ADMINISTRATIVE RULES SUBCOMMITTEE
OF THE
ARKANSAS LEGISLATIVE COUNCIL

Wednesday, December 16, 2020
9:00 a.m.
Room A, MAC
Little Rock, Arkansas

A. Call to Order.

B. Reports of the Executive Subcommittee.

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

1. <u>DEPARTMENT OF AGRICULTURE, ARKANSAS LIVESTOCK & POULTRY COMMISSION</u> (Mr. Patrick Fisk, Ms. Andrea Andrews, Mr. Wade Hodge)

a. <u>SUBJECT</u>: National Poultry Improvement Plan Rule

<u>DESCRIPTION</u>: The Arkansas Livestock and Poultry Commission is proposing an amendment to the Rules for the Administration of the National Poultry Improvement Program ("the NPIP rule").

The NPIP is a federal plan for the surveillance of poultry disease and provides uniform best management practices for developing and maintaining poultry flocks free of avian diseases. The NPIP is administered through partnership between the United States Department of Agriculture – Animal and Plant Health Inspection Service and the Arkansas Department of Agriculture. Under the NPIP, poultry growers may certify flocks that are either confirmed to be free of certain diseases or grown in conformity with NPIP best management practices. Poultry growers enjoy a variety of benefits from certification under NPIP, which includes ease of access to interstate and international trade markets.

The NPIP rule is being amended for practical reasons and does not constitute a significant policy change. The NPIP is updated every two years, which has historically required the ALPC to promulgate new rules with each change. This proposed rule will instead incorporate the NPIP by reference as amended from time to time. As a result, subsequent amendments will not be necessary.

PUBLIC COMMENT: No public hearing was held. The public comment period expired on August 22, 2020. No public comments were received.

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

Typically, when incorporating by reference, an agency will specify the date or version of the rules or regulations being incorporated so as to avoid any potential delegation-of-authority issues or issues under the Administrative Procedure Act, resulting from changes to the rules without having gone through the promulgation and/or legislative-review-and-approval processes. Is the Commission comfortable with simply incorporating the standards "as amended by APHIS from time to time"?
RESPONSE: We are comfortable with the language as is. If we reference a particular version of the federal rules, then we are right back where we started, i.e., having to change our rules anytime the federal rules change. I've consulted with the Attorney General's office and have been told they have no problem with it and that other agencies have similar rules.

The proposed effective date is pending legislative review and approval.

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

LEGAL AUTHORIZATION: The authority for the control, suppression, and eradication of livestock and poultry diseases and pests, and supervision of livestock and poultry work in this state, including authority to promulgate rules governing the handling, sale, and use of vaccines, antigens, and other biological products used for reportable diseases and emergencies affecting livestock and poultry, is vested in the Arkansas Livestock and Poultry Commission. *See* Ark. Code Ann. § 2-33-107(a). Pursuant to Arkansas Code Annotated § 2-33-107(c), the Commission shall have the authority to make, modify, and enforce such rules and orders, not inconsistent with law, as it shall from time to time deem necessary to effectively carry out the functions performable by it.

2. DEPARTMENT OF COMMERCE, ARKANSAS ECONOMIC DEVELOPMENT COMMISSION (Mr. Steven Porch, item a; Mr. Jim Hudson, Ms. Renee Doty, item b)

a. SUBJECT: Supplemental Arkansas Rural Connect Coronavirus Rule

DESCRIPTION: The Arkansas Economic Development Commission ("AEDC") is proposing a supplemental Arkansas Rule Connect Coronavirus Rule ("ARC"). The agency provided the following summary of the rule:

Legislative Authority for Rule
This rule is issued by the Director of the Arkansas Economic Development Commission ("Director"). Ark. Code Ann. § 15-4-209(b)(5) provides that AEDC may promulgate rules necessary to implement the programs and services offered by AEDC. On or about August 9, 2019, Governor Asa Hutchinson authorized a transfer of funding for the implementation and administration of the ARC Program to AEDC. Pursuant to Ark. Code Ann. § 15-4-209(a)(1), AEDC is authorized to administer grants to assist with the economic development in the State. The ARC Program is therefore authorized to administer the ARC grant and authorized to issue administrative rules under Ark. Code Ann. § 15-4-209(b)(5) as a service offered by AEDC.

Background & Purpose of Rule
The funding round of Arkansas Rural Connect (ARC) is occurring under circumstances that were not anticipated when the Arkansas Rural Connect program was developed. The COVID-19 pandemic has severely impacted the citizens of Arkansas and the world. COVID-19 has necessitated the imposition of new public health guidelines that encourage, and in some cases require, citizens to practice "social distancing," staying at least 6 feet away from other people as much as possible. COVID-19 has brought about an urgent and immediate need for broadband internet access. Normal day to day activities can no longer be done safely. Broadband enables workers to telework, patients to use telemedicine services, K-12 and college students and unemployed workers in need of reskilling to participate in distance education, religious people to participate in online worship services, and all citizens to shop online, interact with friends through Skype and other video chat tools, and keep up with the latest news and public health guidelines.

While the COVID-19 pandemic has negatively impacted the state's economy, the federal government has instituted a major relief effort entitled the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). The CARES Act provides substantial allocations of funding to states for coronavirus response, broadly defined. Guidance provided by the US Treasury describes allowable uses of CARES Act funding. In general, CARES Act money cannot be used for regular budget support, and must be used for coronavirus response, but this includes both public health related measures and economic relief to address the "second-order effects" of the crisis. All CARES Act funds must be spent before the end of December 30, 2020.

The Arkansas Rural Connect program promotes broadband deployment in rural areas of Arkansas that lacks meaningful and efficient broadband services. The ARC program and its purposes align with allowable uses of CARES Act funds. However, Arkansas Rural Connect is designed as a medium- to longer-term investment program, requiring deployment only by late in 2022, which lies well outside the CARES Act spending window.

Due to the urgent need for broadband, necessitated by the COVID-19 pandemic, this rule is needed to disperse funds immediately and to accelerate deployment to the extent possible. The ARC program has recently received $100 million in CARES Act money to fund broadband projects. The Supplemental Arkansas Rural Connect Coronavirus Rule allows more companies capable of deploying broadband in Arkansas an opportunity to apply and receive ARC grant funding.

Explanation of Proposed Supplemental Rule

Electric Cooperatives or their subsidiaries and any other entity that has a one-year track record of providing voice, internet, broadband and/or electric distribution or transmission services to at least 500 retail customers are now eligible to apply for ARC grants. This includes municipalities that own their own utility service. Electric Cooperatives and other qualified entities must follow all ARC rules the same as the internet service providers (ISP) and will receive the same treatment as ISPs under the ARC rules. Financial records, deployment experience and/or retail customer lists are not an absolute bar to funding projects. Moreover, organizations or entities that do not meet this criteria for eligibility may submit an application and the project will be reviewed on a case by case basis. These organizations may be required to submit financial records, customer lists and any other documentation deemed necessary for the Broadband Office to determine the stability of the company and the ability for the company to deploy within the time prescribed by the Broadband Office. ARC funding caps may be waived. Special attention entitling organizations for expedited review will be given to: (a) qualified projects that are able to deploy six months to a year, to at least 90% of the locations targeted by the project. The number of months to deploy is flexible and can be extended beyond one year at the discretion of the ARC Broadband Office, but one year is the max time preferred. The 90% deployment rate is flexible, but preferred, and must be clearly stated in your application and; (b) projects falling under the Broadband Rule's $3,000 cap per unserved location connection is preferred, but flexible. These qualified projects must state, in a separate writing, attached to the application, how they will assist with telemedicine, distance learning, telework or all three. Areas that are eligible for federal broadband grants will receive a low priority towards funding but will still be eligible to apply. Preference may be given to applications that expedite

current expansion plans of providers. The expansion plans must deploy to areas that lack broadband and can be deployed in six months or a year. The ARC population threshold of five hundred (500) is preferred, but flexible. Failure to accurately state the number of unserved citizens in an area will not be a bar to applying or possibly receiving a grant award. Rural unserved or underserved communities is a primary goal of this program. Communities that do not meet the population threshold will still be able to partner with other communities to meet that eligibility criteria. Focus will be given to internet speed and whether there is internet service in the areas meeting the population threshold. All approved applications must meet eligibility criteria and follow all program requirements under the ARC rules. However, grant awards under these Supplemental Emergency ARC Coronavirus Rules shall control over any conflicting ARC broadband rules.

Deadlines under Broadband Rule
These rules are in defense or preparation for not only COVID-19 but any other pandemic or disaster that may befall Arkansans now or the foreseeable future. Telemedicine/health, telework and distance learning statewide are goals of this program. As such, the Broadband Office and technical review team will evaluate applications until funding ends.

PUBLIC COMMENT: A public hearing was held on November 9, 2020. The public comment period expired on November 9, 2020. The Arkansas Economic Development Commission did not receive any comments.

This rule was filed on an emergency basis and reviewed and approved by the Executive Subcommittee on August 31, 2020, with an effective date of September 2, 2020. The proposed effective date for permanent promulgation is pending legislative review and approval.

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

LEGAL AUTHORIZATION: The Arkansas Economic Development Commission has authority to administer grants, loans, cooperative agreements, tax credits, guaranties and other incentives, memoranda of understanding, and conveyances to assist with economic development in the state. *See* Ark. Code Ann. § 15-4-209(a)(1). Additionally, AEDC has authority to promulgate rules necessary to implement the programs and services offered by the commission. *See* Ark. Code Ann. § 15-4-209(b)(5).

b. **SUBJECT: Consolidated Incentives Act of 2003 Administrative Rules**

DESCRIPTION: The Arkansas Economic Development Commission(AEDC), a division of the Arkansas Department of Commerce, has created proposed revised rules for administration of the Consolidated Incentives Act of 2003 at Ark. Code Ann. § 15-4-2701 *et seq.* AEDC is authorized by authority granted under Ark. Code Ann § 15-4-2710(1) to promulgate administrative rules for the Consolidated Incentives Act programs. The proposed changes in the revised rule include the following:

- Updates the rule to reflect changes to the NAICS code in 2017;
- Amends definitions and eligibility requirements for programs administered under the Act;
- Provides enhanced payroll incentives for higher paying wages for certain programs;
- Limits eligible expenditures for Research and Development programs to wages and benefits paid to employees/contractors involved in research;
- Clarifies the process by which the incentive is calculated for a business that qualifies for the In-House Research and Development Tax Credit Program;
- Amends the Tax Back Program to tie the investment required to qualify to the Tier status of the county in which a project locates;
- Amends the Create Rebate program to include a Tier structure that lowers the payroll threshold to qualify based on the county a project locates and sets an average hourly wage requirement;
- Allows existing business to qualify for the Targeted Business Payroll Credit;
- Specifies the process by which a county may temporarily change Tier status during a period of severe economic distress; and
- Makes various technical corrections.

PUBLIC COMMENT: A public hearing was held in this matter on November 4, 2020. The public comment period expired on November 13, 2020. The Arkansas Economic Development Commission received no public comments.

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

1. In Section II(6) of the rule, the definition in the rule appears to mirror the definition in Ark. Code Ann. § 15-4-2703, except for the usage of "this Act" in place of "this subchapter" throughout the definition.
(a) Did the agency mean "this rule?"

(b) If the agency intended to say "this Act," wouldn't adding a definition of the term or specifying which Act be helpful?
RESPONSE: The usage of "this Act" was language included in the original rules for the Consolidated Incentives Act of 2003. It would be more appropriate to use "this rule." Staff will revise the language to reflect this.

2. Is there a difference between the colors (red, black or blue) used in the markup? Please explain. **RESPONSE:** There is no difference in the mark up. Color difference was internal to reflect input from different people assisting with the rule drafting. To avoid confusion staff will remove colors.

3. In Section II, 12 of the rule, the definition of "eligible businesses" mirrors the definition in Ark. Code Ann. § 15-4-2703(8), except for A(ii).
(a) Could you please confirm whether the agency intended to include this?
(b) If so, please provide background, clarification, and authority on why this section was added?
RESPONSE: Yes. This section was included in the original rules and is intended to provide interpretive guidance to companies. NAICS classification and SIC classification can vary. The language is to account for inconsistencies a company may experience between one system vs the other related to various additions and updates that have occurred for both classification systems. Section A(ii) does not enlarge the types of eligible businesses.

4. In Section II, 28 of the rule, the definition of "new full-time permanent employee" appears to mirror the definition in Ark Code Ann. § 15-4-2703(23), except for the new language in Section 28(A)(ii). Is this language contained elsewhere in the code? If so, could you please provide the citation? **RESPONSE:** This language is not included in the code. It was added as interpretive guidance to reflect that certain industries utilize nonstandard shifts. This type of scheduling could have an employee exceed 30 hours a week for several months, followed by an idle period for several days, then a resumption of work. The aggregate hours worked over the course of a tax year would be the same as an employee working a normal shift. The interpretive guidance clarifies that the idle period does not disqualify the employee as being a full-time, permanent employee.

5. In Section II, 36(A) of the rule, you reference "this Act." Do you mean this rule? If referencing the Act, could you please provide the Act number and year? **RESPONSE:** The usage of "this Act" was language included in the original rules for the Consolidated Incentives Act of 2003. It would be more appropriate to use "this rule". Staff will revise the language to reflect this.

6. In Section II, 46 of the rule, you reference "the Act." Do you mean this rule? If referencing the Act, could you please provide the Act number and year? **RESPONSE:** The usage of "this Act" was language included in the original rules for the Consolidated Incentives Act of 2003. It would be more appropriate to use "this rule". Staff will revise the language to reflect this.

The proposed effective date is pending legislative review and approval.

FINANCIAL IMPACT: The agency indicated that the proposed rules have no financial impact. The agency listed a cost of $350 for legal advertisement and copying fees incurred during the promulgation process.

LEGAL AUTHORIZATION: The Arkansas Economic Development Commission has authority to promulgate rules to carry out the provisions of Title 15, Chapter 4, Subchapter 27, concerning the Consolidated Incentive Act of 2003. *See* Ark. Code Ann. § 15-4-2710(1). The purpose of the Consolidated Incentive Act was to make Arkansas more competitive for the creation of new and better jobs for the citizens of Arkansas. *See* Ark. Code Ann. § 15-4-2701. The proposed rules implement Act 327 of 2019, sponsored by Representative Carlton Wing, which amended the Consolidated Incentive Act by clarifying and adding definitions, making changes to tier system, and making changes to the tax credits, incentives, and rebates available under the Act. *See* Act 327 of 2019.

3. DEPARTMENT OF COMMERCE, STATE INSURANCE DEPARTMENT (Mr. Booth Rand, Ms. Amanda Rose)

a. SUBJECT: Rule 49 - Life and Health Insurance Guaranty Association Notices

DESCRIPTION: Act 520 of 2019 amended the Arkansas Life and Health Insurance Guaranty Association Act to add health maintenance organizations to the entities covered by the Guaranty Fund. The proposed amended rule incorporates that change and modifies the forms accordingly.

PUBLIC COMMENT: A public hearing was held on October 22, 2020. The public comment period expired on October 22, 2020. The State Insurance Department indicated that it received no written public comments, however, a request at the public hearing for ninety days to comply following the effective date was granted.

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

1. Are Appendix A and Appendix B being promulgated as part of the rule? **RESPONSE:** Yes. Appendix A is required and, while Appendix B is optional, its terms are part of the Rule.

2. Concerning the Notice section of the rule, you cite to Ark. Code Ann. § 23-96-105(a) as authority.
(a) Is Appendix A of the rule an effectuation of Ark. Code Ann. § 23-96-105(b) & (c)? **RESPONSE:** It would appear that I should not have cited subsection (a), as the Rule is an effectuation of the entire statute, Ark. Code Ann. § 23-96-105, and I also should have included Ark. Code Ann. § 23-96-107(c).
(b) If so, would it not be helpful to add that authority at the beginning of the second paragraph of the Notice section, or in the alternative, include these sections in the first paragraph of the Notices section? **RESPONSE:** I think we could change the first paragraph to Ark. Code Ann. § 23-96-105 – no subsection – and remove the (2) from Ark. Code Ann. § 23-96-107(c)(2).

3. Concerning Appendix B, is there statutory authority for this or is there a place in the code where this Notice is addressed? **RESPONSE:** We believe the statutory authority is Ark. Code Ann. § 23-96-105(a)(1). The optional Appendix B is in response to producers and insurers who wanted to have material to present to consumers at the point of sale in response to questions about various protections.

The proposed effective date is pending legislative review and approval.

FINANCIAL IMPACT: The State Insurance Department indicated that the proposed rule does not have a financial impact.

LEGAL AUTHORIZATION: The Insurance Commissioner, in consultation with the Secretary of the Department of Commerce, has authority to make reasonable rules necessary for or as an aid to the effectuation of any provision of the Arkansas Insurance Code. *See* Ark. Code Ann. § 23-61-108(a)(1). The commissioner also has authority to promulgate rules necessary to implement Title 23, Chapter 63, Subchapter 20, concerning the Corporate Governance Annual Disclosure Act. *See* Ark. Code Ann. § 23-63-2010(a).

The proposed rules implement Act 520 of 2019, sponsored by Senator Jason Rapert, which amended the Arkansas Life and Health Insurance Guaranty Association Act. *See* Act 520 of 2019. Pursuant to the Act, the commissioner has specific rulemaking authority concerning notices to

policy holders and policy owners. *See* Ark. Code Ann. §§ 23-96-105(a) and 23-96-107(c).

b. <u>SUBJECT</u>: Rule 82 – Suitability in Annuity Transactions

<u>DESCRIPTION</u>: The proposed amended rule will update the Department's existing Rule 82 regarding suitability in the sale of annuities to Arkansas consumers. This amendment reflects the most current changes to the NAIC model regulation. The proposed amended rule is intended to provide guidance to producers to assist in determining the appropriateness of a specific annuity product for a particular consumer.

<u>PUBLIC COMMENT</u>: A public hearing was held on October 22, 2020. The public comment period expired on October 22, 2020. The State Insurance Department provided the following summary of comments it received and its responses thereto:

- *October 2, 2020*: We received correspondence from the ACLI (American Council of Life Insurers), the IRI (Insured Retirement Institute), the Committee of Annuity Insurers, IALC (Indexed Annuity Leadership Council), the FSI (Financial Services Institute), and the NAFA (National Association for Fixed Annuities). This was a single piece of correspondence signed by each of the listed parties that was sent to the National Association of Insurance Commissioners (NAIC) encouraging several substantive changes to this national model. It does not appear that the NAIC was inclined to make any of the suggested changes.
- *October 15, 2020*: LPL Financial, a Massachusetts company, submitted correspondence requesting an additional six months to comply with the updated Rule after it is signed by our Commissioner. This request was granted at our October 22, 2020 hearing.
- *October 20, 2020*: IRI submitted correspondence commending the Arkansas Insurance Department on adopting this model regulation and requesting an additional six months to comply with the updated Rule after it is signed by our Commissioner. This request was granted at our October 22, 2020 hearing.
- *October 21, 2020*: The ACLI submitted correspondence regarding two technical changes that needed to be made to the draft and requesting an additional six months to comply with the updated Rule after it is signed by our Commissioner. This request was granted at our October 22, 2020 hearing.
- All parties were given the opportunity to attend the hearing in person or via Zoom. Legal counsel for State Farm attending the hearing in person, also requesting the additional six months to comply with this Rule following its effective date.

The proposed effective date is pending legislative review and approval.

FINANCIAL IMPACT: The State Insurance Department indicated that the proposed rule does not have a financial impact.

LEGAL AUTHORIZATION: The Insurance Commissioner, in consultation with the Secretary of the Department of Commerce, may make reasonable rules necessary for or as an aid to the effectuation of any provision of the Arkansas Insurance Code. *See* Ark. Code Ann. § 23-61-108(a). Additionally, the Commission also has specific authority to: **(1)** promulgate rules necessary for the effective regulation of the business of insurance or as required for this state to be in compliance with federal law (*See* Ark. Code Ann. § 23-61-108(b)(1)), **(2)** promulgate rules for the purposes of adopting all or part of publications of the National Association of Insurance Commissioners or publications by other authors if the commissioner determines that such an action is in the best interest of the public (*See* Ark. Code Ann. § 23-61-108(d)(3)), **(3)** promulgate reasonable rules, as are necessary and proper to identify specific methods of competition or acts or practices which are prohibited by Ark. Code Ann. §§ 23-66-206 and 23-66-312, provided that the rules do not enlarge upon or extend the provisions of those sections (*See* Ark. Code Ann. § 23-66-207(a)), and **(4)** promulgate reasonable rules after notice and hearing to implement Ark. Code Ann. § 23-66-307 concerning actions required to replace a life insurance policy or annuity (*See* Ark. Code Ann. § 23-66-307(c)(2)).

c. SUBJECT: Rule 121 – Declaratory Orders

DESCRIPTION: This proposed rule implements Ark. Code Ann. § 25-25-206, which states that 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. AID does not have a validly promulgated modern rule authorizing declaratory actions or orders. The proposed rule allows AID to issue declaratory orders and to administer declaratory actions filed at the Insurance Department.

PUBLIC COMMENT: A public hearing was held on this rule on October 20, 2020. The public comment period expired October 20, 2020. The agency indicated that it received no public comments.

This rule was filed on an emergency basis and was reviewed and approved by the Executive Subcommittee on September 17, 2020. On September 18, 2020, ALC voted for the Executive Subcommittee to reconsider. The Executive Subcommittee reconsidered the emergency rule and subsequently reviewed and approved it a second time on October 1, 2020.

The proposed effective date for permanent promulgation is pending legislative review and approval.

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

LEGAL AUTHORIZATION: Under Arkansas law, each administrative agency must "provide by rule for the filing and prompt disposition of petitions for declaratory orders as to the applicability of any rule, statute, or order enforced by it." Ark. Code Ann. § 25-15-206. "These declaratory orders shall have the same status as agency orders in cases of adjudication." *Id.* This proposed rule implements model language from the Arkansas Attorney General's Office. *See* Ark. Att'y Gen.'s Office, Model Rules of Procedure for Regulatory and Licensing Agencies, at 12-13.

4. DEPARTMENT OF EDUCATION, DIVISION OF ELEMENTARY AND SECONDARY EDUCATION (Ms. Courtney Salas-Ford)

a. SUBJECT: DESE Rules Governing Special Education and Related Services, Sec. 18.00 Residential Placement

DESCRIPTION: The Division of Elementary and Secondary Education proposes changes to Section 18.00, Residential Placement, of its Rules Governing Special Education and Related Services. The proposed amendments incorporate provisions of Act 523 of 2019, allowing reimbursement of costs for educational services provided to students without disabilities placed in residential treatment facilities in states that border Arkansas. The out-of-state placement must be deemed medically necessary and the most appropriate placement available by a physician.

PUBLIC COMMENT: A public hearing was held on February 12, 2020. The public comment period expired on March 7, 2020. The Division provided the following summary of the comments that it received and its response thereto:

Lucas Harder, Arkansas School Boards Association
Comment:
18.01.1: I would recommend striking the ".1" here as with the elimination of the existing 18.01.1, the existing 18.01.2 can just be moved to 18.01 instead. I would recommend moving 6-41-202 to be after 6-20-107 so that the statutes are in numerical order.

18.04.2.6: I would recommend changing this to read "DESE Special Education Rules" to match the language at 18.07.2.6 and to account for Act 315 of 2019.

18.05.2.1: In accordance with Act 315, "regulations" should be changed to "Rules."

18.05.3.1: In the second unnumbered paragraph, "regulations" should be changed to "rules" in accordance with Act 315.

18.05.6.2: In accordance with Act 315, "regulations" should be changed to "rules."

18.06.1.3: I believe that the reference to ADE here should actually be to DESE.

