ADMINISTRATIVE RULES & REGULATIONS SUBCOMMITTEE
OF THE
ARKANSAS LEGISLATIVE COUNCIL

Room A, MAC
Little Rock, Arkansas

Tuesday, September 20, 2016
9:00 a.m.

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Sen. David Johnson
Sen. Jonathan Dismang
Sen. Ronald Caldwell
Sen. Jane English
Sen. Bobby J. Pierce
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Rep. Mary P. "Prissy" Hickerson, Alternate
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Rep. David Hillman, Alternate
Rep. Deborah Ferguson, Alternate
Rep. Rebecca Petty, Alternate
Rep. Clarke Tucker, Alternate
Rep. Tim Lemons, Alternate
Rep. Bob Johnson, Alternate
Rep. Dave Wallace, Alternate

A. Call to Order.

B. Report of the Department of Correction on Administrative Directives for the quarter ending June 30, 2016 pursuant to Act 1258 of 2015 (Solomon Graves)

C. Report of the Executive Committee Concerning Emergency Rules.

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

1. <u>DEPARTMENT OF EDUCATION</u> (Lori Freno)

a. <u>SUBJECT</u>: How to Meet the Needs of Children with Dyslexia

<u>DESCRIPTION</u>: The summary follows:

<u>Section</u>

2.00 Removes Act 1294 of 2013 as authority for rules and replaces it with Ark. Code Ann. §§ 6-41-601 through 6-41-610, which incorporate Act 1268 of 2015.

3.00 Adds definition of "dyslexia interventionist," "dyslexia program," and "dyslexia specialist"; revises definitions of "dyslexia therapist" and "dyslexia therapy." All changes made to mirror definitions set forth in Act 1294 of 2013. Also adds definition of "program approved or defined by the Department."

4.00 Changes made to mirror language of Act 1268 of 2015. Allows school districts to use a screener equivalent to DIBELS (Dynamic Indicators of Basic Early Literacy Skills), and adds that if the screener shows a student is at risk, additional screening shall be conducted.

5.00 Paragraph struck after section 5.01 ("NOTE") moved to section 4.00 with minor changes. Note under section 5.03 (now 5.02) struck because term "therapeutic services" no longer used in the law, having been replaced by "intervention" services. Language in 5.04 (now 5.03) added qualification language. The remainder of changes made to mirror language of Act 1268 of 2015.

6.00 Revisions made to mirror language of Act 1268 of 2015. Clarifies that a parent may request an independent, comprehensive dyslexia evaluation at their own cost, and actions a school district must take when presented with a diagnosis of dyslexia. Adds note clarifying that whether an individual is qualified to provide a diagnosis is dependent upon their licensure.

7.00 Minor language changes to mirror Act 1268 of 2015.

9.00 Mirroring language of Act 1268 of 2015, clarifies qualifications for a dyslexia specialist.

10.0 Minor language changes to mirror Act 1268 of 2015 (removed language defining and establishing training for dyslexia interventionist, which under Act 1268 now is defined section 3.00).

11.0 Minor language change to mirror Act 1268 of 2015 and removed dates that already have passed.

12.0 Mirroring language of Act 1268 of 2015, clarifies collaboration between Arkansas Department of Education and Arkansas Department of Higher Education related to teacher education programs.

13.0 Sets forth the membership of the Dyslexia Resource Guide committee, as set forth in Act 1268 of 2015.

Post-Public Comment

The following non-substantive changes were made following public comment:

1.03 Language added to remind readers to refer to the Dyslexia Resource Guide for additional guidance.

2.02 Language added for clarification (e.g., to remind that Ark. Code Ann. § 6-41-601 *et seq.* does not relieve a school district of its obligation to meet the requirements of the IDEA or § 504 of the Rehabilitation Act).

3.08 Removal of language that was intended to clarify but that caused confusion.

4.03 Language added to clarify that DIBELS or an "equivalent screener" might not alone be a sufficient measurement tool.

4.05 Language added to clarify that a student with an existing diagnosis of dyslexia is exempt from dyslexia screening *only if* the school district is providing interventions to that student.

