ADMINISTRATIVE RULES AND REGULATIONS SUBCOMMITTEE
OF THE
ARKANSAS LEGISLATIVE COUNCIL

Room A, MAC
Little Rock, Arkansas

Tuesday, November 14, 2017
1:00 p.m.

A. Call to Order.

B. Reports of the Executive Subcommittee.

C. Report of the Department of Community Correction on Administrative Directives for the Quarter ending September 30, 2017. (Dina Tyler)

D. Rules Deferred from the August 15, 2017 Meeting of the Administrative Rules and Regulations Subcommittee:

1. <u>REAL ESTATE COMMISSION</u> (Gary Isom)

a. <u>SUBJECT</u>: Reg. 11.5: Post-License Education Requirements

<u>DESCRIPTION</u>: This amendment will expedite the completion time for post-license education by new real estate licensees from 12 months to 6 months. The post-license education requirement is 30 classroom hours for new brokers and 18 classroom hours for new salespersons. Consumer protection will be enhanced by having new licensees complete their post-license education requirements sooner. Many real estate brokers already consider it advisable to have their new licensees complete this education as soon as possible and require such internally.

<u>PUBLIC COMMENT</u>: A public hearing was held on July 10, 2017, and the public comment period expired on that date.

Prior to the public hearing, the commission received written comments expressing support for the amendment from Maurice Taylor, President of the Arkansas REALTORS® Association and from Sally Goss,

representing the Arkansas Chapter of the National Association of Residential Property Managers.

During the public hearing, support for the amendment was voiced by Maurice Taylor, President of the Arkansas REALTORS® Association; Ralph Bogner, Real Estate Instructor, Fort Smith School of Real Estate; and Howard Lee Kilby, Consumer.

The proposed effective date is pending legislative review and approval.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: The Arkansas Real Estate Commission may do all things necessary and convenient for carrying into effect the provisions of the Real Estate License Law, Ark. Code Ann. § 17-42-101 *et seq*., and may from time to time promulgate necessary or desirable rules and regulations. Ark. Code Ann. § 17-42-203(a).

The commission shall establish a post-licensure education requirement for individuals in their first year of licensure as salespersons or brokers. Ark. Code Ann. § 17-42-303(c)(1). The commission shall not require more than thirty (30) classroom hours of post-licensure education hours. Ark. Code Ann. § 17-42-303(c)(2).

E. Rules filed Pursuant to Ark. Code Ann. § 10-3-309.

1. ALCOHOLIC BEVERAGE CONTROL (Mary Robin Casteel)

a. SUBJECT: Section 1.23; Publication of Notice that Application has been made for Permit

DESCRIPTION: This rule is amended to facilitate the application process for the Grocery Store Wine permit created by Act 508 of 2017. ABC waives the notice by publication requirement for current permittees who apply for permits to sell products with equal of lesser alcohol content as the products currently being sold by the business. Many of the applicants that qualify as grocery stores under Act 508 of 2017 are currently permitted to sell wine products within the same range allowed under the Grocery Store Wine permit. They are currently licensed to sell wine products not in excess of 1% alcohol by weight; therefore, the public has already been notified that this type of product is sold on the premises.

PUBLIC COMMENT: A public hearing was held on September 20, 2017. The public comment period expired on September 18, 2017. No public comments were submitted.

This rule was promulgated on an emergency basis and was approved at a meeting of the Executive Subcommittee on September 6, 2017. The proposed effective date for permanent promulgation is pending legislative review and approval.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: The Director of the Alcoholic Beverage Control Division shall adopt and promulgate such rules and regulations as shall be necessary to carry out the intent and purposes of the alcohol control acts enforced in this state. Ark. Code Ann. § 3-2-206(a). The Director is "clothed with broad discretionary power to govern the traffic in alcoholic liquor and to enforce strictly all the provisions of the alcohol control laws of this state." Ark. Code Ann. § 3-2-206(d).

This rule is being amended to facilitate the application process for the grocery store wine permit created by Act 508 of 2017, sponsored by Senator Bart Hester. This rule waives the publication of notice requirement for an applicant who holds a small farm wine retail permit and who subsequently makes an application for a grocery store wine permit at the same location. The agency waives the notice by publication requirement for current permittees who apply for permits to sell products with equal or lesser alcohol content as the products currently being sold by the business. According to the agency, many of the applicants that qualify as grocery stores under Act 508 are currently permitted to sell wine products within the same range allowed under the grocery store wine permit. As they are currently licensed to sell wine products not in excess of 21% alcohol by weight, the public has already been notified that this type of product is sold on the premises.

b. SUBJECT: Section 1.26; Notice of Application to be Posted at Premises

DESCRIPTION: This rule is amended to facilitate the application process for the Grocery Store Wine permit created by Act 508 of 2017. ABC waives the notice by posting requirement for current permittees who apply for permits to sell products with equal or lesser alcohol content as the products currently being sold by the business. Many of these applicants that qualify as grocery stores under Act 508 of 2017 are currently permitted to sell wine products within the same range allowed under the Grocer Store Wine permit. They are currently licensed to sell wine products not in excess of 21% alcohol by weight; therefore, the public has already been notified that this type of product is sold on the premises.

PUBLIC COMMENT: A public hearing was held on September 20, 2017. The public comment period expired on September 18, 2017. No public comments were submitted.

This rule was promulgated on an emergency basis and was approved at a meeting of the Executive Subcommittee on September 6, 2017. The proposed effective date for permanent promulgation is pending legislative review and approval.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: The Director of the Alcoholic Beverage Control Division shall adopt and promulgate such rules and regulations as shall be necessary to carry out the intent and purposes of the alcohol control acts enforced in this state. Ark. Code Ann. § 3-2-206(a). The Director is "clothed with broad discretionary power to govern the traffic in alcoholic liquor and to enforce strictly all the provisions of the alcohol control laws of this state." Ark. Code Ann. § 3-2-206(d).

This rule is being amended to facilitate the application process for the grocery store wine permit created by Act 508 of 2017, sponsored by Senator Bart Hester. This rule waives the requirement for posting a notice of application at the premises for an applicant who holds a small farm wine retail permit and who subsequently makes an application for a grocery store wine permit at the same location. The agency waives the notice by posting requirement for current permittees who apply for permits to sell products with equal or lesser alcohol content as the products currently being sold by the business. According to the agency, many of the applicants that qualify as grocery stores under Act 508 are currently permitted to sell wine products within the same range allowed under the grocery store wine permit. As they are currently licensed to sell wine products not in excess of 21% alcohol by weight, the public has already been notified that this type of product is sold on the premises.

c. SUBJECT: Section 1.27; Application for Transfer of Location of Premises

DESCRIPTION: Act 1112 of 2017 requires applicants for private club permits to obtain an ordinance from the municipality or county in which the club seeks to operate prior to filing an application with the ABC. The proposed rule change amends the existing rule to implement the requirements of Act 1112 of 2017, regarding private clubs.

PUBLIC COMMENT: A public hearing was held on September 20, 2017. The public comment period expired on September 18, 2017. No comments were received.

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

Will proposed subsection (4) apply to private clubs (including a large event center private club) seeking to transfer location within the *same* county or municipality as its current location? Or is it solely applicable to those seeking to transfer the location of premises to a *different* county or municipality from its current location? **RESPONSE:** It will apply to any transfer, including those within the same municipality or county.

This rule was promulgated on an emergency basis and was approved at a meeting of the Executive Subcommittee held on September 6, 2017. The proposed effective date for permanent promulgation is pending legislative review and approval.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: Changes to the rule were made in light of **Act 1112 of 2017**, sponsored by Senator Eddie Joe Williams, which served to authorize the governing bodies of counties and municipalities to initiate the permitting process for private clubs. Arkansas Code Annotated § 3-9-222(a)(1), as amended by Act 1112, § 1, allows an application for a permit to operate as a private club to be made first to the governing body of the county or municipality in which the private club seeks to be located. If the governing body of the county or municipality approves by ordinance the application for a permit made under subsection (a)(1) of the statute, the Alcoholic Beverage Control Division ("Division") may then issue a permit to operate as a private club to the applicant for the proposed location. *See* Ark. Code Ann. § 3-9-222(a)(2), as amended by Act 1112, § 1.

The instant proposed rule requires that any application to transfer a private club permit, including a large event center private club permit, likewise be accompanied by an ordinance of approval. The Alcoholic Beverage Control Board is authorized and directed to establish rules and regulations with respect to permits issued under the provisions of Ark. Code Ann. § 3-9-222 to assure compliance with the provisions and to prohibit any permittee from engaging in the unlawful sale of alcoholic beverages. *See* Ark. Code Ann. § 3-9-225. The Director of the Division shall adopt and promulgate such rules and regulations as shall be necessary to carry out the intent and purposes of any alcohol control acts enforced in this state. *See* Ark. Code Ann. § 3-2-206(a). By the grant of this power to adopt rules and regulations, it is intended "that the director shall be clothed with broad discretionary power to govern the traffic in alcoholic liquor and to enforce strictly all the provisions of the alcohol control laws of this state." Ark. Code Ann. § 3-2-206(d).

d. **SUBJECT: Section 1.33(2); Premises Operated in Conjunction with Certain Other Businesses**

DESCRIPTION: Act 508 of 2017 authorizes retail liquor stores to begin selling consumables and edible products that complement alcoholic beverages. Act 508 instructs the ABC to promulgate rules to facilitate the sale of these items.

PUBLIC COMMENT: A public hearing was held on September 20, 2017. The public comment period expired on September 18, 2017. Positive comments were received on the proposed rule from John Akins of United Beverage Retailers of Arkansas. The comments encouraged the provisions in the rule to be interpreted as broadly as possible. ABC did not make any changes as a result of the comment received.

This rule was promulgated on an emergency basis and was approved at a meeting of the Executive Subcommittee on September 6, 2017. The proposed effective date for permanent promulgation is pending legislative review and approval.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: The Director of the Alcoholic Beverage Control Division shall adopt and promulgate such rules and regulations as shall be necessary to carry out the intent and purposes of the alcohol control acts enforced in this state. Ark. Code Ann. § 3-2-206(a). The Director is "clothed with broad discretionary power to govern the traffic in alcoholic liquor and to enforce strictly all the provisions of the alcohol control laws of this state." Ark. Code Ann. § 3-2-206(d).

This rule implements Act 508 of 2017, sponsored by Senator Bart Hester, which authorizes retail liquor stores to sell consumables and edible products that complement alcoholic beverages. Arkansas Code Annotated § 3-4-218(a)(3), as amended by Act 508, requires the Alcoholic Beverage Control Division to promulgate rules to facilitate the sale of complementary products under this act.

e. **SUBJECT: Section 1.34; Continuation of Permit Conditioned Upon Operation of Originally Proposed Business**

DESCRIPTION: Act 1112 of 2017 requires applicants for private club permits to obtain an ordinance from the municipality or county in which the club seeks to operate prior to filing an application with the ABC. This

rule is being amended to ensure that private clubs remain compliant with the local ordinance authorizing their operations.

PUBLIC COMMENT: A public hearing was held on September 20, 2017. The public comment period expired on September 18, 2017. No comments were received.

This rule was promulgated on an emergency basis and was approved at a meeting of the Executive Subcommittee held on September 6, 2017. The proposed effective date for permanent promulgation is pending legislative review and approval.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: Changes to the rule were made in light of **Act 1112 of 2017**, sponsored by Senator Eddie Joe Williams, which served to authorize the governing bodies of counties and municipalities to initiate the permitting process for private clubs. Arkansas Code Annotated § 3-9-222(a), as amended by Act 1112, § 1, allows an application for a permit to operate as a private club to be made first to the governing body of the county or municipality in which the private club seeks to be located, and if the governing body approves by ordinance the application for a permit made under subsection (a)(1) of the statute, the Alcoholic Beverage Control Division ("Division") may then issue a permit to operate as a private club to the applicant for the proposed location.

Pursuant to Ark. Code Ann. § 3-9-225, the Alcoholic Beverage Control Board is authorized and directed to establish rules and regulations with respect to permits issued under the provisions of Ark. Code Ann. § 3-9-222 to assure compliance with the provisions and to prohibit any permittee from engaging in the unlawful sale of alcoholic beverages. Further authorization for the proposed changes can be found in Ark. Code Ann. § 3-2-206(a), which provides that the director of the Division shall adopt and promulgate such rules and regulations as shall be necessary to carry out the intent and purposes of any alcohol control acts enforced in this state. By the grant of this power to adopt rules and regulations, it is intended "that the director shall be clothed with broad discretionary power to govern the traffic in alcoholic liquor and to enforce strictly all the provisions of the alcohol control laws of this state." Ark. Code Ann. § 3-2-206(d).

f. SUBJECT: Section 2.28(4); Gifts and Services to Retailers Prohibited

DESCRIPTION: Act 508 of 2017 prohibits slotting allowances, i.e., allowances paid by a manufacturer to a grocery store for making room for a product on the grocery store's shelves. ABC Rules and Regulations

have always prohibited, with narrow exceptions, wholesalers providing gifts and services to retailers. This rule is amended to clarify certain gifts and services that may not be provided to retailers concerning the stocking of shelves.

PUBLIC COMMENT: A public hearing was held on September 20, 2017. The public comment period expired on September 18, 2017.

Positive comments were received on the proposed rule from John Akins of United Beverage Retailers of Arkansas. The retail liquor stores will prevent the wholesalers from having time to stock their stores. They are willing to forego stocking by wholesalers in their stores with the hope that it will not disrupt the current level of service and product provided to their stores.

Negative comments were received from Charlie Spakes of Wal-Mart and Sam's Club and Paul Rowton of Food Giant. The grocery/retail stores fear that customers will suffer because the wholesaler's input on marketing and freshness of wine products will be lacking.

ABC did not make any changes as a result of the comments received.

This rule was promulgated on an emergency basis and was approved at a meeting of the Executive Subcommittee on September 6, 2017. The proposed effective date for permanent promulgation is pending legislative review and approval.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: The Director of the Alcoholic Beverage Control Division shall adopt and promulgate such rules and regulations as shall be necessary to carry out the intent and purposes of the alcohol control acts enforced in this state. Ark. Code Ann. § 3-2-206(a). The Director is "clothed with broad discretionary power to govern the traffic in alcoholic liquor and to enforce strictly all the provisions of the alcohol control laws of this state." Ark. Code Ann. § 3-2-206(d).

This rule implements Act 508 of 2017, sponsored by Senator Bart Hester, which creates the grocery store wine permit. This rule prohibits slotting allowances in accordance with Act 508. *See* Ark. Code Ann. § 3-5-1803. Slotting allowances are defined as allowances paid by a manufacturer to a grocery store for making room for a product on the grocery store's shelves. Ark. Code Ann. § 3-5-1801(2). Additionally, the rule clarifies certain gifts and services that may not be provided to retailers concerning the stocking of shelves.

g. **SUBJECT: Section 2.53; Microbrewery-Restaurant and Separate Brewing Facility Application and Operations**

DESCRIPTION: Act 308 of 2017 increased the production limits for microbrewery restaurants. It also authorized microbrewery restaurant permittees to maintain a separate brewing facility. This rule incorporates the provisions of Act 308 of 2017 into existing ABC rules. It also provides a means by which the microbrewery restaurant shall notify the ABC of its intent to operate a separate brewing facility.

PUBLIC COMMENT: A public hearing was held on September 20, 2017. The public comment period expired on September 18, 2017. No public comments were submitted.

This rule was promulgated on an emergency basis and was approved at a meeting of the Executive Subcommittee on September 6, 2017. The proposed effective date for permanent promulgation is pending legislative review and approval.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: The Director of the Alcoholic Beverage Control Division shall adopt and promulgate such rules and regulations as shall be necessary to carry out the intent and purposes of the alcohol control acts enforced in this state. Ark. Code Ann. § 3-2-206(a). The Director is "clothed with broad discretionary power to govern the traffic in alcoholic liquor and to enforce strictly all the provisions of the alcohol control laws of this state." Ark. Code Ann. § 3-2-206(d).

This rule implements Act 308 of 2017, sponsored by Representative Grant Hodges, which increases production limits for microbrewery restaurants and authorizes microbrewery restaurant permittees to maintain a separate brewing facility. Additionally, this rule provides a means by which the microbrewery restaurant shall notify the Alcoholic Beverage Control Division of its intent to operate a separate brewing facility.

h. **SUBJECT: Section 2.66; Separate Brewing Facility – Application**

DESCRIPTION: A separate brewing facility for small breweries was created by Act 950 of 2017. The Act did not provide procedures for the small brewery to notify ABC of its intent to operate the separate facility. This new rule creates those procedures.

PUBLIC COMMENT: A public hearing was held on September 20, 2017. The public comment period expired on September 18, 2017. No comments were received.

This rule was promulgated on an emergency basis and was approved at a meeting of the Executive Subcommittee held on September 6, 2017. The proposed effective date for permanent promulgation is pending legislative review and approval.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: This rule was promulgated in light of **Act 950 of 2017**, sponsored by Senator Will Bond, which amended Arkansas Code Annotated § 3-5-1405 concerning the scope of licenses for small breweries, permitting a separate brewing facility for small breweries. Section 3-5-1405 is found within the Arkansas Small Brewery Act ("Act"), Ark. Code Ann. §§ 3-5-1401 through 3-5-1418, as amended by Act 950. Pursuant to Ark. Code Ann. § 3-5-1413, the Director of the Alcoholic Beverage Control Board and the Director of the Department of Finance and Administration may adopt rules for the implementation of the Act.

i. SUBJECT: Section 2.67; Small Brewery Tap Room – Application

DESCRIPTION: Small brewery tap rooms for small breweries were created by Act 950 of 2017. The Act did not provide procedures for the small brewery to notify ABC, local officials, or general public of its intent to operate an off-site tap room. This new rule creates those procedures.