18.06.2.1: In accordance with Act 315, "regulations" should be changed to "rules."

18.06.5.2: In accordance with Act 315, "regulations" should be changed to "rules."

18.07.1.3: I believe that the reference to ADE here should actually be to DESE.

18.0~~7~~8: All subsection numbers from 18.0~~7~~8.1 through 18.0~~7~~8.4.9 appear to be missing the stricken "7" and the underlined "8" to indicate the change from the addition of the new 18.07.
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18.0~~7~~8.2.1a: I believe that the reference to ADE here should actually be to DESE.

18.0~~7~~8.4.7a: The language correctly changed the ".4" to ".5" but failed to strike the "7" and replace it with an "8."

18.0~~8~~9.1: The stricken "8" and the underlined "9" appear to be missing to indicate the change from the addition of the new 18.07.
Agency Response: Technical corrections made.

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

(1) Section 18.03.7.1 – Does the out-of-state facility for a student with disabilities not also have to be one located in a state that borders Arkansas, pursuant to Ark. Code Ann. § 6-20-107(b)(1)(D)? **RESPONSE:** No; it is our interpretation and the intent of the 2019 Act's sponsor that (b)(2)(A)

allows for payment in any residential facility if the student qualifies as having a disability under IDEA.

(2) Section 18.04.2.2 – What is the reasoning behind this change? **RESPONSE:** ADE determined that failure to follow notification timelines should warrant loss of funding but not rise to the level of complete loss of approval.

(3) Section 18.04.3.4 –

(a) Should "State Department of Education" be "DESE" per Ark. Code Ann. § 6-20-107(c)? **RESPONSE:** Yes; nonsubstantive change has been made.

(b) Should "or other related costs" follow "any education costs" per Ark. Code Ann. § 6-20-107(c)? **RESPONSE:** Yes; nonsubstantive change has been made.

(4) Section 18.04.3.4(C) – Should "Department" be "DESE" per Ark. Code Ann. § 6-20-107(c)(2)(B)? **RESPONSE:** Yes; nonsubstantive change has been made.

(5) Section 18.04.3.5 – Should "Department" be "DESE" per Ark. Code Ann. § 6-20-107(d)? **RESPONSE:** Yes; nonsubstantive change has been made.

(6) Section 18.05.4.1 –

(a) Should "State Department of Education" be "DESE" per Ark. Code Ann. § 6-20-107(c)? **RESPONSE:** Yes; nonsubstantive change has been made.

(b) Should "or other related costs" follow "any education costs" per Ark. Code Ann. § 6-20-107(c)? **RESPONSE:** Yes; nonsubstantive change has been made.

(7) Section 18.05.4.1(C) – Should "Department" be "DESE" per Ark. Code Ann. § 6-20-107(c)(2)(B)? **RESPONSE:** Yes; nonsubstantive change has been made.

(8) Section 18.05.4.2 – Should "Department" be "DESE" per Ark. Code Ann. § 6-20-107(d)? **RESPONSE:** Yes; nonsubstantive change has been made.

(9) Section 18.06.3.1 –

(a) Should "Department of Education" be "DESE" per Ark. Code Ann. § 6-20-107(b)(1)? **RESPONSE:** Yes; nonsubstantive change has been made.

(b) Under subsection (A)(1) and (2), should the language be replaced by that from Ark. Code Ann. § 6-20-107(b)(1)(A), per Act 523 of 2019, § 2? **RESPONSE:** No; it is our interpretation and the intent of the 2019 Act's sponsor that (b)(2)(A) allows for payment in any residential facility if the student qualifies as having a disability under IDEA.

(c) In subsection (B), should "Department" be "DESE" per Ark. Code Ann. § 6-20-107(b)(1)(B)? **RESPONSE:** Yes; nonsubstantive change has been made.

(d) In subsection (C), should "department" be "DESE" per Ark. Code Ann. § 6-20-107(b)(1)(C)(ii)? **RESPONSE:** Yes; nonsubstantive change has been made.

(e) Should the language from Ark. Code Ann. § 6-20-107(b)(1)(D) regarding the requirement that the out-of-state facility be located within a state that borders Arkansas be included? **RESPONSE:** No; it is our interpretation and the intent of the 2019 Act's sponsor that (b)(2)(A) allows for payment in any residential facility if the student qualifies as having a disability under IDEA.

(10) Section 18.06.3.5 – Should "Department" be "DESE" per Ark. Code Ann. § 6-20-107(d)? **RESPONSE:** Yes; nonsubstantive change has been made.

(11) Section 18.07.3.4 – Should "or other related costs" follow "any education costs" per Ark. Code Ann. § 6-20-107(b)(1)? **RESPONSE:** Yes; nonsubstantive change has been made.

(12) Section18.07.3.6 – What is the reasoning for the omission of the "lesser of" language and second option set forth in Ark. Code Ann. § 6-20-107(d) and (d)(2)? **RESPONSE:** Language has been added.

(13) In looking over the rules, I noticed that the term "regulations" remains present in the following sections: 18.04.2.1, 18.04.2.6, 18.04.3.2, 18.05.2.1, 18.05.3.1, 18.05.6.2, 18.06.2.1, and 18.06.5.2. **RESPONSE:** Language has been changed to "rules" in sections that included "regulations."

The proposed effective date is pending legislative review and approval.

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

LEGAL AUTHORIZATION: The proposed changes include those made in light of Act 523 of 2019, sponsored by Senator Jane English, which provided for consistency in the reimbursement of educational costs for students who are placed in a residential or inpatient facility that is located in a bordering state. Arkansas Code Annotated § 6-20-107, concerning the prohibition of educational cost reimbursement for juveniles placed in treatment facilities, establishes the limited conditions under which the Division of Elementary and Secondary Education, a public school district, or an open-enrollment public charter school may be liable for educational or other related costs associated with the placement of a juvenile in an out-of-state residential or inpatient facility for any care and treatment, including psychiatric treatment. Pursuant to Ark. Code Ann. § 6-11-105(a)(1) and (7)(A), (B), the State Board of Education has general supervision of the public schools of the state and shall take such action as it may deem necessary to promote the physical welfare of school children and the organization and efficiency of the public schools of the state. It shall further perform all other functions delegated to it by law. *See* Ark. Code Ann. § 6-11-105(a)(8)(A).

5. DEPARTMENT OF HEALTH, DIVISION OF HEALTH RELATED BOARDS AND COMMISSIONS, STATE BOARD OF DENTAL EXAMINERS (Mr. Kevin O'Dwyer, Ms. Meredith Rogers)

a. SUBJECT: Article IX – Credentials Required in Issuing Dental or Dental Hygiene License

DESCRIPTION: Proposed amendment to remove the wording moral character and to revise the wording "shall present himself or herself" to "may be required to appear" and to remove the requirement for "good moral character" pursuant to Act 990 of 2019.

The proposed change to the rule was discussed at several board meetings throughout 2019 in an effort to allow an applicant, who has no issues with his or her application, to obtain a dental license quicker. Historically, per the rule, an applicant would submit the application and fee and then travel to Little Rock and attend a regularly scheduled meeting to be interviewed by the full Board. Naturally, for out of state applicants, this was a slow and expensive process. The proposed change to the rule was made by the Dental Board Rules committee and presented to the full Board, which approved the change. The rule still allows the Board to require an applicant to appear should there be an issue with his or her application. An "issue" might involve any substance abuse problems, previous board

action from the applicant's home state, criminal charges and malpractice issues.

PUBLIC COMMENT: A public hearing was held on November 13, 2020. The public comment period expired on November 13, 2020. The State Board of Dental Examiners received no comments.

The proposed effective date is pending legislative review and approval.

FINANCIAL IMPACT: The State Board of Dental Examiners indicated that the proposed rules do not have a financial impact.

LEGAL AUTHORIZATION: The Arkansas State Board of Dental Examiners has authority to promulgate rules in order to carry out the intent and purposes of this Title 17, Chapter 82 concerning dentists, dental hygienists and dental assistants. *See* Ark. Code Ann. § 17-82-208(a). The proposed rules implement Act 990 of 2019, sponsored by Senator John Cooper, which amended the law to obtain consistency regarding criminal background checks for professions and occupations, and disqualifying offenses for licensure. In addition, licensing entities were prohibited from using vague or generic terms, including without limitation the phrase "moral turpitude" or "good character," as a basis to deny licensure. The Act required licensing entities to promulgate rules to implement the Act. *See* Act 990 of 2019, § 2.

6. DEPARTMENT OF HEALTH, DIVISION OF HEALTH RELATED BOARDS AND COMMISSIONS, STATE BOARD OF OPTOMETRY (Mr. Kevin O'Dwyer, Dr. Bryant Ashley)

a. SUBJECT: Chapter VIII, Article I – Qualifications for an Arkansas Licensed Optometrist to be Credentialed to Utilize and Perform Authorized Procedures Listed in Ark. Code Ann. § 17-90-101(a)(3)(D)

DESCRIPTION: Proposed Chapter VIII, Article I expands the definition of the practice of optometry to include the following procedures:

i. Injections, excluding intravenous or intraocular injections;
ii. Incision and curettage of a chalazion;
iii. Removal and biopsy of skin lesions with low risk of malignancy, excluding lesions involving the lid margin or nasal to the puncta;
iv. Laser capsulotomy; and
v. Laser trabeculoplasty.

The intent of this rule is to establish credentialing requirements for an optometrist to perform the procedures outlined in Act 579. After the act

was passed, the Optometry Board began the process of drafting a rule that would be as thorough as possible regarding the credentials and requirements necessary for the safety of patients to allow optometrists to be permitted to perform the various procedures listed in the Act. Dr. Bryant Ashley, Chairman of the Board of Optometry traveled to North Carolina to visit the National Board Examination Center to discover the exact testing requirements for the national test as well as the various subjects covered. He then traveled to Oklahoma to visit an optometry school that teaches these procedures. After getting an understanding of their curriculum, he then researched the rules that already exist in states that allow optometrists to perform these procedures. These states included Kentucky, Louisiana, and Oklahoma. After review of the various state rules, it was clear that there were similarities in the requirements; however, Kentucky's rule appeared to be provide the most thorough and comprehensive list of requirements. The Arkansas rule as drafted is based, in part, on Kentucky and to a lesser extent the other states in order to capture all the requirements of the various states. The Board looked at other states because these rules have been in effect for some time and seem to work well. The Board believes that the rule, as drafted, provides an extremely comprehensive list of requirements that provide the maximum amount of protections to patients because it requires a high level of proven competency by the optometrist who applies for the certificate.

PUBLIC COMMENT: A public hearing was held on October 29, 2020. The public comment period expired on October 29, 2020. The State Board of Optometry provided the following summary of comments received and its responses thereto:

Commenter's Name: Jeff Netzel, O.D.
Commenter's Agency: Arkansas Optometric Association
Summary of Comment: Arkansas Optometric Association and its 330 members support the proposed rule.

Commenter's Name: Jonathan Shrewsbury, O.D.
Commenter's Agency: Kentucky Board of Optometric Examiners
Summary of Comment: The Kentucky Board of Examiners believe the proposed requirements serve to properly protect the health and safety of the public by creating responsible professional standards to competent providers. Dr. Shrewsbury strongly supports the proposed rules.

Commenter's Name: James Sandefur, O.D.
Commenter's Agency: Louisiana State Board of Optometry Examiners
Summary of Comment: The rules proposed by the Arkansas State Board of Optometry are certainly consistent with the rules of other states

with a similar scope of practice and where there is a proven track records of safety. These credentialing requirements are well defined, comprehensive and rigorous. The rules have unquestionably been written to ensure both competency in the provider and safety for patients.

Commenter's Name: Lewis Reich, PhD
Commenter's Agency: Southern College of Optometry
Summary of Comment: The Arkansas Board of Optometry is to be commended for requiring a high level of proven competency by ODs who will apply for credentials in order to perform the various procedures authorized by Act 579.

Commenter's Name: Russell Laverty, O.D.
Commenter's Agency: Oklahoma Board of Examiners in Optometry
Summary of Comment: The proposed Board Rules mandate that the necessary training be in place. The board's oversight by testing applicants will assure safety prior to certification. Optometry graduates have eight years of higher education prior to licensure. Technological advancements to provide laser technology have been developed for over thirty years. It's time that all states recognize the benefits that this technology will provide with the delivery by competent, trained optometrists.

Commenter's Name: William Reynolds, O.D.
Commenter's Agency: American Optometric Association
Summary of Comment: The rules proposed by the Arkansas State Board of Optometry are consistent with the rules of other states with a similar scope of practice, where there are proven track records of safety. These credentialing requirements are well defined, comprehensive and rigorous. The rules have unquestionably been written to ensure both competency in the provider and safety for patients in Arkansas.

The proposed effective date is pending legislative review and approval.

FINANCIAL IMPACT: The State Board of Optometry indicated that the proposed rules do not have a financial impact.

LEGAL AUTHORIZATION: The State Board of Optometry has authority to make rules for the administration and enforcement of Title 17, Chapter 90, concerning optometrists. *See* Ark. Code Ann. § 17-90-204(1).

The proposed rule implements Act 579 of 2019, sponsored by Representative Jon Eubanks, which amended the definition of the practice of optometry to include the following procedures: injections, excluding intravenous and extraocular injections; incision and curettage of a chalazion; removal and biopsy of skin lesions with low risk of

malignancy, excluding lesions involving the lid margin or nasal to the puncta; laser capsulotomy; and laser trabeculoplasty. *See* Act 579 of 2019 § 2, codified as Ark. Code Ann. § 17-90-101(a)(3)(D). The State Board of Optometry is authorized to establish credentialing requirements for a licensee to administer or perform procedures as listed in Ark. Code Ann. § 17-90-101(a)(3)(D). *See* Act 579 of 2019, §3, codified as Ark. Code Ann. § 17-90-204(9). Additionally, the State Board of Optometry shall require every optometrist who meets the requirements for certification to perform authorized laser procedures to report to the board regarding the outcome of the procedures performed in a format as required or directed by the board. *See* Act 579 of 2019, §4, codified as Ark. Code Ann. § 17-90-206(a).

Concerning fee-making, the board has authority to require applicants for licensure to pay a fee in a reasonable amount to be fixed by the board. *See* Ark. Code Ann. § 17-90-301(c). The board also has authority to require a reasonable renewal fee pursuant to Ark. Code Ann. § 17-90-304(a)(1).

7. <u>DEPARTMENT OF HUMAN SERVICES, DIVISION OF AGING, ADULT, AND BEHAVIORAL HEALTH SERVICES</u> (Mr. Mark White, Mr. Kirk Lane)

a. <u>SUBJECT</u>: Uniform Program Operations – State Funded Multijurisdictional Drug and Crime Task Forces (DCTFs)

<u>DESCRIPTION</u>:

<u>Statement of Necessity</u>

Ark. Code Ann. § 12-17-101 et seq. established the "State Drug Crime Enforcement and Prosecution Grant Fund," for the purpose of funding state grant awards for multi-jurisdictional drug crime task forces (DCTFs) to investigate and prosecute drug crimes within the State of Arkansas. DCTFs are an association consisting of a minimum of two (2) law enforcement agencies, and one (1) prosecuting attorney, acting by agreement to jointly investigate and prosecute drug crimes in a defined geographic area or judicial district.

The enabling statute for DCTFs sets out basic definitions, the grant application and administration process, matching funds, and appropriate use of grant awards. However, the statutes do not provide a clear, uniform guide for how DCTFs are to operate. As a result, DCTFs around the State vary widely in basic structure and operation which, at times, has made coordination difficult. Additionally, the State has seen a reduction in

funding for DCTFs which means it is more important than ever for DCTFs to operate as efficiently as possible.

The purpose of this new rule is to build uniformity and increase accountability in the reporting of operations and expenditure of funding, making DCTFs more financially efficient.

Rule Summary

This rule clarifies the following as to DCTFs:

1. Clearly defines and states the objectives of DCTFs per the enabling statute;

2. Clarifies the local match requirement for funding and specifies that the allowable use of grant funding will be pursuant to Ark. Code Ann. 12-17-107;

3. Clearly defines the allowable organizational and management structure for DCTFs as well as defines allowable personnel;

4. Establishes strict reporting requirements to ensure funding is being spent appropriately and as efficiently as possible; and,

5. Establishes mandated meeting requirements and training compliance.

PUBLIC COMMENT: No public hearing was held on this rule. The public comment period expired on November 9, 2020. The agency indicated that it received no public comments.

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

1. Are the various reports mentioned in Section 6 required by statute or do they fall under the heading of general task force record maintenance? **RESPONSE:** They would meet the requirements of the grant evaluation that we submitted and was accepted by our federal provider, BJA (Bureau of Justice Assistance). DFA is the fiduciary for the Alcohol and Drug Coordinating Council, who oversees the grant that was awarded as well as the financial operation of the Drug Task Forces.

2. Section 6.D requires submission of an annual match report to the State Drug Director. However, Ark. Code Ann. § 12-17-105 seems to put DFA in charge of determining whether matching requirements are met. Is DFA involved in this rule promulgation in any way? **RESPONSE:** See answer above. The State Drug Director is the Chairperson for the Arkansas

Alcohol and Drug Coordinating Council. DFA is represented on the council and serves as the fiduciary for the council. Please know that this rule was developed after years of work by the AADCC, which DFA and the AG are part of. It was then vetted by the Governor's Office. The AADCC voted unanimously to approve the rule.

3. Are the training topics listed in Section 7 taken from somewhere else, or was this list compiled for these rules? **RESPONSE:** These were suggested training topics by our federal grant provider to insure that law enforcement (DTF's) comply with BJA's concerns for law enforcement improvement. Although not mandated, they were highly suggested and part of our grant submission that was approved for the federal funding, and we submitted in our grant application that we would abide by them. Needless to say, it makes good sense to improve training as we serve the public that is demanding improved standards.

The proposed effective date is January 1, 2021.

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

LEGAL AUTHORIZATION: The Arkansas Drug Director, located within the Department of Human Services, Division of Aging, Adult, and Behavioral Health Services, "is authorized to establish and enforce rules regarding . . . the maintenance and inspection of drug task force records concerning . . . grant funds." Ark. Code Ann. § 20-64-1001(d)(2). The Arkansas Alcohol and Drug Abuse Coordinating Council, chaired by the Drug Director, has oversight of all State Drug Crime Enforcement and Prosecution Grant Fund expenditures and possesses authority to "[d]evelop and promulgate by rule criteria for the grant applications and awards process[.]" Ark. Code Ann. § 12-17-104. The Council also has authority to oversee "all planning, budgeting, and implementation of expenditures of state and federal funds allocated for alcohol and drug education, prevention, treatment, and law enforcement." Ark. Code Ann. § 20-64-1003(a). Per the agency, the Council voted unanimously to approve this rule.

8. DEPARTMENT OF HUMAN SERVICES, DIVISION OF CHILDREN AND FAMILY SERVICES (Mr. Mark White, Ms. Christin Harper)

a. SUBJECT: Adoption Policies and Procedures Updates

DESCRIPTION:

Statement of Necessity

These revised rules are necessary to update the Division of Children and Family Services' policy and procedure related to adoption services and supports to update current practice.

Rule Summary

Effective January 1, 2021, the Division of Children and Family Services will implement the following revised rules:

Policy VIII-E: Decisions Involving Children in DHS Custody Whose Parents' Rights Have Been Terminated:

- To clarify consents needed for children in foster care under the age of 18 versus children in the Extended Foster Care Program Ages 18-21.
- To remove duplicative information located elsewhere in the DCFS policy manual.

Policy VIII-F: Infants Relinquished for Adoption Under the Safe Haven Act and related procedure:

- To better align requirements for infants relinquished for adoption under the Safe Haven Act with A.C.A. 9-34-202.
- To remove duplicative information located elsewhere in the DCFS policy manual.

Policy VIII-G: Selection, Preparation, and Finalization of Adoptive Placements and related procedures:

- To synthesize adoption selection, preparation, and finalization placement requirements into one policy for all types of adoptive placements rather than maintaining separate but virtually identical requirements for relative/fictive kin adoptions and non-relative adoptions.
- To emphasize preferential consideration for relative placements and adoptions as well as the importance maintaining sibling groups in adoptive placements.
- To formalize existing guidance around the type of adoption recruitment activities in which a child may participate (depending on the status of termination of parental rights).
- To define legal risk placements and considerations.
- To include additional information regarding post-mortem adoptions.
- To provide detailed guidance to adoptions staff regarding their role in the development of adoption disclosure packets, including associated timeframes, and to ensure that all appropriate elements are included in the disclosure packet, such as any documentation regarding relative and fictive kin efforts.

- To establish specific timeframes for response to adoption inquiries for staff and efforts to be taken prior to considering out-of-state adoption inquiries.
- To provide instructions regarding placement of children available for adoption on the Arkansas Heart Gallery.
- To clarify requirements for pre-placement activities and transitioning into a pre-adoptive placement.
- To formalize existing guidance regarding collaboration between the child's Family Service Worker and Adoption Specialist as it relates to finding, preparing, and transitioning a child into an adoptive placement.
- To make general organizational and formatting improvements.

Policy VIII-H: Legal Custodian Petition to Adopt a Child Previously in Foster Care and related procedure:

- To establish guidance regarding how to proceed if a legal custodian wishes to adopt the child in their custody following the termination of rights of the child's biological parent.

Policy VIII-I: Adoption Subsidy and related procedures:

- To remove obsolete references to Fostering Connections phase-in schedule.
- To clarify that any subsidy agreement and associated payments extended past the age of 18 due to a mental or physical handicap will take effect on the date the new subsidy agreement reflecting the extension is signed.
- To put into policy requirements for requesting child support from an adoptive parent whose child re-enters foster care.
- To clarify existing practice as to how subsidy assistance may be submitted in cases of unknown medical and psychiatric conditions that surface after adoption finalization.
- To add reference to existing Division of County Operations policy allowing Medicaid coverage for children adopted on or after January 1, 2019, regardless of whether IV-E adoption subsidy payments have been made for the child.
- To provide guidance to staff regarding determining if a change in subsidy payee is appropriate based on documentation of divorce and custody arrangements
- To make technical corrections.

Policy VIII-J: Mutual Consent Voluntary Adoption Registry and related procedures

- To make technical corrections.

- To update and specify staff duties associated with the Mutual Consent Voluntary Adoption Registry.

Procedure VIII-D4: Fast Track to Adoption Under Garrett's Law

- To better align with A.C.A. 9-9-702.
- To update and correct policy cross-references.

Appendix 2: Adoption Summary Guidelines

- To make technical corrections and improve formatting.

PUBLIC COMMENT: No public hearing was held on this rule. The public comment period expired on November 2, 2020. The agency provided the following summary of the single public comment it received and its response to that comment:

Commenter's Name: Consevella James LCSW, Executive Director, Treatment Homes, Inc., on behalf of Family Focused Treatment Association – Arkansas Chapter

COMMENT:

DCFS should be applauded for updating the adoption policies with emphasis on permanency and the best interests of the child. However, we have concerns that the most vulnerable child, the foster child who has experienced the most severe trauma with the most serious therapeutic needs, has not been adequately addressed in the proposed policies. It appears that none of the suggestions or concerns that have been discussed in FFTA meetings for several years regarding preparation for adoption of foster children placed in therapeutic foster care were addressed in these changes.

Private providers are not specifically included as part of the team. There are references to: "Other members of the child's team," "Child's support team," or "As requested by Adoption Specialist"

When discussing the Consideration to Adopt Staffing's, it does say that Resource Parents interested in adopting their foster child(ren) will be invited but says nothing about any private agency staff being invited.

