (both paraprofessional and clinical) that are employed to provide services to IDD and BH clients, and raising the quality of the care with evidence-based and/or recognized service models.

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

This rule includes a large amount of policy work aimed to position both our provider types and service array to provide more home and community-based services to our clients with IDD and BH.

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

This rule includes a large amount of policy work aimed to position both our provider types and service array to provide more home and community-based services to our clients with IDD and BH.

(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).

l. SUBJECT: ARHOME, Workers with Disabilities, Transitional Medicaid Cost Sharing

DESCRIPTION:

Statement of Necessity

Arkansas previously submitted State Plan Amendments (SPA) to CMS that require cost sharing updates. During the approval of the SPAs, CMS noted problems relating to cost sharing charges imposed on traditional Medicaid clients. CMS has also requested that traditional SPA pages be

removed and cost sharing updates be submitted through the Medicaid Model Data Lab (MMDL) system. A rule change and SPA is also necessary to revise copayment amounts and limits for the ARHOME Program, Workers with Disabilities, and Transitional Medicaid.

Rule Summary

The rule has been updated to correct the following issues:

- Co-pays for emergency services have been removed. Sections 1916(a)(2)(D), 1916(b)(2)(D), and 1916A(b)(3)(vi) of the Social Security Act prohibit copays on emergency services.
- Non-emergency copayments have been revised and rules mandating hospital compliance with screening requirements updated. Previously, there were inconsistent amounts for nonemergency copays for income group ranging from 100-150% FPL and no evidence of hospitals complying with screening requirement rules.
- Outpatient copay amounts have been updated. Previously, some outpatient service copay amounts exceeded the federally allowed percentages of 10% for 100-150% FPL and 20% for over 150% FPL.
- Inpatient hospital stay coinsurance has been eliminated. The limit on the coinsurance amount that can be charged for hospital inpatient stay changed to no more than $75/stay in July 2013 and has subsequently changed in the calendar years since.
- System updates will be implemented for calculation of the 5% aggregate cap across all Medicaid populations. Currently, Arkansas does not collect information on income in determining eligibility for the Workers with Disabilities program, therefore the aggregate cap of 5% of family income on cost sharing cannot be calculated.

This rule change repeals various state plan pages and amends others to define cost-sharing requirements, amounts, limitations, exemptions, and payments.

Section I of the Medicaid Provider Manual is amended to provide information about Transitional Medicaid and the ARHOME Program, add a hyperlink to a table containing the eligibility aid categories, and clean up language and formatting.

Section II of the Medicaid Visual Provider Manual is amended to clarify copays and change “beneficiaries” to “clients.”

Section A of the Medical Services Policy Manual is amended to remove business processes, add information regarding copays and exemptions, update cost information for EPSDT, and clean up language and dates.

The ARHOME State Plan Amendment implements copayment requirements and quarterly copayment limits for the ARHOME program. It changes service-specific copayment amounts and limits for ARHOME clients in a qualified health plan and introduces new copayment amounts and limits for ARHOME clients receiving services through fee for service while they await enrollment in a QHP. The SPA also limits the amount of quarterly copayments individual ARHOME clients may incur, and it limits the amount of quarterly copayments their entire household may incur.

Following the public comment period and discussions with the Centers for Medicare and Medicaid Services (CMS), the agency made the following changes:

- Removed CMS form ABP7, regarding benefits assurances, from the proposed rule
- Removed the copay for hearing aids

PUBLIC COMMENT: A public hearing was held on this rule on October 27, 2022. The public comment period expired on November 13, 2022. The agency indicated that it received no public comments.

The proposed effective date is January 1, 2023.

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

Per the agency, this rule will result in reduced costs of $743,040 for the current fiscal year ($210,875 in general revenue and $532,165 in federal funds) and $1,486,080 for the next fiscal year ($421,749 in general revenue and $1,064,330 in federal funds). The total estimated cost reduction by fiscal year to state, county, and municipal government is $210,875 for the current fiscal year and $421,749 for the next fiscal year.

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

This rule implements Act 530 of 2021. The Act, sponsored by Senator Missy Irvin, created the Arkansas Health and Opportunity for Me Act of 2021 and the Arkansas Health and Opportunity for Me Program. "The Department of Human Services shall adopt rules necessary to implement"

the Health and Opportunity for Me Act. *See* Ark. Code Ann. § 23-61-1012, *as created by* Act 530.

9. DEPARTMENT OF HUMAN SERVICES, DIVISION OF PROVIDER SERVICES AND QUALITY ASSURANCE (Martina Smith)

a. SUBJECT: Rules for the Arkansas Long Term Care Facility Nursing Assistant Training Program

DESCRIPTION:

Statement of Necessity

To update the existing Rules in the Arkansas Long Term Assistant Training Manual with language that reflects new Rules regarding virtual training.