PUBLIC COMMENT: A public hearing was held on September 20, 2017. The public comment period expired on September 18, 2017. No comments were received.

This rule was promulgated on an emergency basis and was approved at a meeting of the Executive Subcommittee held on September 6, 2017. The proposed effective date for permanent promulgation is pending legislative review and approval.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: This rule was promulgated in light of **Act 950 of 2017**, sponsored by Senator Will Bond, which amended Arkansas Code Annotated § 3-5-1405, concerning the scope of licenses for small breweries, to allow a small brewery to operate no more than two (2) small brewery tap rooms. Section 3-5-1405 is found within the Arkansas Small Brewery Act ("Act"), Ark. Code Ann. §§ 3-5-1401 through 3-5-1418, as

amended by Act 950. Pursuant to Ark. Code Ann. § 3-5-1413, the Director of the Alcoholic Beverage Control Board and the Director of the Department of Finance and Administration may adopt rules for the implementation of the Act.

j. SUBJECT: Section 3.17.3; Retailer Loyalty Programs

DESCRIPTION: This new rule authorizes retailers to offer consumer loyalty programs. The proposed rule was presented to the ABC by retail liquor store permittees. Retail liquor stores are seeking additional means to attract and maintain customers as a result of the wine in grocery stores permit.

PUBLIC COMMENT: A public hearing was held on September 20, 2017. The public comment period expired on September 18, 2017. Positive comments were received from John Akins of United Beverage Retailers of Arkansas. The retail liquor stores are supportive of loyalty programs as a means to retail customers after the implementation of wine in grocery stores. ABC did not make any changes as a result of the comments received.

This rule was promulgated on an emergency basis and was approved at a meeting of the Executive Subcommittee on September 6, 2017. The proposed effective date for permanent promulgation is pending legislative review and approval.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: The Director of the Alcoholic Beverage Control Division shall adopt and promulgate such rules and regulations as shall be necessary to carry out the intent and purposes of the alcohol control acts enforced in this state. Ark. Code Ann. § 3-2-206(a). The Director is "clothed with broad discretionary power to govern the traffic in alcoholic liquor and to enforce strictly all the provisions of the alcohol control laws of this state." Ark. Code Ann. § 3-2-206(d).

This rule is prompted by Act 508 of 2017, sponsored by Senator Bart Hester, which creates the grocery store wine permit. This rule is in response to industry members, specifically retail liquor store permittees, who wish to maintain customers in the wake of wines becoming available in grocery stores. This rule authorizes retailers of alcoholic beverages to offer loyalty programs to customers.

k. **SUBJECT: Section 5.15; Local Ordinance Required, Presumption that the Application is Qualified to be Received by Agency; Information, Statements and Documents to be Furnished by Applicant**

DESCRIPTION: This rule is being amended to comply with Act 1112 of 2017, which requires applicants for private club permits to obtain an ordinance from the municipality or county in which the club seeks to operate prior to filing an application with the ABC.

PUBLIC COMMENT: A public hearing was held on September 20, 2017. The public comment period expired on September 18, 2017. No comments were received.

This rule was promulgated on an emergency basis and was approved at a meeting of the Executive Subcommittee held on September 6, 2017. The proposed effective date for permanent promulgation is pending legislative review and approval.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: The instant proposed rule implements **Act 1112 of 2017**, sponsored by Senator Eddie Joe Williams, which authorized the governing bodies of counties and municipalities to initiate the permitting process for private clubs. Arkansas Code Annotated § 3-9-222(a)(1), as amended by Act 1112, § 1, allows an application for a permit to operate as a private club to be made first to the governing body of the county or municipality in which the private club seeks to be located. If the governing body of the county or municipality approves by ordinance the application for a permit made under subsection (a)(1) of the statute, the Alcoholic Beverage Control Division ("Division") may then issue a permit to operate as a private club to the applicant for the proposed location. *See* Ark. Code Ann. § 3-9-222(a)(2), as amended by Act 1112, § 1.

The Alcoholic Beverage Control Board is authorized and directed to establish rules and regulations with respect to permits issued under the provisions of Ark. Code Ann. § 3-9-222 to assure compliance with the provisions and to prohibit any permittee from engaging in the unlawful sale of alcoholic beverages. *See* Ark. Code Ann. § 3-9-225. Further, the Director of the Division shall adopt and promulgate such rules and regulations as shall be necessary to carry out the intent and purposes of any alcohol control acts enforced in this state. *See* Ark. Code Ann. § 3-2-206(a). By the grant of this power to adopt rules and regulations, it is intended "that the director shall be clothed with broad discretionary power to govern the traffic in alcoholic liquor and to enforce strictly all the

provisions of the alcohol control laws of this state." Ark. Code Ann. § 3-2-206(d).

l. SUBJECT: Section 5.50; Hotel or Large Event Facility Private Club Permit for "Dry" Areas Only

DESCRIPTION: This rule is being amended to comply with Act 1112 of 2017, which requires applicants for private club permits to obtain an ordinance from the municipality or county in which the club seeks to operate prior to filing an application with the ABC.

PUBLIC COMMENT: A public hearing was held on September 20, 2017. The public comment period expired on September 18, 2017. No comments were received.

This rule was promulgated on an emergency basis and was approved at a meeting of the Executive Subcommittee held on September 6, 2017. The proposed effective date for permanent promulgation is pending legislative review and approval.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: Changes to the rule were made in light of **Act 1112 of 2017**, sponsored by Senator Eddie Joe Williams, which authorized the governing bodies of counties and municipalities to initiate the permitting process for private clubs. Arkansas Code Annotated § 3-9-222(a), as amended by Act 1112, § 1, allows an application for a permit to operate as a private club to be made first to the governing body of the county or municipality in which the private club seeks to be located, and if the governing body approves by ordinance the application for a permit made under subsection (a)(1) of the statute, the Alcoholic Beverage Control Division ("Division") may then issue a permit to operate as a private club to the applicant for the proposed location. The Alcoholic Beverage Control Board is authorized and directed to establish rules and regulations with respect to permits issued under the provisions of Ark. Code Ann. § 3-9-222 to assure compliance with the provisions and to prohibit any permittee from engaging in the unlawful sale of alcoholic beverages. *See* Ark. Code Ann. § 3-9-225. Likewise, the director of the Division shall promulgate rules to enforce Ark. Code Ann. § 3-9-240, concerning hotel or large-event facility private club permits, which specifically provides that an application for such a permit shall provide information as the director requires. *See* Ark. Code Ann. § 3-9-240(a)(1), (i).

Further authorization for the proposed changes can be found in Ark. Code Ann. § 3-2-206(a), which provides that the director of the Division shall

adopt and promulgate such rules and regulations as shall be necessary to carry out the intent and purposes of any alcohol control acts enforced in this state. *See* Ark. Code Ann. § 3-2-206(a). By the grant of this power to adopt rules and regulations, it is intended "that the director shall be clothed with broad discretionary power to govern the traffic in alcoholic liquor and to enforce strictly all the provisions of the alcohol control laws of this state." Ark. Code Ann. § 3-2-206(d).

2. CONTRACTORS LICENSING BOARD (Gregory Crow)

a. SUBJECT: Issuance of License

DESCRIPTION: This rule lists the type of business entities that may apply for a license. The legislatures across the country occasionally create a new business type. This change will allow the board to accept any type of legally recognized business organization without having to change the regulations in the future.

PUBLIC COMMENT: A public hearing was held on September 7, 2017, and the public comment period expired on that date. Public comments were as follows:

The Arkansas Chapter of the Associated General Contractors of America by its Executive Vice President, J. Kelly Robbins, supports all of the proposed changes to the Rules and Regulations put forth by the Arkansas Contractors Licensing Board. No response was made by the Board.

The Associated Builders and Contractors, Arkansas Chapter, by its Chapter President, Bill Roachell, supports all of the proposed changes to the Rules and Regulations put forth by the Arkansas Contractors Licensing Board. No response was made by the Board.

The Arkansas HVACR Association, by its Executive Director, Tom Hunt, supports all of the proposed changes to the Rules and Regulations put forth by the Arkansas Contractors Licensing Board. No response was made by the Board.

The Mechanical Contractors Associations of Arkansas, Inc., by its Executive Director, Jo Kinley, supports all of the proposed changes to the Rules and Regulations put forth by the Arkansas Contractors Licensing Board. No response was made by the Board.

The proposed effective date is pending legislative review and approval.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: The Contractors Licensing Board is authorized to make rules and regulations "for its operation as it shall consider appropriate, provided that they are not in conflict with the laws of the State of Arkansas." Ark. Code Ann. § 17-25-203(a).

b. SUBJECT: License Expiration and Renewal

DESCRIPTION: This rule modification will clarify that the board may extend an existing license more than once while a renewal application is pending.

PUBLIC COMMENT: A public hearing was held on September 7, 2017, and the public comment period expired on that date. Public comments were as follows:

The Arkansas Chapter of the Associated General Contractors of America by its Executive Vice President, J. Kelly Robbins, supports all of the proposed changes to the Rules and Regulations put forth by the Arkansas Contractors Licensing Board. No response was made by the Board.

The Associated Builders and Contractors, Arkansas Chapter, by its Chapter President, Bill Roachell, supports all of the proposed changes to the Rules and Regulations put forth by the Arkansas Contractors Licensing Board. No response was made by the Board.

The Arkansas HVACR Association, by its Executive Director, Tom Hunt, supports all of the proposed changes to the Rules and Regulations put forth by the Arkansas Contractors Licensing Board. No response was made by the Board.

The Mechanical Contractors Associations of Arkansas, Inc., by its Executive Director, Jo Kinley, supports all of the proposed changes to the Rules and Regulations put forth by the Arkansas Contractors Licensing Board. No response was made by the Board.

The proposed effective date is pending legislative review and approval.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: The Contractors Licensing Board is authorized to make rules and regulations "for its operation as it shall consider appropriate, provided that they are not in conflict with the laws of the State of Arkansas." Ark. Code Ann. § 17-25-203(a).

c. SUBJECT: Inactive Status

DESCRIPTION: This change would eliminate the six-year limit as to how many times a license can be placed in inactive status.

PUBLIC COMMENT: A public hearing was held on September 7, 2017, and the public comment period expired on that date. Public comments were as follows:

The Arkansas Chapter of the Associated General Contractors of America by its Executive Vice President, J. Kelly Robbins, supports all of the proposed changes to the Rules and Regulations put forth by the Arkansas Contractors Licensing Board. No response was made by the Board.

The Associated Builders and Contractors, Arkansas Chapter, by its Chapter President, Bill Roachell, supports all of the proposed changes to the Rules and Regulations put forth by the Arkansas Contractors Licensing Board. No response was made by the Board.

The Arkansas HVACR Association, by its Executive Director, Tom Hunt, supports all of the proposed changes to the Rules and Regulations put forth by the Arkansas Contractors Licensing Board. No response was made by the Board.

The Mechanical Contractors Associations of Arkansas, Inc., by its Executive Director, Jo Kinley, supports all of the proposed changes to the Rules and Regulations put forth by the Arkansas Contractors Licensing Board. No response was made by the Board.

The proposed effective date is pending legislative review and approval.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: The Contractors Licensing Board is authorized to make rules and regulations "for its operation as it shall consider appropriate, provided that they are not in conflict with the laws of the State of Arkansas." Ark. Code Ann. § 17-25-203(a).

d. SUBJECT: Classification and Experience; Number of Years of Experience Needed to Obtain A Specialty License

DESCRIPTION: This rule modification changes the number of years of experience necessary to obtain a license with a specialty classification. The number of years is being reduced from 5 years to 1 year.

PUBLIC COMMENT: A public hearing was held on September 7, 2017, and the public comment period expired on that date. Public comments were as follows:

The Arkansas Chapter of the Associated General Contractors of America by its Executive Vice President, J. Kelly Robbins, supports all of the proposed changes to the Rules and Regulations put forth by the Arkansas Contractors Licensing Board. No response was made by the Board.

The Associated Builders and Contractors, Arkansas Chapter, by its Chapter President, Bill Roachell, supports all of the proposed changes to the Rules and Regulations put forth by the Arkansas Contractors Licensing Board. No response was made by the Board.

The Arkansas HVACR Association, by its Executive Director, Tom Hunt, supports all of the proposed changes to the Rules and Regulations put forth by the Arkansas Contractors Licensing Board. No response was made by the Board.

The Mechanical Contractors Associations of Arkansas, Inc., by its Executive Director, Jo Kinley, supports all of the proposed changes to the Rules and Regulations put forth by the Arkansas Contractors Licensing Board. No response was made by the Board.

The proposed effective date is pending legislative review and approval.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: The Contractors Licensing Board is authorized to make rules and regulations "for its operation as it shall consider appropriate, provided that they are not in conflict with the laws of the State of Arkansas." Ark. Code Ann. § 17-25-203(a).

e. SUBJECT: Classification and Experience; Modification to the License Classifications

DESCRIPTION: This rule modifies the license classifications to clarify some classifications and to raise the amount of work, per project, that can be done by a contractor with a Light Building classification from $500,000 to $750,000.

PUBLIC COMMENT: A public hearing was held on September 7, 2017, and the public comment period expired on that date. Public comments were as follows:

The Arkansas Chapter of the Associated General Contractors of America by its Executive Vice President, J. Kelly Robbins, supports all of the proposed changes to the Rules and Regulations put forth by the Arkansas Contractors Licensing Board. No response was made by the Board.

The Associated Builders and Contractors, Arkansas Chapter, by its Chapter President, Bill Roachell, supports all of the proposed changes to the Rules and Regulations put forth by the Arkansas Contractors Licensing Board. No response was made by the Board.

The Arkansas HVACR Association, by its Executive Director, Tom Hunt, supports all of the proposed changes to the Rules and Regulations put forth by the Arkansas Contractors Licensing Board. No response was made by the Board.

The Mechanical Contractors Associations of Arkansas, Inc., by its Executive Director, Jo Kinley, supports all of the proposed changes to the Rules and Regulations put forth by the Arkansas Contractors Licensing Board. No response was made by the Board.

The proposed effective date is pending legislative review and approval.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: The Contractors Licensing Board is authorized to make rules and regulations "for its operation as it shall consider appropriate, provided that they are not in conflict with the laws of the State of Arkansas." Ark. Code Ann. § 17-25-203(a).

f. SUBJECT: Classification and Experience; Licenses Issued with a Compiled Financial Statement

DESCRIPTION: This rule is in response to Act 805 of 2017 which allows the board to issue a license to a contractor who submits a Compiled Financial Statement, with a limit of projects less than $750,000. It creates the name for the type of license that will be issued if a Compiled Financial State is used, "Restricted."

PUBLIC COMMENT: A public hearing was held on September 7, 2017, and the public comment period expired on that date. Public comments were as follows:

The Arkansas Chapter of the Associated General Contractors of America by its Executive Vice President, J. Kelly Robbins, supports all of the proposed changes to the Rules and Regulations put forth by the Arkansas Contractors Licensing Board. No response was made by the Board.

The Associated Builders and Contractors, Arkansas Chapter, by its Chapter President, Bill Roachell, supports all of the proposed changes to the Rules and Regulations put forth by the Arkansas Contractors Licensing Board. No response was made by the Board.

The Arkansas HVACR Association, by its Executive Director, Tom Hunt, supports all of the proposed changes to the Rules and Regulations put forth by the Arkansas Contractors Licensing Board. No response was made by the Board.

The Mechanical Contractors Associations of Arkansas, Inc., by its Executive Director, Jo Kinley, supports all of the proposed changes to the Rules and Regulations put forth by the Arkansas Contractors Licensing Board. No response was made by the Board.

The proposed effective date is pending legislative review and approval.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: The Contractors Licensing Board is authorized to make rules and regulations "for its operation as it shall consider appropriate, provided that they are not in conflict with the laws of the State of Arkansas." Ark. Code Ann. § 17-25-203(a). These rules are in response to Act 805 of 2017, sponsored by Representative Bob Johnson, which amended the law concerning financial statements required to be submitted by a licensee of the Contractors Licensing Board.

g. SUBJECT: Financial Requirements

DESCRIPTION: This makes two changes. First, it allows the financial statement that is provided to the board to be either in accordance with GAAP or on an income tax basis. Second, it modifies the rule in response to Act 805 of 2017, which allows the board to issue a license to a contractor who submits a Compiled Financial Statement. It allows the statement to be in accordance with GAAP or on an income tax basis and states that footnotes will not be required unless specifically requested.

PUBLIC COMMENT: A public hearing was held on September 7, 2017, and the public comment period expired on that date. Public comments were as follows:

The Arkansas Chapter of the Associated General Contractors of America by its Executive Vice President, J. Kelly Robbins, supports all of the proposed changes to the Rules and Regulations put forth by the Arkansas Contractors Licensing Board. No response was made by the Board.

The Associated Builders and Contractors, Arkansas Chapter, by its Chapter President, Bill Roachell, supports all of the proposed changes to the Rules and Regulations put forth by the Arkansas Contractors Licensing Board. No response was made by the Board.

The Arkansas HVACR Association, by its Executive Director, Tom Hunt, supports all of the proposed changes to the Rules and Regulations put forth by the Arkansas Contractors Licensing Board. No response was made by the Board.