There are specifics laid out that address transition for the older and the very young, but again do not include those that have worked with the child in a closer capacity than the DCFS staff, oftentimes for a much longer period of time. It would be helpful to have TFC providers, private

providers or PLPA providers specifically listed in the policy to ensure that these providers are routinely included in this critical process.

The following is an example of how the policy can be changed to include the treatment providers as part of this process as well as additional focus on the therapeutic needs of the foster child as a primary factor in the preparation for adoption transition.

The Child's Adoption Specialist will:

Q. Schedule and conduct a selection staffing with the Family Service Worker, the family's Adoption Specialist, and other appropriate DCFS staff and professionals (including the child's attorney ad-litem and CASA involved with the child in the identification of an adoptive family). Include therapeutic foster care treatment staff

Create a written pre-placement visitation plan in conjunction with the parties which addresses the logistical, add therapeutic, and developmental needs of all parties. Ensure that the plan is modified throughout the pre-placement process according to the adjustment of the child and adoptive family. Refer to VIII-G4: Disclosure, Pre-Placement, and Placement Activities for pre-placement visitation guidelines;

Additionally, there was no information that indicated there had been a focus group with previously adoptive youth to speak to transitioning to an adoptive placement.

We would appreciate the opportunity to address some of the additional changes that would ensure that the therapeutic needs of the foster child is the primary concern to facilitate permanency and decrease the percentage of disruptions for this specific population.

RESPONSE: Thank you for your comment. We are in agreement with adding specific references to TFC providers, private providers or PLPA providers to ensure that these providers are routinely included in adoption decision process. These revisions will be made for the final submission to the Bureau of Legislative Research, the Secretary of State, and the Arkansas State Library.

While there was not a focus group convened specific to the development of this policy, the Division of Children and Family Services have held focus groups with our Youth Advisory Board within the past two years specific to the recruitment of foster and adoptive homes for older youth and other issues pertinent to this age demographic to help us inform planning, practice, and policy.

Discussion regarding this proposed policy has been placed on the Family Focused Treatment Association November 13, 2020 meeting agenda.

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

1. The proposed rules state, "Children will attend matching events after termination of parental rights has occurred, even if an appeal of the termination of parental rights is pending." Is there a specific source for this provision (Policy VIII-G, page 3)? **RESPONSE:** No, this is Division policy.

2. Is there statutory authority for the preference for in-state adoptions, or is this a policy decision (Procedure VIII-G, page 12)? **RESPONSE:** The only preference in statute regarding adoption of children in public custody is the preference for relative caregivers. The Juvenile Code and Adoption Code are silent on in-state versus out-of-state adoption. It is Division policy in an effort to try to keep the child connected with his or her school, friends, and other community groups when possible.

3. The entirety of Policy VIII-H appears in the first paragraph of Procedure VIII-G11. In addition, Procedure VIII-H1 repeats Procedure VIII-G11, with the exception of the listed procedures the Adoption Specialist is directed to follow. Is there a reason these provisions are repeated? **RESPONSE:** No. This was an oversight resulting from multiple versions being passed back and forth during the development process. At some point what is now Procedure VIII-H was a part of Policy VIII-G, but we later decided to pull it out since it is really a whole separate policy and a rarity. Procedure VIII-G11 will be deleted in the final version. Thank you for catching.

4. The Title IV-E eligibility rules in Policy VIII-I state, "Beginning January 1, 2018 through June 30, 2024, all children age two (2) and older by the end of that fiscal year are eligible based on age. Starting July 1, 2024 all children will be eligible based on age." However, the old rules indicated that all children would become eligible based on age beginning in 2018. Was there an intervening federal law change, or is there another reason that this date changed?

RESPONSE: Yes, the Family First Prevention Services Act (FFPSA) amended this provision. Per ACYF-CB-PI-18-07, before FFPSA, all children were considered an "applicable child" for determining eligibility for title IV-E adoption assistance as of October 1, 2017. However, the FFPSA revised the program eligibility rules to delay phasing in the "applicable child" requirements based on the age of the child. This means that from January 1, 2018 until June 30, 2024, the "applicable child"

requirements apply only to children who will be age two or older by the end of the fiscal year their adoption assistance agreement was entered into. However, a child may still be considered "an applicable child" if the child is a sibling of an "applicable child" and meets requirements as detailed at section 473(a)(2)(A)(ii) of the Act. Title IV-E adoption assistance agreements entered into prior to January 1, 2018 are not affected by these changes. For more information:
https://www.acf.hhs.gov/sites/default/files/cb/pi1807.pdf

5. Policy VIII-I and Procedure VIII-I8 require a 14-calendar-day written notice when the Division intends to terminate an adoption subsidy. Is there a specific source for that timeframe? **RESPONSE:** Not for the timeframe. Federal regulations only require that the agency sends adequate notice not later than the date of action when the recipient. Please see [45 C.F.R. § 205.10].

The proposed effective date is January 1, 2021.

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

LEGAL AUTHORIZATION: The Arkansas Department of Human Services is tasked with administering and supervising "all child welfare activities . . . , including . . . the care and supervision of children placed for adoption[.]" Ark. Code Ann. § 20-76-201(2)(C). The Department may promulgate rules to accomplish this duty, *see* Ark. Code Ann. § 20-76-201(12), and it also has the authority to promulgate rules implementing the Arkansas Subsidized Adoption Act. Ark. Code Ann. § 9-9-405(a). The Department's Division of Children and Family Services has the authority and responsibility to "[e]nsure child placements support the goal of permanency for children when the division is responsible for the placement and care of a child[,]" and the Division may promulgate rules to administer this duty. Ark. Code Ann. § 9-28-103(a)(6), (b). Some of these changes implement Act 185 of 2019, sponsored by Senator Cecile Bledsoe, which amended the Safe Haven Act.

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

a. SUBJECT: Elderly Simplified Application Project (ESAP)

DESCRIPTION:

Statement of Necessity

Currently, the agency participates in a thirty-six (36) month Certification Demonstration Project waiver allowing certain elderly or disabled households to be certified for longer than twenty-four (24) months in the Supplemental Nutrition Assistance Program (SNAP). This project waiver has become obsolete and USDA Food and Nutrition Service (FNS) has asked states to instead adopt the Elderly Simplified Application Project (ESAP) waiver program. Implementing the ESAP will allow the agency to continue to serve vulnerable, low-risk, and low-error households by assisting them in maintaining the benefits they need while reducing the risk of churn in this population.

The elderly are a historically underserved group and face many barriers to participation, including limited mobility and minimal access to electronic equipment that facilitates compliance with verification and reporting requirements. Similarly, households containing members living with a disability struggle to meet the verification and paperwork requirements. However, this population with no earned income often live in stable settings where factors like unearned income, such as Supplemental Security Income (SSI), Social Security number, or proof of residency, are readily verifiable through data matches. As a result, the burden of the typical SNAP application process may hinder participation in these vulnerable groups, while contributing relatively little information that cannot be found and verified elsewhere. The ESAP business process is designed to minimize these barriers while balancing the need for ESAP participants to get the best benefit they can.

ESAP is a process that seeks to streamline SNAP participation among the elderly low-income population by simplifying the application and certification process. ESAP is limited to elderly or disabled households with no earned income. The waiver is granted for five (5) years and waives the recertification interview requirement, makes use of data matches to reduce the amount of client-provided verification, and extends the certification period for certain elderly and disabled households to thirty-six (36) months, as opposed to the regulatory length limit of twenty-four (24) months. This process will decrease the instances of cases being closed because of missing requested information. Eligibility workers will be required to assist an ESAP household with income and resource verification. Assigning a thirty-six (36) month certification period aids these stable elderly and disabled households by eliminating the requirement to reapply for assistance and complete a new application every twelve (12) months.

The revisions for ESAP required changes in three (3) sections of the Supplemental Nutrition Assistance Program Certification Manual. The subsequent information details the rule changes for the following sections:

SNAP 8000 Initial Applications, SNAP 10000 Recertifications, and SNAP 11000 Reporting Requirements.

Rule Summary

Effective January 1, 2021, the Division of County Operations Manual is being revised as follows:

SNAP 8000 Initial Application:

- This rule introduces the purpose of the Elderly Simplified Application Project. Provisions have been added to meet the requirements of the waiver as well as explain the goal of the project.

- Eligibility workers are advised to collect any necessary verifications on the household's behalf as part of the waiver requirement and to aid the households in determining eligibility for their SNAP benefits.

- The Initial Application section has been revised to define the criteria for ESAP households as well as designating the certification period.

- The word "calendar" has been added to distinguish from business days.

- A virtual option has been added for interviews.

SNAP 10000 Recertifications:

- This rule defines the SNAP recertification process as it applies to ESAP households.

- Provisions have been added to the rule that remind eligibility workers that the agency is responsible for obtaining all needed verification on behalf of the elderly and disabled households.

-The waiver also removes the recertification interview requirement unless the eligibility worker has identified that the recertification application might be denied.

- The guidelines for contacting the households before disposing of the application by the end of the certification period have been included in the section.

- The word "calendar" has been added to distinguish from business days.

- A virtual option has been added for interviews.

SNAP 11000 Reporting Requirements:

- Significant revisions have been made to the SNAP 11000 Reporting Requirements that include removing the annual reporting requirement for ESAP households.

- ESAP households will be reminded annually of their ten (10) day reporting requirements until is it time to recertify. When ESAP households are determined to be ineligible for the thirty-six (36) month certification period at reported change of circumstances, the certification period will be shortened.

- The impacted section titles have been changed to reflect the removal of the annual report requirement.

- The word "calendar" has been added to distinguish from business days.

Business Process Removal:

- To simplify the certification manual and clarify the rule, business processes not controlled by regulation have been removed.

- This cleanup also includes correcting grammar, removing jargon, and system-specific language.

- These changes will allow the division to react faster to error trends, new system processes, and other issues that require a quick response.

PUBLIC COMMENT: No public hearing was held on this rule. The public comment period expired on October 24, 2020. The agency provided the following summary of the public comment it received and its response to that comment:

Commenter's Name: Jeanette Dotson

COMMENT: Dear Ms. Franklin/Office of Rules Promulgation,

I would like to share comments from the Case Managers and myself who work diligently with the elderly in eastern Arkansas.

We assist them in completing the applications for SNAP formerly known as food stamps because many cannot read or write legibly.

We agree whole heartedly agree that:

The Elderly Simplified Application Project (ESAP) should be increased from a three (3) year period to a five (5) year period.

We ask that the elderly continue to report to Department of Human Services when someone else has moved in with them.

Thank you for this opportunity to share our comments.

If you have any questions, please feel free to call me at ***-***-****

RESPONSE: Thank you for your response and support of Rule-75, Elderly Simplified Application Project (ESAP).

Due to the guidance received from FNS, this project is only limited to three years, with an opportunity to renew.

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

1. The proposed rules state that households participating in ESAP "do not include minor dependent children aged fifteen or younger." Where does this requirement come from?

RESPONSE: The guidance received from FNS states that ESAP is only limited to elderly households with no earned income.

2. The proposed rules change the certification period for households composed entirely of individuals with disabilities, persons aged 60 or older, and minor dependent children under 15 from 36 months to 12 months. Why has the certification period been reduced?

RESPONSE: ESAP is only limited to elderly and disabled households and does not include children. Those that have minor dependent children, will be subject to normal certification periods.

3. Sections 10900 and 11600 state that ESAP eligibility is limited to households that "do not include minor dependent children." Are these sections meant to be consistent with the provisions limiting eligibility to households that do not include "minor dependent children aged fifteen or younger"? **RESPONSE:** Yes.

4. Section 11620 lists reporting requirements for ESAP households. Where does this list of requirements come from? **RESPONSE:** These changes are consistent with current policy (SNAP 11200) and federal regulations, CFR 273.12 (a) (5), regarding reporting changes.

The proposed effective date is January 1, 2021.

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

Per the agency, the cost to implement a federal rule or regulation is $15,960 for the current fiscal year ($7,980 in general revenue and $7,980 in federal funds) and $0.00 for the next fiscal year. The total estimated cost by fiscal year to state, county, and municipal government to implement the rule is $7,980 for the current fiscal year and $0.00 for the next fiscal year.

LEGAL AUTHORIZATION: The Department of Human Services has the responsibility to administer assigned forms of public assistance. *See* Ark. Code Ann. §§ 20-76-201(1), 20-77-107(a)(1). The Department may promulgate rules that are necessary or desirable to carry out its public assistance duties, *see* Ark. Code Ann. § 20-76-201(12), and the Department and its divisions may promulgate rules as necessary to conform their programs to federal law and receive federal funding. Ark. Code Ann. § 25-10-129(b). These proposed rules implement guidance provided by the federal Supplemental Nutrition Assistance Program (SNAP). See USDA, SNAP, *Elderly Simplified Application Project Guidance* (July 6, 2018), https://www.fns.usda.gov/snap/elderly-simplified-application-project.

b. SUBJECT: SNAP 6000 Deductions

DESCRIPTION:

Statement of Necessity

Significant changes have been made to the Supplemental Nutrition Assistance Program (SNAP 6000) Deduction section of the SNAP Certification Manual by adding the Homeless Shelter Allowance and Basic Utility Allowance. The Agriculture Improvement Act of 2018 (Pub. L. No. 115-334), also known as the "Farm Bill," mandates the addition of a shelter allowance for homeless SNAP recipient households. These households must have paid for shelter during the month of initial certification or recertification. The Basic Utility Allowance, as permitted by 7 C.F.R. § 273.9(d)(6), will allow households that do not have a cost for heating or cooling their home to receive a deduction for other utility costs such as water, telephone, sewage, waste, and gas (not related to heating or cooling). The addition of these shelter deductions will remove the actual utility allowance. The rule revisions will make the utility deduction less error prone and save the state federal dollars.

In addition, it is necessary to remove internal business processes from the manual because they are not "rules" under the Arkansas Administrative Procedure Act, § 25-15-201 et seq.

Summary

Effective January 1, 2021, the Division of County Operations' Supplemental Nutrition Assistance Program (SNAP) Certification Manual is being revised as follows:

- Deleted internal business process examples, notes, and charts throughout the manual.

- Revised section numbers, as needed.

- Clarified Grammar and corrected language.

- Removed language specific to the eligibility system and replaced with non-system specific terminology.

- Removed all form numbers as part of effort of deleting internal business processes from the manual.

- Replaced "eligibility worker" with "case worker" throughout the section.

- Replaced "aged/disabled" with required disability language, "individual living with a disability or 60 years old or older." The phrase "eligible individual" is used instead of dated disability language.

- Removed Annual Review from SNAP 6000 and replaced with "reported change."

- Deleted the following sections:
    - SNAP 6621 Which Households May Use the Utility Standard;
    - SNAP 6623 Using Actual Utility Costs;
    - SNAP 6624 Allowable Utility Expenses for Households Who Share Costs;
    - SNAP 6626.1 Other Energy Assistance Payments;
    - SNAP 6626.2 Households with Housing and Urban Development (HUD) or Farmers Home Administration (FMHA) utility reimbursements;
    - SNAP 6627 Verification of Documentation of Shelter Costs;
    - SNAP 6628 Applying the Excess Shelter Deduction;
    - SNAP 6700 Determining If an Expense Should Be Deducted;

- SNAP 6710 Determining the Month A Deduction Should Be Allowed;
- SNAP 6720 Projecting Expenses in a Prospective Budget;
- SNAP 6721 Special Procedures for Projecting Medical Expenses;
- SNAP 6722 Special Procedures for Projecting Utility Expenses;
- SNAP 6723 Special Procedures for Projecting Child Support Payments; and
- SNAP 6730 Averaging Expenses.

Rule revisions by section:

- SNAP 6100 Clarified the excess medical deduction;
- SNAP 6300 Deductions: Added language stating that the Standard Medical Deduction "will be assigned" to the household. The household cannot elect to use the standard;
- SNAP 6400 The Dependent Care Deduction: Changed language to state the deduction is allowed for a household member to "Pursue education to prepare for employment";
- SNAP 6410 Documentation and Verification of Dependent Care Costs: Deleted requirements for verification. Added language to update the verification process to state that the application or change of process will not be delayed if the household fails to provide verification documents;
- SNAP 6500 Medical Deduction: "declares" has been changed to "attests to" for a more precise description of what the client is required to do;
- SNAP 6510 Allowable Medical Costs: Revised dated language to accurately refer to people with disabilities;
- SNAP 6511 Allowable Medical Deductions in Alphabetical Order: Changed "disabled" to "living with a disability";
- SNAP 6520 Medical Standard or Actual Expenses: Deleted and added language for clarification of the standard medical deduction;
- SNAP 6521 One-Time Medical Expenses: Revised the section to allow the deduction to continue for the remainder of the certification period until recertification;
- SNAP 6523 Factor Three: Is the Medical Expense Past Due: Changed "case worker" to "certified eligibility worker";
- SNAP 6526 Changes in Medical Costs: Removed "annual review" from the section. "The household will determine if the expense is averaged over 12 months or deducted in the month it occurred," has been added to correspond with the reporting requirements for Elderly Simplified Application Project (ESAP) households. ESAP households will not be required to complete an Annual Review;
- SNAP 6527 Verification of Medical Expenses: Added a provision stating "new" deductible expenses will be verified at initial application and a reported change to correspond with reporting requirements for ESAP households;

- SNAP 6550 Child Support Deductions: Changed Pampers to “diapers”, which removes a brand name by replacing it with a general common name;
- SNAP 6552 Verification of Child Support Payments: Specified acronyms;
- SNAP 6600 The Excess Shelter Deduction: Updated disability language;
- SNAP 6610 Allowable Shelter Costs: Updated allowable utility expenses;
- SNAP 6620 Explanation of Utility Standard: Renamed Utility Expenses to introduce new utility standards and shelter allowances. Basic Utility Allowance (BUA) and Homeless Living Allowance (HLA) are new shelter costs that will be assigned to the household if ineligible for the Standard Utility Allowance (SUA);
- SNAP 6620.1 Standard Utility Allowance (SUA): New section explaining eligibility for the SUA based on costs incurred for heating and cooling;
- SNAP 6620.2 Utility Expenses of Expedited Households: New section describing how eligibility for each utility allowance will be applied based on selection and verification of the expense. If the household chooses SUA, but fails to verify, the household will be certified using the Basic Utility Allowance (BUA);
- SNAP 6620.3 Specific Costs: Added sections on heating and cooling;
- SNAP 6622 Choosing Between Utility Standard and Actual Utilities: Section renamed Basic Utility Allowance (BUA). This section explains that the BUA includes utility charges that a household incurs that do not include heating and cooling. These are households that are not eligible for SUA or failed to verify eligibility for SUA;
- SNAP 6624 Allowable Utility Expenses for Households Who Share Costs: Section renamed Homeless Living Allowance (HLA). The HLA is a predetermined amount similar to the SUA that is annually updated. Homeless households must verify their costs and meet the definition of homeless in order to receive this deduction;
- SNAP 6625 Households in Public Housing and Rental Units Charged Only for Excess Utility Usage: Section renamed Telephone Standard. This section clarifies how the telephone standard should be applied. This deduction is standalone and should not be included with any other utility allowance;
- SNAP 6626 Households with Utility Bills Paid by LIHEAP: This section has been deleted and incorporated in the section on Standard Utility Allowance (SUA);
- Revised section SNAP 6627 regarding Verification and Documentation of Shelter Costs;
- Revised section SNAP 6628 regarding Applying the Excess Shelter Deduction; and
- SNAP 6800 Chart: This chart has been deleted.

PUBLIC COMMENT: No public hearing was held on this proposed rule. The public comment period expired on November 2, 2020. The agency indicated that it received no public comments.

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

Q. Where do the provisions in the first two paragraphs of Section 6710, regarding the month in which deductions should be allowed, come from?
RESPONSE: This provision comes from the federal regulations at 7 CFR 273.10(d)(4) Anticipating expenses.

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

Per the agency, this rule implements a federal rule or regulation. The estimated cost to implement the federal rule or regulation is $59,736 for the current fiscal year ($29,868 in general revenue and $29,868 in federal funds) and $0.00 for the next fiscal year. The total estimated cost to state, county, and municipal government to implement this rule is $29,868 for the current fiscal year and $0.00 for the next fiscal year.

LEGAL AUTHORIZATION: The Department of Human Services has the responsibility to administer assigned forms of public assistance, *see* Ark. Code Ann. §§ 20-76-201(1), and it has the authority to make rules that are necessary or desirable to carry out its public assistance duties. Ark. Code Ann. § 20-76-201(12). The Department and its divisions also have the authority to promulgate rules as necessary to conform their programs to federal law and receive federal funding. Ark. Code Ann. § 25-10-129(b). This proposed rule implements the federal Agriculture Improvement Act of 2018, which made changes to the availability of the standard utility allowance to certain recipients of energy assistance. Pub. L. 115-334, *codified at* 7 U.S.C. § 2014(e)(6)(C)(iv)(I).

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

a. SUBJECT: EIDT-1-20 and Rules for DDS EIDT

DESCRIPTION:

Statement of Necessity

The Early Intervention Day Treatment (EIDT) Medicaid Provider Manual is being updated and the Rules for the Division of Developmental Disabilities Early Intervention Day Treatment are being created to facilitate billing for EIDT services, bring language used up to date with current industry language, clarify available EIDT services, and establish the new rules relating to EIDT licensure and monitoring.

Rule Summary

Effective January 1, 2021, the Early Intervention Day Treatment (EIDT) Medicaid Provider Manual is being revised as follows:

- Remove duplicative and unnecessary information, revise section arrangement for clarity, and clarify available services.
- Address the evaluations used to establish eligibility and align those evaluations with the standards of practice in the field.
- Remove the opt-in and opt-out requirements for the Part B program under the Individuals with Disabilities Education Act (IDEA) because the program transferred back to the Arkansas Department of Education (ADE) on July 1, 2019. The new language sets out referral requirements for all children ages 3-5 in compliance with the IDEA. This referral process mirrors the one in place for children ages 0-3 under Part C of the IDEA.
- Remove the codes from the manual based on Act 605 of 2017 to allow for faster updates when national code changes occur.
- Combine the treatment planning and evaluation service to align with how these services are paid nationally.
- Change "Speech Therapy" to "Speech-Language Therapy" to mirror current language in the field.

Effective January 1, 2021, the Rules for the Division of Developmental Disabilities Early Intervention Day Treatment will serve as the new set of minimum standards for EIDT programs covering all topics related to EIDT licensure and monitoring.

PUBLIC COMMENT: A remote access public hearing was held on this rule on October 16, 2020. The public comment period expired October 29, 2020. The agency provided a summary of the public comments received and its responses thereto, which due to its length is attached separately.

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

1. Is CMS approval required for this proposed rule change? If so, what is the status on that approval? **RESPONSE:** No CMS approval required.

2. Have PAs always been required for reimbursement for (a) more than five hours of EIDT day habilitative services in a single day and (b) over eight hours of covered EIDT services in a single day, or are these new requirements (PM Section 220.000)? **RESPONSE:** This is not a new requirement.

3. Where do the qualifications for an early child development specialist come from (Rule 103(i))? **RESPONSE:** Brought over from Section 214.200 of the EIDT Medicaid Manual.

4. Where does the definition of "serious injury" in Rule 103(w) come from? **RESPONSE:** This is a new definition.

5. Where does the definition of "solicitation" in Rule 103(x)(2) come from? **RESPONSE:** Was in DDS Policy #1091 with some tweaks based on provider feedback.

6. Where do the licensure conditions in Rule 203(a)(4)(B) and (C) come from? **RESPONSE:** DDS Policy #1089-B

7. Where do the requirements for employees under age 18 come from (Rule 302(d)(2))? **RESPONSE:** Based on feedback from stakeholders and program experience.

8. Are student observers statutorily excluded from needing background checks or is there another reason they are not required to have background checks? **RESPONSE:** They would not have direct contact with beneficiaries.