6.03 Language added to ensure that if a school district decides against providing services based upon an independent comprehensive dyslexia evaluation, it must notify the student's parent or guardian of its reasoning. Also, the "NOTE" clarifies that whether an individual may conduct an evaluation (in addition to a diagnosis) is dependent upon his or her licensure.

7.01 Language added to clarify that a school district must provide all services it deems appropriate for the student.

PUBLIC COMMENT: A public hearing was held on February 2, 2016. The public comment period expired February 16, 2016. The agency states that as a result of public comment, only non-substantive changes were made to the rules. These changes included Section 1.03, which was added to the proposed rules in response to various questions asked by certain commenters as outlined below. This particular change sought to clarify that further clarification, guidance, and instruction regarding the applicable law and accompanying rules is provided in the Arkansas Dyslexia Resource Guide, which can be accessed through the Department's website. The following comments were received:

Commenter: Mary Bryant, Ed.S., Nationally Certified School Psychologist, Arkansas Licensed Psychological Examiner, Arkansas School Psychology Specialist (1/19/16)

Comment:

Section 4.01.1: I believe that students should be screened each year in grades kindergarten, one, and two... each year. As skill levels increase and the demands on students grow each year it is essential to assess/screen if students are gaining the necessary basal skills for effective and fluent reading. The skills are very different from kindergarten compared to 2nd grade. Students who may have the skills down in kindergarten may not demonstrate that they understand or grasp the skills by 2nd grade. It is important that they be screened each year in grades K-2 to prevent reading difficulties, which may lead to a retention, identification of a disability, increased dropout rate, etc.

Section 6.01.2.3: In terms of those professionals who are qualified and fully capable of conducting the independent comprehensive evaluation, the following should be added to the list that parents can choose from. With the limited number of LPEs in the state of AR now (license of LPE no longer awarded after October 2013), it would be beneficial to parents to understand all of the professionals they may choose from. The list should include the following: School Psychology Specialist (SPS); Licensed Psychologist (LP); Licensed Psychological Examiner (LPE/LPE-I); Licensed Professional Counselor with Appraisal Specialization (LPC). Additionally, the license of Certified Dyslexia Testing Specialist is not a license recognized at this time in the state of AR. There is no governing body to define a scope of practice for this particular license. Additionally, there is no governing body should a parent or school have an ethics complaint. This license should be stricken from the list until there is a licensing body that awards this credential in AR.

A Dyslexia Therapist should not be allowed to conduct independent "comprehensive" evaluations for dyslexia. The only professionals licensed to practice psychology (including psycho-educational evaluations) are licensed by the ADE, the AR Psychology Board, and the AR Counseling Board. The Dyslexia Therapist license is not awarded by any of the three licensing bodies listed above. They should be stricken from the list of professionals appropriate for selection by parents to conduct an independent comprehensive evaluation.

The connotation that the independent evaluation will be "comprehensive" means that the evaluation includes a full assessment of intellectual abilities/cognition and other processing strengths and weaknesses which is a skill level relegated only to those in the list provided above: LP, LPE, SPS, and LPC with Appraisal. Typically, a full, comprehensive assessment would include individual intelligence (full battery), individual achievement (full battery), screening of communicative abilities, screening of social-emotional/behavioral issues, a thorough record review (education, development, behavior, etc.), summary, recommendations, and a determination of diagnosis. Parents should be aware of the credentials of the person they are choosing to

conduct this evaluation, and a disservice will be done to these children if unqualified and unlicensed individuals are conducting evaluations without extensive training in standardized test administration, interpretation, child development, literacy, and response to intervention.

Multidisciplinary teams depend on reliable and valid data, which are properly interpreted, in order to make determinations regarding educational programming for children. It is the position of the Arkansas School Psychology Association that multidisciplinary teams use only assessment data provided by qualified examiners who are properly trained to both administer and interpret assessment results. This will help ensure that children and their families are provided services by professionals who are fully qualified to perform their assigned roles. This will also provide protection for school districts should an evaluation be challenged or taken to a due process hearing.