The Mechanical Contractors Associations of Arkansas, Inc., by its Executive Director, Jo Kinley, supports all of the proposed changes to the Rules and Regulations put forth by the Arkansas Contractors Licensing Board. No response was made by the Board.

The proposed effective date is pending legislative review and approval.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: The Contractors Licensing Board is authorized to make rules and regulations "for its operation as it shall consider appropriate, provided that they are not in conflict with the laws of the State of Arkansas." Ark. Code Ann. § 17-25-203(a). These rules are in response to Act 805 of 2017, sponsored by Representative Bob Johnson, which amended the law concerning financial statements required to be submitted by a licensee of the Contractors Licensing Board.

h. SUBJECT: Definitions

DESCRIPTION: This adds a definition of "Remodeler." It clarifies that an addition of 50% or less to an existing building is remodeling and is not considered to be new construction. This will allow a contractor with a remodeling classification to add on up to 50% to an existing structure without having to have the full "Building" classification.

PUBLIC COMMENT: A public hearing was held on September 7, 2017, and the public comment period expired on that date. Public comments were as follows:

The Arkansas Chapter of the Associated General Contractors of America by its Executive Vice President, J. Kelly Robbins, supports all of the proposed changes to the Rules and Regulations put forth by the Arkansas Contractors Licensing Board. No response was made by the Board.

The Associated Builders and Contractors, Arkansas Chapter, by its Chapter President, Bill Roachell, supports all of the proposed changes to the Rules and Regulations put forth by the Arkansas Contractors Licensing Board. No response was made by the Board.

The Arkansas HVACR Association, by its Executive Director, Tom Hunt, supports all of the proposed changes to the Rules and Regulations put forth by the Arkansas Contractors Licensing Board. No response was made by the Board.

The Mechanical Contractors Associations of Arkansas, Inc., by its Executive Director, Jo Kinley, supports all of the proposed changes to the Rules and Regulations put forth by the Arkansas Contractors Licensing Board. No response was made by the Board.

The proposed effective date is pending legislative review and approval.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: The Contractors Licensing Board is authorized to make rules and regulations "for its operation as it shall consider appropriate, provided that they are not in conflict with the laws of the State of Arkansas." Ark. Code Ann. § 17-25-203(a).

3. DEPARTMENT OF EDUCATION (Lori Freno)

a. SUBJECT: Educator Support and Development and Repeal of Rules Leader Excellence and Development System, Teacher Excellence and Support System, and Educator Mentoring Program

DESCRIPTION: This is a new rule that combines the Rules Governing the Teacher Excellence and Support System (T.E.S.S.), Leader Excellence and Development System (L.E.A.D.S.), and Educator Mentoring Programs. The three rules – T.E.S.S., L.E.A.D.S., and Educator Mentoring Programs – are being repealed simultaneously with this proposed rule. The proposed rule reflects changes pursuant to Act 295 of 2017 as well as the ADE's vision for ensuring that all students have equitable access to excellent educators.

Section 4.0 – Definitions

Generally The definitions relating to T.E.S.S. and L.E.A.D.S. have been changed to reflect that evaluations will be based on evidence: direct observation, indirect observation, artifacts, and data. Each of those terms is defined. Student growth measures may be included at any one of these types of evidence and will be determined by the school district. The changes reflect revised definitions under Act 295 of 2017.

4.24 The definitions of "teacher" has been amended to reflect that the rules apply to teachers employed under a waiver from licensure.

Section 5.0 – General Provisions

5.02 These provisions set out the support the Department will provide to implement these systems.

5.03 These are school district obligations, including the changes in Act 295 of 2017 to include school districts under waivers from licensure.

5.04 These provisions describe the ability to obtain a waiver from using T.E.S.S. or L.E.A.D.S., as provided in Act 295 of 2017.

Section 6.0 – T.E.S.S.

6.01 School districts are not required to (but may) conduct summative evaluations for novice teachers. This encourages school districts to provide support for new teachers rather than using an evaluation system designed for veteran teachers. Also, the school district is responsible for determining the 4-year schedule for summative evaluations for their teachers.

The provisions relating to summative evaluations provide greater flexibility for school districts, particularly in Section 6.03.3, as changed in Act 295 of 2017.

6.04 Language is revised to read more clearly, following public comment.

6.06 Requires that professional growth plans are tailored to the individual educator and clearly links personalized, competency-based professional learning to those needs.

6.07 Adds that the use of micro-credentials approved by the Department are appropriate for professional learning under a PGP, as provided in Act 295 of 2017.

6.09-6.12 Set out the requirements for years that do not involve a summative evaluation (formative years). These provisions encourage support, professional learning, feedback, etc., that help teachers grow as professionals. Importantly, the rules no longer require an annual overall rating (but school districts may continue to provide that annual rating).

6.13 Revises intensive support by making it an option rather than a requirement and aligns the identifying characteristics with the state's accountability under ESSA. Also, as provided in Act 295 of 2017, the superintendent may but is not required to recommend termination if intensive support is not successfully completed. However, as in previous rules, there is a rebuttable presumption in a termination proceeding if the intensive support status has been used with fidelity.

6.23-6.27 Set out the requirements for and Department involvement in three (3) years of novice teacher mentoring for each novice teacher through grant partnerships to provide mentoring.

Section 7.0 – L.E.A.D.S.

7.01 Describes the summative evaluation process for building-level and district-level leaders (who are not superintendents or deputy/assistant superintendents). School districts are not required to (but may) conduct a summative evaluation of beginning administrators. This encourages school districts to provide support for new leaders rather than using an evaluation system designed for veteran leaders.

7.03 Requires the use of multiple sources of evidence for a summative evaluation.

7.04 Requires the development of a professional growth plan for each leader.

7.05-7.06 The formative (non-summative) years are for the support and professional development of the leader.

7.07-7.14 Revise intensive support by making it an option rather than a requirement and align the identifying characteristics with the state's accountability under ESSA. Also, as provided in Act 295 of 2017, the superintendent may but is not required to recommend termination if intensive support is not successfully completed. However, as in previous rules, there is a rebuttable presumption in a termination proceeding if the intensive support status has been used with fidelity.

7.15-7.16 Provide for three (3) years of beginning administrator induction for each beginning administrator, developed and implemented through partnership grants from the Department with state or national school leadership organizations, or institutions of higher education with school leadership programs.

Section 8.0 – Data Reporting

This section describes the school district obligations for reporting data that will assist the state in meeting federal requirements under ESSA, which includes the state's obligation for determining whether students of minority and poverty are being disproportionately served by ineffective teachers.

PUBLIC COMMENT: A public hearing was held on September 7, 2017. The public comment period expired on September 13, 2017. The Department provided the following summary of the public comments it received and its responses:

Name: Lucas Harder, Arkansas School Boards Association
Date Received: 8/25/2017

Comment: 3.01.4: I would recommend amending this section to read "Provide an integrated system that links evaluation procedures with curricular standards, leadership standards, **and** professional growth activities **that are** aligned with systems of support, targeted support, and human capital decisions;"
Agency Response: Comment considered. Non-substantive corrections made.

Comment: 4.04.1.4 ends with an unnecessary "and" as the list continues.
Agency Response: Comment considered. Non-substantive correction made.

Comment: 4.21 should have an "and" before "development of."
Agency Response: Comment considered. Non-substantive correction made.

Comment: All of those under 4.23 should be under 4.22 and 4.24 through 4.26 should be one number lower.
Agency Response: Comment considered. Non-substantive corrections made.

Comment: 5.02.2.1 states that the electronic system is supposed to be used to provide a "professional practice rating." A.C.A. § 6-17-2805(d), as amended by Act 295, and Section 6.05 of the proposed rules uses the phrase "overall performance rating." I would recommend changing the language in 5.02.2.1 to be a "professional performance rating" so that it more closely matches.
Agency Response: Comments considered. Non-substantive change made.

Comment: 6.04: The language in this section of "not teaching in a classroom" makes me concerned on the carrying out of the intent of the section since several of the listed teachers would teach in a classroom, such as a majority of those at the School for the Blind and the School for the Deaf, while it might also bring into question those who should be evaluated under the traditional teacher rubric but who do not typically teach in a traditional classroom, such as a physical education teacher who uses the gymnasium floor as a classroom. I understand the intent of the language to incorporate the requirement from A.C.A. § 6-17-2806 to require that the evaluator use an evaluation rubric and evidence that appropriately recognizes the roles of those individuals who are still considered a teacher rather than an administrator, such as a guidance counselor, or those who are teaching in a non-traditional classroom setting, such as a digital course instructor. I believe that the intent of the

section would be more consistently carried out if the language in the section was based around recognizing the job duties and circumstances of the individual being evaluated rather than specifically where the duties are being performed. A possible suggestion for language is:

> An evaluator shall use an evaluation rubric and evidence that appropriately takes into account the teacher's role, job duties, and circumstances when conducting a summative evaluation of any of the following:
> 6.04.1 Contributing professionals;
> 6.04.2 Distance learning teachers;
> 6.04.3 Virtual charter school teachers;
> 6.04.4 Special education teachers;
> 6.04.4 [*sic*] Teachers at the Arkansas School for the Blind;
> 6.04.5 Teachers at the Arkansas School for the Deaf; and
> 6.04.6 Teachers at the Arkansas Correctional School.

Agency Response: Comments considered. The rules are revised to reflect the suggested language.

Comment: 6.13: The language in this section is missing a final noun for all of the subsections to refer back to so that 6.13.1 through 6.13.4 are all missing a subject. I would recommend adding words right before the colon so that it reads as follows: An evaluator may place a teacher in intensive support status if, as evidenced by low performance ratings on a summative evaluation**, the teacher**:.
Agency Response: Correction made.

Comment: 6.22.2: There is a doubling of "Ark. Code Ann."
Agency Response: Comment considered. Non-substantive correction made.

Comment: 6.27: The second sentence would be clearer if written as "An educational entity that ~~does~~ **elects to** not utilize mentoring **services** through its education service cooperative ~~will~~ **shall** advise ~~the~~ **its** education service cooperative and the Department **of its decision**, ~~and shall use the educational entity's own~~ **be responsible for all** funding **for its novice mentoring program**, and ~~will~~ be subject to Department monitoring **of it's** [*sic*] **novice mentoring program**.
Agency Response: Comment considered. Non-substantive change made.

Comment: Section 7 appears to be missing some directions. There's nothing following 7.03 indicating what becomes of the completion of the evaluation rubric and the evidence as there was for TESS at 6.05. 7.07 states that a leader may be placed in intensive support for low overall performance ratings, but there's no language in the summative evaluation portion of the rules stating that the LEADS summative evaluations requires an overall performance rating.

Agency Response: Comment considered. The definition of evaluation includes a performance rating, as does Section 6.02.2.1. Therefore a performance rating is a requirement of a summative evaluation that is conducted every four years. No changes made.

Name: Mark White, Arkansas Public School Resource Center
Date Received: 8/31/2017

Comment: Sections 4.04.1.4 & 4.04.1.5: Delete the "and" at the end of 4.04.1.4, and replace the period at the end of 4.04.1.5 with a semicolon.
Agency Response: Comment considered. Non-substantive correction made.

Comment: Sections 4.05.1 & 4.05.2: The phrase "at the local level" is ambiguous; we recommend that it be replaced with the phrase "by an educational entity." In addition, an "and" should be added to the end of 4.05.2.
Agency Response: Comment considered. Non-substantive correction made.

Comment: Section 4.11: Although the proposed rules contain a generic definition of the term "evaluation framework," they do not contain the specific requirements for evaluation frameworks set forth at Ark. Code Ann. § 6-17-2805(b). We recommend that the proposed rules be amended to include these specific requirements, including the educational entity's discretion to define evaluation domains and rubric components.
Agency Response: Comment considered. The evaluation framework is provided in detail on the ADE website and meets the requirements. No changes made.

Comment: Sections 4.24.3.1 & 5.03: There are two subsections that are both numbered "4.24.3.1." In addition, the language is confusing in that not all charter waivers are granted "by the State Board." The State Board's review authority is discretionary, and some waiver decisions may be made by the Charter Authorizing Panel with no additional action by the State Board. We recommend that the phrase "by the State Board" be deleted from both of the sections numbered 4.24.3.1 as well as from section 5.03, or replaced in all three sections with "by the State Board or the state charter authorizer."
Agency Response: Comment considered. Non-substantive change made.

Comment: Section 6.03.4: This section is inconsistent with Ark. Code Ann. § 6-17-2805(c)(4), in that it requires both the evaluator and the teacher to present evidence. We recommend this section be reworded to reflect the one-or-both language of the statute.

Agency Response: Comment considered. The language as written reflects the intent of the overall scheme of evidence-based evaluations. No changes made.

Comment: Section 6.04: Most of this section is statutory language that was repealed by Act 295.
Agency Response: Comment considered. This language was left in the rules for clarity.

Comment: Sections 6.21 & 6.22: These sections are potentially ambiguous and confusing in the context of a public school district or public charter school that has a waiver from the Teacher Fair Dismissal Act. This ambiguity and confusion is amplified by the qualifying phrase used in section 7.14.1 in reference to administrators: "If the [TFDA] is applicable to the … contract, a recommendation…," when no similar qualifying language is used in reference to teachers. We recommend that an additional section be added after 6.22 to read as follows:

> 6.23 These rules shall not be construed in any way to limit, impair, counteract, or otherwise modify a waiver of the Teacher Fair Dismissal Act of 1983, Ark. Code Ann. § 6-17-1501 et seq., held by a public charter school under Ark. Code Ann. § 6-23-101 et seq. or by a public school district under Ark. Code Ann. § 6-15-103.

Alternatively, sections 6.21.1, 6.21.2, 6.22.1, and 6.22.2 could be amended to add this phrase to the beginning of each:

> "If the Teacher Fair Dismissal Act of 1983, Ark. Code Ann. § 6-17-1501 et seq., is applicable to the teacher's contract,"

Agency Response: Comment considered. No change is necessary. As stated in Section 2.04, these rules do not pre-empt the application of the TFDA. Section 6.21.1 references the authority granted under the TFDA. Therefore, if the TFDA is not applicable, then the subsections of 6.21would not apply.

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

(1) Do these rules also cover the rules required by Ark. Code Ann. § 6-15-2913, as amended by Act 930 of 2017, concerning levels of support to school districts by ADE, or will those be different rules? **RESPONSE:** Comment considered. No, those will be contained in different rules.

(2) Section 6.04: It looks like this language was stricken from Ark. Code Ann. § 6-17-2805 by Act 295 of 2017. Can you reconcile its continued inclusion in these rules? **RESPONSE:** Comment considered. Although it does not need to be included in the law, we believe the practice is a good one and should be continued in rules.

(3) Section 6.19.1: Should the term "status" be "plan" as used in Ark. Code Ann. § 6-17-2807(f)(1), as amended by Act 295? **RESPONSE:** Comment considered. Non-substantive change (status to plan) was made.

(4) Section 6.20: It looks like this language was stricken from Ark. Code Ann. § 6-17-2807 by Act 295. Can you reconcile its continued inclusion? **RESPONSE:** Comment considered. Although it does not need to be included in the law, we believe the practice is a good one and should be continued in rules. No changes made.

(5) Section 6.21.2: It appears that Ark. Code Ann. § 6-17-2807(g)(3), as amended by Act 295, requires the notice to be both written and meet the minimum requirements of the TFDA. Is there a reason the rules do not require the notice to be written in accord with the statute? **RESPONSE:** Comment considered. The TFDA requires written notice.

(6) Am I correct that these rules implement Ark. Code Ann. § 6-17-2809, as amended by Act 295, concerning the required design of a system of administrator leadership support and evaluations by ADE? **RESPONSE:** Comment considered. Yes.

The proposed effective date is pending legislative review and approval.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: The instant proposed rule changes include the repeal of the Rules Governing the Teacher Excellence and Support System; Rules Governing the Leader Excellence and Development System; and Rules Governing Educator Mentoring Programs, individually, and their consolidation into a new, single set of rules, Rules Governing Educator Support and Development. The new rules also incorporate changes brought about by **Act 295 of 2017**, sponsored by Representative DeAnn Vaught, which amended the Arkansas Code concerning the teacher excellence and support system and amended provisions of the Arkansas Code concerning administrator evaluation, and **Act 930 of 2017**, sponsored by Senator Jane English, which amended provisions of the Arkansas Code concerning the public school state accountability system.

Pursuant to Arkansas Code Annotated § 6-17-2804(a), the State Board of Education shall promulgate rules for the Teacher Excellence and Support System consistent with the Teacher Excellence and Support System, codified at Ark. Code Ann. §§ 6-17-2801 through 6-17-2809, as amended by Act 295 of 2017. The State Board may further promulgate rules as necessary for the administration of Ark. Code Ann. § 6-17-2809, which provides that the Department of Education shall design a system of

administrator leadership support and evaluations. *See* Ark. Code Ann. § 6-17-2809(a)(1), (b), as amended by Act 295 of 2017, § 1. Finally, the State Board may promulgate rules that promote the state's goal of providing all Arkansas public school students with qualified and effective educators, including without limitation: systems to support educator effectiveness; the method of reporting educator effectiveness by public schools and school districts; and the methods of calculating and reporting the rate at which low-income and minority students are disproportionately taught by educators who are ineffective, inexperienced, or teaching a subject for which they are not currently licensed. *See* Ark. Code Ann. § 6-15-2912(b), as amended by Act 930 of 2017, § 2.

4. <u>DEPARTMENT OF FINANCE AND ADMINISTRATION, BUILDING AUTHORITY DIVISION</u> (Anne Laidlaw, Susan Wilson, and Doran White)

a. <u>SUBJECT</u>: 3-101 Capital Improvements

<u>DESCRIPTION</u>: Current law states that capital improvement projects exceeding $20,000 must be formally bid.