9. Are the staff-to-beneficiary ratios statutory, required by other regulation, or sourced from somewhere else? **RESPONSE:** Based on feedback from stakeholders and program experience.

10. Are the training topics listed in Rule 303(a) topics in which training is required by statute or federal regulation, or does this list come from somewhere else? **RESPONSE:** Primarily compiled for these rules based upon feedback from stakeholders.

11. What is the source for the five-year timeframe on employee record and beneficiary service record storage? **RESPONSE:** Nothing statutory, common timeframe used for DHS policy purposes.

12. The proposed rules require beneficiary service records to be kept in a file cabinet or room that is always locked. Are there any comparable security requirements for electronic records? **RESPONSE:** As written,

the locked room requirement would apply to where any computer is used for accessing/storing electronic records.

13. The proposed rules require an EIDT facility to have at least one toilet and one sink for every ten beneficiaries. Where does this ratio come from? **RESPONSE:** Based upon feedback from stakeholders.

14. The proposed rules add a new section regarding referrals to local education agencies. Is this section required by statute? **RESPONSE:** It was brought over from the EIDT Medicaid Manual and are [sic] required by Part B and Part C of the Individuals with Disabilities Education Act.

15. Where does the one-year timeframe for storing beneficiary arrival and departure documentation come from? **RESPONSE:** Regulatory experience based on typical investigatory timeframe for transportation incidents.

16. Rules 701(a)and 702(a) list events/incidents that an EIDT must report. Were these lists compiled for these rules or do they come from somewhere else? **RESPONSE:** The list is primarily a carryover from prior standards with some minor additions based upon program experience.

17. Rule 803(b)(5) and Rule 806 both state that DPSQA may impose monetary penalties on a noncompliant EIDT. What is the specific statutory authority for these penalties? **RESPONSE:** Ark. Code Ann. §25-15-217

The proposed effective date is January 1, 2021.

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

LEGAL AUTHORIZATION: The Department of Human Services has the responsibility to administer assigned forms of public assistance and is specifically authorized to maintain an indigent medical care program (Arkansas Medicaid). *See* Ark. Code Ann. §§ 20-76-201(1), 20-77-107(a)(1). The Department has the authority to make rules that are necessary or desirable to carry out its public assistance duties. Ark. Code Ann. § 20-76-201(12). The Department and its divisions also have the authority to promulgate rules as necessary to conform their programs to federal law and receive federal funding. Ark. Code Ann. § 25-10-129(b). As an agency with the authority to suspend, revoke, or deny licenses, the Department may, as an alternative sanction, impose a monetary penalty up to $500 on persons or entities under its jurisdiction. Ark. Code Ann. § 25-15-217(a)-(b).

"The [B]oard [of Developmental Disabilities Services] may make rules regarding the care, custody, training, and discipline of individuals with intellectual and developmental disabilities in the human development centers or receiving services for individuals with intellectual and developmental disabilities[.]" Ark. Code Ann. § 20-48-205(b). The Division of Developmental Disabilities Services has the authority to promulgate rules implementing Arkansas law regarding the managed expansion for child health management services. Ark. Code Ann. § 20-48-1107(a).

This rule implements Act 605 of 2017, sponsored by Representative Justin Boyd, which codified the process for the review of rules impacting state Medicaid costs and exempted medical codes from the rulemaking process and legislative review and approval.

b. SUBJECT: ADDT-1-20; SPA #2020-0020; Rules for DDS ADDT

DESCRIPTION:

Statement of Necessity

The Adult Developmental Day Treatment Medicaid Provider Manual and the Arkansas Medicaid State Plan are being updated and the Rules for the Division of Developmental Disabilities Adult Developmental Day Treatment are being created to facilitate billing for ADDT services, bring language used up-to-date with current industry language, clarify available ADDT services, and establish the new rules relating to ADDT licensure and monitoring.

Rule Summary

Effective January 1, 2021, the Adult Developmental Day Treatment (ADDT) Medicaid Provider Manual will be revised as follows:

- Removes duplicate and unnecessary information, revises section arrangement for clarity, and clarifies available services.
- Removes recoupment and appeal sections, which are covered in other sections of the Medicaid Manual.
- Removes codes from the manual based on Act 605 of 2017 to allow for faster updates when national code changes occur.
- Changes the term "Speech Therapy" to "Speech-Language Therapy" to mirror current language in the field.
- Removes definitions of "unit".

Effective January 1, 2021, the Arkansas Medicaid State Plan will be revised as follows:

- Reflects that the evaluation and treatment plan development services are now combined into one (1) service for billing purposes.
- Clarifies that Speech-Language Therapy evaluations are limited to four (4) units per State Fiscal Year.
- Provides that Physical Therapy and Occupational Therapy evaluations are limited to two (2) units per State Fiscal Year.
- Changes the term "Speech Therapy" to "Speech-Language Therapy to mirror current language in the field.
- Removes definitions of "unit".

Effective January 1, 2021, the Rules for the Division of Developmental Disabilities Adult Developmental Day Treatment will serve as the new set of minimum standards for ADDT programs covering all topics related to ADDT licensure and monitoring.

Effective January 1, 2021, the following standards and policies will be repealed and superseded by the Rules for the Division of Developmental Disabilities Adult Developmental Day Treatment:

- The DDS Standards for Certification, Investigation, and Monitoring for Center-Based Community Services
- DDS Policy 1090 Certification Policy for Non-Center Based Services
- DDS Policy 1091 Licensing Policy for Center-Based Community Services

PUBLIC COMMENT: A public hearing was held on this rule on October 16, 2020. The public comment period expired on October 29, 2020. The agency provided the following summary of the public comments it received and its responses to those comments.

Commenter's Name: Larry Stang

COMMENT 1: There is no mention of an annual employee evaluation requirement. We are in the "people helping people" business, and to not require at least an annual employee evaluation, which allows supervisors to interact with employees regarding their work performance, is a recipe for disaster. This requirement should be considered a "minimum standard". Thank you for this opportunity to comment on these proposed rules.

RESPONSE: Thank you for your comment. DDS does not consider an annual employee evaluation a required minimum standard. An ADDT provider in compliance with the proposed rules can deliver safe and effective ADDT services to beneficiaries without conducting annual employee evaluations for each employee. An annual employee evaluation

may be a very beneficial and perhaps even best business practice; however, for the above reason DDS believes whether or not to conduct annual employee evaluations is an individual business decision to be made by each ADDT provider and not a required minimum standard.

COMMENT 2: UPDATED DRAFT – 10/26/20

DDPA Comments on ADDT Medicaid Manual and ADDT Rules Promulgated September 30, 2020

ADDT Medicaid Manual 212.100 Age Requirement

This language is too restrictive for certain individuals. Some referrals are individuals 17 years of age who had a diploma or a letter of completion from their high school. They need to be able to access services. Also, some individuals are referrals who dropped out of high school prior to receiving a diploma or letter of completion and who were between the age of 18 and 21. Will these individuals be considered if there is no possibility of them returning to high school? In the past, with several calls, we have been able to get the two above scenarios approved and would not want the new rules to preclude that.

RESPONSE: Thank you for your comment. The age requirements applicable to ADDT eligibility were not changed as part of this promulgation. These age requirements are aligned with the release of special education obligations, which is when Medicaid can be billed. Additionally, ADDT is an adult program and should therefore be limited to beneficiaries 18 years and older.

COMMENT 3: 212.200 Prescription

B. Please clarify that it will be acceptable to obtain a faxed or scanned/emailed copy of the prescription for services.

RESPONSE: Thank you for your comment. Section 212.200(B) does not require an original signature, so a scanned/emailed and faxed prescription would comply so long as it meets the other requirements of the section.

COMMENT 4: 214.110 ADDT Evaluation and Treatment Planning Services

All these required elements cannot be accomplished within the one hour of reimbursement.

RESPONSE: Thank you for your comment. This was not changed during this promulgation.

COMMENT 5: 214.220 Nursing

Thank you for adding cecostomy or ileostomy tube.

RESPONSE: Thank you for your comment.

COMMENT 6: ADDT Licensure Rules

General Comments

These rules do not match the statutory language that requires licensed providers to be a "nonprofit community program." As written the rules would appear to allow a for-profit entity to be licensed, and indeed, the rules talk about change of "ownership" and other for-profit language. Also, the rules do not require accreditation for new programs, as the statute does under Ark. Code 20-48-105. If the statute is changed in the future the rules should be changed at that time. But the current rules should match the current statutory requirements. Otherwise, it invites confusion and litigation. We request the following definitions from Ark. Code 20-48-101 be added to the definitions and incorporated into the context of these rules:

(5)(A) "Nonprofit community program" means a program that provides only nonresidential services to persons with developmental disabilities or provides nonresidential and residential services to persons with developmental disabilities and is licensed by the division.
(B) A nonprofit community program serves as a quasi-governmental instrumentality of the state by providing support and services to persons who have a developmental disability or delay and would otherwise require support and services through state-operated programs and facilities; and

(6)(A) "Qualified nonprofit community program" means a nonprofit community program that holds a valid nonprofit community program license issued by the division.

(B) "Qualified nonprofit community program" includes:
(i) A nonprofit community program that holds a license that was issued by the division on or before February 1, 2007; and
(ii) An accredited nonprofit entity that is awarded a license as a nonprofit community program by the division after February 1, 2007.
We request the underserved Sections 203 and 204 reflect the statutory requirement for accreditation.

RESPONSE: Thank you for your comment. All statutory requirements applicable to ADDT programs are unaffected by these rules. DPSQA

would have to adhere to any statutory authority pertaining to ADDT programs as part of its review of any application. If there is any aspect of an applicant which is not in compliance with applicable statutes, then the application would be rejected by DPSQA. It would be duplicative to copy all statutory requirements into the proposed rules.

COMMENT 7: The rules do not sync with the "DDS Standards for Certification, Investigation and Monitoring for Center-Based Community Services"? How does DHS intend to handle that issue? Note also that the Center-Based Standards apply to group homes as well as ADDT.

RESPONSE: Thank you for your comment. These proposed rules will supersede and replace the DDS Standards for Certification, Investigation and Monitoring for Center-Based Community Services, which will be repealed on the effective date of these proposed rules. Any references to group homes in the DDS Standards for Certification, Investigation and Monitoring for Center-Based Community Services are incorrectly included since group homes do not provide a center-based service, and those standards were specifically limited to EIDT and ADDT programs.

COMMENT 8: 101 Authority

(b)(2) It seems this list also should include Ark. Code Ann. 20-48-105 (how DDS will make a determination on underserved status).

RESPONSE: Thank you for your comment. Ark. Code Ann. § 20-48-105 is already included as part of the first statutory reference in Section 101(a).

COMMENT 9: 103 Definitions
(j) "Employees" – Employees and independent contractors are different legally and ideally should not encompassed in the same definition. While we understand it is easier to include independent contractors in the definition, and some provisions should apply to contractors, other provisions, such as background checks should not apply to ALL contractors, such as vendors and professionals who do not have contact with beneficiaries. You have explained in the text when certain sections apply to independent contractors, so it doesn't seem necessary to blur the distinction.

RESPONSE: Thank you for your comment. Section 103(h) will be broken into subsection (1) and (2). Section 103(h)(1) will remain as currently written. Section 103(h)(2) will be added stating:

(2) "Employee" does not mean an independent contractor if:

(i) the independent contractor does not assist in the day-to-day operations of the ADDT; and

(ii) the independent contractor has no beneficiary contact."

COMMENT 10: (r) "underserved" – please reference the statutory criteria at 20-48-105.

RESPONSE: Thank you for your comment. The phrase "…in accordance with 20-48-105 of the Arkansas Code" will be added to the end of Section 103(q).

COMMENT 11: 202 Licensure Application

203 Licensure Process

See General Comments above.

RESPONSE: Thank you for your comment.

COMMENT 12: 301 Organization and Ownership

In (c)(3), please reword so that a name change requires "notice" to DPSQA, not approval.

RESPONSE: Thank you for your comment. Section 301(c)(3) only requires notice to DPSQA as currently written.

COMMENT 13: 303 Employee Training

New hire and annual topics with specific categories has been added back - we appreciate flexibility to make determinations on most needed trainings.

RESPONSE: Thank you for your comment. These are basic health and safety trainings for employees that have direct contact with beneficiaries and will be required for such employees in all Medicaid program provider certification manuals.

COMMENT 14: 304 Employee Records

(5) Drug screen results. Those should be in medical files not personnel files (as required by DOL). We have no opposition to providing a copy to DPSQA, but they should be segregated.

RESPONSE: Thank you for your comment. The current Section 304(b) will become Section 304(c) and a new Section 304(b) will be added that states:

(b)(1) An ADDT must ensure that each personnel record is kept confidential and
available only to:

(A) Employees who need to know the information contained in the personnel record;

(B) Persons or entities who need to know the information contained in the personnel record;

(C) DPSQA and any governmental entity with jurisdiction or other authority to access the personnel record;

(D) The employee; and

(E) Any other individual authorized in writing by the employee.

(2)(A) An ADDT must keep personnel records in a file cabinet or room that is always locked.

(B)(i) An ADDT may use electronic records in addition to or in place of physical records to comply with these standards.

(ii) An ADDT provider that uses electronic records must take reasonable steps to backup all electronic records and reconstruct a personnel record in the event of a breakdown in the ADDT's electronic records system.

COMMENT 15: 305 Beneficiary Service Records

Recommend add "attributed PASSE information, if applicable."

RESPONSE: Thank you for your comment. Section 305(b)(12) will be changed to add, "or managed care organization information, if applicable."

COMMENT 16: 310 Infectious Diseases

This should be changed to "contagious" diseases or similar term. Not all infectious diseases, such as HIV, are contagious or easily transmittable. This may violate the ADA and Rehab Act as written. The EEOC guidance and court cases do not allow discrimination against individuals with diseases not transmitted through casual contact.

RESPONSE: Thank you for your comment. Section 309 is labeled "Infection Control" as opposed to Infectious Diseases, and is used because it is the term of art used by the Arkansas Department of Health.

COMMENT 17: Facility Requirements

401. General Requirements

Please grandfather in those providers whose centers do not meet new physical plant requirements. It would not be fair to impose new standards on them.

RESPONSE: Thank you for your comment. DDS believes the limited number of new physical plant requirements are important for beneficiary safety and welfare and should not be subject to grandfathering.

COMMENT 18: (6) requires an emergency alarm system throughout the building to alert employees and beneficiaries when there is an emergency. Does this have to be a systemwide alert or can this be foghorn or other system? Please use "alert" instead of "alarm."

RESPONSE: Thank you for your comment. As written, any system would comply that is able to alert employees and beneficiaries throughout the facility when there is an emergency.

COMMENT 19: (7) requires that each site have that each site have "at least one (1) toilet and one (1) sink for every ten (10) beneficiaries with running hot and cold water, toilet tissue, liquid soap, and paper towels or air dryers." Was 15 not 10 in the last version. And in CSSP it is 12. The current standards just require adequacy to meet client needs. It is unfair to impose structural changes on centers already licensed.

RESPONSE: Thank you for your comment. Section 401(7) will be changed to reflect one (1) sink and toilet for every fifteen (15) beneficiaries.

COMMENT 20: (20) requires "an emergency power system to provide lighting and power to essential electrical devices throughout the center, including without limitation power to exit lighting and fire detection, fire alarm, and fire extinguishing systems." Many centers do not have this in place, so it could be a costly change if they are not grandfathered in.

RESPONSE: DDS believes the requirements in Section 401(20) are an appropriate best practice for the safety and welfare of beneficiaries at any facility and should not be subject to grandfathering. Section 401(20) does not require anything in and of itself to be installed. The proposed rule

only requires the essential electrical devices located in an ADDT to have emergency power source in the event of a power outage. The examples listed in Section 401(20) are types systems and devices that run on electricity that would be considered essential electrical devices if located in an ADDT.

COMMENT 21: Subchapter 5 Programs and Services

There is no mention of ratios. Please insert that language to safeguard beneficiaries.

RESPONSE: Thank you for your comment. A new Section 302(e) will be included which will set a 10:1 minimum beneficiary to staff ratio. What is currently Section 302(e) will become Section 302(f).

COMMENT 22: 501 Transportation

We suggest transportation provisions be handled for both EIDT and ADDT in a separate Transportation Manual.

RESPONSE: Thank you for your comment. This is not possible at this time. DDS is actively working to provide one mechanism for transportation.

COMMENT 23: 502 Exits

D says: "An ADDT shall remain responsible for the health, safety, and welfare of the exiting beneficiary until all transitions to new service providers are complete." Please remove. A day program does not provide services 24/7 as waiver can. We cannot remain responsible for an individual's welfare in that manner. We can coordinate with another provider if they are transitioning to a different program.

RESPONSE: Thank you for your comment. Section 502 (d) will be removed.

COMMENT 24: 504 Nutrition

With COVID, we need more flexibility. Some individuals are bringing their own lunch now, but if they do not, we provide them a lunch for free. However, it is difficult under these conditions to maintain USDA compliance in terms of strict dietary and portion requirements, and then we have to address allergy, puree, and other restrictions. With the fluctuating census due to COVID we need flexibility on this standard.

RESPONSE: Thank you for your comment. This change aligns the ADDT nutrition requirements with that of child care centers and EIDTs.

COMMENT 25: 601 Arrivals, Departures, and Transportation

601(a)(2) requires: "(B) Documentation of arrivals to and departures from an ADDT must include without limitation the beneficiary's name, age, and date of birth, date and time of arrival and departure, name of the person or entity that provided transportation, and method of transportation" Why is the DOB and age necessary for ADDT? It may be for EIDT but this is unnecessary for ADDT. Also, we may not know the name of the person that provided transportation when it is a transportation broker/subcontractor or family dropping off individuals. It would be more appropriate in those situations to notate the transportation company or family?

RESPONSE: Thank you for your comment. The age requirement will be removed from Section 601(a)(2)(B).

COMMENT 26: 601(d)(2) says, "Any vehicle designed or used to transport more than seven (7) passengers and one (1) driver must have a safety alarm device.

(B) The safety alarm device must:

Always be in working order and properly maintained;
Installed so that the driver is required to walk to the very back of the vehicle to reach the switch that deactivates the alarm;

Be installed by a certified technician or mechanic employed by a recognized electronics or automotive business in accordance with the device manufacturer's recommendations; and (iv) Sound the alarm no longer than one (1) minute after the activation of the safety alarm device.

This is a new mandate without funding. Reimbursement rates are not sufficient to cover this added cost and were not included when rates were last adjusted.

RESPONSE: Thank you for your comment. This change aligns ADDT transportation requirements with all other types of Medicaid funded transportation. Section 601(d)(2)(B)(iii) will be revised to state, "Be installed in accordance with the device manufacturer's recommendations." Section 601(d)(2)(B)(iv) will be revised to state, "Sound the alarm for at least one (1) minute after the activation of the safety alarm device.

COMMENT 27: 601(f)(2) says:

The walk-through inspection for any vehicles designed or used to transport more than seven (7) passengers and one (1) driver must be conducted in one (1) of the following ways:

An employee unloads all beneficiaries from the vehicle, walks or otherwise moves through the interior of the vehicle to ensure that no beneficiaries remain on board, and deactivates the safety alarm device.

This option can only be used if all beneficiaries are able to unload from the vehicle in less than one (1) minute.

The one-minute rule is not realistic for individuals with disabilities; in many centers, it would make the option unusable.

RESPONSE: Thank you for your comment. This change aligns ADDT transportation requirements with all other types of Medicaid funded transportation.

COMMENT 28: 602 Medications

Most ADDTs do not "administer" medications. It is possible that a nurse may administer some under the nursing service, but non-nursing staff generally are not allowed to "administer" medications.

RESPONSE: Thank you for your comment.

COMMENT 29: 603 Behavior Management Plans

(c)(1) says the plan must be evaluated quarterly. Unless the plan is not working, there is no need to review more than annually.

RESPONSE: Thank you for your comment. Since behavior management plans would only be implemented for beneficiaries exhibiting challenging behaviors on a chronic basis, DDS believes quarterly review to be appropriate.

COMMENT 30: 701 Incidents to Be Reported

(7) includes interruptions in service for more than one hour. If a beneficiary arrives later or leaves early is that considered an "interruption." We would suggest that the other categories of incidents encompass any concerns from negative events that interrupt services.

RESPONSE: Thank you for your comment. Section 701(7) will be changed to any "unanticipated" situation where services to a beneficiary are interrupted for more than two (2) hours.

COMMENT 31: 805 Transfer of Beneficiaries

says "An ADDT must continue providing services until the beneficiary is transferred to his or her new service provider of choice." It is not within the ADDT's control as to when another provider the beneficiary has chosen will accept the individual. If the individual chooses to remain, and is complying with health and safety requirements, it is not an issue, but it should not be mandated.

RESPONSE: Thank you for your comment. Section 805(b) will be revised to insert "If directed by DPSQA,…" at the beginning.

COMMENT 32: 901 Reconsideration of Adverse Regulatory Actions (a)(1) Reconsiderations should be handled by someone not involved in the original determination nor reporting to someone who was.

RESPONSE: Thank you for your comment. A reconsideration request under Section 901 is required to be addressed to and will be conducted by the DPSQA Office of the Director, which means it would not be conducted by an individual involved in the original determination or anyone reporting to an individual that was involved in the original determination.

COMMENT 33: (d) Can you make it clear that DHS will not proceed with allowing an expansion based on underserved determination until any appeal is resolved. Otherwise, an appeal becomes pointless.

RESPONSE: Thank you for your comment. An appeal right would exist only when DDS declines a request for a county to be declared underserved. There is no appeal right if DDS were to grant a request to declare a county underserved.

COMMENT 34: I have a question as to whether the CSSP providers perform services in-home, or only at "CSSP Locations" as defined by Section 103(k). Or in other words, do CSSP providers only operate at CSSP locations?

Thank you for your assistance and I hope to hear from you soon.

RESPONSE: Thank you for your comment. This comment does not pertain to ADDT.

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

1. What is the status on CMS approval on the SPA? **RESPONSE:** It was approved by CMS on October 26, 2020.

2. Where does the new definition of "serious injury" come from (Rule 103(o))? **RESPONSE:** This is a new definition.

3. Where does the new definition of "solicitation" come from (Rule 103(p))? **RESPONSE:** This is a new definition.

4. The new rules regarding the licensure process set forth conditions that must be met in order for DPSQA to issue a license (Rule 203). Where do the requirements in Rule 203(a)(4)(B)-(C) come from? **RESPONSE:** DDS Policy #1089-A

5. Is the age requirement for ADDT employees statutorily mandated or is it a policy decision? **RESPONSE:** It is NOT statutorily mandated.

6. Are the required training topics (Rule 303(a)) statutory, required by federal regulation, taken from somewhere else, or compiled for these rules? **RESPONSE:** Primarily compiled for these rules based upon feedback from stakeholders.

7. Where does the five-year timeframe for record retention come from? **RESPONSE:** Nothing statutory, common timeframe used for DHS policy purposes.

8. The proposed rules require beneficiary service records to be kept in a file cabinet or room that is always locked. Are there any comparable security requirements for electronic records? **RESPONSE:** As written, the locked room requirement would apply to where any computer is used for accessing/storing electronic records.

9. The proposed rules require an ADDT facility to have at least one toilet and one sink for every ten beneficiaries. Where does this ratio come from? **RESPONSE:** Based upon feedback from stakeholders.

10. Where does the one-year timeframe for storing beneficiary arrival and departure documentation come from? **RESPONSE:** Regulatory experience based on typical investigatory timeframe for transportation incidents.