Department Response:

Regarding Section 4.01.1, this language closely mirrors Ark. Code Ann. § 6-41-603(a)(1), which provides that students (who do not fall within an exception) must be screened in kindergarten, grade one, and in grade 2. (Emphasis added.)

Regarding Section 6.01.2.3, this language mirrors Ark. Code Ann. § 6-41-604(a)(2)(C)(i)-(v) and includes only the individuals listed in the law. The "NOTE" following 6.03 was revised to read that whether an individual is qualified to "conduct an evaluation" or provide a diagnosis is dependent upon their licensure.

Comments considered. Non-substantive change made.

Commenter: John Hall, Ph.D., Licensed Psychologist (AR), Licensed School Psychology Specialist (AR), Nationally Certified School Psychologist (NCSP) (1/19/16)

Comment:

Recent review of the Arkansas Dyslexia Resource Guide (2015) and Arkansas Department of Education (ADE) Rules Governing How to Meet the Needs of Children with Dyslexia (2014) has raised several serious concerns specific to the evaluation practices for dyslexia. These are addressed below.

First, the sections of these documents that address the independent evaluation for the condition state the evaluation must be conducted by a Licensed Psychological Examiner, School Psychology Specialist, Licensed Speech Language Pathologist, Certified Dyslexia Testing Specialist, or Dyslexia Therapist. It has long been understood that School Psychology Specialists, who are solely licensed by the Arkansas Department of Education (ADE) can only practice/deliver professional services in educational settings (i.e., preK-12 schools) associated with their employment through a school district or educational cooperative within the State of Arkansas. These practitioners are not licensed or eligible to provide any professional services independently including

assessment/testing even though most would agree they are more than competent to conduct these types of evaluations. As noted on the current NASP website, the scope of practice for School Psychology Specialists in Arkansas states these practitioners "are not permitted to practice in any other arena other than the schools." Currently, only a few states in the U.S. allow for school psychologists licensed by a state department of education to engage in non-school practice. For example, in Ohio, school psychologists who hold the SEA credential can provide services in preK-12 schools, but not outside of the schools. However, the Ohio State Board of Psychology offers a School Psychologist License which allows for the practice outside of the schools if the practitioner meets specific conditions (i.e., passing score on the Praxis, oral examination, three reference letters, minimum of a master's degree in school psychology, internship, three years of experience, and supervision by a qualified licensee of the board who verifies and documents the latter activity). Similar restrictions in terms of practice setting also likely hold true for Certified Dyslexia Testing Specialists and Dyslexia Therapists. That is, it would be unlikely for these practitioners to lawfully provide services outside of the schools where they are also employed. Finally, it is unclear whether School Psychology Specialists, Certified Dyslexia Testing Specialists, or Dyslexia Therapists could secure professional liability insurance in Arkansas that would cover their independent practice. One would be ill-advised to practice independently without this type of coverage.

A second concern rests with the possibility of a dual relationship. This could occur if one of the sanctioned practitioners noted above (e.g., an ADE-licensed school psychology specialist) who was employed by a school district also conducted the independent evaluation on a student who was also enrolled within that district. The NASP Principles for Professional Ethics, in Section V. Professional Practice Settings-Independent Practice A.2., states, "School psychologists dually employed in independent practice and in a school district may not accept any form of remuneration for clients who are entitled to the same service provided by the school district employing the school psychologist. This includes children who attend nonpublic schools within the school psychologist's district." Furthermore, Section V.A.3. notes, "School psychologists in independent practice have an obligation to inform parents of any school psychological services available to them at no cost from the public or private schools prior to delivering such services for remuneration."

A third concern is whether a Certified Dyslexia Testing Specialist or a Dyslexia Therapist would by education and training have the necessary knowledge and skills to competently conduct these types of evaluations. The NASP Principles for Professional Ethics, in Section IV. Professional Practices-General Principles C.5., states, "School psychologists do not condone the use of psychological or educational assessment techniques, or the misuse of the information these techniques

provide, by unqualified persons in any way, including teaching, sponsorship or supervision."