- The state must publish ads at least one (1) time for projects exceeding $20,000.
- The state must publish ads at least two (2) times for projects exceeding $50,000.
- The law states that Building Authority shall set quote bid limits. The current rule, 3-101, sets the quote bid limit:
    - Small order limit: up to $5,000;
    - Quote bid (3 quotes) limit: $5,000 to $20,000.

Act 725 of 2017 raises the threshold amount for the formal bidding of capital improvement projects from exceeding $20,000 to projects which exceed $35,000. This law became effective on August 1, 2017.

- Since the threshold for formal bidding has risen to $35,000, the proposed rule is making adjustments to this increase. Building Authority proposes the following limits:
    - Small order limit: up to $25,000;
    - Quote bid limit: $25,000.01 to $35,000.

- Under these new limits, the running of advertisements will not change:
    - Projects exceeding $35,000 and are $50,000 or less will remain to be advertised at least one (1) time;
    - Projects exceeding $50,000 will still be required to be advertised at least two (2) times.

PUBLIC COMMENT: A public hearing was held on September 13, 2017. The public comment period expired on October 1, 2017. The Building Authority Division received no comments.

The proposed effective date is pending legislative review and approval.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: The instant proposed rule implements changes brought about by **Act 725 of 2017**, sponsored by Representative Mike Holcomb, which amended the award procedure for public improvement contracts. The Building Authority Division of the Department of Finance and Administration shall carry out the duties and responsibilities set out in Arkansas Code Annotated § 22-2-108 under the policies, guidelines, standards, and procedures established by the Department of Finance and Administration ("Department"). *See* Ark. Code Ann. § 22-2-104. Pursuant to Ark. Code Ann. § 22-2-108(9)(A), (16), the Director of the Department may establish policies, guidelines, standards, and procedures that shall guide and govern the Department's Building Authority Division with regard to certain responsibilities, duties, powers, and activities, including "[t]o establish, promulgate, and enforce minimum design and construction standards and criteria for all capital improvements undertaken by any state agency, including without limitation procedures regarding flood plain management and the bidding and awarding of capital improvements regarding projects under the jurisdiction of the division" and "[t]o promulgate reasonable rules, regulations, and procedures as may be required to carry out its duties, responsibilities, powers, and authorities" under Title 22, Chapter 2 of the Arkansas Code, the Building Authority Division Act ("Act"), which are consistent with the purposes and intent of the Act.

5. DEPARTMENT OF HEALTH, CENTER FOR HEALTH ADVANCEMENT (Robert Brech)

a. SUBJECT: Licensed Lay Midwifery

DESCRIPTION: The State Board of Health has delegated the authority to administer the Lay Midwifery program, including the regulating and licensing of Lay Midwives to the Arkansas Department of Health (ADH). The Rules and Regulations for Governing the Practice of Lay Midwifery in Arkansas were last revised in 2007 with forms added in 2008.

The order of the material has been restructured to allow for a more user friendly format. The 2017 proposed revisions seek to elevate the

profession of licensed lay midwifery in Arkansas by requiring new minimum standards for licensure. The license requirements have been modified to include mandatory national certification for all newly licensed lay midwives (LLM). These revisions would expand the scope of practice for midwives who hold certain additional certifications. An "informed refusal" process has been created based on the LLM's educational level and credentials.

Revisions have been made to ensure Arkansas LLMs practice under the most current nationally recognized, evidence based standards of care. New sections have been added to clarify or expand minimum requirements of midwifery care. In addition, a required standard disclosure form has been created in order to eliminate any discrepancy of information provided to clients who engage the services of an LLM.

Language has been added to require the use of the title "Licensed Lay Midwife" on any professional or advertising materials in an effort to avoid public confusion regarding the education and credential of a "Licensed Lay Midwife" versus other professional titles, such as "Certified Nurse Midwife". The investigation and disciplinary process was also clarified.

PUBLIC COMMENT: A public hearing was held on September 21, 2017, and the public comment period expired on that date. The department submitted a public comment summary, attached hereto, detailing all of the comments received regarding these rules. The proposed effective date is March 1, 2018.

FINANCIAL IMPACT: There is no additional cost to the state.

It could cost entities affected by the rule $0-600 for the current fiscal year and $0-950 for the next fiscal year.

Costs to LLM or Apprentice:

Costs that are additional to those incurred under the current rule will vary depending on whether the individual will be starting an apprenticeship, already has a Certified Professional Midwife (CPM) credential, or is being grandfathered in and does not plan to become a CPM. The timing of license renewal is also a factor and some LLMs may have no additional costs in the current or next fiscal year if their renewal is not due during that time period.

Costs are greatest for the new apprentice: The process of NARM apprenticeship evaluation and certification is broken down into 4 parts: Phase 1 ($200), Phase 2 ($400), Phase 3 ($400) and Phase 4 ($100) plus additional course costs for a total of about $1,385. However, according to

NARM, the average apprenticeship takes three to five years so it is not anticipated that the cost for any fiscal year would be greater than $400 although it is possible an apprentice might complete Phase l and Phase 2 within one year for a cost of $600. A different scenario could have an apprentice completing Phase 2 and Phase 3 in one year for a total cost of $950 (Phase 2 and 3 fees plus the estimated neonatal resuscitation certification course fee).

For the LLM that already has a CPM, if their 3 year renewal of that certification is due during the current or next fiscal year, the fee will be $150.

All LLMs will also now be required to have neonatal resuscitation certification and renew that every 2 years at an estimated cost of $75-$150 each time.

Current apprentices will not have any additional costs in the current or next fiscal year unless they complete their apprenticeship and apply for licensure. The required neonatal resuscitation certification required before licensure is estimated at $150 for initial certification.

Costs to Consumers of Midwifery Care:

As part of their initial risk assessment, consumers will now be required to get a urine culture instead of a urine test; and at the 36 week risk assessment, a complete blood count (CBC) with platelets will be required instead of a Hemoglobin and Hematocrit (H&H). The maximum additional cost of these tests varies from $30 to $130 depending on the lab and the level of insurance.

Savings to LLMs:

The requirement for proof of rubella immunity upon initial licensure and a negative TB test for initial licensure and renewal every two years has been removed in the proposed revisions. This will be an estimated potential savings to LLMs at each licensure renewal ranging from $5 to $400 (if a chest x-ray was indicated and dependent on insurance coverage.)

The agency also provided the following information:

(a) How the additional benefits of the more costly rule justify its additional cost:
The additional cost to Licensed Lay Midwives (LLMs) to become (and maintain) a CPM (Certified Professional Midwife) in order to be licensed will result in a higher level of professionalism and conformity to the standards set by the national certifying body.

The additional cost to consumers for the new tests are to provide better and timelier assessment of medical issues that may affect their prenatal care.

(b) The reason for adoption of the more costly rule:
To raise the level of professional services provided by LLMs to the standards set by the national certifying organization NARM (North American Registry of Midwives).

The two new tests that are proposed for consumers will bring the requirement I keeping with the national standards for prenatal care.

(c) Whether the more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain:
Yes. Requiring certification by a national body will assure the public that all licensed lay midwives have met the national standards for their training, resulting in better care and safety for the clients of the LLMs. In addition, the new rules allow a greater level of client autonomy by providing the option of informed refusal based on the level of the LLM's certification and training.

Yes, for consumers, the requirement for the two new tests will provide a better assessment of their health status and guide their prenatal care.

LEGAL AUTHORIZATION: The State Board of Health is empowered to license lay midwives in this state pursuant to regulations established by the Board to include, but not be limited to (1) the qualifications for licensure; (2) standards of practice for prenatal, intrapartum, and postpartum care of mother and baby; (3) physician supervision, physician consultation, licensed nurse-midwife supervision or consultation, or physician and hospital backup; (4) grievance procedures; and (5) recordkeeping and reporting. Ark. Code Ann. § 17-85-107(a).

6. DEPARTMENT OF HEALTH, EMERGENCY MEDICAL SERVICES (Robert Brech)

a. SUBJECT: Emergency Medical Services

DESCRIPTION: The department proposes two amendment components, as follows:

1. Adds a new licensed professional, the Emergency Vehicle Operator. The new professional designation is defined in a new subsection I(X). A new section V(3)(b)(a) provides that permitted

ambulances providing general patient transfer and not primary 9-1-1 emergency responses, or that have depleted all available 9-1-1 resources must be staffed by an Emergency Vehicle Operator. Also, a new section IX(B)(5) sets forth the initial licensing requirements for the Emergency Vehicle Operator.

2. Adds a Tiered Response protocol which allows EMS services to dispatch ambulances according to the assessed severity of the call. This is set forth in the new section IV(B)(6).

PUBLIC COMMENT: A public hearing was held on September 19, 2017, and the public comment period expired on that date. No public comments were submitted. The proposed effective date is January 1, 2018.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: The State Board of Health is authorized to promulgate and implement rules, regulations, and standards which it deems necessary to carry out the provisions of the Emergency Medical Services Act. Ark. Code Ann. § 20-13-208(a)(1).

7. DEPARTMENT OF HUMAN SERVICES, COUNTY OPERATIONS
(Larry Crutchfield, items a and b; Dave Mills and Mary Franklin, item c)

a. SUBJECT: SNAP 17-6; Resource Eligibility Standards

DESCRIPTION: The resource limit for households where at least one person is age 60 or older, or is disabled, will increase to $3,500.

PUBLIC COMMENT: No public hearings were held. The public comment period expired on October 13, 2017. The Department received no comments.

The proposed effective date is January 1, 2018.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: Pursuant to Arkansas Code Annotated §20-76-201, the Department of Human Services ("Department") shall administer assigned forms of public assistance, supervise agencies and institutions caring for dependent or aged adults or adults with mental or physical disabilities, and administer other welfare activities or services that may be vested in it. The Department is authorized to "make rules and regulations and take actions as are necessary or desirable to carry out the

provisions of this chapter [Public Assistance] and that are not inconsistent therewith." Arkansas Code Annotated § 20-76-201 (12).

Per the agency, these rules are further being promulgated to comply with provisions of the Food and Nutrition Act of 2008 (Public Law No. 110-246), which allow for a cost of living adjustment to the SNAP maximum allotments, income eligibility standards, and deductions.

b. **SUBJECT: SNAP 3500: The SNAP Requirement to Work**

DESCRIPTION: Allows individuals that participate in an Employment and Training Program operated or supervised by the State that meets standards approved by the Governor to be in compliance with the Requirement to Work.

PUBLIC COMMENT: No public hearings were held. The public comment period expired on October 13, 2017. The Department received no comments.

The proposed effective date is January 1, 2018.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: Pursuant to Arkansas Code Annotated §20-76-201, the Department of Human Services ("Department") shall administer assigned forms of public assistance, supervise agencies and institutions caring for dependent or aged adults or adults with mental or physical disabilities, and administer other welfare activities or services that may be vested in it. The Department is authorized to "make rules and regulations and take actions as are necessary or desirable to carry out the provisions of this chapter [Public Assistance] and that are not inconsistent therewith." Arkansas Code Annotated § 20-76-201 (12).

Per the agency, these rules are further being promulgated to comply with provisions of the Food and Nutrition Act of 2008 (Public Law No. 110-246).

c. **SUBJECT: Medical Services Policy Manual Section: B-270, E-110, E-268, E-269, F-200, F-201, G-190, I-600, I-610 and Appendix F**

DESCRIPTION: This revises Medical Services policy to comply with the Arkansas Works Waiver by adding a work requirement to the Arkansas Works Program and decreasing the eligibility income limit for the program to 95% of the federal poverty level.

PUBLIC COMMENT: A public hearing was held on September 27, 2017. The public comment period expired on October 13, 2017. The Department received the following comments:

Commenters: Kevin De Liban, Staff Attorney and Lee Richardson, Executive Director Legal Aid of Arkansas, Inc.

We write to comment on the proposed revisions to Medical Services Policy Sections B-270, E-110, E-268, E-269, F-200, F-201, G-190, I-600, I-610, and Appendix F, issued by the Division of Medical Services on September 14, 2017 (the "proposed Medicaid policy revisions"). The public comment period for these revisions is already under way and is set to close shortly.

Premature Promulgation

As you know, "participation in Medicaid is voluntary, but if states choose to participate, they must comply with the requirements outlined in the Medicaid statute." *Ark. Med. Soc., Inc. v. Reynolds*, 6 F.3d 519, 522 (8th Cir. 1993); *see also* 42 U.S.C. § 1396a(a). Section 1115 of the Social Security Act allows the Secretary of the Department of Health and Human Services ("DHHS") to waive some federal requirements under certain conditions. 42 U.S.C. § 1315(a). Any requirements not explicitly waived by the Secretary remain in full force and effect. *See* Letter to Cindy Gillespie, Dir., Ark. Dep't of Human Servs. from DHHS, *Arkansas Works Section 1115 Demonstration* 3 (Dec. 8, 2016). Moreover, any changes to the existing waiver must occur only with federal permission. *See id*. at 8 ("The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid state plan and/or amendment to the demonstration. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below.").

The Division submitted proposed amendments to the State's existing Section 1115 project to DHHS on June 30, 2017, among other things seeking to impose work requirements and change income eligibility requirements for many Medicaid enrollees. As of the date of this letter, DHHS has not granted Arkansas the waivers needed to make these changes. As a result, the Division's promulgation of Medicaid policy revisions is "beyond the agency's . . . legal power or authority." *McLane S., Inc. v. Ark. Tobacco Control Bd*., 375 S.W.3d 628, 644 (Ark. 2013); *see Ark. State Bd. of Election Comm'rs v. Pulaski Cty. Election Comm'n*, 437 S.W.3d 80, 89 (Ark. 2014) ("[T]he law is elementary that an agency has no right to promulgate a rule or regulation contrary to a statute.").

Further, even if DHHS were to approve the proposed amendments to Arkansas Works, it may deny or require revisions to specific proposals. In 2015, for example, DHHS generally approved Indiana's application for a new Section 1115 demonstration project but rejected its proposed work requirement.[1] At this time, of course, there is no way for the public to know whether DHHS will reject aspects of the proposal or demand further revisions.

Nevertheless, in its notice of rulemaking, the Division requires that any comments concerning the proposed Medicaid policy revisions be submitted by October 13, 2017. In so doing, the Division is forcing the public to comment on significant state Medicaid policy changes that may or may not be approved—and that may or may not undergo substantial revisions before implementation. By mandating public comment before federal approval, the Division has violated the Arkansas Administrative Procedure Act's ("APA") requirement that a state agency "[a]fford all interested persons *reasonable opportunity* to submit written data, views, or arguments, orally or in writing," before adopting or amending a rule. Ark. Code Ann. § 25-15-204(a)(2)(A) (emphasis added). The APA's "notice and comment procedure assures that the public and the persons being regulated are given an opportunity to participate, provide information and suggest alternatives, so that the agency is educated about the impact of a proposed rule and can make a fair and mature decision." *Wagnon v. State Health Servs. Agency*, 40 S.W.3d 849, 852-53 (Ark. App. Ct. 2001). Here, however, the public is being deprived of the meaningful opportunity to participate in the notice and comment process because they lack critical information about whether and how the proposed rules will comply with the federal Medicaid requirements should the State's request ultimately be approved.

In light of the deficiencies identified above, we respectfully request that the Division rescind its notice of rulemaking and proposed Medicaid policy revisions until DHHS acts on the proposed amendments to the State's Section 1115 demonstration project. Additionally, we respectfully request that were the Division to seek to make regulatory changes after DHHS has taken final action to approve the proposed amendments in whole or in part, the Division initiate a new 30-day notice and comment period pursuant to § 25-15-204(a) of the Arkansas APA. We believe that failure to take these steps would render the final rules invalid and unlawful. Republication of the proposed regulations as requested above will allow Arkansans to participate more fully and knowingly in their State government.

[1] See Press release: CMS and Indiana Agree on Medicaid Expansion (Jan. 27, 2015), http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-01-27.html.

Comments on the Substance of the Proposed Policy Changes

Legal Aid of Arkansas previously submitted comments concerning the proposed changes to Arkansas Works contained in the waiver application to the Centers for Medicare and Medicaid Services, particularly the reduction of the eligibility cap to 100% FPL and the imposition of work requirements. Legal Aid of Arkansas explained the ways these changes would negatively impact our client communities and we incorporate those comments by reference and attachment. Turning to the present promulgation, the proposed policies operationalize the reduced eligibility cap and work requirements in ways that are likely to further harm clients by frustrating enrollment, encouraging churning, and violating due process principals.

A. The proposed polices impose significant administrative burdens on beneficiaries and the agency.

Each exemption from the work requirement requires verification at a differing interval, whether two months, six months, or a change in circumstances. Meanwhile, for individuals who are not exempt, verification of compliance with work requirements must happen monthly.

This imposes a new regulatory entanglement on a program that already features challenging eligibility income, resource, and categorical restrictions. In addition to the myriad requirements already managed, beneficiaries and agency staff must know whether or not an individual qualifies for an exemption to the work requirement, how long any exemption lasts, how to continue an exemption, how to comply if no exemption exists, and how to prove compliance. Meanwhile, agency workers and the administrative appeal process will have to compare each month of a beneficiary's entitlement year to the work requirements to determine if an individual is eligible for that month or not. The eligibility backlog, which persisted for over two years and required CMS intervention, demonstrates that the agency is not administratively equipped to handle a more complicated eligibility or renewal process with sufficient timeliness or accuracy. As a result, beneficiaries may experience inappropriate terminations, bars to re-enrollment, and discouragement from future enrollment. The additional administrative complexity is likely to result in complication for providers of Qualified Health Plans, who must now manage increasingly complex periods of beneficiary ineligibility and re-eligibility. Meanwhile, the interruptions in coverage are likely to cause beneficiaries to go without medical care and to be liable for costs of medical care incurred during periods of ineligibility, some of which may be erroneous.