11. Section 601(d)(2)(A) sets forth the required staff/beneficiary ratio in a transportation vehicle. Where does this ratio come from? **RESPONSE:**

Requirement was intended to apply to multi-passenger vans used primarily for business purposes, and not to sedans and other personal vehicles.

12. Section 601(d)(2)(B) requires every vehicle used to transport seven or more passengers to have a safety alarm device. What is the purpose of this alarm? **RESPONSE:** To ensure staff complete a walk-through of the entire vehicle after drop-off and make sure no beneficiaries have been left on vehicle.

13. Where do the insurance coverage requirements for transportation vehicles come from? **RESPONSE:** Mimics Minimum Licensing Requirements for Child Care Centers, NET broker contracts and our NET-like EIDT and ADDT contracts.

14. Rules 701(a)and 702(a) list events/incidents that an ADDT must report. Were these lists compiled for these rules or do they come from somewhere else? **RESPONSE:** The list is primarily a carryover from prior standards with some minor additions based upon program experience.

15. Rule 803(b)(5) and Rule 806 both state that DPSQA may impose monetary penalties on a noncompliant ADDT. What is the specific statutory authority for these penalties? **RESPONSE:** Ark. Code Ann. §25-15-217.

The proposed effective date is January 1, 2021.

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

LEGAL AUTHORIZATION: The Department of Human Services has the responsibility to administer assigned forms of public assistance and is specifically authorized to maintain an indigent medical care program (Arkansas Medicaid). *See* Ark. Code Ann. §§ 20-76-201(1), 20-77-107(a)(1). The Department has the authority to make rules that are necessary or desirable to carry out its public assistance duties. Ark. Code Ann. § 20-76-201(12). The Department and its divisions also have the authority to promulgate rules as necessary to conform their programs to federal law and receive federal funding. Ark. Code Ann. § 25-10-129(b). "The [B]oard [of Developmental Disabilities Services] may make rules regarding the care, custody, training, and discipline of individuals with intellectual and developmental disabilities in the human development centers or receiving services for individuals with intellectual and developmental disabilities[.]" Ark. Code Ann. § 20-48-205(b).

As an agency with the authority to suspend, revoke, or deny licenses, the Department may, as an alternative sanction, impose a monetary penalty up to $500 on persons or entities under its jurisdiction. Ark. Code Ann. § 25-15-217(a)-(b).

This rule implements Act 605 of 2017, sponsored by Representative Justin Boyd, which codified the process for the review of rules impacting state Medicaid costs and exempted medical codes from the rulemaking process and legislative review and approval.

c. **SUBJECT: SPA Amendment #2020-0021 Therapy Amendments to the Occupational, Physical, & Speech-Language Therapy Services Medicaid Provider Manual, with Related Changes to ARKids First-B, Hospital, Rehabilitative Hospital, Prosthetics, Home Health, Physician, and Nurse Practitioner Provider Manuals**

DESCRIPTION:

Statement of Necessity

The revisions in this promulgation are necessary so that the Arkansas Medicaid State Plan and provider manuals reflect current procedural terminology and evaluation limits for occupation, physical, and speech-language therapy services. In addition, other revisions are necessary to reflect current practices and guidelines.

Rule Summary

The Arkansas Medicaid State Plan is being amended to update terminology and evaluation limits for occupational, physical, and speech-language therapy services.

The amendments to the Occupational, Physical, and Speech-Language Therapy Services Medicaid Provider Manual include the following:

- Change “Speech Therapy” to “Speech-Language Therapy” and “Augmentative Communication Device” to “Speech Generating Device” to mirror current language.

- Remove the opt-in requirements for the Part B program under Individuals with Disabilities Education Act (IDEA), because the program transferred back to the Arkansas Department of Education on July 1, 2019. The new language sets out referral requirements for children ages 3-5 in compliance with the IDEA.

- Remove the Intelligence Quotient testing requirement to provide speech-language therapy for children over 10, as this no longer complies with recommended practice guidelines.

- Update the evaluation requirements for Speech Generating Devices, based on provider concerns that the appropriate device was not being chosen for the child's identified needs.

- Procedure codes are being removed from the manual pursuant to Ark. Code Ann. § 25-15-202(9)(B)(iv) and to allow for faster updates when national procedure codes change.

- Add place of service "49-independent-clinic" so that Early Intervention Day Treatment and Adult Developmental Day Treatment facilities may continue to provide therapy.

- Replace references to AFMC and their specific quality review process with generic language that is not vendor specific.

In addition, therapy references in the ARKids First-B, Rehabilitative Hospital, Prosthetics, Home Health, Physician, and Nurse Practitioner provider manuals have been updated to reflect the above changes in the Occupational, Physical, and Speech-Language Therapy Services provider manual.

PUBLIC COMMENT: No public hearing was held on this rule. The public comment period expired on November 2, 2020. The agency provided a summary of the public comments received and its responses thereto, which due to its length is attached separately.

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

1. What is the status on CMS approval? **RESPONSE:** CMS approved the SPA on November 9, 2020.

2. Section 208.000 of the Occupational, Physical, & Speech-Language Therapy Services Manual requires referral to LEA, pursuant to Part B of the IDEA. Could you provide me with the section of the IDEA requiring therapists to refer children to LEA?

RESPONSE: Part C of the [I]ndividual with [D]isabilities [E]ducation [A]ct , Section 303.303(a)(2)(i) requires primary referral sources to refer child to the Part C program as soon as possible but no case more than seven days after identification

3. Section 215.000 of the Occupational, Physical, & Speech-Language Therapy Services Manual requires a client to complete a trial period with a speech-generating device before the device can be prior authorized for purchase. Is this a statutory requirement or just a policy decision?
RESPONSE: A policy decision.

The proposed effective date is January 1, 2021.

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

LEGAL AUTHORIZATION: The Department of Human Services has the responsibility to administer assigned forms of public assistance and is specifically authorized to maintain an indigent medical care program (Arkansas Medicaid). *See* Ark. Code Ann. §§ 20-76-201(1), 20-77-107(a)(1). The Department has the authority to make rules that are necessary or desirable to carry out its public assistance duties. Ark. Code Ann. § 20-76-201(12). The Department and its divisions also have the authority to promulgate rules as necessary to conform their programs to federal law and receive federal funding. Ark. Code Ann. § 25-10-129(b). This rule implements Act 605 of 2017.

Act 605, sponsored by Representative Justin Boyd, codified the process for the review of rules impacting state Medicaid costs and exempted medical codes from the rulemaking process and legislative review and approval.

11. DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL SERVICES (Mr. Mark White, Ms. Janet Mann, items a-g; Ms. Elizabeth Pittman, item d)

a. SUBJECT: Community Support System Provider Standards

DESCRIPTION:

Statement of Necessity

Although changes were made in the last few years to improve and better connect clients with Home and Community-Based Services and more tailored and intensive levels of services through the PASSE program and the new Adult Behavioral Health Services for Community Independence, significant needs yet remain, specifically:

- We still lack a robust number of providers for Behavioral Health (BH), Developmental Disabilities (DD), and dually diagnosed clients, leaving

gaps in care. The services and payment structures are in place, but providers need two separate certifications to provide all services.

- Providers have continued to provide either intellectual/developmental disabilities services OR behavioral health services – not both, which is an ongoing and persistent need.

Rule Summary

DHS is proposing two overall changes: (1) creating a new Arkansas Medicaid provider type and certification called a Community Support System Provider that would allow providers to become certified to serve the BH, DD, and dually-diagnosed populations; and (2) updating rules to create a path forward for a crisis continuum of services to support providers' work. These changes will:

- Eliminate the need for two different certifications for providers to serve the BH and DD populations, though those individual certifications will remain in place and available to providers who choose to serve a single population.

- Break down the barrier between home and community-based services and intensive services to allow for easier and faster program transitions for our clients.

- Open new business opportunities for providers and allow us to maximize the current provider networks.

- Fill gaps in the continuum of care for our highest need clients.

PUBLIC COMMENT: A public hearing was held on this rule on October 16, 2020. The public comment period expired on October 27, 2020. The agency provided a summary of the public comments received and its responses thereto, which due to its length is attached separately.

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

1. Where do the definitions of "marketing," "medical service encounter," "professional service encounter," "serious injury," and "solicitation" come from?

RESPONSE: Marketing: a new definition intended to allow a program to accurately advertise their services so long as it does not meet the definition of solicitation.

Medical Service Encounter: This definition was created to provide a specific framework for and at the request of providers. “Medical” describes a psychiatrist/APRN and similar.

Professional Service Encounter: This definition was created to provide a specific framework for and at the request of providers. “Professional” describes a licensed mental health professional.

Serious Injury: Serious injury is a term of art that appears in the waiver document; it is required to be reported but it is not defined federally.

Solicitation: revised version from former DDS Policy 1091

2. Is there a specific statute giving DPSQA licensing authority? **RESPONSE:** Special language in the DPSQA appropriation bill. [Agency attached Act 88 of 2020.]

3. Where do the employee qualifications in section 302(e)(2) come from? **RESPONSE:** These are minimum requirements for paraprofessional services. As for the work experience, this provider type is specialized for IDD and BH clients and experience with those groups is appropriate.

4. Subsections 303(b)(1) and (2)(A) list topics that must be covered in employee training before an employee may have contact with beneficiaries. Where do these topics come from? **RESPONSE:** (b)(1) are basic safety training requirements consistent with other Medicaid programs; (2)(A) pertains to specific training for the paraprofessionals working with clients with IDD and BH under this combined provider type.

5. The proposed rules require CSSPs to retain all employee records for 5 years. Is this timeframe statutory? **RESPONSE:** Nothing statutory, common timeframe used for DHS policy purposes.

6. The proposed rules state that beneficiary service records must be kept in a locked room or file cabinet. Are there any analogous security requirements for electronic records? **RESPONSE:** As written, the locked room requirement would apply to where any computer is used for accessing/storing electronic records.

7. Where does the list of required components for an emergency plan come from? **RESPONSE:** Parts of various other DHS standards, including child care licensing standards, center-based standards, and CES waiver.

8. Section 401(a)(2) states that the maximum number of beneficiaries that may be residents of a CSSP at one time is 16. Where does this number

come from? **RESPONSE:** Federal regulations generally define structures with more than 16 beds as institutions instead of homes.

9. Is the required 20 square feet of bedroom space per beneficiary a statutory requirement? **RESPONSE:** No.

10. Is the requirement for at least one shower per six beneficiaries taken from somewhere else? **RESPONSE:** This requirement does not have a source. In creating this rule, DHS utilized its rule-making discretion to establish this reasonable requirement for the benefit of the residents.

11. Section 603(c)(2)(B) sets forth the required staff/beneficiary ratio in a transportation vehicle. Where does this ratio come from? **RESPONSE:** This ratio does not have a source. In creating this rule, DHS utilized its rule-making discretion to establish this reasonable requirement for the safety of the persons in the transport vehicle.

12. Section 603(d)(A) requires every vehicle used to transport eight or more passengers to have a safety alarm device. What is the purpose of this alarm? **RESPONSE:** Ensure all beneficiaries that are being transported exit the vehicle.

13. Where do the insurance coverage requirements for transportation vehicles come from? **RESPONSE:** Minimum Licensing Requirements for Child Care Centers

14. Are the behavior management plan requirements taken from other rules? If not, where do they come from? **RESPONSE:** Similar to those contained in the former CES Waiver, "i" state plan amendments, standards and EIDT/ADDT rules.

15. Where do the restrictions and guidelines on use of restraints come from (Section 606)? **RESPONSE:** Similar to those contained in the former CES Waiver standards. The language is also outlined in the federal waivers that serve IDD and BH clients.

16. Section 608(b)-(c) addresses community reintegration and therapeutic communities. Where do these requirements come from? **RESPONSE:** These requirements were developed with stakeholders.

17. Is the list of incidents a CSSP is required to report a statutory list or does it come from somewhere else? **RESPONSE:** This is the standard list of reportable incidents that are being implemented across Medicaid programs.

18. What specific statutory authority is DMS relying on to impose monetary penalties on a noncompliant CSSP? **RESPONSE:** Ark. Code Ann. § 25-15-217

The proposed effective date is January 1, 2021.

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

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

As an agency with the authority to suspend, revoke, or deny licenses, the Department may, as an alternative sanction, impose a monetary penalty up to $500 on persons or entities under its jurisdiction. Ark. Code Ann. § 25-15-217(a)-(b). Special language in Act 88 of 2020 gave the Department's Division of Provider Services and Quality Assurance the authority to "use funds appropriated for the certification or licensure of an entity on behalf of any division of the Department of Human Services." Act 88, § 5.

b. SUBJECT: Repeal Section V of the Arkansas Medicaid Provider Manuals

DESCRIPTION:

Statement of Necessity

Section V of the Arkansas Medicaid Provider Manuals contains lists of claims forms and information on how to obtain them, a list of generic forms related to Arkansas Medicaid and links to those forms, and a list of Arkansas Medicaid Contacts, including contacts for various divisions of the Department of Human Services (DHS) and contacts for other entities. In conducting its continuing review of agency rules, DHS determined that Section V does not require promulgation under the Arkansas Administrative Procedure Act, § 25-15-201 et seq., and as such is repealing Section V. Section V will still be operational but will not be a promulgated document.

Rule Summary

Effective January 1, 2021, Section V of the Arkansas Medicaid Provider Manuals will be repealed.

PUBLIC COMMENT: No public hearing was held on this rule. The public comment period expired on November 3, 2020. The agency indicated that it received no public comments.

The proposed effective date is January 1, 2021.

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

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

c. SUBJECT: Children's Health Insurance Program (CHIP) State Plan Amendment for Parity and Therapy Units

DESCRIPTION:

Statement of Necessity

This promulgation consists of two Children's Health Insurance Program (CHIP) State Plan Amendments (SPAs).

The first SPA is necessary to update the CHIP State Plan to clarify that a small number of ARKids-B beneficiaries with a higher level of care needs due to behavioral health or developmental disability diagnoses will receive services from a Provider-led Arkansas Shared Savings Entity (PASSE) rather than through fee-for-service.

The second SPA is necessary to comply with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) by providing assurances that the CHIP State Plan does not impose financial requirements on benefits and limitations on benefits are not more restrictive for mental health or substance use disorders than the requirements and limitations for medical and surgical benefits. In addition, the second SPA updates terminology and changes benefit thresholds for

occupational, physical, and speech therapy services from 4 units of each discipline daily to 6 units of each weekly with an option for extension of benefits, comparable to recently revised Medicaid standards.

The MHPAEA requires health insurers as well as group health plans to guarantee that financial requirements on benefits, including co-pays, deductibles, and out-of-pocket maximums, and limitations on treatment benefits such as caps on visits with a provider or days in a hospital visit, for mental health or substance use disorders are not more restrictive than the insurer's requirements and restrictions for medical and surgical benefits. Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) are not group health plans or issuers of health insurance. They are public health plans through which individuals obtain health coverage. However, provisions of the Social Security Act that govern CHIP plans, Medicaid benchmark benefit plans, and managed care plans that contract with State Medicaid programs to provide services require compliance with certain requirements of MHPAEA.

Rule Summary

The following updates have been made to the first CHIP State Plan as described above:

- Clarifies that a small number of ARKids-B beneficiaries with a higher level of care needs due to behavioral health or developmental disability diagnoses will receive services from a Provider-led Arkansas Shared Savings Entity (PASSE).

The following updates have been made to the second CHIP State Plan as described above:

- Assurances are provided that the State Plan complies with the requirements of MHPAEA.
- The use of generic prescriptions has been changed from "when available" to "when obtainable."
- Substance Abuse Treatment Services (SATS) has been changed to Outpatient Behavioral Health Services (OBHS) which includes Substance Abuse Services.
- The benefit thresholds for occupational, physical and speech therapy services have been changed from four (4) units of each discipline daily to six (6) units of each weekly with an option for extension of benefits, comparably to recently revised Medicaid standards.

PUBLIC COMMENT: No public hearing was held on this rule. The public comment period expired on November 3, 2020. The agency indicated that it did not receive any public comments.

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

1. What is the status on CMS approval? **RESPONSE:** A call was scheduled with CMS on Monday, November 1 to discuss all remaining concerns. Once those are addressed, the official SPA can be resubmitted and should be approved.

2. Where does the definition of "inpatient services" on page 105 come from? R**ESPONSE:** This is a standard definition used for the purposes of distinguishing between inpatient services and the other three services in which parity must be met.

The proposed effective date is January 1, 2021.

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

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

This rule implements the federal Mental Health Parity and Addiction Equity Act (MHPAEA). *See* 29 U.S.C. § 1185a; 42 U.S.C. § 300gg-26(a)(1). The MHPAEA requires parity in mental health and substance use disorder benefits provided by group health plans that offer both medical and surgical benefits and mental health or substance use disorder benefits. *See* 29 U.S.C. § 1185a(a)(1); 42 U.S.C. § 300gg-26(a)(1). Per the agency, while Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) are not group health plans or issuers of health insurance, provisions of the Social Security Act that govern CHIP plans, Medicaid benchmark benefit plans, and managed care plans that contract with State Medicaid programs to provide services require compliance with certain requirements of MHPAEA.

d. SUBJECT: Hospital Acute Crisis Units

DESCRIPTION:

Statement of Necessity

In an effort to fill gaps and improve continuity of behavioral health services in Arkansas, it is necessary to include a new section in the Arkansas Medicaid Provider Manual to define the operation of Acute Crisis Units in the Hospital and Critical Access Hospital settings.

Rule Summary

Section 218.400 is added to recognize Acute Crisis Units as part of Hospital and Critical Access Hospital services.

PUBLIC COMMENT: A public hearing was held on this rule on October 23, 2020. The public comment period expired November 9, 2020. The agency provided the following summary of the public comments it received and its responses to those comments:

Commenter's Name: Laura H. Tyler, PhD, LPC, Chief Executive Officer, Ozark Guidance

COMMENT 1: How does the language proposed in 218.400 for Hospital/Critical Access Hospital (CAH)/End Stage Renal Disease (ESRD) satisfy the following?

"Acute Crisis Unit" means a program of non-hospital emergency services for mental health and substance use disorder crisis stabilization, including, but not limited to, observation, evaluation, emergency treatment and referral, when necessary, for inpatient psychiatric or substance use disorder treatment services. This service is limited to individual sites which are certified by the Arkansas Department of Human Services, (DHS) or facilities operated by the Arkansas Department of Human Services. Acute Crisis Units shall be freestanding facilities that must adhere to the following:
1.) Have 16 beds or less
2.) Be independently certified by DHS outside of an existing Hospital"
"Provider" means an entity that is certified by DHS as an Acute Crisis Unit and enrolled by DMS as a behavioral Health Agency."

RESPONSE: The acute crisis units proposed in this rule will follow inpatient hospital rules under the authority of Arkansas Department of

Health. Because these Units will be in hospitals, the DHS licensure will not be required, but ADH licensure will be a required component.

COMMENT 2: Will a CAH that includes a ACU be exempt from DHS guidelines?
RESPONSE: The CAHs with an ACU will follow DHS inpatient hospital guidelines.

COMMENT 3: "Will these critical access hospitals have to be certified by DHS's (indiscernible)? **RESPONSE:** No. They are licensed under the authority of Arkansas Department of Health.

COMMENT 4: "If so, is there a you know, how will the language and the definition for "acute crises unit," which requires that these be free-standing facilities, be addressed? **RESPONSE:** Arkansas Department of Health licensure will be utilized.

The proposed effective date is January 1, 2021.

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

Per the agency, the additional cost to implement this rule is $956,420 for the current fiscal year ($271,910 in general revenue and $684,510 in federal funds) and $1,912,840 for the next fiscal year ($543,820 in general revenue and $1,369,020 in federal funds). The total estimated cost by fiscal year to state, county, and municipal government to implement this rule is $271,910 for the current fiscal year and $543,820 for the next fiscal year.

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

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

To provide services for psych/substance abuse for over age 18.

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

Fill gaps and improve continuity of behavioral health services. Not required by statute.

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

AR Medicaid is clarifying the Hospital provider manual to define the operation of Acute Crisis Units in the hospital and critical access hospital settings.

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

None.

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

No alternatives are proposed at this time.

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

No, they have not. The change is in effort to fill gaps and improve behavioral services.

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended.

The agency monitors state and federal rules and policies for opportunities to reduce and control costs.

LEGAL AUTHORIZATION: The Department of Human Services has the authority to administer assigned forms of public assistance and to make rules as necessary to carry out its duties. Ark. Code Ann. § 20-76-201(1), (12). The Department is specifically tasked with establishing and maintaining an indigent medical care program. Ark. Code Ann. § 20-77-

107(a)(1). This includes promulgating rules to ensure compliance with federal law and receive federal funding. Ark. Code Ann. § 25-10-129(b).

e. **SUBJECT: AR Choices 1-20, LCAL 1-20, PERSCARE 3-20, ARChoices and Living Choices Waiver Amendments, and Medical Services Policy C-265, I-630, I-640, and L-120**

DESCRIPTION:

Statement of Necessity

The proposed rule change seeks to change the way appeals and evaluations are handled for Long Term Care and Home and Community Based (HCBS) waiver programs.

For the current appeals process, when a beneficiary receives a notice of adverse action, the beneficiary must request that their case remain open during the appeals process. With this change, the beneficiary's case will automatically remain open during the appeals process, unless the petitioner affirmatively opts out of receiving ongoing services pending the appeal.

Steps are being added for members of HCBS waiver programs to request reassessments by the DHS RN when necessary or if a change in condition warrants a change to the Person-Centered Service Plan (PCSP).

Rule Summary

Medical Services Policy (MSP) is being updated to incorporate the new appeals process.

MSP C-265 – Pace Disenrollment: A sentence has been added stating, "If a timely appeal is received on or before the effective date of the action, the petitioner's case will remain open and benefits will continue until the hearing decision. If the petitioner wishes not to continue benefits until the hearing decision, they must opt out."

MSP I-630 – ARChoices Waiver: A sentence has been added stating, "If a timely appeal is received on or before the effective date of the action, the petitioner's case will remain open and benefits will continue until the hearing decision. If the petitioner wishes not to continue benefits until the hearing decision, they must opt out."

MSP H-640 – Assisted Living Facility (ALF): A sentence has been added stating, "If a timely appeal is received on or before the effective date of the action, the petitioner's case will remain open and benefits will

continue until the hearing decision. If the petitioner wishes not to continue benefits until the hearing decision, they must opt out."

MSP L-120 – Continuation of Assistance or Services During Appeal Process:

- Added paragraph "In cases where an adverse action is taken against a beneficiary who qualifies for an institutional level of care (e.g. ARChoices, Living Choices, TEFRA, Autism, PACE, CES/DD, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) and LTC/nursing home), if a timely appeal is received on or before the effective date of the action, the petitioner's case will remain open and benefits will continue until the hearing decision. If the petitioner wishes not to continue benefits pending the hearing decision, they must opt out."

- Added statement that in all other cases benefits will not continue if the petitioner does not file for hearing within the then day notice period, or five days in the case of probable fraud.

- Made other technical corrections.

Medicaid Provider Manuals are being updated to include the following:

ARChoices in Home Care and Community-Based 2176 Waiver

- Section 212.000 – Eligibility for the ARChoices Program: Grammatical and technical corrections.

- Section 212.050 – Definitions: Added definitions for "Assessment," "Evaluation," "Functional Eligibility," and "Reassessment."

- Section 212.200 – Prospective Individual Services Budget: Changed "Division of Aging, Adult, and Behavioral Health Services" to "Department of Human Services Registered Nurse." Added that the DHS RN may order a reassessment of the participant based on a change of condition.

- Section 212.312 – Comprehensive Person-Centered Plan (PCSP): Added the statements, "Prior to the expiration of the 365 days, financial and functional eligibility will be reviewed for renewal of the PCSP. Functional eligibility will be determined by an evaluation done by the DHS RN."