A fourth concern pertains to the designated practitioners in Arkansas who may conduct dyslexia evaluations. Licensed Psychological Examiners can provide assessment/testing services independently and also in the schools in accord with the psychology licensing law and their statement of intent. The same holds true for Licensed Psychologists in terms of the psychology licensing law and Licensed Professional Counselors with the Assessment Specialization under the counseling law; however, these qualified and licensed practitioners are for some reason not included in the dyslexia guide, rules, or law. Should they not be included as qualified practitioners to conduct these types of evaluations?

A fifth concern relates to ethical complaints. Both Licensed Psychological Examiners and Licensed Psychologists are licensed through the Arkansas Psychology Board, and Licensed Professional Counselors with the Assessment Specialization are licensed through the Arkansas Counseling Board. They can and do under their respective practice laws and rules and regulations provide professional services to the public both inside and outside of preK-12 school settings. Furthermore, if a consumer (i.e., client, patient, guardian) or another licensed practitioner has a legal or ethical concern with one of these practitioners specific to assessment, they can report the matter to the respective state licensing board for review and possible intervention. Who would the consumer or other practitioner report the concerning issue to if the practitioner is not licensed by one of the above state boards? Would the ADE ethics board now assume the oversight of ADE licensed or certified practitioners engaged in independent dyslexia evaluations? If so, would that be appropriate?

A sixth issue rests with the ADE rules section 9.00. In this section, the term "licensed psychometrist" is listed as someone who the ADE could employ. However, this term is not defined, and it is also not a license that is issued in the State of Arkansas.

In sum, the language in the above documents places some school psychology specialists (and perhaps Certified Dyslexia Testing Specialists and Dyslexia Therapists) at-risk in terms of offering and engaging in independent evaluations outside of their allowed settings. In terms of Certified Dyslexia Testing Specialists and Dyslexia Therapists, they appear to be certified, not licensed. The education, training, knowledge, skills, and competency of these practitioners in conducting these types of evaluations remain unclear. Extensive instruction, which is typically only offered through an advance accredited program of academic study at a university, is a necessary prerequisite for this type of practice. Without this type of professional preparation, the risk of negative side-effects associated with these evaluations for children/students and parents within the state may be high. Constructive changes in the ADE guide and rules are needed to correct the above concerns.

Department Response:

Regarding Section 9.00, the term "psychometrist" already was removed in both the law and the proposed rules.

Regarding licensure comments, please see above the response to the 1/19/16 comment of Mary Bryant.

Comments considered. No changes made.

Commenter: Karleen Sheets, Asst. Superintendent, Jonesboro Public Schools (1/19/16)

Comment:

Section 3.04.1. What "endorsement or certification" is required to be a "dyslexia specialist"? Is this a "qualified instructor"? Is the endorsement or certification from ADE?

Section 3.05. Is a "dyslexia therapist" as defined specifically talking about a Certified Academic Language Therapist (CALT)? Are there other certifications in dyslexia therapy to be a dyslexia therapist?

Section 4.01.1. Is every student in grades K-2 required to be screened annually? If no characteristics of dyslexia are evident in the initial screening, is the student required to be screened in subsequent years?

Sections 4.03, 8.01, and 13.01. Due to the impact of the Dyslexia Resource Guide on the implementation of these rules, will there be an opportunity for public review and comment on the Dyslexia Resource Guide and revisions?

NOTE after Section 6.03. What licensure or credentials qualify an individual to provide a diagnosis of dyslexia? Which agency or organization is approved to provide the licensure or credentials to determine if an individual is qualified to provide a diagnosis of dyslexia?

Sections 7.01 and 7.01.1 are directly from the law; however, 7.01.2, 7.01.3, and 7.01.4 are not specified in the law. How is it determined if an instructional approach is "highly concentrated instruction methods and materials that maximize student engagement"? What is the definition of "meaning-based instruction"? How is it determined if the instructional approach is "directed at purposeful reading and writing"? It would be more clear if 7.01.2, 7.01.3, and 7.01.4 were deleted and replaced with: 7.01.2 The district's dyslexia intervention program as defined in 3.03.