At the same time, the agency's proposed policies do not adequately address the process to determine the eligibility for different Medicaid

groups once Arkansas Works eligibility is terminated. The policy manual states in Section I-610 that, "[w]hen possible, eligibility in another group should be determined at the time ineligibility for the current group is established." Here, the agency underestimates its obligations. In fact, the agency must consider all bases of eligibility prior to making a determination of ineligibility. 42 C.F.R. § 435.916(f). Presumably, both the work requirements and reduced eligibility cap will result in significant numbers of terminations from Arkansas Works. In the proposed policy manual, the agency has provided no proof that it has any process in place to evaluate terminated beneficiaries for other categories of eligibility.

In addition to being administratively complex, the verification procedures for the new policies run counter to established Medicaid law meant to minimize the administrative burden on applicants and beneficiaries. *See, e.g.*, 42 U.S.C. § 18083(b)(1)(A); 42 C.F.R. § 435.1200(b)(3)(i) (the agency must "minimize burden on individuals seeking to obtain or renew eligibility"); 42 C.F.R. § 435.916(c) (requiring that the agency accept beneficiary reports of change of circumstances "through any of the modes for submission of applications described in § 435.907(a) of this part"). Simply, DHS will be requiring beneficiaries to submit information that it should not request in ways that are unlawful and overly restrictive.

B. Electronic compliance requirements are unlawful and will further burden program beneficiaries who do not have ready access to or literacy with required technologies.

One element of the proposed policy changes likely to prove problematic for Arkansas Works beneficiaries is the reliance on an electronic compliance mechanism, apparently to the exclusion of more traditional forms of communication with the agency. As mentioned just above, federal regulations do not support the restrictions on the means that beneficiaries use to communicate relevant information. Despite the federal regulations, the agency proposes an electronic verification system, captured in essence by the following provisions:

B-270: "Arkansas Works recipients subject to the work requirement must have a valid e-mail address in order to report work activities, exemptions, or changes on the Arkansas Works portal."

G-190: "All other exemptions will be reported and validated by the individual through an online portal. Clients who log in to the portal and report an exemption after the initial determination will receive a notice informing them when the exemption will be revalidated."

G-190: "Demonstration of an exemption or work activity must be done electronically, except when information regarding a work activity or exemption is provided on an application."

The waiver application itself does not specify that electronic compliance operates to the exclusion of traditional forms of client interaction with DHS around public benefit programs. Imposing electronic-only

verification requirements is likely to disadvantage significant numbers of beneficiaries.

Arkansas, a predominantly rural state, is especially likely to face problems caused by electronic verification requirements. Recent studies from the Pew Research Center substantiate the "digital divide" in which rural residents have less access to connective technologies than their suburban and urban counterparts.[2] Rural residents own significantly fewer smartphones, tablets, and laptops, meaning that they may lack the devices needed to submit the information DHS is requesting. Moreover, rural residents use the internet less frequently. Roughly 4 in 10 rural adults do not use the internet every day. 1 in 5 rural adults never goes online. And, rural residents less frequently have broadband in their own homes. Even those rural Arkansans who do have access to broadband are likely to connect at much slower speeds than elsewhere.[3]

The Pew Research Center study further shows that the gravity of the digital divide is magnified by socioeconomic status.[4]4 The people who qualify for Arkansas Works have less access to connective technologies than their better-off rural neighbors. Independent of the rural-urban digital divide, there is a gap in technological readiness based strictly on income.[5] Those who qualify financially for Arkansas Works are more likely to be "digitally unprepared" than better-off individuals. Similarly, internet usage and ownership of connective devices is lower among individuals with disabilities than those without a disability.[6] Many Arkansas Works beneficiaries are likely to thus be disadvantaged.

In summary, there are systemic societal issues regarding connective technologies that argue against DHS's proposed requirement for beneficiaries to electronically verify compliance with work requirements.

These societal issues are accompanied by many administrative challenges for operating and maintaining an electronic compliance system that strictly demands that beneficiaries provide proof of compliance by the 5th of the following month. The portals require a log-in. What is to happen if the

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[2] http://www.pewresearch.org/fact-tank/2017/05/19/digital-gap-between-rural-and-nonrural-america-persists/

[3] https://www.brookings.edu/blog/the-avenue/2017/02/13/in-infrastructure-plan-a-big-opening-for-rural-broadband/

[4] http://www.pewresearch.org/fact-tank/2017/03/22/digital-divide-persists-even-as-lower-income-americans-make-gains-in-techadoption/

[5] http://www.pewinternet.org/2016/09/20/appendix-detail-on-digital-readiness-and-other-metrics-across-groups/

[6] http://www.pewresearch.org/fact-tank/2017/04/07/disabled-americans-are-less-likely-to-use-technology/

log-in or password is lost? What happens if the portal website is down for maintenance or for unplanned reasons? What is DHS's plan to provide technical support to users in a timely way that allows them to readily meet the strict timelines for demonstrating compliance? How user-friendly and simple will the portal be? Will the portal be designed to be used on a smartphone screen or on bigger screens such as laptops? Will the portal require comparatively fast internet speeds in order to connect? With reduced funding for navigators, where can beneficiaries go to get help to demonstrate compliance? Will DHS field offices have staff trained on the system and readily available at all times to help beneficiaries? Will DHS field offices have laptops or tablets that the public can use to demonstrate compliance?

Will all the information be provided be safely maintained? Recently, over 20,000 Medicaid beneficiaries had personal information stolen from DHS. What steps has the agency taken to prevent something similar from re-occurring?

Will compliance require beneficiaries to upload actual documents? If so, how does DHS plan to accommodate the extra layer of challenges caused by needing to convert physical documents to digital form and then upload them? How to ensure that documents submitted are connected to the appropriate file? Is mere attestation of compliance enough? Will beneficiaries receive any sort of proof of receipt from the system once the information has been provided?

How will the notice contemplated in Section G-190 be transmitted ("[c]lients who log in to the portal and report an exemption after the initial determination will receive a notice informing them when the exemption will be revalidated")? How far in advance of the expiration of the exemption is the notice to be transmitted? What guarantees are there that DHS will structure the notices in a way that will not be filtered automatically to spam folders? Will a beneficiary's non-receipt of the electronic notice offer the possibility of a retroactive exemption period? Apart from all these unanswered questions regarding the operation of the electronic system, the departure from the traditional practices of verification does not seem sensible. Many beneficiaries have used nonelectronic forms of communication, such as office visits, regular mail, or, occasionally, fax to communicate with DHS as needed. What harm is there in allowing verification to happen through these traditional means while adding the electronic verification system as an alternative? Relatedly, electronic-only verification could discriminate against individuals with disabilities who require alternative means to verify compliance, as not all disabilities, as that term is defined in relevant federal law, would necessarily qualify an individual for an alternative category of Medicaid or for an exemption from the work requirements.

To the extent that DHS is convinced that the electronic application systems inaugurated under Medicaid Expansion and the Affordable Care Act adequately prepare Arkansas Works beneficiaries for electronic verification, the agency should remember that not all applicants enrolled electronically. For those who did, the agency should remember that a significant number of beneficiaries received enrollment assistance from navigator and similar programs, most of which no longer operate. And, even those who did so unassisted were completing a one-time application, which involves different circumstances and substantially less burden than an ongoing obligation to provide electronic verification.

C. The definitions of the exemptions and work activities are not sufficiently clear to ensure consistent application.

Consistent application of any exemptions and work activities are necessary to the functioning of any modified Arkansas Works program, but the definitions of various exemptions and activities are problematically vague.

A beneficiary "living in home with a dependent minor" is exempt. The meaning of "dependent minor" is unclear. Does it include grandchildren or nieces or nephews who may be living in a kinship arrangement with a non-parent family member? Does it include separated parents who have joint custody of children?

Another exemption is providing to beneficiaries "caring for [an] incapacitated person." Who is an "incapacitated person" for these purposes? Must it be someone who is legally determined to lack capacity? What if person being cared for has profound physical disabilities requiring care but is mentally competent?

There is an exemption for someone "experiencing a short-term incapacitation." How is the "short-term incapacitation" to be established? Notably, this language differs from the exemption listed in the waiver application to CMS, which provided an exemption not only for short-term incapacitation, but also for individuals "medically certified as physically or mentally unfit for employment."[7] Does the proposed policy manual's definition of "short-term incapacitation" include the provision for people "unfit for employment?" If not, are people who are "medically certified as physically or mentally unfit for employment" entitled to an exemption, and what form must certification take?

[7] Centers for Medicare and Medicaid Services Expenditure Authority Number 11-W-00287/6, as promulgated by DHS on or around 5/19/17, Page 23 of 43.

Similarly, "volunteering" is a work activity. Other than a reference to an "agency name, address, and phone number" under Section G-190, there is no information about what qualifies. Will work voluntarily performed at a church qualify? How about a neighborhood clean-up session? What must an individual do to establish that she has volunteered?

Moreover, all exemptions and work activities require an "electronic demonstration of compliance." Is the "demonstration of compliance" an attestation by the beneficiary that she has met the given exemption or activity? Must documents be furnished? What kinds of documents? As it stands, the definitions of the proposed exemptions and work activities do not provide adequate guidance to the public. These definitions of the exemptions and work activities should be changed and made sufficiently specific to allow beneficiaries, DHS workers, and hearing officers to decide if a particularly category is met.

D. The proposed policies violate due process.

The onerous verification requirements are themselves riddled with due process concerns.

Section G-190 requires that beneficiaries report hours, exemptions, or work activity by the 5th of the following month. There are no apparently no exceptions: "Recipients cannot provide electronic demonstration of compliance retroactively after the 5th of the following month. For example, a recipient cannot provide electronic demonstration of compliance on April 7th for meeting the work requirement in March." The reason for non-report does not apparently matter to the agency, even if technical problems on its end were the cause.

Then, "[i]f the recipient does not report by the deadline, a notice will be sent informing the recipient that a month of non-compliance has accrued." The proposed policy offers no details on this notice. What information will the notice contain? Will it be sent by mail or only electronically? Can the determination of non-compliance be appealed?

Furthermore, "[i]f the recipient accrues a second month of non-compliance, a notice will be sent informing the recipient of the second month of non-compliance and that their case will be closed at the end of the third month of non-compliance." Also, the policy states, "This notice will serve as the notice of adverse action." That policy is unlawful. A notice of adverse action with expiring appeal rights cannot be validly issued prior to an actual agency decision to terminate. See, e.g., 42 C.F.R. §§ 431.206(c), 431.201, 431.210. Of course, here, the agency cannot decide to terminate an individual after only two months of noncompliance. Moreover, even were the agency aware of a third month of non-compliance, the agency cannot accurately state that a case will be closed

until the agency has evaluated a beneficiary's eligibility under other Medicaid categories, as required by 42 C.F.R. § 435.916(f).

The statement in the proposed policy's following statement betrays a troubling understanding of due process, declaring, "If the recipient satisfactorily complies with reporting work activities by the 5th of the month following the third month of non-compliance, their case will be reinstated." This is tautological, as complying with the work activities would mean that the third month is not one of non-compliance. Moreover, a case cannot be "reinstated" if it was never terminated in the first place. And, of course, a case cannot be terminated until after the third month of non-compliance. In addition, the beneficiary would be entitled to continuing benefits pending the outcome of any appeal. 42 C.F.R. § 431.230.

The requirements of due process are more stringent considering what is at stake. As Section F-200 provides, "Those Adult Expansion Group recipients who lose coverage for non-compliance with the work requirement but meet an exemption later in the calendar year will not be allowed to regain coverage in Arkansas Works until the following year." If an individual who later would be eligible on the basis of an exemption is denied due to three prior months of non-compliance, the process used to determine those three prior months must be flawless. Moreover, there are legitimate fairness concerns about excluding an individual who meets conditions of eligibility due to a change in circumstances, which could, for example, include becoming a custodial parent or having to suddenly start caring for an incapacitated family member.

Conclusion

The agency has prematurely promulgated proposed policies before receiving CMS approval of the waiver application. Thus, the promulgation is beyond the agency's authority and unlawful. Meanwhile, the substance of the proposed policies to implement work requirements and reduced eligibility caps are fraught with legal and administrative problems and are likely to harm Legal Aid of Arkansas's client communities and cause administrative dysfunction to DHS.

RESPONSE:

The Department is in receipt of your public comment dated October 13, 2017 in reference to proposed revisions to Medical Services Policy Sections B-270, E-110, E-268, E-269, F-200, F-201, G-190, I-600, I-610, and Appendix F. We also received a second copy of your organization's comments dated June 18, 2017 in reference to "Comments on Arkansas 1115 Waiver Demonstration." Unfortunately, the public comment period for that rule has ended.

We thank you for your continued interest in this program and appreciate the time and effort that went into your letter concerning the proposed revisions to the Medicaid Services Policy Manual. The Department encourages stakeholder engagement and involvement when development programmatic changes. We will take your comments under advisement.

The agency states that the instant rules will require CMS approval; that approval is pending as of October 19, 2017. The proposed effective date is January 1, 2018.

FINANCIAL IMPACT: The agency anticipates a savings for the current fiscal year of $4,759,286 ($285,557 in general revenue and $4,435,729 in federal funds) and $59,913,838 in the next fiscal year ($3,936,310 in general revenue and $55,977,527 in federal funds).

LEGAL AUTHORIZATION: The proposed rule change revises Medical Services policy to comply with the Arkansas Works Waiver.

The proposed amendments to existing rules are authorized by Act 6 of the first Extraordinary Session of the 91st General Assembly [Arkansas Code Annotated § 23-61-1003 (10)] and Arkansas Works Section 1115 Demonstration #11-W-00287/6.

The Department of Human Services is authorized to "make rules and regulations and take actions as are necessary or desirable to carry out the provisions of this chapter and that are not inconsistent therewith." Arkansas Code Annotated § 20-76-201 (12).

8. DEPARTMENT OF HUMAN SERVICES, MEDICAL SERVICES (Tami Harlan)

a. SUBJECT: Patient Centered Medical Home (PCMH) 2-17 and Section V-4-17

DESCRIPTION: The following changes are proposed to the 2018 manual:

200.000 – Added the definition of Quality Improvement Plan (QIP).

211.000 – Reduced the number of minimum beneficiaries required to participate, added EHR certification requirements, and clarified how a previously suspended/terminated practice may return to the PCMH program.

221.000 – Updated dated for Practice Transformation sunset.

232.000 – Removed eligibility requirements pertaining to Comprehensive Primary Care (CPC) Program.

233.000 – Added a new pooling option (petite pool) to accommodate practices with fewer than 300 beneficiaries.

234.000 – Removed exception disallowing voluntary pools to move to default pool when attribution gets below 5000 beneficiaries, added petite pool definition, and clarified how a practice leaving the pool during Q4 affects performance.

237.000 – Updated floor, medium and high threshold amounts as required in the state plan amendment.

244.000 – Added instructions pertaining to provider reports and updated, added guidelines for practice support payments during appeals and reconsiderations, and corrected address for reconsiderations.

250.000 – Deleted section regarding CPC as the program ended on 12/31/2016.

PUBLIC COMMENT: No public hearings were held. The public comment period expired on October 13, 2017. The Department provided the following comments and its response:

Commenter: Dr. Culber Mack Shotts, Medical Director, Paragould Doctors' Clinic

We wish to submit comments addressing a few concerns with the 2018 Arkansas PCMH Manual and Addendum. Our first and primary concern centers on the proposed per-beneficiary medium cost threshold for shared savings. According to the manual, the medium cost threshold per beneficiary is only increasing 1.5% to $2150.00. We do not feel that this is a realistic medium cost threshold, especially considering that the cost threshold is directly tied to whether or not PCMHs are eligible for shared savings incentives. In researching our clinic cost from 2015 to 2016, we found that there are many factors which are out of our direct control that affected our cost, and we question whether or not these factors are considered when the cost threshold is determined. We also question whether or not a realistic approach is being taken when considering the often high cost of providing high quality healthcare.

For example, as a rural health clinic, we are paid an all-inclusive rate of $83.61 for office visits rather than being paid according to the physician fee schedule. If a patient is seen 12 times in a year as patients with

chronic issues often are, that totals $1003.32. This is nearly half of the total medium cost threshold in primary care office visits alone. This leaves very little room for cost of care for things such as specialist visits, pharmacy claims, or inpatient physician or facility claims, all of which are pertinent costs associated with a patient's overall care. One inpatient stay or a handful of specialist visits can easily put the beneficiary over the medium cost threshold for the entire year. While it's understandable that a goal of the PCHM program is for PCPs to strive to improve overall health of their patients and reduce the need for excessive specialist and emergency room visits and inpatient stays and thereby lower costs, it is not realistic to expect that lower healthcare costs necessarily correlates to improved quality of patient health or that PCPs can necessarily directly lower cost of these additional necessary services. Considering that we are the ones held responsible for the total cost of care of these patients, we feel that the threshold is too low and should be reevaluated and raised to a more realistic amount.

As it relates to cost, we understand that the reasoning behind the lower medium cost threshold might be that patients who exceed this threshold might be the exception and not the rule. If that is the case, we feel that only allowing one cost exclusion per 1,000 beneficiaries is currently not much of an asset to lowering our calculated cost in the PCMH program. Even if higher cost patients are not considered typical, surely DMS realizes that high cost patients who often require additional services at additional cost to improve overall health represent a greater demographic than the 0.001% of our total patients that we are allowed to exclude.