- Section 212.500 – Reporting Changes in Beneficiary's Status: Added that a Targeted Case Manager is responsible for referring the beneficiary

for evaluation of any beneficiary complaints or change of condition. Added the statement, "The DHS RN will determine if a reassessment is necessary or if a change in condition warrants a change to the PCSP based upon the DHS RN's evaluation of the beneficiary."

Living Choices Assisted Living

- Section 211.100 – Eligibility for the Living Choices Assisted Living Program: Added "evaluation" to process for beneficiary intake.

- Section 211.125 – Added definitions for "ARIA Assessment Tool," "Assessment," "DHS RN," "Evaluation," "Extensive Assistance," "Functional Eligibility," "Independent Assessment Coordinator," "Reassessment," and "Serious Mental Illness or Disorder."

- Section 211.150 – Level of Care Determination: Changed "functional disability" to "functional eligibility." Added the statements, "An evaluation is completed annually by the DHS RN to determine continued functional eligibility. Should a change of medical condition be present, a referral may be made to the Independent Assessment Contractor to complete a reassessment."

PUBLIC COMMENT: No public hearing was held on this proposed rule. The public comment period expired on November 9, 2020. The agency provided the following summary of the comments it received and its responses to those comments:

Commenter's Name: Robert W. Wright, Mitchell Blackstock Law Firm

COMMENT: The Medical Services policy is being changed to make the "default" in the event of an adverse action continuing services rather than requiring the beneficiary to request continuation. If the services continue and the hearing officer finds in favor of the beneficiary, am I correct that Medicaid pays for the continued services between the notice and the hearing decision? What if the hearing officer upholds the adverse action? Who is responsible for the continued services between the adverse action and the hearing decision? Thank you.

RESPONSE: Medicaid services will continue for the designated population during the appeal process. Beneficiaries who do not wish to continue benefits pending the appeal may elect to discontinue benefits. If the agency's action is sustained by the hearing decision, the agency may institute recovery procedures against the applicant or beneficiary to recoup the cost of any services furnished the beneficiary, per current federal regulations.

Commenter's Name: Kay Newton, RN, Home Care Administrator, Area 2, Area Agency on Aging of Southeast Arkansas

COMMENT: I have worked in the Home Health industry for 30 years and during this time, I have watched the Aides work hard to maintain the elderly population in their home setting. Allowing the elderly to remain in their homes is one of the most important factors in promoting well-being and longevity of life. In order to allow clients to age gracefully in the home setting, we must provide them with the services they desperately need including ARChoices waiver programs.

The COVID-19 pandemic is only one example of why the elderly population benefit from receiving services in their homes. Their home is a much safer environment than a facility setting. They deserve the many Home and Community Based services that are available and allow them to remain in the safety and comfort of their homes.

The rapid increase in minimum wage, without a rate increase for this program, threaten in-home services. The Attendant Care and Respite Care rates in the waiver need to be increased to match the proposed Medicaid Personal Care Rate in SPA 20-0022. In addition, the Service Budget caps will need to increase to accommodate the recommended increase in the Personal Care rate along with the prospective increase in the Attendant Care and Respite rates. Waiver recipients are among the frailest older Arkansans and they deserve in-home care. Thank you.

RESPONSE: Thank you for your comment. The purpose of the proposed changes are to simplify the eligibility process for ARChoices and Living Choices so that it is in line with other HCBS services and reduces the need for an annual external independent assessment for those clients who do not have a change in circumstance. These changes include technical changes to the language of the current waivers to better clarify the use of the terms: evaluation, assessment, determination and review which, were previously used interchangeably.

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

COMMENT 1: Submitted by CareLink

212.200 Prospective Individual Services Budget, D. Methodology for Determining Individual Services Budgets,

The maximum individual service budget for a participant…

These caps need to be increased to accommodate the recommended increase in the Personal Care Rate and prospectively an increase in the Attendant Care and Respite Rates
Without increasing the caps, service recipients receiving maximum care will see a reduction in services

At a minimum 2.a. should be increased to $ 34,134

At a minimum 2.b. should be increased to $ 22,756

At a minimum 2.c. should be increased to $ 5,689

In general, the caps are set too low and should be raised even higher than the above limits to allow for more care.

RESPONSE: Thank you for your comment. The purpose of the proposed changes are to simplify the eligibility process for ARChoices and Living Choices so that it is in line with other HCBS services and reduces the need for an annual external independent assessment for those clients who do not have a change in circumstance. These changes include technical changes to the language of the current waivers to better clarify the use of the terms: evaluation, assessment, determination and review which, were previously used interchangeably.

COMMENT 2: The Attendant Care and Respite Care rates in the waiver need to be increased to match the proposed Medicaid Personal Care Rate in SPA 20-0222. Waiver service recipients are amongst the frailest older Arkansans and deserve in-home care. If the rate is not adjusted to offset the rapid increase in minimum wage these services will be unsustainable after the minimum wage increases again on Jan 1, 2021 without an increase to the rate.

RESPONSE: Thank you for your comment. The purpose of the proposed changes are to simplify the eligibility process for ARChoices and Living Choices so that it is in line with other HCBS services and reduces the need for an annual external independent assessment for those clients who do not have a change in circumstance. These changes include technical changes to the language of the current waivers to better clarify the use of the terms: evaluation, assessment, determination and review which, were previously used interchangeably.

COMMENT 3: 212.050 Definitions

Evaluation means the process completed, at a minimum of every three hundred sixty-five (365) days, by the DHS RN to determine continued

functional eligibility or a change in medical condition that may impact continued functional eligibility.

Please clarify which DHS RN determines continued functional eligibility (OLTC or DAABHS) and the procedure for determining continued functional eligibility or a change in medical condition.

RESPONSE: During the annual review process, documentation of changes or lack thereof in functional ability or medical condition will be determined by the DAABHS RN. The review of functional and medical information for final determination of eligibility and level of care will be completed by an RN with the Division of County Operations.

COMMENT 4: How is the evaluation determination communicated to providers?

RESPONSE: The evaluation determination will continue to be communicated to providers in the same manner as today. The DAABHS RNs will communicate via AAS-9511.

COMMENT 5: FUNCTIONAL ELIGIBILITY means the level of care needed by the waiver applicant/beneficiary to receive services through the waiver rather than in an institutional setting. To be determined an individual with functional eligibility, an individual must not require a skilled level of care, as defined in the state rule, and must meet at least one (1) of the following three (3) criteria, as determined by a licensed medical professional:
1. The individual is unable to perform either of the following:
a. At least one (1) of the three (3) activities of daily living (ADLs) of transferring/locomotion, eating or toileting without extensive assistance from, or total dependence upon another person; or
b. At least two (2) of the three (3) ADLs of transferring/locomotion, eating, or toileting without limited assistance from another person; or
2. The individual has a primary or secondary diagnosis of Alzheimer's disease or related dementia and is cognitively impaired so as to require substantial supervision from another individual because he or she engages in inappropriate behaviors which pose serious health or safety hazards to themselves or others; or
The individual has a diagnosed medical condition which requires monitoring or assessment at least once a day by a licensed medical professional and the condition, if untreated, would be life-threatening.

Missing #3 for the third component of the eligibility criteria, beginning with "the individual has a diagnosed medical condition…."

RESPONSE: Thank you. We have made corrections to the document.

COMMENT 6: 212.312 Comprehensive Person-Centered Service Plan (PCSP)

The comprehensive PCSP expiration date will be three hundred sixty-five (365) days from the date of the DHS RN's signature on form AAS 9503, the ARChoices PCSP. Prior to the expiration of the 365 days, financial and functional eligibility will be reviewed for renewal of the PCSP. Functional eligibility will be determined by an evaluation done by the DHS RN. Once the renewal is either approved or denied by the DHS Division of County Operations the providers will be notified by the DHS RN. The notification of the approval will be in writing via a PCSP that includes the waiver eligibility date and Medicaid ID number. The notification for a denial will be via a form AAS -9511 reflecting the date of denial.

Please explain the evaluation method and tools used for determining functional eligibility that will be done by the DHS RN and when it will be performed. Which DHS RN will complete the evaluation, OLTC or DAABHS?

Inserting the above statement for renewals confuses the intent for this paragraph. This paragraph explains to providers how the initial comprehensive PCSP is processed if services began under a provisional PCSP. For clarity, I recommend removing the inserted language from the original paragraph and creating a separate paragraph that speaks to the renewal process rather than the approval process. There is a difference between approvals/renewals and denials/closures.

RESPONSE: DHS is proposing that the rules related to the federally required eligibility re-evaluation conducted each year be modified to permit a DHS Division of Aging, Adult, and Behavioral Health Services (DAABHS) nurse to conduct the eligibility re-evaluation based on a personal interview with the client (in-person when it is safe to do so) and review of the client's current records.
− The process to schedule re-evaluations would begin 90 days from the date services would otherwise end.
− Following that interview, the nurse would report one of the following scenarios to the Division of County Operations (DCO) eligibility team:

- Client's functional needs have not significantly changed and continues to meet requirements for services. DCO staff would then complete financial and medical review and extend beneficiary's eligibility another year. OR
- An independent assessment should be given to determine whether functional needs have changed significantly. DCO staff would then

work with Optum to schedule a new independent assessment for the client. OR

- Client's functional needs have significantly changed to the point he or she no longer meets the eligibility criteria for placement in an intermediate care nursing facility because of improvement. DCO would then inform the client of his or her appeal rights. OR
- Client's functional needs have significantly increased, requiring placement in a skilled nursing facility and is no longer eligible for LTSS HCBS services. DCO would then coordinate with DAABHS staff and the Division of Provider Services and Quality Assurance (DPSQA), to help the client and family with nursing home placement or provide information on other resources along with the client's appeal rights.

− Any recommendation from the DAABHS nurse that a client's services should be terminated or reduced would be reviewed by an internal panel of clinicians and confirmed as the appropriate recommendation prior to any action taken on the client's case.
− While a nurse evaluation will be used to determine continued eligibility based on the personal interview and review of client records, the levels of service the client receives will continue to be guided by the objective Task & Hour Standards based on the client's responses to his or her initial independent assessment.

Changes will be made as per this public comment. A new paragraph will include the inserted language.

COMMENT 7: 212.500 Reporting Changes in Beneficiary's Status

The Targeted Case Manager is responsible for monitoring the beneficiary's status on a regular basis for changes in service need, referring the beneficiary for evaluation of any beneficiary complaints or change of condition to the DHS RN, or DHS RN Supervisor immediately upon learning of the change. The DHS RN will determine if a reassessment is necessary or if a change in condition warrants a change to the PCSP based upon the DHS RNs evaluation of the beneficiary.

What does the DHS RNs evaluation consist of? What are the beneficiary's appeal rights if the DHS RN determines a reassessment is not necessary? How will the DHS RN notify the Targeted Case Manager of the decision to reassess or not reassess?

RESPONSE: DHS is proposing that the rules related to the federally required eligibility re-evaluation conducted each year be modified to permit a DHS Division of Aging, Adult, and Behavioral Health Services (DAABHS) nurse to conduct the eligibility re-evaluation based on a

personal interview with the client (in-person when it is safe to do so) and review of the client's current records.
- The process to schedule re-evaluations would begin 90 days from the date services would otherwise end.
- Following that interview, the nurse would report one of the following scenarios to the Division of County Operations (DCO) eligibility team:
    - Client's functional needs have not significantly changed and continues to meet requirements for services. DCO staff would then complete financial and medical review and extend beneficiary's eligibility another year. OR
    - An independent assessment should be given to determine whether functional needs have changed significantly. DCO staff would then work with Optum to schedule a new independent assessment for the client. OR
    - Client's functional needs have significantly changed to the point he or she no longer meets the eligibility criteria for placement in an intermediate care nursing facility because of improvement. DCO would then inform the client of his or her appeal rights. OR
    - Client's functional needs have significantly increased, requiring placement in a skilled nursing facility and is no longer eligible for LTSS HCBS services. DCO would then coordinate with DAABHS staff and the Division of Provider Services and Quality Assurance (DPSQA), to help the client and family with nursing home placement or provide information on other resources along with the client's appeal rights.
- Any recommendation from the DAABHS nurse that a client's services should be terminated or reduced would be reviewed by an internal panel of clinicians and confirmed as the appropriate recommendation prior to any action taken on the client's case.
- While a nurse evaluation will be used to determine continued eligibility based on the personal interview and review of client records, the levels of service the client receives will continue to be guided by the objective Task & Hour Standards based on the client's responses to his or her initial independent assessment.
- The beneficiary retains all appeals rights based on notification of an adverse action.
- DHS RN notifies TCM that request for reassessment has been approved or denied via electronic mail.

COMMENT 8: Waiver Contact – This should be Ashley Fisher not Ashley Foster

RESPONSE: Yes, we will make this correction.

COMMENT 9: B-6(i) Procedures to Ensure Timely Reevaluations

The following language is stricken, "Each Targeted Case Manager is also required to maintain a "Tickler" system to track the Medicaid eligibility reevaluation date and the service plan expiration date. If the reassessment process has not been completed timely, the Targeted Case Manager notifies the DHS RN prior to the expiration date of the current service plan."

Will DHS be removing the requirement to maintain a tickler system from Section II of Targeted Case Management Medicaid provider manual?

RESPONSE: Not at this time.

COMMENT 10: Please provide a stakeholder engagement meeting to explain the application and revised terminology before submitting to Legislature for approval.

RESPONSE: DHS will make staff available to meet with stakeholders to discuss changes to the waiver.

Commenter's Name: Luke Mattingly, on behalf of the Arkansas Area Agency on Aging Association

COMMENT 1: 212.200 Prospective Individual Services Budget, D. Methodology for Determining Individual Services Budgets,

The maximum individual service budget for a participant…

These caps need to be increased to accommodate the recommended increase in the Personal Care Rate and prospectively an increase in the Attendant Care and Respite Rates
Without increasing the caps, service recipients receiving maximum care will see a reduction in services

At a minimum 2.a. should be increased to $ 34,134

At a minimum 2.b. should be increased to $ 22,756

At a minimum 2.c. should be increased to $ 5,689

In general, the caps are set too low and should be raised even higher than the above limits to allow for more care.

RESPONSE: Thank you for your comment. The purpose of the proposed changes are to simplify the eligibility process for ARChoices and Living Choices so that it is in line with other HCBS services and reduces the need for an annual external independent assessment for those

clients who do not have a change in circumstance. These changes include technical changes to the language of the current waivers to better clarify the use of the terms: evaluation, assessment, determination and review which, were previously used interchangeably.

COMMENT 2: The Attendant Care and Respite Care rates in the waiver need to be increased to match the proposed Medicaid Personal Care Rate in SPA 20-0222. Waiver service recipients are amongst the frailest older Arkansans and deserve in-home care. If the rate is not adjusted to offset the rapid increase in minimum wage these services will be unsustainable after the minimum wage increases again on Jan 1, 2021 without an increase to the rate.

RESPONSE: Thank you for your comment. The purpose of the proposed changes are to simplify the eligibility process for ARChoices and Living Choices so that it is in line with other HCBS services and reduces the need for an annual external independent assessment for those clients who do not have a change in circumstance. These changes include technical changes to the language of the current waivers to better clarify the use of the terms: evaluation, assessment, determination and review which, were previously used interchangeably.

Commenter's Name: Katie Bell, Director of Housing, Area Agency on Aging of Northwest Arkansas

COMMENT: 212.200 Prospective Individual Services Budget, D. Methodology for Determining Individual Services Budgets, 2. The maximum individual service budget for a participant…

These caps need to be increased to accommodate the recommended increase in the Personal Care Rate and prospectively an increase in the Attendant Care and Respite Rates
Without increasing the caps, service recipients receiving maximum care will see a reduction in services

At a minimum 2.a. should be increased to $ 34,134

At a minimum 2.b. should be increased to $ 22,756

At a minimum 2.c. should be increased to $ 5,689

The caps are set too low and should be raised even higher than the above limits to allow for more care. Quality of life should always be a priority.

The Attendant Care and Respite Care rates in the waiver need to be increased to match the proposed Medicaid Personal Care Rate in SPA 20-

0222. Waiver service recipients are amongst the most frail older Arkansans and deserve in-home care. If the rate is not adjusted to offset the rapid increase in minimum wage these services will be unsustainable after the minimum wage increases again on Jan 1, 2021 without an increase to the rate.

RESPONSE: Thank you for your comment. The purpose of the proposed changes are to simplify the eligibility process for ARChoices and Living Choices so that it is in line with other HCBS services and reduces the need for an annual external independent assessment for those clients who do not have a change in circumstance. These changes include technical changes to the language of the current waivers to better clarify the use of the terms: evaluation, assessment, determination and review which, were previously used interchangeably.

Commenter's Name: Angie Dunlap, Director of Senior Center Services, Area Agency on Aging of Northwest Arkansas

COMMENT:

On the proposed rule: ARChoices 1-20, LCAL 1-20, PERSCARE 3-20, ARChoices and Living Choices Waiver Amendments, and Medical Services Policy C-265, I-630, I-640, and L- 120, I would like to provide the public comment for this rule.

This rate is increase is much needed to sustain the Medicaid Personal Care services and has been needed for quite some time.

Rapid escalation of minimum wage rates have created a dire situation that tis threatening services without this rate increase. Thank you,

RESPONSE: Thank you for your comment. The purpose of the proposed changes are to simplify the eligibility process for ARChoices and Living Choices so that it is in line with other HCBS services and reduces the need for an annual external independent assessment for those clients who do not have a change in circumstance. These changes include technical changes to the language of the current waivers to better clarify the use of the terms: evaluation, assessment, determination and review which, were previously used interchangeably.

Commenter's Name: Barbara Flowers, Executive Director, Area Agency on Aging of West Central Arkansas, Inc.

COMMENT: These caps need to be increased to accommodate the recommended increase in the Personal Care Rate and prospectively an increase in the Attendant Care and Respite Rates.

Without increasing the caps, service recipients receiving maximum care will experience a reduction in services. The caps are set too low and should be increased to allow for services these participants need in their homes to prevent early institutionalization.

The Attendant Care and Respite Care rates should be increased to match the proposed Medicaid Personal Care rate in SPA 20-0222. Waiver recipients typically need more services to meet their needs to live independently in their homes. If the rate is not adjusted to offset the rapid increase in minimum wage, these services will be unsustainable after the minimum wage increases again on January 1, 2021 without an increase to the rate. Thank you,

RESPONSE: Thank you for your comment. The purpose of the proposed changes are to simplify the eligibility process for ARChoices and Living Choices so that it is in line with other HCBS services and reduces the need for an annual external independent assessment for those clients who do not have a change in circumstance. These changes include technical changes to the language of the current waivers to better clarify the use of the terms: evaluation, assessment, determination and review which, were previously used interchangeably.

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

COMMENT 1: Waiver services enable frail and disabled beneficiaries to receive services that are critical to maintain their viability and independence from a nursing facility. Beneficiaries and their families depend on these services, therefore, in light of minimum wage increases, as well as other cost increases, the individual service budgets need to be raised to adequately fund services.

In 212.200 Prospective Individual Services Budget, D. Methodology for Determining Individual Services Budgets, 2. The maximum individual service budget for a participant…

These caps need to be increased to accommodate the recommended increase in the Personal Care Rate and prospectively an increase in the Attendant Care and Respite Rates.

Without increasing the caps, service recipients receiving maximum care will see a reduction in services

At a minimum 2.a. should be increased to $ 34,134

At a minimum 2.b. should be increased to $ 22,756

At a minimum 2.c. should be increased to $ 5,689

In general, the caps are set too low and should be raised even higher than the above limits to allow for more care.

RESPONSE: Thank you for your comment. The purpose of the proposed changes are to simplify the eligibility process for ARChoices and Living Choices so that it is in line with other HCBS services and reduces the need for an annual external independent assessment for those clients who do not have a change in circumstance. These changes include technical changes to the language of the current waivers to better clarify the use of the terms: evaluation, assessment, determination and review which, were previously used interchangeably.

COMMENT 2: Waiver services require a reliable network of providers to accommodate these must needed services. With increases in Arkansas' minimum wage in six out of seven years, the sustainability of quality home and community-based services was in imminent danger of broad provider network collapse.

Because Home and Community-Based Services cost a fraction of the cost of institutional care, it is imperative the Attendant Care and Respite Care rates in the waiver increase to match the proposed Medicaid Personal Care Rate in SPA 20-0222. This rate increase needs to be effective January 1, 2021 consistent with the Personal Care rate change and to coincide with the next mandatory minimum wage increase.

An increase in the attendant care and respite care rate from $18.24 per hour to $20.48 per hour will provide the relief needed to secure much desired home and community-based services for the near future. This was an important step in the right direction of caring for our frail and disabled population!

RESPONSE: Thank you for your comment. The purpose of the proposed changes are to simplify the eligibility process for ARChoices and Living Choices so that it is in line with other HCBS services and reduces the need for an annual external independent assessment for those clients who do not have a change in circumstance. These changes include technical changes to the language of the current waivers to better clarify the use of the terms: evaluation, assessment, determination and review which, were previously used interchangeably.

Commenter's Name: Bill Dearmore, Director of Client Services, Area Agency on Aging of Northwest Arkansas, Inc.

COMMENT: Please consider increasing the caps of the Individual Service Budget to accommodate the recommended increase in the Personal Care Rate. Without increasing the caps, service recipients receiving maximum care will see a reduction in services.

The Attendant Care and Respite Care rates in the waiver need to be increased to match the proposed Medicaid Personal Care Rate in SPA 20-0222. Thank you for you [*sic*] consideration.

RESPONSE: Thank you for your comment. The purpose of the proposed changes are to simplify the eligibility process for ARChoices and Living Choices so that it is in line with other HCBS services and reduces the need for an annual external independent assessment for those clients who do not have a change in circumstance. These changes include technical changes to the language of the current waivers to better clarify the use of the terms: evaluation, assessment, determination and review which, were previously used interchangeably.

Commenter's Name: Brad Bailey, Executive Director, Area Agency on Aging of Northwest Arkansas

COMMENT: The Attendant Care and Respite Care rates in the waiver need to be increased to match the proposed Medicaid Personal Care Rate in SPA 20-0222. Waiver service recipients are amongst the most frail older Arkansans and deserve in-home care. If the rate is not adjusted to offset the rapid increase in minimum wage these services will be unsustainable after the minimum wage increases again on Jan 1, 2021 without an increase to the rate.

RESPONSE: Thank you for your comment. The purpose of the proposed changes are to simplify the eligibility process for ARChoices and Living Choices so that it is in line with other HCBS services and reduces the need for an annual external independent assessment for those clients who do not have a change in circumstance. These changes include technical changes to the language of the current waivers to better clarify the use of the terms: evaluation, assessment, determination and review which, were previously used interchangeably.

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

Q. What is the status on CMS approval for the waivers? **RESPONSE:** We are in the process of answering CMS's Informal Request for Additional Information.

The proposed effective date is January 1, 2021.

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

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

f. SUBJECT: SPA 20-0022 Medicaid Personal Care Rate

DESCRIPTION:

Statement of Necessity

A revision to the Arkansas Medicaid State Plan is necessary to increase rates for personal care services in the Medicaid program based upon a rate review survey recommendation.

Rule Summary

Effective January 1, 2021, the Medicaid State Plan is being amended as follows:

Rates in the Personal Care program will increase by 13.72% based upon rate review of the service. The rate increase was recommended due to a rate review survey process.