Section 7.02. This should be deleted since it is not in Act 1268. Districts are not providing "dyslexia therapy"; therefore, there is no need for "dyslexia therapists." Act 1268 requires districts to have "dyslexia interventionists" who are trained in the district's dyslexia program. If 7.02 remains in the rules, will districts be required to hire dyslexia therapists? If so, when?

Section 11.01. Are teachers required to receive professional awareness one time? Annually? On the rotation cycle of state PD?

Section 11.02. If the professional awareness is offered by the school district, must this venue have prior approval by ADE?
Department Response:

Regarding Section 4.01.1, please see above the response to the 1/19/16 comment of Mary Bryant.

Regarding Section 6.03, please see above the response to the 1/19/16 comment of Mary Bryant. The "NOTE" after 6.03 is self-explanatory: one must consult his/her individual licensure requirements or consult the appropriate licensure authority to make this determination.

Sections 7.01.2, 7.01.3, and 7.01.4 mirror the law. *See* Ark. Code Ann. § 6-41-605(a)(2)-(4). Likewise, the language in 7.02 mirrors the law. *See* Ark. Code Ann. § 6-41-605(b).

Suggestions for revisions to the Dyslexia Resource Guide may be sent to Vicki King (ADE Dyslexia Specialist) at vicki.king@arkansas.gov, or Mary Bryant (chair of committee that updates the guide) at mbryant@crmail.k12.ar.us.

Comments considered. No changes made.

Commenter: Melinda Harris, Maynard School District (2/2/16)
Comment: I think a rule should be added stating that a Dyslexia Interventionist or Therapist should not be expected to serve more students than is possible to ensure the fidelity of the program being used. I also feel that it should be a rule that the position of Dyslexia Interventionist or Therapist should be a full-time position on its own. Dyslexia Interventionists and Therapists are being "added," but sometimes the job is being tacked onto an already full-time position. For instance, at my school, the 4-6 Reading Teacher, who has full classes for 6 periods out of a 7-period schedule each day, is being expected to also serve identified dyslexics (K-12) with interventions on top of this full-time schedule. This is not fair to either group of students. The 4-6 Reading classes or the students with dyslexia needing the interventions. It is also not fair to ask this of the teacher who isn't receiving any compensation other than her regular salary. There needs to be some way of ensuring that the needs of these students are being met. It should not be at the expense of other groups of students or teachers.
Department Response: ***Comments considered. No changes made.***

Commenter: Joan Simon, Ph.D., Licensed Psychologist, Associate Professor, UCA (1/19/16)
Comment:

1. The following are not clearly defined: a. Level 1 dyslexia screener – seems to refer to the same screening described in 4.02, why do same screening twice? b. Level 2 dyslexia screener

2. Under 3.04.1: "A professional at each education service cooperative or school district who has expertise IN TEACHING READING SKILLS (Simon comment – It seems that there are some key

words missing here & I've filled in an option. We want expertise in teaching reading, right?!) and is working towards an…"

3. Under 3.05: "Dyslexia therapist"… I do not agree that it is sufficient for a dyslexia therapy training program to simply meet an ADE definition. If we are expecting these professionals to work with the children in our schools who most need of quality assistance, we need a better way to ensure that their training programs are of the highest quality.

4. Under 3.04.7: "Response to Intervention (RTI)" is the practice of…. a. 3.047.2 – Replace "appropriate" with "research supported"; b. This is an excellent opportunity to help AR educators better understand the components of a quality school-based RTI system. Therefore, the components of RTI listed here are incomplete as they stand. i. Add: Universal screening and benchmarking numerous times per year; ii. Add: Ongoing professional development for teachers; iii. Add: School-based problem solving teams; iv. Add: Interventions for which the integrity is monitored regularly; v. Add: Parent involvement.

5. Under 4.01.1: "Each student in kindergarten, grade one, and grade two;" This type of screening needs to happen three times per year in order to establish school-based norms and/or benchmarks against which future universal screening data can be compared. Screening should minimally occur once per year with the goal of increasing screening to 3x per year.

6. Under 5.00: Consider replacing "Intervention and Services" with "Dyslexia Program Implementation" because the only intervention is such a program.