Rule Summary

The Nursing Assistant Training Program for Long-Term Care Nursing Assistant providers will be able to be conveyed in a hybrid virtual and in-person instruction manner. NATP programs will be able to provide a portion of basic NATP knowledge through virtual means. The manual also updates all major sections by removing business practices, updating terminology, and providing clarification and new requirements throughout.

PUBLIC COMMENT: No public hearing was held on this rule. The public comment period expired on November 11, 2022. The agency indicated that it received no public comments.

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

1. I'm unclear on whether the proposed rules provide for automatic licensure under § 17-4-105 or expedited licensure under § 17-4-106. Could you clarify this? **RESPONSE:** After a review of the proposed rules and the newly enacted law, the intention was for automatic licensure.

2. *Section III, definition of "primary instructor."* The semicolon between "licensed in this state" and "or holds a multistate privilege" appears to split this definition into two parts. Do the disciplinary action and experience requirements apply to registered nurses licensed in Arkansas or only those with multistate privilege to practice who meet requirements for Arkansas licensure? **RESPONSE:** (Page 7) Remove semicolon from

between “licensed in this state” and “or holds a multistate privilege.” The disciplinary action and experience requirements would apply to any registered nurse practicing in the state of Arkansas.

3. Do the provisions of Section V(E)(1)(k) apply when a program withdraws itself from consideration for approval, or is this subsection meant to apply solely when “the State determines that any of the applicable requirements of § 483.152 or § 483.154 are not met by the program”? **RESPONSE:** The intention is to only have this apply when the State determines that the applicable requirements are not met. Change verbiage to – V(E)(1)(k) “The State determines that any of the applicable requirements of §483.152 or § 483.154 are not met by the program.”

4. A.C.A. § 20-10-702(2)(C)(ii) states that nursing experiences may include, among other things, employment in a “long-term acute care hospital, home healthcare, hospice care, or other long-term care setting.” Why was “other long-term care setting” excluded from item (d) in the list in Section VI(A)(c)? **RESPONSE:** “Other long-term care setting” should not have been excluded and we have updated and section VI (d).

5. In light of A.C.A. § 20-10-705(b)(1)(C), why was the language requiring each program to have “one, and only one Primary Instructor” deleted (Section VI(B)(1))? **RESPONSE:** The work group determined, and DPSQA agreed, that with us moving to a virtual option, a primary instructor may oversee a maximum of four sites. [The agency indicated that the proposed rule changes were not altered as a result of this question.]

6. In light of the answer to my prior question regarding expedited versus automatic licensure for uniformed service members, veterans, and spouses, does DHS intend to change the language of the Automatic or Expedited CNA Licensure section to clarify that automatic, rather than expedited, licensure was intended for these individuals? **RESPONSE:** Yes. The language should be changed to “automatic.”

7. Does the section providing for temporary or provisional CNA licensure apply to those who do not qualify for automatic licensure as uniformed service members, veterans, and spouses? If not, how does the temporary/provisional licensure work in conjunction with automatic licensure? **RESPONSE:** The difference between the two subsections (1 & 2 on Page 29) is 1 is automatic licensure for those already holding licensure in some form, whether due to military service, or licensure existing in another state, and 2 is for those seeking initial licensure.

8. The section regarding extension of continuing education requirements for deployed service members or their spouses (page 29 of the markup)

includes language referencing the "spouse's return from deployment." Is this accurate? **RESPONSE:** (Page 29) Should say "from the uniformed service member's return from deployment."

The proposed effective date is January 1, 2023.

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

LEGAL AUTHORIZATION: "The Department of Human Services shall promulgate rules necessary to implement an aide training program for all long-term care facilities in this state, to prescribe in-service training programs, and to enforce compliance with those programs." Ark. Code Ann. § 20-10-705(a).

E. Request for Expedited Repeal of Rules Not Meeting the Definition of a Rule Under the Arkansas Administrative Procedure Act Pursuant to Act 65 of 2021

1. DEPARTMENT OF FINANCE AND ADMINISTRATION (Jan Bartlett, Andy Babbitt)

a. Financial Management Guide

2. DEPARTMENT OF HUMAN SERVICES (Sarah Linam)

a. Policy 1009 – Equal Opportunity Policy

b. Policy 1078 – Americans with Disabilities Act

c. Policy 1094 – DHS DRC Cooperation Rule

F. Review of Recommendation Reports from the House and Senate Committees on Agriculture, Forestry, and Economic Development Relating to the Review and Sunset of State Agency Rules Pertaining to Milk and Cattle Production Pursuant to Act 1076 of 2021

G. Agency Updates on the Status of Outstanding Rulemaking Pursuant to Act 595 of 2021

1. Department of Agriculture (Wade Hodge)

2. Department of Education (Courtney Salas-Ford)

3. Department of Health, State Board of Health (Laura Shue)

4. Office of Arkansas Lottery (Brent Standridge)

H. Agency Updates on the Status of Outstanding Rulemaking Pursuant to Act 517 of 2019

1. Department of Agriculture, Arkansas Bureau of Standards (Wade Hodge)

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

J. Adjournment