PUBLIC COMMENT: A public hearing was held on this rule on October 29, 2020. The public comment period expired on November 9, 2020. The agency provided the following summary of the comments it received and its responses to those comments:

Commenter's Name: Kathy Tynes, MPA | Executive Director, Area Agency on Aging of Southeast Arkansas

COMMENT: We are 110% in support of the Personal Care rate increase. As costs continue to increase, this rate is necessary for our Agency to continue to provide home care services for the those in the 10 counties are we serve in Southeast Arkansas. Those counties include Jefferson,

Arkansas, Ashley, Drew, Chicot, Grant, Lincoln, Cleveland, Bradley, and Desha. Thank you. **RESPONSE:** Thank you for your comment and support of the rate increase.

Commenter's Name: Lillian Arnold, BSN, RN, Home Health Care Coordinator, Area Agency on Aging of Southeast Arkansas

COMMENT: All personal care and ARChoices services for In Home Medicaid should have the same rates because regardless of the program, our agency is committed to providing quality care and we do not adjust an employee pay based on the differences in reimbursement. Our agency continued to provide services for clients when minimum wages were increased and there were no Medicaid increase for services.

RESPONSE: Thank you for your comment. We will consider your comment when we do the rate review for ARChoices services.

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

COMMENT: CareLink is in favor of the proposed increase.

Rapid increases in the minimum wage, $ 2.50 per hour in wages and the accompanying increased payroll tax and fringe benefit costs - all in a 3-year period, have made providing this service unsustainable without a rate increase. A much-needed adjustment to ensure older Arkansans have access to this crucial service to remain independent in their own home environment.

The Attendant Care and Respite Care rates are in the same dire situation and need to be adjusted as well to match the Medicaid Personal Care Rate. ARChoices services will be unsustainable without a similar increase.

RESPONSE: Thank you for your comment and support of the rate increase. We will consider your comment when we do the rate review for ARChoices services.

Commenter's Name: Luke Mattingly, on behalf of the Arkansas Area Agency on Aging Associates

COMMENT: The Association is in favor of the proposed increase.

Rapid increases in the minimum wage, $ 2.50 per hour in wages and the accompanying increased payroll tax and fringe benefit costs - all in a 3-year period, have made providing this service unsustainable without a rate increase. A much-needed adjustment to ensure older Arkansans have

access to this crucial service to remain independent in their own home environment.

The Attendant Care and Respite Care rates are in the same dire situation and need to be adjusted to match the Medicaid Personal Care Rate. ARChoices services will be unsustainable without a similar increase.

RESPONSE: Thank you for your comment and support of the rate increase. We will consider your comment when we do the rate review for ARChoices services.

Commenter's Name: Tena M. Matthews, Home Care Financial Supervisor

COMMENT: The rate increase will be positive for all agencies who provide such important services such as personal care.

RESPONSE: Thank you for your comment and support of the rate increase.

Commenter's Name: Kay Newton, RN, Home Care Administrator, Area 2, Area Agency on Aging of Southeast Arkansas

COMMENT:

I have worked in the Home Health industry for 30 years and during this time, I have watched the Aides work hard to maintain the elderly population in their home setting. Allowing the elderly to remain in their homes is one of the most important factors in promoting well-being and longevity of life. In order to allow clients to age gracefully in the home setting, we must provide them with the services they desperately need including Medicaid Personal Care.

The COVID-19 pandemic is only one example of why the elderly population benefit from receiving services in their homes. Their home is a much safer environment than a facility setting. They deserve the many Home and Community Based services that are available and allow them to remain in the safety and comfort of their homes.

The rapid increase in minimum wage, without a rate increase for this program, threaten in-home services. The proposed rate increase is a step in the right direction and will be beneficial in obtaining this objective. The elderly population deserves to remain at home if they are able.

RESPONSE: Thank you for your comment and support of the rate increase.

Commenter's Name: Donna Plumlee, Executive Assistant, Area Agency on Aging of Northwest Arkansas, Inc.

COMMENT: The rate increase for Medicaid Personal Care is needed to sustain personal care services. Rapid increase of minimum wage rates are causing the providers of personal care services to suffer by not being able to afford to hire enough staff to cover the demand of clients needing these services. **RESPONSE:** Thank you for your comment and support of the rate increase.

Commenter's Name: Katie Bell, Director of Housing, Area Agency on Aging of Northwest Arkansas

COMMENT: No brainer: The rapid escalation of minimum wage rates have created a dire situation threating services without this increase. The rate is needed to sustain Medicaid Personal Care Services. Quality of life should be a priority. **RESPONSE:** Thank you for your comment and support of the rate increase.

Commenter's Name: Kimmela Steed, on behalf of Kindred at Home, submitted by Scott Pace

COMMENT: On behalf of Kindred at Home, one of the largest personal care providers in Arkansas, we would like to thank you and the Department for your commitment to re-conducting a rate review for personal care rates in Arkansas Medicaid. Kindred at Home is very grateful and supportive of the proposed rate of $20.47 per hour for personal care services.

We feel that the proposed rate more accurately takes into consideration the overall operating expense reality that has impacted our industry as a result of the changes to the Arkansas minimum wage over the last couple of years, which has dramatically impacted not only wages, but the cost and ability to recruit and retain employees. The proposed rule will provide a rate for personal care services that will ensure access to these important services, which is more important than ever during our pandemic.

Kindred at Home does believe that the same proposed rate should also be applied to attendant and respite care services as well. These services provide a much-needed service to family members and they have been equally impacted by the increase in Arkansas's minimum wage. Additionally, the cost basis on these services is virtually identical to the cost basis for personal care services.

We are in support of this current rule for personal care being approved as is, and we respectfully request that a new proposed rule be promulgated

before the end of the fiscal year that brings respite care and attendant care services into line with the new $20.47 per hour rate that will soon be applied to personal care services.

Again, we are very appreciative of the Department's work on this new rate review and we are in support of the proposed rule. Warm regards,

RESPONSE: Thank you for your comment and support of the rate increase. We will consider your comment when we do the rate review for ARChoices services.

Commenter's Name: Brad Bailey, Executive Director, Area Agency on Aging of Northwest Arkansas

COMMENT: I am very much in support of SPA 20-0022. This increased rate will help in meeting recent minimum wage increases in the State of Arkansas that was voted upon by the citizens of the state. I very much hope that other in-home services will also received [sic] consideration for the same rate increase as these are the same employees that provide personal care. **RESPONSE:** Thank you for your comment and support of the rate increase. We will consider your comment when we do the rate review for ARChoices services.

Commenter's Name: Barbara Flowers, Executive Director , Area Agency on Aging of West Central Arkansas, Inc.

COMMENT: I believe an increased rate for Medicaid Personal Care Services is needed to sustain Medicaid Personal Care Services. Due to the increased minimum wage rates, home care services have been threatened without an increase in the Personal Care rate. These services are essential for clients to remain in their homes with the care they require. Thank you,

RESPONSE: Thank you for your comment and support of the rate increase.

Commenter's Name: Bill Dearmore, Director of Client Services, Area Agency on Aging of Northwest Arkansas, Inc.

COMMENT:

The Medicaid Personal Care Rate increase is much needed to sustain Medicaid Personal Care services. Among other things, an escalation of minimum wage rate has created a dire situation threatening services without this increase. Thank you for your consideration in this matter.

RESPONSE: Thank you for your comment and support of the rate increase.

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

COMMENT: Home and community-based services are a critical link in the care continuum for Arkansans. When surveyed, eighty percent (80%) of older adults want to remain in their homes as they age. With increases in Arkansas' minimum wage in six out of seven years, the sustainability of quality personal care services was in imminent danger of broad provider network collapse.

The increase in the personal care rate from $18.00 per hour to $20.48 per hour will provide the relief needed to secure much desired home and community-based services for the near future.

This was an important step in the right direction of caring for our ever-increasing senior population!

RESPONSE: Thank you for your comment and support of the rate increase.

Commenter's Name: Charles D. Martin Executive Director, HomeCare Association of Arkansas

COMMENT: Overall, HCAA is in favor of the proposed increase of 13.72% for Personal Care rates. This is a much-needed adjustment and it allows older Arkansans to have access to crucial services and be able to remain in their home.

Our concern is that the proposed rate increase does not include a corresponding rate increase for Attendant Care and Respite Care. There is a serious need to adjust these rates to match the increase to the Arkansas Personal Care Rate. It will be difficult to provide these crucial services without an increase to these program areas. HCAA requests a similar rate increase for these program areas before this rule is made Final.

Thank you for the opportunity for us to present our comments on behalf of Arkansas Home Health Agencies. Please let us know if you have any questions on our request.

RESPONSE: Thank you for your comment and support of the rate increase. We will consider your comment when we do the rate review for ARChoices services.

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

Q. What is the status on CMS approval? **RESPONSE:** CMS approval is currently pending. We have responded to CMS's Informal Request for Additional Information and CMS has indicated it is being processed for approval. [The agency later clarified that CMS approval was received on November 16, 2020.]

The proposed effective date is January 1, 2021.

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

Per the agency, the total estimate cost to implement this rule is $12,176,842 for the current fiscal year ($3,488,665 in general revenue and $8,688,177 in federal funds) and $24,353,684 for the next fiscal year ($6,943,235 in general revenue and $17,410,449 in federal funds). The total estimated cost by fiscal year to state, county, and municipal government to implement this rule is $3,488,665 for the current fiscal year and $6,943,235 for the next fiscal year.

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

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

A revision of the Arkansas Medicaid State Plan is necessary to increase rates for personal care services.

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

Personal Care rates have not been increased in over six years; additionally the new minimum wage increases have caused expenses for providers to increase.

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

The rate increase is based on a rate review conducted by DHS and its actuaries with input from the providers. The rate increase helps ensure access to care.

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

There are no less costly alternatives.

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

None at this time.

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

None.

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended.

Rates for personal care services will be reviewed periodically.

LEGAL AUTHORIZATION: The Department of Human Services has the authority to administer assigned forms of public assistance and to make rules as necessary to carry out its duties. Ark. Code Ann. § 20-76-201(1), (12). The Department is specifically tasked with establishing and maintaining an indigent medical care program. Ark. Code Ann. § 20-77-107(a)(1). This includes promulgating rules to ensure compliance with federal law in order to receive federal funding. Ark. Code Ann. § 25-10-129(b).

g. **SUBJECT: SPA #2020-0023 Physicians' Evaluation & Management Code Rate Increase**

DESCRIPTION:

Statement of Necessity

Effective for dates of service occurring on or after January 1, 2021, the Arkansas Department of Human Services (DHS), Division of Medical Services (DMS) will adjust the Medicaid maximum unit reimbursement rate for physicians' evaluation and management codes by three percent (3.0%) subject to the routine rate study performed by DHS in the Fall of 2019.

Rule Summary

Effective January 1, 2021:

The Director of the Division of Medical Services (DMS) will adjust the Medicaid maximum reimbursement rate for physician evaluation and management codes by three percent (3.0%) subject to the routine rate study performed by DMS in the Fall of 2019. All rates are published on the agency's website: https://medicaid.mmis.arkansas.gov. The financial impact will be $411,876 for State Fiscal Year (SFY) 2021 and $823,752 for SFY 2022.

PUBLIC COMMENT: A public hearing was held on this rule on October 29, 2020. The public comment period expired on November 9, 2020. The agency indicated that it received no public comments.

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

1. What is the status on CMS approval? **RESPONSE:** We are working with CMS to answer all outstanding questions and get approval as quickly as possible. We are on track for an effective date of 1/1/21.

2. The financial impact statement for these rules states that Physicians' Evaluation & Management rates have not been increased in over 14 years. How do these rules relate to the Physicians' Evaluation & Management Code Rate Increase promulgated back in June?

RESPONSE: Effective July 1, 2020, the most commonly used physicians codes were increased 5.0%. Based on the same rate review, DMS has determined that rates for the same set of codes should be increased an additional 3.0%, for a total rate increase this year of 8.0%.

The proposed effective date is January 1, 2021.

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

Per the agency, the additional cost to implement this rule is $1,448,738 for the current fiscal year ($411,876 in general revenue and $1,036,862 in federal funds) and $2,897,475 for the next fiscal year ($823,752 in general revenue and $2,073,723 in federal funds). The total estimated cost by fiscal year to state, county, and municipal government to implement this rule is $411,876 for the current fiscal year and $823,752 for the next fiscal year.

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

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

A revision of the Arkansas Medicaid State Plan is necessary to increase rates for physicians' evaluation and management services.

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

Physicians' Evaluation and Management rates have not been increased in over 14 years; additionally, the new minimum wage increases have caused expenses for providers to increase.

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

The rate increase is based on a rate review conducted by DHS and its actuaries in the Fall of 2019.

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

There are no less costly alternatives.

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

None at this time.

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

None.

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

Rates for physicians' services will be reviewed periodically.

LEGAL AUTHORIZATION: The Department of Human Services has the authority to administer assigned forms of public assistance and to make rules as necessary to carry out its duties. Ark. Code Ann. § 20-76-201(1), (12). The Department is specifically tasked with establishing and maintaining an indigent medical care program. Ark. Code Ann. § 20-77-107(a)(1). This includes promulgating rules to ensure compliance with federal law and receive federal funding. Ark. Code Ann. § 25-10-129(b).

12. DEPARTMENT OF PARKS, HERITAGE, AND TOURISM, DIVISION OF PARKS (Mr. Grady Spann)

a. SUBJECT: PD 3097 Arkansas State Parks Pedal Assist and Electric Bicycles

DESCRIPTION: This rule will permit pedal assist bicycles on Arkansas State Park mountain bike trails, all-terrain vehicle trails, and off-road motorcycle trails. This rule will prohibit Class 2 and Class 3 bicycles from Arkansas State Park mountain bike trails, or paved and unpaved multi-use trails that allow bicycles of any type; Class 1 and Class 3 pedal assist bicycles and Class 2 electric bicycles are permitted on all roads within Arkansas State Parks.

PUBLIC COMMENT: A public hearing was held in this matter on October 30, 2020. The public comment period expired on October 30, 2020. The agency received no comments.

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

1. What rule-making authority is the Department/Division relying upon in proposing these rules? **RESPONSE:** Ark. Code Ann. §§ 22-4-305, 22-4-310, and Act 170 of 1937.
(a) Ark. Code Ann. 27-51-1705 states that "local authorit[ies] having jurisdiction over a bicycles path or multi-use path may prohibit the operation of a Class I electric bicycle or a Class 2 electric bicycle on that path." However, does the Department have rule-making authority concerning Arkansas Parks' paths? If so, could you please provide the statutory citation? **RESPONSE:** The Agency owns the paths within State Parks and these rules will impact the public. The general rules governing rule making authority for the Agency for State Parks are as follows: Ark. Code Ann. §§ 22-4-305, 22-4-310, and Act 170 of 1937.

2. The financial impact statement indicates that these rules have a financial impact. However, no financial impact appears to be disclosed in the rest of the FIS. Does this proposed, amended, or repealed rule have a financial impact? Please clarify or explain. **RESPONSE:** The Financial Impact statement is incorrect. There is no financial impact from this rule. [A revised Financial Impact Statement was submitted.]

The proposed effective date is January 1, 2021.

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

LEGAL AUTHORIZATION: Pursuant to Ark. Code Ann. § 22-4-305(b), the State Parks, Recreation, and Travel Commission (SPRTC) has authority and power to erect and operate cabins, lodges, restaurants, and other facilities and improvements for the convenience of the public. Concerning rulemaking, SPRTC has authority to make, amend and enforce all reasonable rules not inconsistent with law which will aid in the performance of any of the function, powers, or duties conferred or imposed upon it by law. *See* Ark. Code Ann. § 15-11-206(a). The administrative functions of the State Parks, Recreation and Travel Commission were transferred to the Department of Parks, Heritage and Tourism, pursuant to Act 910 of 2019 (the Transformation and Efficiencies Act of 2019).

b. **SUBJECT: CY 2021 Arkansas State Parks Fees and Rates**

DESCRIPTION: The proposed rates and fees for calendar year 2021 for the Arkansas State Parks reflect modifications recommended to maximize park operating revenues while providing affordable services to our guests. The rates and fees are reviewed and updated yearly. The process for making these recommendations includes the Agency recording local competitive pricing, reviewing occupancy and use figures from the various rental facilities, taking cost increases and property improvements into account, and staff recommendations based on guest needs. In making these recommendations, the Agency considers several factors, including the following items listed below.

• *Remove rental inventory that may no longer exist*

Adjust marina boat rental changes as older equipment is taken out of inventory and new equipment is added. For example Rent-A-Camp was removed from Lake Catherine State Park this year and was the last facility like this in the park system.

• *Add new rental inventory that was created since the previous update*

Add new rental boats to marinas, new campgrounds, cabins as they have become available during the year. For 2021, this will include new camper cabins at Mississippi River State Park.

• *Simplify pricing for customer service*

Update pricing to improve ease of payments for guests to use exact change to pay. Eliminate separate pricing for weekdays and weekends.

• *Rate adjustments to compensate for inflation, local service changes, improved properties, and changes in demand*

The Agency recommends modification of rates at varying parks based on lack of demand for occupancy (e.g., Brunson House) and also by a large demand for occupancy (e.g., Mount Nebo and Queen Wilhelmina State Parks) depending on the various locations. The Agency also recommends a slight increase in rates due to recent remodel of some facilities.

PUBLIC COMMENT: A public hearing was held on October 30, 2020. The public comment period expired on October 30, 2020. The agency received no comments.

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

1. The draft indicates that this is a "park directive." Has this been promulgated as a rule before? **RESPONSE:** Yes, see attached Final Transmission Sheet 07-26-2019.

2. If it has been promulgated before, when? **RESPONSE:** August 5, 2019, see attached Final Transmission Sheet 07-26-2019; relevant rule

making authority Ark. Code Ann. §§ 22-4-305, 22-4-310, and Act 170 of 1937.

The proposed effective date is January 1, 2021.

FINANCIAL IMPACT: The agency indicated that the proposed rule has a financial impact and provided the following explanation:

The overall projected increase of revenue for calendar year 2021 from the proposed modification of fees will total $31,534.14. These projections are based on Arkansas State Parks maintaining the same occupancy rates of calendar year 2019 which is the last full calendar year upon which to base revenue. The overall recommendation of increase of fees is an average of 0.11% increase in rates compared to the rates of calendar year 2019.

Lodging	$23,107.32
Camping	No change
Meeting Rooms and Pavilions	$5,702.17
Marina Slip Rental and Boat Rental	$2,486.15
Interpretive Tours	$238.50
Golf	No change
Museum	No change
Miscellaneous Rental Equipment	No change
Swimming	No change
Entrance Fees	No change

Total $31,534.14

LEGAL AUTHORIZATION: Pursuant to Ark. Code Ann. § 22-4-305(a), the State Parks, Recreation, and Travel Commission (SPRTC) has authority 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. Concerning rulemaking, SPRTC has authority to make, amend and enforce all reasonable rules not inconsistent with law which will aid in the performance of any of the function, powers, or duties conferred or imposed upon it by law. *See* Ark. Code Ann. § 15-11-206(a). The administrative functions of the State Parks, Recreation and Travel Commission were transferred to the Department of Parks, Heritage and Tourism, pursuant to Act 910 of 2019 (the Transformation and Efficiencies Act of 2019).

c. SUBJECT: Minimum Hours of Operation and Guidelines for Facility Hours

DESCRIPTION: This rule establishes minimum hours of operation and guidelines to ensure a consistent process for establishing facility hours for all Division of Arkansas State Parks properties. The existing *Park*

Directive 1050 - Hours of Operation, Opening and Closing Dates, and Holidays in State Park Facilities For 2019 does not allow sufficient flexibility for the State Parks system to appropriately operate and manage facilities.

PUBLIC COMMENT: A public hearing was held in this matter on November 10, 2020. The public comment period expired on November 10, 2020. The Department of Parks, Heritage and Tourism received no comments.

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

1. Could you please identify the statutory rulemaking authority that the agency is relying upon to make these rules? **RESPONSE:** Ark. Code Ann. §§ 22-4-305, 22-4-310, 15-11-206(a), 25-43-1302(a)(21)(c), and Act 170 of 1937.

2. In Question 5 of the Questionnaire, the agency indicated that this is a new rule in the first question, but indicated that it replaces an existing rule in second question.
(a) Could you please clarify?
RESPONSE: This is a new rule. I have attached our communication with the Secretary of State's office reflecting updated notice for a new rule.
(b) In looking at the language in the rule, the only thing identified to be replaced is PD 1050. Is PD 1050 promulgated as a rule? **RESPONSE:** No, PD 1050 is not promulgated as a rule.
(c) If PD 1050 is not currently a rule, why did the agency choose to pursue a rule rather than amend the park directive? **RESPONSE:** In following the guidance of ADPHT legal counsel, the Agency pursued promulgation of this rule to provide for consistency and efficiency similar to the rule in place on hours of operation for State Parks.

3. The rule states that ASP properties and facilities will be available to the public during "reasonable hours and for regular periods with appropriate standards to ensure the health, safety, and accessibility of visitors and personnel." The rule appears to define hours for day-use properties, year-round facilities, and museums.
(a) Could you please clarify what the agency believes "reasonable hours" means?
RESPONSE: Reasonable hours are defined as standard hours for state park facilities to be open considering weather, seasons, safety, health and accessibility. For example during normal business hours (8-5) or hours comparable to similar facilities and operations outside of Arkansas State Parks. Hours will be recommended by park staff and approved by

Director of Arkansas State Parks and Secretary Hurst, Secretary of Parks Heritage and Tourism.
(b) Are facilities like lodges and campgrounds covered in this rule?
RESPONSE: No, overnight facilities never close. We have staff and procedures in place to cover those facilities 24/7.

The proposed effective date is January 1, 2021.

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

LEGAL AUTHORIZATION: Pursuant to Ark. Code Ann. § 22-4-305(b), the State Parks, Recreation, and Travel Commission (SPRTC) has authority and power to erect and operate cabins, lodges, restaurants, and other facilities and improvements for the convenience of the public. Concerning rulemaking, SPRTC has authority to make, amend and enforce all reasonable rules not inconsistent with law which will aid in the performance of any of the function, powers, or duties conferred or imposed upon it by law. *See* Ark. Code Ann. § 15-11-206(a). The administrative functions of the State Parks, Recreation and Travel Commission were transferred to the Department of Parks, Heritage and Tourism, pursuant to Act 910 of 2019 (the Transformation and Efficiencies Act of 2019).

13. ARKANSAS TREASURER OF STATE (Mr. T.J. Lawhon, Mr. Grant Wallace, Ms. Fran Jansen)

a. SUBJECT: The Arkansas Achieving a Better Life Experience Program

DESCRIPTION: These changes amend the rules for the Achieving a Better Life Experience (ABLE) program in Arkansas. The amendments were necessary to remove unused language and to better align with the plan description.

PUBLIC COMMENT: A public hearing was held on this rule on April 27, 2020. The public comment period expired on April 27, 2020. After receiving no public comments, the agency chose to open a second public comment period. The second public comment period ended November 3, 2020. The agency indicated that it received no public comments.

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

1. The proposed rules state, "Contributions may be made by check, wire transfer, payroll direct deposit, automated clearing house funds transfer, rollover from another ABLE or 529 Plan account." However, Ark. Code Ann. § 20-3-108(b) states, "Contributions to an ABLE account shall be made only in cash," and Ark. Code Ann. § 20-3-109 allows funds to be transferred from another account. Could you provide the statutory authority for allowing contributions by other means?

RESPONSE: The term "cash" is carried over from the ABLE federal statute but not meant to be strictly construed to mean only coins and paper currency of the U.S. The ABLE program is not designed to take that form of payment. The intent is to restrict contribution methods to not allow credit card, money order, securities, debt and non-cash asset type payments. This same method of payment language is found in the 529 qualified tuition savings program under A.C.A. 6-84-107(b) and associated rules.