7. Under 5.02: Consider replacing "intervention services" with "dyslexia program."

8. Under 6.00: "Independent, comprehensive dyslexia evaluation" – consider replacing with "Screening and Evaluation for Dyslexia."

9. Under 6.01.2.3.2: School Psychology Specialists are not licensed to practice outside of the purview of ADE. Therefore, without another license, they cannot conduct a psycho-educational assessment outside of the school setting. This may be an issue with the way the law is written, but it does currently seem to violate the psychology licensure law, ACT 129 (1955), "AN ACT TO REGULATE THE PRACTICE OF PSYCHOLOGISTS IN ARKANSAS, INCLUDING INSTRUCTIONS THEREIN; TO CREATE A BOARD TO BE KNOWN AS ARKANSAS BOARD OF EXAMINERS IN PSYCHOLOGY; AND TO FIX PENALTIES FOR VIOLATIONS OF ITS PROVISIONS." In Section 2: Definition of Practice of Psychology, it states … A. A person practices as a Psychological Examiner within the meaning of this act when he holds himself out to be a Psychological Examiner, or renders to individuals or to the public for remuneration any service involving the application of recognized principles, methods and procedures of the science and profession of psychology, such as interviewing or administering and interpreting tests of mental abilities, aptitudes, interests and personality

characteristics, for such purposes as psychological evaluation or for educational or vocational selection, guidance or placement. The Psychological Examiner practices the following only under qualified supervision; overall personality appraisal or classification, personality counseling, psychotherapy or personality readjustment techniques.

10. Under 6.01.2.3.4: Certified dyslexia testing specialist is not defined elsewhere, nor am I aware of any state license that would allow for such an evaluation outside of the public school setting.

11. Under 6.01.2.3.5: Dyslexia therapist – not appropriate for this person to evaluate without a license to do so.

12. Under 7.00: Instructional Approaches – why not just say "Dyslexia Program."

13. Under 13.02.7.1: Why is this statement needed when no other professional in the group is defined in such a way? I suggest removing this statement.

Department Response:

The language contained in Sections 3.04.1, 3.05, 5.02, 6.01.2.3.2, 6.01.2.3.4, and 6.01.2.3.5 closely mirrors the law. *See* Ark. Code Ann. §§ 6-41-602(4)(A); 6-41-602(5); 6-41-603(c)(1); and 6-41-604(a)(2)(C)(ii), (iv), (v).

Regarding licensure comments, please see above the response to the 1/19/16 comment of Mary Bryant.

Regarding Section 4.01.1, please see above the response to the 1/19/16 comment of Mary Bryant.

Regarding 13.02.7.1, the 3-year experience requirement mirrors the law. *See* § 6-41-610(b)(2)(A)(vi).

Comments considered. No changes made.

Commenters: Maleah Bufford, SPS, LPE-1., NCSP; Amy Cunningham, SPS, LPE; (2/12/16)

Comment:

Title, 1.01, 1.02, 2.02 Wording. Title, 1.01 "Children with Dyslexia," 1.02 "students with dyslexia," 2.02 "students with dyslexia" and "student with dyslexia." More appropriate wording to be consistent with other areas within this document (with the exception of under 6.00 Independent, Comprehensive Dyslexia Evaluation) would be "characteristics of dyslexia." The current wording implies diagnosis prior to comprehensive evaluation. The implication is that the screenings mentioned below will result in a diagnosis of dyslexia. It is never appropriate to make a diagnosis based on screening information. Not every student who does not perform well on the screenings has dyslexia. *See also* Arkansas Dyslexia Resource Guide (July 10, 2015 page 22) Level II Dyslexia Screening working "…documenting the characteristics of dyslexia." Sections 5.01, 5.02, and 5.03 of this document are worded "characteristics of dyslexia."