The other concern we have with the program relates to care plans. This is a complaint that we have found to be common among PCMHs over the last several years in the program. We do not select our high-priority patients until the end of March of each year, yet we must attest that we have two valid care plans on these patients by the end of December each year, yet we must attest that we have two valid care plans on these patients by the end of December each year. This means that in reality, we only have nine months to complete the car plans on these patients, not a full year. We have been told that the logic behind this is that we can still complete care plans on these patients between January and March prior to selecting them, so we still technically have a full year to compete the care plans. However, this logic is flawed because it makes no sense to complete care plans on patients in advance if we don't know that we will select them as high-priority patients in March because other patients might be considered more high-priority and selected instead. A more efficient way of handling this would be to either allow us to select the high-priority patients by the end of the December the year before the new PCMH year or to allow us until the end of March the following year to attest that two care plans for each high-priority patient have been obtained. Either of

these options would give PCMHs a full year with the currently-selected high-priority list in order to obtain valid care plans.

RESPONSE:
We are writing in response to your October 6, 2017 letter regarding the proposed changes for the 2018 PCMH Program, specifically the medium cost threshold and Care Plan requirements.

The PCMH program has always had per member per year thresholds and target inflation rate in place since the beginning of the program. We are actively reviewing the program thresholds as well as monitoring provider program performance and cost. In your letter, you also mention the one cost exclusion per 1,000 beneficiaries is currently not much of an asset to lowering the calculated cost in the PCMH program. This exclusion of 0.1%, was set by Medicaid's previous Director. We now have a new Medicaid Director in place and one of her interests is the next iteration of the PCMH program. We will bring your concern to her attention for further review.

At this time, no additional standards are being added to care plan requirements. We are reviewing all comments and suggestions for improvement for future PCMH performance periods. It is important to remember, that many of mature PCMH practices have mostly the same high priority beneficiaries each year and it is expected that these patients have existing care plans on file that can be updated with regular visits.

The proposed effective date is January 1, 2018.

FINANCIAL IMPACT: The estimated additional cost to implement the rule for the current fiscal year is $184,890 ($54,395 in general revenue and $130,495 in federal funds). For the next fiscal year, the agency anticipates a savings of $1,015,621 ($298,796 in general revenue and $716,825 in federal funds).

LEGAL AUTHORIZATION: The amendment to an existing rule is necessary to update the Patient Centered Medical Home (PCMH) provider manual to implement the Health Task Force's recommendations and to update thresholds after Medical Services review as required by the PCMH Medicaid State Plan Amendment.

The Department of Human Services is authorized to "make rules and regulations and take actions as are necessary or desirable to carry out the provisions of this chapter [Public Assistance] and that are not inconsistent therewith." Arkansas Code Annotated § 20-76-201 (12). Arkansas Code §20-77-107 specifically authorizes the department to "establish and maintain an indigent medical care program."

9. DEPARTMENT OF LABOR, BOARD OF ELECTRICAL EXAMINERS (Denise Oxley)

a. SUBJECT: Rule 010.13-008: The National Electrical Code

DESCRIPTION: The summary follows:

Rule 010.13-008. This rule would be amended to update the National Electrical Code from the 2014 edition to the 2017 edition, with the continued exception that arc fault circuit interrupters will not be required in the kitchen and laundry room.

Rule 010.13-023. This rule reflecting the history and effective dates of the board's rules would be amended to include the foregoing with an effective date of December 15, 2017.

PUBLIC COMMENT: A public hearing was held on September 19, 2017, and the public comment period expired on that date. Public comments were as follows:

Don Iverson, Midwest Field Representative, National Electrical Manufacturers Association (NEMA)

Mr. Iverson submitted written comments to the board on behalf of the over 400 member companies of NEMA. NEMA supports the adoption of the 2017 National Electrical Code (NEC) as the standard for performance of electrical work in Arkansas. The organization has a long history of supporting timely adoption of the NEC by state and local jurisdictions. Mr. Iverson states the organization believes that current codes mean safer and more economically prosperous communities.

NEMA requested that the board remove the Arkansas exception to the NEC adoption that would eliminate the requirement for arc fault circuit interrupters (AFCI) in kitchen and laundry areas. NEMA cited other groups involved in fire and electrical safety that support AFCI expansion, including: the National Fire Protection Association, the Electrical Safety Foundation International, the National Association of State Fire Marshals, the National Electrical Contractors Association, the International Association of Electrical Inspectors, the Independent Electrical Contractors Association, the Underwriters Laboratories, and the U. S. Consumer Product Safety Commission.

RESPONSE: No change was made as a result of the comment.

Mike Stone, West Coast Field Representative, NEMA

Mr. Stone provided verbal testimony before the board that reiterated the position of NEMA as stated by Mr. Don Iverson.

RESPONSE: No change was made as a result of the comment.

The proposed effective date is December 15, 2017.

FINANCIAL IMPACT: The cost to the regulated party will vary depending on the nature and design of any particular construction project. This is particularly true for non-residential construction. Further, many of the large electrical contractors are already complying with the changes due to industry practice, client needs, contract requirements, or liability issues.

For residential construction, the cost estimate is under $150 per residence based on average construction. Specifically, this is itemized as follows:

a. If the new residence is to have lighting outlet(s) in a crawl space under the home, new requirements would increase costs less than $50.

b. There is a new requirement for a minimum 20 amp branch circuit for residential garage receptacles that would increase costs less than $100 if applicable.

Note: The 2014 National Electrical Code (NEC) would have required AFCI protection in the kitchen and laundry areas. This was specifically amended out of the 2014 NEC as adopted in Arkansas for statewide standards. Adoption of the 2017 NEC would continue these two exceptions, so that AFCI protection would not be required in the kitchen and laundry areas.

LEGAL AUTHORIZATION: The Board of Electrical Examiners is empowered to adopt rules and regulations to establish statewide standards for the construction, installation, and maintenance of electrical facilities and the performance of electrical work. Ark. Code Ann. § 20-31-104(a). Pursuant to Arkansas Code Annotated § 20-31-104(b), the Board was required to adopt the National Electrical Code, 1990 edition, of the National Fire Protection Association. If there are updates and new editions to the National Electrical Code, the board, after notice and public hearing, shall adopt such changes and editions which it determines are necessary to ensure public health and safety. Ark. Code Ann. § 20-31-104(c).

10. DEPARTMENT OF LABOR, LABOR STANDARDS DIVISION
(Denise Oxley)

a. SUBJECT: Rules 010.14-200 through -225; Prevailing Wage Rules

DESCRIPTION: Act 1068 of 2017 repealed the prevailing wage law. This is the repeal of the corresponding administrative rules effective November 30, 2017.

PUBLIC COMMENT: A public hearing was held on September 18, 2017, and the public comment period expired on that date. No public comments were submitted. The proposed effective date is November 30, 2017.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: Act 1068 of 2017, sponsored by Senator Bart Hester, repealed the Arkansas Prevailing Wage Law, under which the Department of Labor was required to promulgate rules. As the law has now been repealed, the department is repealing its corresponding rules.

11. DEPARTMENT OF PARKS AND TOURISM, STATE PARKS DIVISION
Grady Spann and Joe Jacobs)

a. SUBJECT: CY 2018 Arkansas State Parks Fees and Rates

DESCRIPTION: This establishes the CY 2018 fees and rates for facilities and services in Arkansas State Parks. Forty-one percent of the park system's daily maintenance and operation budget is from services and the rental of facilities. Adjustments in fees and rates are made over time to compensate for inflation, expenses, and to maintain Arkansas State Parks' mission (conservation, recreation, education, and tourism).

PUBLIC COMMENT: A public hearing was held on August 17, 2017, and the public comment period expired on that date. No public comments were submitted. The proposed effective date is January 1, 2018.

FINANCIAL IMPACT: The following chart indicates the dollar increase of CY 2018 fees over the CY 2017 fees:

Lodging	$110,563
Camping	$305,252
Meeting Rooms and Pavilions	0
Marina Slip Rental and Boat Rental	$ 2,135
Interpretive Tours	0

Golf	$ (4,500)
Museum	0
Miscellaneous Rental Equipment	0
Swimming	$ 21,459
Entrance Fees	0
Total	**$434,909**

LEGAL AUTHORIZATION: The State Parks, Recreation, and Travel Commission is authorized and directed to prescribe and collect reasonable fees, rates, tolls, and charges for the services, facilities, and commodities rendered by the properties and equipment of the state parks system. Ark. Code Ann. § 22-4-305(a).

12. STATE BOARD OF PHARMACY (John Kirtley)

a. SUBJECT: Regulation 7; Drug Products/Prescriptions

DESCRIPTION: The changes follow:

1. Update definitions to match FDA definitions and glossary terms to add terms for biological product, biosimilar, biosimilar product, drug, generic drug, and interchangeable biological product.

2. Clarify language regarding pharmacists' ability to substitute products that are either generically equivalent, interchangeable biological products, or manufacturer authorized generics.

(The changes in 1 and 2 above are necessary to clarify confusion regarding whether or not biologic products are "drugs" and to proactively show how pharmacists can follow federal guidance in substituting those products shown to be interchangeable once products meet those qualifications.)

3. Add language to show that a pharmacist cannot dispense more of a schedule II narcotic medication than a prescriber can prescribe.

PUBLIC COMMENT: A public hearing was held on September 26, 2017, and the public comment period expired on that date. The board submitted a public comment summary, attached hereto, detailing all of the comments received regarding these rules. The proposed effective date is pending legislative review and approval.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: The Arkansas State Board of Pharmacy is authorized to make reasonable rules and regulations, not inconsistent with law, to carry out the purposes and intentions of the pharmacy laws of this state that the board deems necessary to preserve and protect the public health. Ark. Code Ann. § 17-92-205(a)(1). Additionally, Act 820 of 2017, sponsored by Senator Jeremy Hutchinson, requires the board to promulgate rules limiting the amount of Schedule II narcotics that may be dispensed by licensees of the board. *See* Ark. Code Ann. § 17-92-205(d), as amended by Act 820.

b. SUBJECT: Regulation 9; Pharmaceutical Care/Patient Counseling

DESCRIPTION: Due to Act 284 of 2017, a clarification is promulgated to remove the statutory language regarding the Medications Administration Advisory Committee as well as the list of medications that can be administered by pharmacists.

The rule also deletes a reference that CPR courses must be accredited by the American Heart Association as it does not make sense.

PUBLIC COMMENT: A public hearing was held on September 26, 2017, and the public comment period expired on that date. No public comments were submitted to the agency. The proposed effective date is pending legislative review and approval.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: The Arkansas State Board of Pharmacy is authorized to make reasonable rules and regulations, not inconsistent with law, to carry out the purposes and intentions of the pharmacy laws of this state that the board deems necessary to preserve and protect the public health. Ark. Code Ann. § 17-92-205(a)(1). The board shall by regulation establish standards for the administration of medications by licensed pharmacists. Ark. Code Ann. § 17-92-205(a)(2).

A portion of this rule implements Act 284 of 2017, sponsored by Senator Bledsoe, which removed statutory language regarding the Medications Administration Advisory Committee as well as a list of medications that can be administered by pharmacists. *See* Ark. Code Ann. § 17-92-101(16), as amended by Act 284.

13. STATE PLANT BOARD, PESTICIDE DIVISION (Susie Nichols)

a. SUBJECT: Pesticide Enforcement and Response Regulation

DESCRIPTION: This rule amends the Enforcement Response Regulations in accordance with Act 778 of 2017 that increases the maximum civil penalty from $1,000 to $25,000 for egregious violations from applications of Dicamba, or an Auxin containing herbicide, or any new herbicide technology released after August 1, 2017. The purpose of the amendment is to define terms in Act 778 and to incorporate the penalty range of "up to $25,000" into the civil penalty matrix.

PUBLIC COMMENT: A public hearing on the rule was held on September 21, 2017. The public comment period expired on September 19, 2017. The Board received no comments.

This rule was promulgated on an emergency basis and was approved at a meeting of the Executive Subcommittee on July 5, 2017. The proposed effective date for the permanent rule is pending legislative review and approval.

FINANCIAL IMPACT: Individuals who comply with the law will not have any financial impact. Anyone found to have committed an egregious violation will be subject to a civil penalty of up to $25,000. There will be no cost to the state, county, or municipal government.

LEGAL AUTHORIZATION: The proposed rule implements **Act 778 of 2017**, sponsored by Senator Blake Johnson, which created penalties under the State Plant Board for the misuse of dicamba or dicamba-related products; limited the use of penalties above one thousand dollars ($1,000); and directed moneys to scholarships and training of personnel. Arkansas Code Annotated § 2-16-203(b)(1)(A)(ii)(*a*), as amended by Act 778, § 1, specifically permits the Board to assess a civil penalty greater than one thousand dollars ($1,000), but not more than twenty-five thousand dollars ($25,000), only if the Board finds that a violation is egregious. As defined by the statute, "[a]violation is egregious only if significant off-target crop damage occurred as a result of the application of dicamba or an auxin-containing herbicide or any new herbicide technology released after August 1, 2017." Ark. Code Ann. § 2-16-203(b)(1)(A)(ii)(*b*), as amended by Act 778, § 1. Pursuant to Ark. Code Ann. § 2-16-203(b)(2)(A), the Board shall by rule establish a schedule designating the minimum and maximum civil penalty that may be assessed under the statute for violation of each statute, rule, or order over which the Board has regulatory control. The Board may also promulgate any other regulation necessary to carry out the intent of the statute. *See* Ark. Code Ann. § 2-16-203(b)(2)(B).

14. PUBLIC EMPLOYEES RETIREMENT SYSTEM (Gail Stone and Jay Wills)

a. SUBJECT: Declaratory Order

DESCRIPTION: The Arkansas Public Employees' Retirement System ("APERS") Regulation 223 permits any retirant or member of APERS to ask questions concerning the applicability of any rule, statute, or other order of the APERS Board of Directors. The retiree or member must submit a written petition for a declaratory order to the Executive Director of APERS.

PUBLIC COMMENT: A public hearing was held on October 9, 2017. The public comment period expired that same day. The System received no comments.

The proposed effective date is pending legislative review and approval.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: Pursuant to Arkansas Code Annotated § 25-15-206, each agency shall provide by rule for the filing and prompt disposition of petitions for declaratory orders as to the applicability of any rule, statute, or order enforced by it. Further authority for the rulemaking can be found in Ark. Code Ann. § 24-4-105(b)(1), which provides that in addition to such other duties imposed on it, the Board of Trustees of the Arkansas Public Employees' Retirement System shall make "all rules and regulations as it shall deem necessary from time to time in the transaction of its business and in administering the Arkansas Public Employees' Retirement System."

15. WORKERS COMPENSATION COMMISSION (Mark McGuire and Barbara Webb)

a. SUBJECT: Workers' Compensation Drug Formulary

DESCRIPTION: Proposed Rule 099.41 is a drug formulary to control costs in workers' compensation claims, provide claimants with the most appropriate drugs for their injury, limit opioid prescriptions, and reduce addictions. The rule improves the way opioids are prescribed and ensures safer treatment while reducing the misuse of these drugs. It also allows for timely dispensing and review of FDA approved prescription drugs for workers' compensation claims. It is necessary to reduce misuse of opioids

and allow timely dispensing and review of FDA approved prescriptions.

PUBLIC COMMENT: A public hearing was held on May 23, 2017. The public comment period expired on June 14, 2017. The Commission provided the following summary of the public comments received and its responses:

Commenter: Eddie Walker, Attorney At Law

Adopting the drug formulary is a good idea, but he believes that such a rule should be given a trial period so that any needed adjustments can be made prior to the actual adoption of the rule. Therefore he suggests that the proposed rule be specifically identified as in interim rule that is initially being considered on a trial basis and that a permanent rule will not be adopted until the effects of the interim rule are evaluated.

Secondly he has grave concerns about the 10 day appeal time. He does not believe that an injured worker that does not already have an attorney will be able to obtain one quickly enough to comply with such a short time frame. Especially since they will be looking for an attorney willing to represent them for free. Even if the attorney is to be paid, he does not know many attorneys who would be willing to agree to handle an appeal on such short notice.

He states that the Public Employee's Claims Division stated they have had very few appeals as support that the program is good and he suggests that they may have had few appeals because the injured worker could not find an attorney to represent them or didn't believe they could get a doctor to explain why the recommended treatment/prescription is appropriate. He says his experience has been that most physicians don't like being second guessed by insurance companies, nurses, or pharmacists.

He says it appears the conditions to which the appealing party have to certify are unnecessarily onerous and place additional requirements on the treating physician which is likely to run more doctors out of the ranks of those who are willing to treat workers' compensation injuries.

Also, he says that since the implementation of a drug formulary will save Respondents a considerable amount of money, some provision for an attorney's fee for an attorney who successfully represents an injured worker would be appropriate and suggests a flat fee of $500.00.

He proposes that attorneys are already donating a significant amount of time helping injured workers when respondents refuse to authorize medical treatment and now, they will be expected to donate even more time representing injured workers regarding disputes relative to

prescription medications even though those prescriptions are coming from authorized treating physicians. He says this clearly creates an unfair situation for injured workers.
AGENCY RESPONSE: The Commission discussed the possibility of a trial period for this Rule but did not see any benefit, in view of the fact that the Public Employee Claims Division of the Arkansas Insurance Department has been using this drug formulary since November of 2015. The Commission also discussed the process and timeframe for appeals of denied medications and decided not to make any changes to the proposed rule. A short appeal time will allow the injured worker to obtain a resolution of the issue quickly. The Commission believes that any provision for an attorney's fee will have to be addressed by the Legislature.