See 26 USCS 529A(b)(2)(A) – Cash contributions.--A program shall not be treated as a qualified ABLE program unless it provides that no contribution will be accepted--(A) unless it is in cash…

2. Is there specific statutory authority for the provision limiting changes in investment allocation to twice annually?

RESPONSE: Yes. See 26 USCA 529A(b)(4) - Limited investment direction.--A program shall not be treated as a qualified ABLE program unless it provides that any designated beneficiary under such program may, directly or indirectly, direct the investment of any contributions to the program (or any earnings thereon) no more than 2 times in any calendar year.

See A.C.A. 20-3-107 - Except as permitted under the Achieving a Better Life Experience Program as provided under the Tax Increase Prevention Act of 2014, Pub. L. No. 113-295, a person shall not direct the investment of any contributions to or earnings from the program more than two (2) times each year.

3. It appears that the proposed rules retain the term "regulations." I just wanted to mention Act 315 of 2019, § 3204(b)(3), which concerns the uniform use of the term "rule" and requires governmental entities to ensure the use of the term "rule" upon promulgation of any rule after the effective date of the Act. Act 315 took effect on July 24, 2019. Is there a reason that the agency has retained the term "regulations" for the time being? **RESPONSE:** We will replace the word 'rule' with regulation.

The proposed effective date is pending legislative review and approval.

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

LEGAL AUTHORIZATION: The Treasurer of State has the authority to manage the Arkansas Achieving a Better Life Experience Program Trust. Ark. Code Ann. § 20-3-105(b)(1). The Achieving a Better Life Experience Program Committee may adopt rules necessary to administer the Achieving a Better Life Experience Program Act and to ensure compliance with the Program. Ark. Code Ann. § 20-3-105(c), (d)(2). Per the agency, the Committee voted to adopt these proposed rules on November 5, 2020.

D. Rules Filed Pursuant to Ark. Code Ann. § 10-3-309 To Be Considered Pending Suspension of Subcommittee Rules Due to Public Comment Period Expiring After November 15, 2020 Deadline

1. DEPARTMENT OF COMMERCE, ARKANSAS ECONOMIC DEVELOPMENT COMMISSION (Mr. Jim Hudson, Ms. Jean Noble, Ms. Renee Doty)

a. SUBJECT: Fresh Start Rental Assistance Program Proposed Rule

DESCRIPTION: The Arkansas Economic Development Commission (AEDC) is seeking to promulgate a permanent rule to administer the Arkansas Fresh Start COVID-19 Housing Stabilization Program (Fresh Start Program). AEDC, in collaboration with the Arkansas Community Action Agencies Association, will provide short-term rental assistance to low to moderate individuals and families in Arkansas who are experiencing housing instability. The program will also assist landlords who are experiencing revenue loss due to the impact of the COVID-19 pandemic. AEDC promulgated an emergency rule to administer the Fresh Start Program that was effective on October 16, 2020 for a 120-day period. The proposed permanent rule is necessary to continue to administer the program after the emergency period expires.

Proposed Rule Summary

- The proposed rule provides an overview of the Fresh Start program and the need created by the impact of COVID-19 on Arkansans and the Arkansas economy.
- $10 million for the Fresh Start Program would be funded by $5.76 million in federal CDBG-CV grant funds from HUD and a $4.24 million CARES Act Funds appropriation approved by the Arkansas Legislative Council (ALC) on October 16, 2020.

- The proposed rule establishes the eligibility criteria for applicants and the required documentation that will demonstrate eligibility.
- Fresh Start Program benefits are outlined in Section III of the proposed rule.
- Eligible applicants may receive benefits of up to 2.5 months of past due rent. The amount of the grant assistance shall not exceed the fair market rental value as determined by HUD for the dwelling occupied by the applicant.
- Benefits will be paid directly to the landlord of the dwelling occupied by the applicant and are strictly limited to rental charges for the dwelling and shall not include separate ancillary charges for property amenities unrelated to rent.
- The Arkansas Community Action Agencies Association (ACAAA) shall serve as the overall project manager of the Fresh Start Program and the duties and responsibilities of the ACAAA are outlined in the proposed rules under Section V.
- Benefits under the Fresh Start Program shall be administered through the 15 Community Action Agencies (CAA) throughout Arkansas. The responsibilities of the CAA's are outlined in Section VI.
- Exhibit A outlines the percentage of overall award that will be allocated to each CAA. This allocation is determined based on the population of the area served by each CAA.

Rulemaking Authority
AEDC has authority granted under Ark. Code Ann. § 15-4-209(a)(1) and § 15-4-209(b)(5) to promulgate rules for programs that the agency administers.

PUBLIC COMMENT: A public hearing was held on November 23, 2020. The public comment period expired on December 6, 2020. The Arkansas Economic Development Commission received no comments.

This rule was filed on an emergency basis and reviewed and approved by the Executive Subcommittee on October 15, 2020, with an effective date of October 16, 2020. The proposed date for permanent promulgation is pending legislative review and approval.

FINANCIAL IMPACT: The Arkansas Economic Development Commission indicated that the proposed rules do not have a financial impact. AEDC estimated a current fiscal year cost of $300 for legal advertising and copying costs incurred during the promulgation process of the permanent rule.

LEGAL AUTHORIZATION: AEDC has authority to administer grants, loans, cooperative agreements, tax credits, guaranties and other incentives, memoranda of understanding, and conveyances to assist with economic

development in the state. See Ark. Code Ann. § 15-4-209(a)(1). Additionally, AEDC has authority to promulgate rules necessary to implement the programs and services offered by the commission. See Ark. Code Ann. § 15-4-209(b)(5).

2. DEPARTMENT OF FINANCE AND ADMINISTRATION, ARKANSAS RACING COMMISSION (Mr. Byron Freeland)

a. SUBJECT: Rule 1217C Prohibited Practices; Extracorporeal Shock Wave Therapy; Radial Pulse Wave Therapy

DESCRIPTION: This proposed amendment prohibits shockwave therapy and other similar treatments on horses on the grounds of Oaklawn, prohibits equipment for shockwave and other similar treatments in the stable area at Oaklawn, and prohibits horses that have received such treatments from racing at Oaklawn for a period of thirty days after the treatment.

PUBLIC COMMENT: A public hearing was held on this rule on December 10, 2020. The public comment period expired on December 7, 2020. As of this date, a public comment summary has not been received. The agency will supplement with a public comment summary after the close of the public comment period. That summary will be provided separately to members of the subcommittee.

The proposed effective date is January 22, 2021.

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

LEGAL AUTHORIZATION: The Arkansas Racing Commission has "sole jurisdiction over the business and the sport of horse racing in this state where the racing is permitted for any stake, purse, or reward[.]" Ark. Code Ann. § 23-110-204(a). The Commission has "full, complete, and sole power and authority" to promulgate rules related to its duties and may "make, amend, and enforce all necessary or desirable rules not inconsistent with law." Ark. Code Ann. § 23-110-204(b)(1)(E), (d).

b. SUBJECT: Rule 1217D(5)

DESCRIPTION: This proposed amendment prohibits the use of clenbuterol or any other beta-2 agonist within sixty days of a race.

PUBLIC COMMENT: A public hearing was held on this rule on December 10, 2020. The public comment period expired on December 7,

2020. As of this date, a public comment summary has not been received. The agency will supplement with a public comment summary after the close of the public comment period. That summary will be provided separately to members of the subcommittee.

The proposed effective date is January 22, 2021.

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

LEGAL AUTHORIZATION: The Arkansas Racing Commission has "sole jurisdiction over the business and the sport of horse racing in this state where the racing is permitted for any stake, purse, or reward[.]" Ark. Code Ann. § 23-110-204(a). The Commission has "full, complete, and sole power and authority" to promulgate rules related to its duties and may "make, amend, and enforce all necessary or desirable rules not inconsistent with law." Ark. Code Ann. § 23-110-204(b)(1)(E), (d).

c. SUBJECT: Rule 1217E Furosemide as a Permitted Substance

DESCRIPTION: This proposed amendment reduces the permitted dosage of furosemide from 500 to 250 milligrams, unless authorized by the commission veterinarian, and sets the testing threshold for furosemide at 50 nanograms if the dosage is 250 milligrams.

PUBLIC COMMENT: A public hearing was held on this rule on December 10, 2020. The public comment period expired on December 7, 2020. As of this date, a public comment summary has not been received. The agency will supplement with a public comment summary after the close of the public comment period. That summary will be provided separately to members of the subcommittee.

The proposed effective date is January 22, 2021.

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

LEGAL AUTHORIZATION: The Arkansas Racing Commission has "sole jurisdiction over the business and the sport of horse racing in this state where the racing is permitted for any stake, purse, or reward[.]" Ark. Code Ann. § 23-110-204(a). The Commission has "full, complete, and sole power and authority" to promulgate rules related to its duties and may "make, amend, and enforce all necessary or desirable rules not inconsistent with law." Ark. Code Ann. § 23-110-204(b)(1)(E), (d).

d. **SUBJECT: Rule 1217E Uniform Classification Guidelines for Foreign Substances and Recommended Penalties**

DESCRIPTION: This rule classifies different prohibited drugs according to their seriousness and provides recommended penalties for owners and trainers that have horses that test positive for the presence of a prohibited drug. This rule was drafted by the Association of Racing Commissioners International, Inc. and is used by many other racing jurisdictions in an attempt to have uniform medication rules and punishment for violators. The Arkansas Racing Commission adopted the January 2014 version as a new Racing Commission rule. The 2020 version of the ARCI Guidelines contains new drugs and reclassifies some existing drugs. This proposed amendment merely amends an existing rule by updating the classification of drugs and recommended penalties so that the Arkansas Racing Commission has the current ARCI model rule.

PUBLIC COMMENT: A public hearing was held on this rule on December 10, 2020. The public comment period expired on December 7, 2020. As of this date, a public comment summary has not been received. The agency will supplement with a public comment summary after the close of the public comment period. That summary will be provided separately to members of the subcommittee.

The proposed effective date is January 22, 2021.

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

LEGAL AUTHORIZATION: The Arkansas Racing Commission has "sole jurisdiction over the business and the sport of horse racing in this state where the racing is permitted for any stake, purse, or reward[.]" Ark. Code Ann. § 23-110-204(a). The Commission has "full, complete, and sole power and authority" to promulgate rules related to its duties and may "make, amend, and enforce all necessary or desirable rules not inconsistent with law." Ark. Code Ann. § 23-110-204(b)(1)(E), (d).

e. **SUBJECT: Rule 1232 Medication: Furosemide (Lasix)**

DESCRIPTION: This amendment proposes to reduce the maximum level of Lasix administration to 250 milligrams unless the official veterinarian approves a dose of up to 500 milligrams; and to allow Oaklawn to write (A) Lasix-free 3-year-old races as necessary for the race participants to be eligible to accumulate Kentucky Derby and Kentucky Oaks points, and (B) Lasix-free stakes races as necessary for such stakes races to remain eligible for graded status.

PUBLIC COMMENT: A public hearing was held on this rule on December 10, 2020. The public comment period expired on December 7, 2020. As of this date, a public comment summary has not been received. The agency will supplement with a public comment summary after the close of the public comment period. That summary will be provided separately to members of the subcommittee.

The proposed effective date is January 22, 2021.

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

LEGAL AUTHORIZATION: The Arkansas Racing Commission has "sole jurisdiction over the business and the sport of horse racing in this state where the racing is permitted for any stake, purse, or reward[.]" Ark. Code Ann. § 23-110-204(a). The Commission has "full, complete, and sole power and authority" to promulgate rules related to its duties and may "make, amend, and enforce all necessary or desirable rules not inconsistent with law." Ark. Code Ann. § 23-110-204(b)(1)(E), (d).

f. SUBJECT: Rule 1236 Testing of Horses

DESCRIPTION: Currently, the Arkansas Racing Commission tests blood, urine, and saliva of horses at Oaklawn Park. This amendment authorizes the Commission to collect and test horse hair for drugs and prohibited substances as well.

PUBLIC COMMENT: A public hearing was held on this rule on December 10, 2020. The public comment period expired on December 7, 2020. As of this date, a public comment summary has not been received. The agency will supplement with a public comment summary after the close of the public comment period. That summary will be provided separately to members of the subcommittee.

The proposed effective date is January 22, 2021.

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

LEGAL AUTHORIZATION: The Arkansas Racing Commission has "sole jurisdiction over the business and the sport of horse racing in this state where the racing is permitted for any stake, purse, or reward[.]" Ark. Code Ann. § 23-110-204(a). The Commission has "full, complete, and sole power and authority" to promulgate rules related to its duties and may "make, amend, and enforce all necessary or desirable rules not inconsistent with law." Ark. Code Ann. § 23-110-204(b)(1)(E), (d).

g. SUBJECT: Rule 1245(A) Horses Testing Positive

DESCRIPTION: This amendment governs eligibility of horses testing positive for certain drugs named in the rule; it adds clenbuterol and other beta-2 agonists to the list of drugs tested for prior to a race. Any horse testing positive for clenbuterol and the other listed drugs shall not be eligible to start a race at Oaklawn until it subsequently tests negative for such substance in a form and substance acceptable to the Stewards.

PUBLIC COMMENT: A public hearing was held on this rule on December 10, 2020. The public comment period expired on December 7, 2020. As of this date, a public comment summary has not been received. The agency will supplement with a public comment summary after the close of the public comment period. That summary will be provided separately to members of the subcommittee.

The proposed effective date is January 22, 2021.

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

LEGAL AUTHORIZATION: The Arkansas Racing Commission has "sole jurisdiction over the business and the sport of horse racing in this state where the racing is permitted for any stake, purse, or reward[.]" Ark. Code Ann. § 23-110-204(a). The Commission has "full, complete, and sole power and authority" to promulgate rules related to its duties and may "make, amend, and enforce all necessary or desirable rules not inconsistent with law." Ark. Code Ann. § 23-110-204(b)(1)(E), (d).

h. SUBJECT: Rule 1272 Intra-Articular Joint Injections

DESCRIPTION: This new rule regulates corticosteroid and intra-articular injections and makes a horse ineligible to race for a period of fourteen days following an intra-articular injection. It also requires the trainer to maintain a complete record of all intra-articular joint injections.

PUBLIC COMMENT: A public hearing was held on this rule on December 10, 2020. The public comment period expired on December 7, 2020. As of this date, a public comment summary has not been received. The agency will supplement with a public comment summary after the close of the public comment period. That summary will be provided separately to members of the subcommittee.

The proposed effective date is January 22, 2021.

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

LEGAL AUTHORIZATION: The Arkansas Racing Commission has "sole jurisdiction over the business and the sport of horse racing in this state where the racing is permitted for any stake, purse, or reward[.]" Ark. Code Ann. § 23-110-204(a). The Commission has "full, complete, and sole power and authority" to promulgate rules related to its duties and may "make, amend, and enforce all necessary or desirable rules not inconsistent with law." Ark. Code Ann. § 23-110-204(b)(1)(E), (d).

i. SUBJECT: Rule 2099.1(a)(4) Required Workouts and Examination by Practicing Veterinarian

DESCRIPTION: This amendment requires a horse which has not run for a period of six months or more to be examined and approved for racing by the trainer's practicing veterinarian; formerly, the Commission veterinarian performed these duties. It also sets out the required number of workouts prior to entering a race for horses that have not raced in six months or more.

PUBLIC COMMENT: A public hearing was held on this rule on December 10, 2020. The public comment period expired on December 7, 2020. As of this date, a public comment summary has not been received. The agency will supplement with a public comment summary after the close of the public comment period. That summary will be provided separately to members of the subcommittee.

The proposed effective date is January 22, 2021.

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

LEGAL AUTHORIZATION: The Arkansas Racing Commission has "sole jurisdiction over the business and the sport of horse racing in this state where the racing is permitted for any stake, purse, or reward[.]" Ark. Code Ann. § 23-110-204(a). The Commission has "full, complete, and sole power and authority" to promulgate rules related to its duties and may "make, amend, and enforce all necessary or desirable rules not inconsistent with law." Ark. Code Ann. § 23-110-204(b)(1)(E), (d).

j. SUBJECT: Rule 2133 Treatment Records

DESCRIPTION: This new rule requires trainers and veterinarians to keep records of all medical treatments administered to horses. Records of

treatments to horses shall be available to the Commission veterinarian upon request.

PUBLIC COMMENT: A public hearing was held on this rule on December 10, 2020. The public comment period expired on December 7, 2020. As of this date, a public comment summary has not been received. The agency will supplement with a public comment summary after the close of the public comment period. That summary will be provided separately to members of the subcommittee.

The proposed effective date is January 22, 2021.

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

LEGAL AUTHORIZATION: The Arkansas Racing Commission has "sole jurisdiction over the business and the sport of horse racing in this state where the racing is permitted for any stake, purse, or reward[.]" Ark. Code Ann. § 23-110-204(a). The Commission has "full, complete, and sole power and authority" to promulgate rules related to its duties and may "make, amend, and enforce all necessary or desirable rules not inconsistent with law." Ark. Code Ann. § 23-110-204(b)(1)(E), (d).

k. SUBJECT: Rule 2163 Requirements for Jockeys, Exercise Riders and Outriders

DESCRIPTION: This amendment amends and further defines the permitted use of a riding crop and defines the only permissible riding crops as 360 Gentle Touch (360 GT) riding crop, Pro-Cush riding crop, or other similar riding crops approved by the Stewards. The amendment also adds exercise riders to the list of persons required to wear safety vests when riding horses at Oaklawn.

PUBLIC COMMENT: A public hearing was held on this rule on December 10, 2020. The public comment period expired on December 7, 2020. As of this date, a public comment summary has not been received. The agency will supplement with a public comment summary after the close of the public comment period. That summary will be provided separately to members of the subcommittee.

The proposed effective date is January 22, 2021.

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

LEGAL AUTHORIZATION: The Arkansas Racing Commission has "sole jurisdiction over the business and the sport of horse racing in this state where the racing is permitted for any stake, purse, or reward[.]" Ark. Code Ann. § 23-110-204(a). The Commission has "full, complete, and sole power and authority" to promulgate rules related to its duties and may "make, amend, and enforce all necessary or desirable rules not inconsistent with law." Ark. Code Ann. § 23-110-204(b)(1)(E), (d).

l. SUBJECT: Rule 2212 Entries

DESCRIPTION: This amendment allows entries coupled because of common ties, i.e. ownership or trainers, to race in the same race if approved by Racing Secretary and Stewards. It also establishes a procedure for a starting preference in races that overfill.

PUBLIC COMMENT: A public hearing was held on this rule on December 10, 2020. The public comment period expired on December 7, 2020. As of this date, a public comment summary has not been received. The agency will supplement with a public comment summary after the close of the public comment period. That summary will be provided separately to members of the subcommittee.

The proposed effective date is January 22, 2021.

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

LEGAL AUTHORIZATION: The Arkansas Racing Commission has "sole jurisdiction over the business and the sport of horse racing in this state where the racing is permitted for any stake, purse, or reward[.]" Ark. Code Ann. § 23-110-204(a). The Commission has "full, complete, and sole power and authority" to promulgate rules related to its duties and may "make, amend, and enforce all necessary or desirable rules not inconsistent with law." Ark. Code Ann. § 23-110-204(b)(1)(E), (d).

m. SUBJECT: Rule 2225 Requirement for Horses to be Stabled on Grounds

DESCRIPTION: This amendment requires horses to be stabled on the grounds of Oaklawn for at least seventy-two hours prior to a race. If a horse has not been stabled on the Oaklawn grounds for seventy-two hours, it cannot start a race unless the owner/trainer gets the permission of the Racing Secretary.

PUBLIC COMMENT: A public hearing was held on this rule on December 10, 2020. The public comment period expired on December 7,

2020. As of this date, a public comment summary has not been received. The agency will supplement with a public comment summary after the close of the public comment period. That summary will be provided separately to members of the subcommittee.

The proposed effective date is January 22, 2021.

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

LEGAL AUTHORIZATION: The Arkansas Racing Commission has "sole jurisdiction over the business and the sport of horse racing in this state where the racing is permitted for any stake, purse, or reward[.]" Ark. Code Ann. § 23-110-204(a). The Commission has "full, complete, and sole power and authority" to promulgate rules related to its duties and may "make, amend, and enforce all necessary or desirable rules not inconsistent with law." Ark. Code Ann. § 23-110-204(b)(1)(E), (d).

n. SUBJECT: Rule 2236 Entries

DESCRIPTION: This amendment allows a horse to enter a race if they are on the official starter's or veterinarian's list; horses remain ineligible to race if they are on the starter's or veterinarian's list at race time. Under the amended rules, a horse can enter a race while on the starter's or veterinarian's list but cannot start if the horse is not removed from the list prior to the race.

PUBLIC COMMENT: A public hearing was held on this rule on December 10, 2020. The public comment period expired on December 7, 2020. As of this date, a public comment summary has not been received. The agency will supplement with a public comment summary after the close of the public comment period. That summary will be provided separately to members of the subcommittee.

The proposed effective date is January 22, 2021.

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

LEGAL AUTHORIZATION: The Arkansas Racing Commission has "sole jurisdiction over the business and the sport of horse racing in this state where the racing is permitted for any stake, purse, or reward[.]" Ark. Code Ann. § 23-110-204(a). The Commission has "full, complete, and sole power and authority" to promulgate rules related to its duties and may "make, amend, and enforce all necessary or desirable rules not inconsistent with law." Ark. Code Ann. § 23-110-204(b)(1)(E), (d).

o. SUBJECT: Rule 2263(A) Horses Testing Positive

DESCRIPTION: This amendment governs eligibility of horses testing positive for certain drugs named in the rule; adds clenbuterol and the beta-2 agonists to the list of drugs tested for prior to a race. Any horse testing positive for clenbuterol and the other listed drugs shall not be eligible to start a race at Oaklawn until it subsequently tests negative for such substance in a form and substance acceptable to the Stewards.

PUBLIC COMMENT: A public hearing was held on this rule on December 10, 2020. The public comment period expired on December 7, 2020. As of this date, a public comment summary has not been received. The agency will supplement with a public comment summary after the close of the public comment period. That summary will be provided separately to members of the subcommittee.

The proposed effective date is January 22, 2021.

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

LEGAL AUTHORIZATION: The Arkansas Racing Commission has "sole jurisdiction over the business and the sport of horse racing in this state where the racing is permitted for any stake, purse, or reward[.]" Ark. Code Ann. § 23-110-204(a). The Commission has "full, complete, and sole power and authority" to promulgate rules related to its duties and may "make, amend, and enforce all necessary or desirable rules not inconsistent with law." Ark. Code Ann. § 23-110-204(b)(1)(E), (d).

p. SUBJECT: Rule 2434 Claiming

DESCRIPTION: This amendment provides for testing for clenbuterol and beta-2 agonists in claimed horses. If a horse tests positive for clenbuterol or other beta-2 agonists after a claim, the successful claiming owner may void the claim under this amended rule.

PUBLIC COMMENT: A public hearing was held on this rule on December 10, 2020. The public comment period expired on December 7, 2020. As of this date, a public comment summary has not been received. The agency will supplement with a public comment summary after the close of the public comment period. That summary will be provided separately to members of the subcommittee.

The proposed effective date is January 22, 2021.

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

LEGAL AUTHORIZATION: The Arkansas Racing Commission has "sole jurisdiction over the business and the sport of horse racing in this state where the racing is permitted for any stake, purse, or reward[.]" Ark. Code Ann. § 23-110-204(a). The Commission has "full, complete, and sole power and authority" to promulgate rules related to its duties and may "make, amend, and enforce all necessary or desirable rules not inconsistent with law." Ark. Code Ann. § 23-110-204(b)(1)(E), (d).

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

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

F. Adjournment.