Commenter: Jason M. Hatfield, P.A., Attorney At Law

He has concerns about the proposed rule. He says from the claimant's perspective delay equals denial and this is one more way to force litigation on injured workers. He says the workers' compensation rules in our state do not provide attorney's fees for disputed medical expenses and injured workers will have a difficult time finding an attorney to represent them in disputes between the carrier and doctor.

Also he says this rule will run more doctors away from handling pain management related issues in workers' compensation claims and result in few, if any, qualified doctors interested in fighting the red tape battles on behalf of their patients.

He says the question of whether medical treatment is appropriate, reasonable and necessary is already an issue in every workers' compensation claim and there is no reason to add additional hurdles over the issue of whether a particular form of medication management is appropriate or not.

He urges the Commission to contact as many pain management professionals as they can in the State of Arkansas to specifically request their opinion and comment on the subject before implementing this rule.
AGENCY RESPONSE: The Commission believes that any provision for an attorney's fee will have to be addressed by the Legislature. The Commission has received and considered public comments from pain management doctors and the Arkansas Medical Society.

Commenter: Steven McNeely, Attorney At Law

His specific concerns with the rule include:

90 MED per day is too low and does not take into account multiple prescriptions, which may be required during the first few days or weeks following an injury or surgery.

This MED bright line does not take into account an individual's body type, body mass or other individual factors.

A 100 mcg/hour Duragesic patch taken once a day would not be allowed under this formula.

He believes a better rule would be whenever an injured worker's MED reaches 120 mg they be sent to a pain management doctor for an evaluation concerning their prescriptions.

The current rule will accomplish its goal of reducing costs for the carrier and it does not have any benefit to the injured worker.

He foresees more doctors not wanting to accept a work comp patient, which will add additional stress to an already stressful worker's life and could delay and even prohibit their recovery.

Also, he says the UAMS Drug Formulary is only 4 pages long and then moves to a prior authorization process.
AGENCY RESPONSE: The Commission understands Attorney McNeely's concerns but has chosen to rely on the CDC guidelines.

Commenter: Greg Giles, Attorney At Law

Mr. Giles addressed his concerns from the claimant's perspective. He said delay equals denial and this is simply one more way to force litigation on an injured worker with very little chance of representation since the workers' compensation rules in Arkansas do not provide attorney's fees for disputed medical expenses. This will result in injured workers being forced to be unrepresented in this dispute between the carrier and doctor.

He suspects this rule will simply run more doctors away from handling pain management related issues in workers' compensation claims and the net result will be few, if any, qualified doctors interested in fighting the red tape battles on behalf of their patients.

Also, he says the question of whether medical treatment is appropriate, reasonable, and necessary is already an issue that comes into play in every workers' compensation claim and there is no reason to add additional red tape to the process over the issue of whether a particular form of medication management is appropriate or not. A "Drug Formulary" should not be necessary to try and establish some boundaries over what is

appropriate medical care. He says the Arkansas Democrat Gazette says this issue is already being addressed in other ways. He includes an article in the Gazette originally printed in the Washington Post.

He urges the Commission to contact as many pain management professionals as they can in Arkansas to specifically request their opinion and comment on the subject before adopting this rule, which limits pain management.
AGENCY RESPONSE: The Commission believes that any provision for an attorney's fee will have to be addressed by the Legislature. The Commission has received and considered public comments from pain management doctors and the Arkansas Medical Society.

Commenter: Steven A. Bennett, Associate General Counsel, American Insurance Association

AIA supports adoption of a workers' compensation drug formulary, but recommends that the Commission adopt the Official Disability Guidelines (ODG) drug formulary produced by the Work Loss Data Institute. It is important to adopt a nationally-recognized, evidence-based formulary that has been adopted in other states (Texas, Oklahoma, Tennessee, New Mexico, North Dakota, and Ohio) and has a proven track record.

They recommend ODG based upon the following:

- The ODG Formulary is based upon evidence-based medical treatment guidelines, applying the most complete and thorough medical knowledge;

- The ODG Formulary is updated monthly so it is current and up-to-date;

- The ODG Formulary has a proven track record of success and Texas is given as an example;

- The ODG Formulary covers the broadest range of potential prescriptions and treatments (covers all 10,000 ICD9 codes; 65,000 ICD10 codes; and 11,000 CPT codes);

- The ODG Formulary has already been successfully integrated by most payers and prescription benefit managers, thereby reducing or eliminating implementation delays and costs;

AIA also offers the following recommended changes to the proposed rule:

Legacy Claims: It is critical that the formulary and the proposed rule apply to all workers' compensation injuries including legacy claims. They suggest a delay of six to nine months before applying the formulary to existing claims, which will allow time to wean the workers off dangerous, addictive drugs.

Compound Medications: The proposed rule should include strong restrictions on the use of all compound medications. The proposed rule should require pre-authorization for any compound drug and require medical certification of the patient's inability to tolerate treatment by other non-compound medications.

Opioid Restrictions: The proposed rule allows initial prescriptions beyond five days and prescriptions for continuing opioid medications beyond 90 days if the treating physician certifies a "medical necessity" for the prescription. This exclusion based merely on a treating doctor's certificate of "medical necessity" may destroy the effectiveness of the proposed restrictions. Departure from the opioid restrictions should be allowed only upon prior authorization and medical certification that more conservative, non-opioid medications were attempted with the injured worker but were ineffective.

AGENCY RESPONSE: The Commission desires patient-centered care. Other states have adopted formularies and have seen good results in reducing opiates and costs. We are more comfortable with UAMS than an out-of-state company with no input by the Commission. UAMS is able to address our concerns and to react quickly. We believe that UAMS is a better fit than ODG. The Public Employee Claims Division has chosen to utilize the UAMS drug formulary and has seen a 20-25% overall reduction in opiates.

Compound medications are subject to fee schedule reimbursement according to the pharmacy schedule in Rule 099.30. Language will be added to the proposed rule to require pre-authorization from the payor for compound medications and to require medical certification of the patient's inability to tolerate treatment by other non-compound medications.

The Commission will make the following change to the proposed rule regarding an Opioid medication beyond 90 days:

PART III. Opioid Medications

5. A Payor shall not be required to pay for continuing an Opioid medication beyond 90 days without written certification of medical necessity which shall include the following:

1. Follow-up visits

2. Documentation of improved function under the medication

3. Periodic drug screening

4. A detailed plan for future weaning off the Opioid medication

5. A summary of conservative care rendered to the worker that focused on increased function and return to work

6. Mandatory and documented review of the PDMP prior to issuing every prescription for a Schedule II or III narcotic or benzodiazepine

7. A statement on why prior or alternative conservative measures were ineffective or contraindicated (including non-opioid pain medications)

8. A summary of findings of the data received from an automated Prescription Drug Monitoring Program (PDMP)

The Commission has excluded legacy claims from the proposed rule. At this point there has not been enough feedback and study to include these claims. The Commission may undertake an interim study on legacy claims.

Commenter: Chris Merideth, Manager, Government & Industry Affairs, Farmers Insurance

Farmers supports policies to control opioid abuse and cost abuse (physician dispensing/repackaged/compound drugs), including opioid dosing limitations, strengthening prescription drug monitoring programs, implementing closed formularies, banning or severely limiting physician dispensing, and requiring pre-authorization for dispensing compounds. Farmers also supports policies on medical treatment that are in accordance with sound treatment guidelines embodying principles of evidence-based medicine.

AGENCY RESPONSE: The Commission will add language to the proposed rule to require pre-authorization by the payor for compound medications and to require medical certification of the patient's inability to tolerate treatment by other non-compound medications.

Commenter: Sandy Shtab, AVP Advocacy & Compliance, Healthe Systems

They offered the following comments in support of the drug formulary rulemaking process.

Adopting a lower Med threshold and requiring physicians to demonstrate medical necessity if the prescriber recommends greater than 50 MED for more than 5 days. This would allow patients with acute injuries or post-operative care to access needed opioids while holding prescribing physicians accountable for addressing ongoing medical necessity when prescribing higher doses for more than a short duration.

They recommend additional language, which specifies "All compounded medications are subject to preauthorization and a medical necessity review."

They oppose the reconsideration process to the reviewing pharmacist. They propose the same utilization review as in Rule 30 be applied to reconsiderations of payor decisions and would then be performed by a certified UR agent rather than a pharmacist. They state that a licensed physician is better qualified to examine all the medical records of the patient to arrive at an appropriate, medically supported finding.

They propose the effective date of the Rule be at least six months after the date of the rule adoption, January 1, 2018, instead of September 1, 2017.
AGENCY RESPONSE: The Commission discussed the MED limit and decided to stay with the CDC guideline of a 90 MED per day limit. As noted in response to previous comments, the Commission will add language to the proposed rule regarding compound medications. The Commission discussed the process for disputes. We modeled this process after the Public Employee Claims Division and will leave the dispute process as it is. The Commission will delay the effective date of the proposed rule to all claims with a date of injury on or after January 1, 2018.

Commenter: Kevin C. Tribout, Executive Director, Government Affairs, Optum Workers' Comp and Auto No-Fault

Optum is supportive of the proposed drug formulary but offers comments and suggestions to better aid the Commission during the rule-making process. They believe their suggested language will assist the Commission in developing a sound and effective drug formulary rule. Optum has extensive experience in working with several other states in the development of their drug formularies.

He suggests the following changes to these parts of the proposed Rule.

Part I. General Provisions

A. Scope.

(a) He suggested that language be added that the formulary shall be reviewed at least quarterly or more frequently if needed to allow provision for all appropriate medications and that updates shall not take effect for a minimum of thirty days.

(b) He suggested this part be changed to say that all initial prescriptions for opioids shall be limited to a 5-day supply. All subsequent opioid prescriptions shall be limited to a 90-day maximum supply and shall not exceed a 90 MED dosage limitation per day.

He suggested adding a definition for "initial prescription" and "drug formulary."

Part III. Opioid Medications

A. He proposed language be added that suggests an implementation date change to January 1, 2018, to allow all stakeholders more time to prepare and address the impact of formulary changes.
B. He suggested the language be changed from should to shall regarding checking the Prescription Drug Monitoring Program database and saying "the prescribing of opioid therapies" rather than what medications to prescribe.
C. Changing the rule language from first to initial prescription of an Opioid medication.
5. Add written to the physician certification of medical necessity for continuing an Opioid medication beyond 90 days.

Part IV. Process for Filling Workers' Compensation Prescriptions

He says that physicians are the key to initiation of formulary conformity and the proposed rule places the initiative on prescribers. The *italics* represent the language of the proposed rule and the **bold** is their suggested language.

A. *Prescribers, before writing* **Pharmacists filling** a workers' compensation prescription **must** *shall check to see if* **verify that** the prescribed drug(s) are listed *as covered* on the **approved** drug formulary.
B. If the prescribed drug(s) is not *listed as covered* on the **approved** drug formulary, *the prescriber shall notify the injured worker that the prescribed medication may require prior authorization.*

C. If the prescriber desires to utilize a drug which is not listed as covered on the drug formulary, the prescriber shall attempt to seek authorization for the medication prior to prescribing.
D. *Unless indicated by the physician, before dispensing any medication not listed as covered on the drug formulary, the pharmacy shall attempt to verify* **pharmacist must contact the Payor for** approval of the prescribed drug(s) and must consult with the Prescribing Physician before switching *the prescription to a drug listed as covered on the drug formulary.* **the medication to a formulary medication(s).**
E. The **filling** *dispensing* pharmacist, *in seeking reimbursement for dispensed opioids, shall* **must** abide by the **rule** requirements *for maximum opioid duration and dosage levels.* **for prescribed Opioids for the Payor to be required to pay for the medication(s). (90 MED per day for five (5) days and a 90 day duration)**
F. Approval through a prior authorization process is required for all topical analgesics or compounds.
G. Where an employer or insurer contracts with a pharmacy benefit manager or pharmacy network for the provision of drugs for treatment of injured workers, drugs available to the injured worker must be consistent with the drug formulary and contractual terms of the agreement.

Part V. Process for Resolving Disputes Between Provider and Reviewing Pharmacist or PBM

When the Payor denies the medication and the injured employee**, filling pharmacist,** or prescribing physician insists on the medication that has been denied, reconsideration may be made to the reviewing pharmacist on staff or contracted with the Payor or the Payor's PBM by submitting a Reconsideration Form. The Payor should promptly send a Reconsideration Form to the prescribing physician to complete and submit together with any supporting documentation **to the reviewing Pharmacist.** The reviewing Pharmacist shall have three (3) business days to consult with the Physician or Medical Director, if necessary, and to respond to the reconsideration request. If the reviewing Pharmacist does not respond within three (3) business days, *the prescription may be dispensed as authorized.* **filling pharmacist may fill the prescription.** If the reviewing Pharmacist denies the reconsideration request, an appeal may be made within 10 business days to the Medical Cost Containment Division of the Arkansas Workers' Compensation Commission.
AGENCY RESPONSE: The Commission discussed the comments received from Mr. Tribout and decided to make changes to the proposed rule. Language will be added to state that the formulary will be reviewed and updated as needed. Language will be changed regarding initial and subsequent opioid prescriptions. A definition will be added for "initial prescription." The implementation date will be delayed until January 1,

2018. The language will be changed from "should" to "shall" regarding checking the Prescription Drug Monitoring Program database.

Commenter: Nathan Culp, Director, Public Employee Claims Division of the Arkansas Insurance Department

Public Employee Claims administers about 3,600 claims a year and we implemented the program that is being proposed in November 2015. It would go into effect for new claims and would not affect people who are currently taking opioids for their workers' compensation claim. Our program has a reconsideration process in place. We have received three reconsideration requests from physicians since implementation. On one of the three reconsideration requests a change of physician was obtained. The Public Employee Claims Division does support the Rule and also the Arkansas Self-Insured Association is in support.
AGENCY RESPONSE: The Commission appreciates the comments made by Mr. Culp during the public hearing.

Commenter: Jill Johnson, Risk Management Resources (TPA)

Risk Management Resources handles claims for self-insured employers and five large groups. She has been doing this 30 years and has seen the effects of opioid addiction and the epidemic, and we try to get people to doctors that will help them get off of opioids and have received thank yous from claimants and their families. Risk Management Resources supports the formulary.

She suggests that the notification requirement to the Commission of the PBM be added to the Form O, which is a form that employers fill out listing their TPA and who's responsible for getting bills and who their contact is and etc.

Under resolving disputes in Part 5, the proposed rule says, "The payor should promptly send a reconsideration form to the prescribing physician to complete and submit together with any supporting documentation to the reviewing pharmacist." She doesn't understand why if they deny it they would be the ones that would pursue that. She doesn't know that the payor is the one that should make that appeal or make that reconsideration request.
AGENCY RESPONSE: The Commission discussed and decided not to modify the Form O. The notification is not burdensome and may be accomplished by sending an e-mail notification to the Medical Cost Containment Administrator, Ms. Pat Hannah.

Commenter: Trey Gillespie, PCI, Property Casualty Insurers

Property Casualty Insurers Association of America (PCI) is a trade association representing over 1000 property and casualty insurance companies and write 34% of the private workers compensation insurance market.

PCI accepts and supports that a request for reconsideration should be reviewed by a Physician or Medical Director and that the payor must have a Physician or Medical Director on staff or has contracted with another entity that has such a contractual relationship.

PCI accepts and supports that Payors and PBMs should be allowed to have a reviewing pharmacist review the request for approval of the prescribed drugs not on the approved drug formulary.

PCI opposes the mandatory requirement that the Payor have on staff or contract with a reviewing pharmacist to review requests for approval of prescribed drugs not on the approved drug formulary. This may create an unnecessary expense and regulatory burden if the ultimate payor decision rests with the review by the Physician/Medical Director.

The Payor should be allowed to have a reviewing pharmacist be part of the process but should not be required to contract with a reviewing pharmacist or have one on staff.

PCI supports the proposed 5-day limitation on the first prescription of an Opioid and requirements for continuing an Opioid medication beyond the first 5-day prescription. However, it appears there are fewer requirements imposed for continuing an Opioid beyond 90 days than for the 5-90 day period. They recommend: In order for an Opioid medication to be continued beyond 90 days, there should be at least the following minimum requirements: (1) follow-up visits, (2) documentation of improved function under the medication, (3) periodic drug screening, (4) detailed plan for future weaning off the Opioid medication, (5) screening for drug abuse disorder, and (6) mandatory and documented review of the PDMP prior to issuing every prescription for a Schedule II or III narcotic or benzodiazepine. Arkansas should follow the "CDC Guideline for Prescribing Opioids for Chronic Pain-United States, 2016."

The Rule should apply to Legacy claims and compounded drugs. The current Rule only applies to FDA approved drugs. They suggest that the language be changed to say: *This Rule is adopted for all prescriptions for workers' compensation claims with a date of injury on or after September 1, 2017, and applies to all drugs that are prescribed and dispensed for*

outpatient use. For workers' compensation claims with a date of injury prior to September 1, 2017, this Rule is effective March 1, 2018.
AGENCY RESPONSE: The Commission discussed and decided not to make any changes to the requirement for the Payor to have a reviewing pharmacist contracted or on staff. As noted in response to previous comments, the Commission is adding additional requirements to the rule for Opioid medications, which are continued beyond 90 days. The Commission is also adding language to address compounded drugs. The Commission has excluded legacy claims from the proposed rule but may undertake an interim study of this issue.

Commenter: Denny Altes, Arkansas State Drug Director

Thanks the Commission for striving to abide by the CDC guidelines and hopes this will cut down on the opioids hitting the street and save the lives of our kids. He appreciates all that is being done in the fight against illegal use of drugs and their destruction.
AGENCY RESPONSE: The Commission appreciates the comments submitted by Mr. Altes.

Commenter: David Wroten, Executive Vice-President, Arkansas Medical Society

The Arkansas Medical Society represents over 4,500 physicians from all over Arkansas.

AMS respectfully requests that the Commission review and adopt an approach that follows this year's Act 820 for maximum consistency so physicians do not have one set of rules for their Workers' Compensation patients and another for all their other patients.

Regarding the 90 MED per day. At the very minimum there should be a mechanism, which is not overly burdensome to obtain approval for a larger dosage if warranted by the patient's injury. This mechanism should be managed similarly to how a "prior authorization" is handled by payers/carriers and/or their contracted agents and should not involve the AWCC.

He suggests that we replace the language in Part III. Opioid Medications B. with the following:

Prior to prescribing Schedule II or III opioid medications, prescribers shall check the Prescription Drug Monitoring Program database according to the provisions of Act 820 of 2017(or Arkansas Code 20-7-604 (d)).

In regards to Part III. Opioid Medications C. The AMS has serious concerns with this language and suggests a complete rewrite. What is intended by "five (5) days of medication? Is there an assumption this would be five days of medication up to 90 MED on each of those five days? Does this unwittingly encourage physicians to prescribe five days of 90 MED per day with each prescription?

AMS opposes limiting this to five days. Gives an example of a patient undergoing outpatient surgery on Monday and receives five days of medication (whatever that may be) and they run out on Friday night or over the weekend. Their pain may not be managed for up to 2 or 3 days or they may present to a hospital ER. What about patients who are admitted to the hospital with major trauma and need pain medications for several days? Even IV pain medication is "prescribed." Proposes a change to 7-10 days for the initial prescription.

Also rather than requiring all five conditions be met for a payor to be required to pay for continuing an Opioid medication beyond the first five day prescription they suggest something like this language "the prior authorization request as mentioned in our response to Part II, A. above for any prescription above the recommended 7-10 day threshold."

If the Commission decides to stay with the current proposed five requirements listed under C the following questions need to be answered.

1. What is meant by "authorized" treating physician? AMS suggests removing "authorized."
2. Who determines if the medication is "reasonable, necessary, and related to the workers' compensation injury or illness"? Is this the treating physician, insurer, employer or the AWCC?
3. It is expected that there will be follow-up visits, but how does the physician "certify" the medication is effective and to whom? Suggests it should say the treating physician "determines and notes in the medical record" rather than certifies. Also, states that opioid medications are to treat the pain associated with injury or illness and do not treat the actual injury or illness. AMS suggests this language, "effective in treating the pain associated with the injured employee's injury or illness."
4. Same comment as #3.
5. How does a physician certify medical necessity and to whom. "Authorized" is not clear and if the physician treating the patient under AWCC rules is authorized. AMS suggests deleting "authorized" and leaving it as "treating physician."

AGENCY RESPONSE: The Commission discussed the comments received from Mr. Wroten. As noted in response to previous comments, the language will be changed from "should" to "shall" regarding checking the Prescription Drug Monitoring Program database. The current meaning

and application of the terms “authorized treating physician” and “reasonable, necessary, and related to the workers’ compensation injury or illness” will not be changed by this rule.

Commenter: M. Carl Covey, M.D.; Medical Director, Pain Treatment Center of America

Commends the AWCC’s attempt to address the opioid epidemic, which is a clear public health disaster.

He states it is clear the AWCC is drawing the “90 MED” in the proposed formulary from the 2016 CDC Guidelines for Prescribing Opioids for Chronic Pain. The result will be a tragedy of suffering and injury to many chronic pain patients and he predicts will result in legislative action and litigation as unintended consequences.

He says he has spoken to many physicians, other medical providers, and other stakeholders who have not read the CDC Guidelines but have simply plucked out the unsupported 90 MME/day number.

He says the first sentence of the CDC Guidelines refutes the AWCC proposal: “This guideline provides recommendations for primary care clinicians who are prescribing opioids for chronic pain…. ”

He also says the following regarding the CDC Guideline:

It was not intended for all Specialties, especially Pain Management physicians whose patients require medically necessary doses of opiates exceeding the 90 MED per day proposed;

It mentions considering referral to a Pain Management Specialist no less than six times;

Experts agreed that lower dosages of opioids reduce the risk for overdose but that a single dosage threshold for safe opioid use could not be identified;

In the list of Grading Clinical Evidence for the document there were 33 study groupings, 18 had serious limitations, 6 had very serious limitations, 7 had insufficient evidence, and only 2 had no limitation but those 2 were for Myocardial Infarction and Motor Vehicle Crash Injuries; and

The CDC was very humble in its closing statement stating, “Yet, given that chronic pain is recognized as a significant public health problem…a guideline for prescribing is warranted with the evidence that is currently available.”

He suggests that the AWCC consider setting the opioid ceiling for Primary Care Physicians/providers as defined in the CDC Guideline for Primary Care of 90 MME/day (if a defined number is necessary) but with the caveat quoted from the same CDC Guideline, "for example, before increasing the long-term opioid therapy dosage to >120 MME/day, clinicians in Washington state must obtain consultation from a pain specialist who agrees that this is indicated and appropriate." To do otherwise according to him will cause unjustified pain and suffering and reduce or eliminate access to medical care for the most desperate and vulnerable patient population.
AGENCY RESPONSE: The Commission discussed and decided not to alter the 90 MED limitation. Other pain management doctors support a limit of 90 MED per day.

Commenter: Carlos Roman, MD

He strongly supports the AWCC's drug formulary Rule 099.41 of limiting prescriptions to CDC recommended 90 MEDs per day and it should be applied to any prescribing physician primary care or pain management specialist. This limitation is appropriate and well founded and is still a tremendous amount of narcotics. These levels of narcotics for chronic non cancer pain are more than generous for proper pain management and will lead to better patient care, lower levels of physical opioid dependency, improved safety, less opioid induced hyperalgesia, better pain control due to lower opioid tolerance, decreased risk of overdose deaths, and help decrease the epidemic of prescription drugs diverted into our communities.

He says the opioid drug epidemic is a direct effect of a well marketed and focused effort by large pharmaceuticals to sell products and they have effectively hijacked the educational process for many physicians. The CDC guidelines represent an undeniable trend in decreasing opioid use for chronic pain.

He says that prior to 2009 the mantra of "pain management" physicians was titrate to effect regardless of dose. In 2009 this argument was addressed by the American Pain Society-American Academy of Pain Management, which recommended a maximum of 200 MeQ and in 2016 the CDC guidelines recommended a max of 90 MeQ. He says this trend will continue and he cites an article by Robert Barth, PhD that says prescription narcotics at a high dose prevents a return to work by injured patients.
AGENCY RESPONSE: The Commission agrees that the current CDC guidelines should be the standard, which is the basis of this rule. The Commission appreciates the comments made by Dr. Roman.

Commenter: John Swicegood, M.D., F.I.P.P., D.A.B.I.P.P.; Advanced Interventional Pain & Diagnostics

Supports Dr. Covey's analysis of the proposed opiate prescribing guidelines and formulary.

He has had 2 workers' compensation patients cut off from their Opana medication (low dose) when medication trials demonstrate efficacy to the patient when nothing else could control their pain and physical function. WC carriers have physicians for hire to opine and question the clinical care of injured workers with no accountability other than to improve financial gain to the WC carrier. The WC expert opinion directed patient to a cheaper opiate that had previously been tried and demonstrated inferior and ineffective in the patient's course of care. Often the drug of choice for WC was methadone with little regard to the risk of this inexpensive opiate.

WC is taking advantage of misinformation and generalization of opiate poisoning and rising death rates at the expense of the injured worker. Raw ER data concerning the opiate death rate is being used rather than data of patients being treated with opiates that are monitored appropriately and followed as part of a comprehensive pain care regimen. WC is manipulating this "raw data" to their financial advantage. He challenges WC to produce data of our patient population under the care of board certified practitioners that support the need for the proposed opiate guidelines.

WC continues to obstruct, obfuscate, and deny chronic pain care as a campaign to deny the injured worker and pushes the patient and his/her family into poverty and into the legal system.

He recommends certification of pain prescribers who treat chronic pain and for WC to be held accountable for failure of duty to the injured workers.
AGENCY RESPONSE: The Commission discussed the concerns of Dr. Swicegood but decided not to make any changes to the proposed rule as a result of these comments.

Commenter: Cathy Luo, MD, Pain Management & Rehabilitation Consultants

Opposed to the 90 MED limit. This may cause patients more suffering. Some patients have been on chronic opioid treatment for a long time and have a high tolerance to pain meds. It will be difficult to keep all patients under 90 MED per day. Suggests that the Commission contact the Arkansas Pain Boards for recommendations.

AGENCY RESPONSE: The Commission discussed the MED limit and decided to stay with the CDC guideline of a 90 MED per day limit. The Commission has received and considered public comments from pain management doctors and the Arkansas Medical Society.

Commenter: Randy Zook, President & CEO, Arkansas State Chamber of Commerce and Associated Industries of Arkansas

His comments are provided on behalf of over 1,200 member businesses, industries, business associations, local chambers of commerce and local economic developers.

The proposed formulary is a positive step, but ODG would provide the most effective service. It is a superior product because it is objective, more detailed, based upon medical evidence, widely available and more comprehensive than the proposed formulary developed by UAMS. ODG is the only independent commercially published and updated monthly workers' compensation drug formulary and guideline with current guideline contact adopted in multiple states that is tied to evidence based treatment guidelines that have been adopted and implemented in any US jurisdiction by rule or regulation.

The UAMS Formulary is only updated quarterly and its adoption will require multi-state businesses to maintain separate systems. They are also concerned about the future cost of the UAMS Formulary over that of ODG.

Texas adopted the ODG Drug Formulary in 2011 and is the only state that has collected, analyzed and reported data from their use of the ODG Drug Formulary and the ODG Treatment Guidelines, and their experience with ODG is remarkable. 30% reduction in medical costs, opioid costs decreased from 27% of the total pharmacy costs in 2009 to 18% in 2015, 49% savings in premiums, total drug costs in TX work comp system fell by 15%, etc.

Arkansas employers using ODG in other states support adoption of ODG in Arkansas because: ODG is based on medical evidence, objective and usable, updated monthly, provides a file that can be uploaded to process pharmacy bills, provides 46,000 NDC codes for the various versions of medications, provides continuing education resources for physicians, and benefits injured employees.

UAMS' Formulary has no downloadable file format and no related guidelines. UAMS has no current plans to provide this for their formulary.

Examples of Experience and Successes in Other States

New Mexico-total annual losses or outliers drop 78%, North Dakota-premium reductions of 40%, Ohio-savings of 66% in absence-60% in medical costs-77% in treatment delay-84% provider approval, Oklahoma-44% cumulative drop in loss-cost rates. Other examples of Industry Success were given for ESIS, Shell Oil, Marathon Oil, Adelaide AHTA, and Rand Corporation.

ODG has a proven methodology. It is owned by MCG Health, the worldwide leader in evidence-based medical guidelines for general health care, and is part of the Hearst Health Network. Its methodology has been ranked among the best and most rigorous in the world for technical quality by Rand Corporation and others. ODG is currently adopted in Texas, Tennessee, Oklahoma and Arizona. The current ODG Drug Formulary includes over 331 prescription medications commonly prescribed for workers' compensation injuries with reasonable options for short acting opioids and musculoskeletal on the preferred Y-drug list, most PBMs and Payors have already integrated the ODG Treatment Guidelines and/or Drug Formulary into their systems and procedures and this eliminates and minimizes obstacles and costs of implementation. Over two million workers' compensation prescriptions have been filled under the ODG Formulary compared to zero by other Commercial Work Comp Guidelines Publishers.

AGENCY RESPONSE: In 2015, the Arkansas Workers' Compensation Commission determined that adoption of ODG Medical Guidelines was not in the best interest of the citizens of Arkansas. Due to an increasing amount of opioid and narcotic prescriptions in the workers' compensation arena, the Commission reviewed and studied several drug formularies, including the UAMS Drug Formulary. The Commission has determined that the UAMS formulary is the best formulary for use in Arkansas. The UAMS Drug Formulary was developed by the College of Pharmacy at UAMS and is an evidence-based formulary based on actual claims experience in Arkansas by Arkansas medical personnel. There are no user fees associated with this formulary and it can be readily available on our website. Because it is local, it will be more responsive to any updates or changes needed.

It has demonstrated its effectiveness since the voluntary adoption of the formulary by the Public Employee Claims Division of the State of Arkansas in both reducing the prescription of opioids and in overall costs without compromise of care to the injured workers.

Commenter: Janice Van Allen, Senior Director, Walmart Risk Management

Walmart supports the adoption of an Arkansas Workers' Compensation Drug Formulary. However they support and ask that consideration be given to adopting the ODG Drug Formulary. It has the following benefits that make it easier for physicians and payors to administer: ODG is updated monthly so new drugs are included sooner than other formularies, ODG is usable, ODG is a continuing education resource for physicians, ODG is based on medical evidence, ODG has been proven to work in several states (TX, OK, TN, NM, ND, and OH), Texas' results after adoption demonstrate several successes, Walmart's results show that claims where narcotics were prescribed on 6 month old claims, associates missed 33 less days from work on average and a 75% reduction in the number of MEDs.

If the Commission adopts Proposed Rule 099.41 and the UAMS Formulary, the following comments are for their consideration:

The formulary should be published and available in a downloadable format.

They say our language in A1 (b)-Establishes that all Opioid prescriptions shall have a 90 MED per day limit for five days for the initial prescription with a 90-day maximum duration period is written inconsistently throughout the proposed rule and needs to be clarified for intent.

The requirement to ensure this rule is followed is ineffective. Allowing treating physicians to simply state that the request for additional days and MEDs is "reasonable and necessary" will be no more effective than the current requirement. Physicians should provide the following to demonstrate why treatment requests are "reasonable and necessary": a summary of conservative care rendered to the worker that focused on increased function and return to work; a statement on why prior or alternative conservative measures were ineffective or contraindicated (including non-opioid pain medications); a statement that the treating physician has considered the results obtained from appropriate industry accepted screening tools to detect factors that may significantly increase the risk of abuse or adverse outcomes including a history of alcohol or other substance abuse; a summary of findings of the data received from an automated Prescription Drug Monitoring Program (PDMP); and a treatment plan, which includes all the following: overall treatment goals and functional progress, periodic urine drug screens, a conscientious effort to reduce pain through the use of non-opioid medications, alternative non-pharmaceutical strategies, or both and consideration of weaning the injured worker from opioid use.

The rule should include existing claims but allow a weaning period. Their proposed language gave a six month weaning period.

They agree clinicians need to be involved in the identification and review of drug misuse but don't necessarily agree it has to involve a PBM. They say the language regarding payors to have on staff a Pharmacist and Physician or Medical Director or shall contract with a PBM, who has a Pharmacist and a Physician or Medical Director on staff or has contracted with a Pharmacist and a Physician or Medical Director is referenced differently throughout the proposed rule and needs to be clarified for intent.

They ask who will be responsible for administering the provision A1(f) requiring for the certification of all payors determined to be in compliance with the criteria and standards established by this rule.

In regards to A1(g)-Provides for the implementation of Medical Cost Containment Division review and decision making responsibility. They ask how will the additional staff for this division be funded and will the appointed individuals have medical/pharmaceutical knowledge/education?
AGENCY RESPONSE: As noted above in response to other comments received, the Commission has carefully considered the comments in support of ODG but has ultimately decided to adopt the UAMS College of Pharmacy Evidence-Based Prescription Program. The drug formulary has been published to the Commission's website and is readily available. As noted in response to other comments, the Commission has added requirements to the proposed rule regarding Opioid medications beyond 90 days. The proposed rule does not include legacy claims, but the Commission may undertake an interim study of that subject. The Medical Cost Containment Division of the Commission will be responsible for certifying payors, and we do not anticipate a need to add additional staff for this purpose.

The proposed effective date is July 1, 2018.

FINANCIAL IMPACT: The financial impact is unknown. All entities involved in any workers' compensation claim filed after December 31, 2017 would be subject to the proposed rule. This would include pharmacists, dispensing physicians, treating physicians, claimants, carriers, and self-insured employers. It will affect reimbursement and the claims processing for all FDA approved prescription drugs.

While the agency does not know how this will affect county and municipal governments, it does have information regarding state employees. Public Employee Claims implemented a drug formulary similar to this one a year

ago, and they have shown a cost savings with few requests for review of claims processed.

LEGAL AUTHORIZATION: The Workers' Compensation Commission is authorized to establish rules and regulations, including schedules of maximum allowable fees for specified medical services rendered with respect to compensable injuries, for the purpose of controlling the cost of medical and hospital services and supplies provided pursuant to Arkansas Code Annotated §§ 11-9-508 through 11-9-516. *See* Ark. Code Ann. § 11-9-517. Further authority for the rulemaking can be found in Ark. Code Ann. § 11-9-205(a)(1), which provides that for the purpose of administering the provisions of the Workers' Compensation Law, Ark. Code Ann. §§ 11-9-101 through 11-9-1001, the Workers' Compensation Commission is authorized to make such rules and regulations as may be found necessary.

f. Adjournment.