3.02.5 Supervision. Are there any stipulations as to how the supervision is to be documented?

3.04.2 Screening Defined. The dyslexia specialist will…provide training in administering screenings, analyzing and interpreting screening data…." Is this referring to initial screening, Level I, and/or Level II? Should the screening they are responsible for training others to use, etc. be clarified in conjunction with 4.03 and 4.04? As noted in the Arkansas Dyslexia Resource Guide (July 10, 2015 Appendix G) Level 2 Dyslexia Screener Test Battery list, it is noted that there are certain tests that require advanced examiner qualifications. Will the dyslexia specialist have the advanced qualifications needed for training others? For example, the Woodcock Johnson IV Tests of Achievement (WJ-IV ACH) manual indicates that "Competent interpretation of the WJ-IV ACH requires a higher degree of knowledge and experience than is required for administering and scoring the tests." "Graduate-level training in educational assessment and a background in diagnostic decision-making are recommended for individuals who interpret the WJ-IV ACH." Graduate level training is further defined as at least "a practicum-type course covering administration and interpretation of standardized tests of academic achievement." (Mather, N. J., & Wendling, B. J. (2014). Examiner's Manual. *Woodcock-Johnson IV Tests of Achievement*. Rolling Meadows, IL: Riverside. Other examples:

WRMT-III

- At least bachelor's level training in measurement and administration and interpretation of tests
- Understanding of testing statistics

CTOPP-2

- "Extensive formal training in assessment"
  (understanding of testing statistics, test administration, content being assessed)

TWS-5

- Formal training in assessment

It is important that those administering, interpreting, and training others be familiar with examiner qualifications and responsibilities set forth by testing companies, assessment manuals, and ethics guidelines.

3.047 and subsections Typo. Should this be 3.07? No line drawn through the 4.

3.047.1 Screening. Is this the screening referred to in 3.04.2?

3.08 Typo. "program approved or defined by the Department" "approved" should be marked through as in 3.05. Does this statement belong here or maybe by 3.05?

4.00 and 4.05 Required Screening and following subsections: How do these screenings apply to students already receiving special education services (which may or may not include those with existing diagnosis of dyslexia but are receiving services for basic reading and/or reading

fluency)? What about severely impaired students for whom formal assessments are not appropriate?

4.03 typo. Wording ands and commas.

4.03 NOTE: screening instruments. Specify which screening: initial. Also references Arkansas Dyslexia Resource Guide for list of screenings; however, Appendix G is for Level II. Maybe wording should say, "Refer to the Arkansas Dyslexia Resource Guide for a list of Initial Screening Instruments." (see page 19 of Guide).

5.02 Consent. Consider putting the information about consent in the guidelines as many of the tests that are listed in the Arkansas Dyslexia Resource Guide are considered "diagnostic." Maybe specify which "screenings" require parental consent.

6.00 Independent, Comprehensive Dyslexia Evaluation; 6.01.1 Notified of the results of the dyslexia evaluation. Seems out of order here if it is referring to the results of the evaluation. Maybe more appropriately placed at end of this section.

6.01.2.3 Psychologist is omitted (as is in the law). Psychologists are qualified to evaluate for dyslexia as defined in the DSM-V.

6.01.2.3.2 School psychology specialist. When referred for an Independent, Comprehensive Dyslexia Evaluation, refer to AR Code 17-97-307 (2012), which specifies that SPSs are "restricted in their practice to employment within those settings under the purview of the State Board of Education."

6.01.2.3.4 & 6.01.2.3.5 others who can provide an independent, comprehensive dyslexia evaluation. All of the professionals listed above have graduate level degrees with practicum and internship experiences and are governed by a licensing board designed to protect the student, as well as a Professional Association with the exception of certified dyslexia testing specialist. How does that compare to the level of training and experience that will be required from a Certified dyslexia testing specialist (which is not defined in this document) or from a Dyslexia therapist? It is likely that these two fields do not have the necessary qualifications to even purchase many of the tests listed under the Level II Dyslexia Screening list in the Guide (Appendix G). Additionally, *see comment section in 3.04.2*. Please refer to the Arkansas School Psychology Position Statement regarding Qualifications to Conduct Psycho-educational/Psychological Evaluations in Arkansas Schools.

According to Parenting Children with Dyslexia website www.Netplaces.com/parenting-kids-with-dyslexia, "dyslexia is diagnosed by a specialist trained in the assessment of learning disabilities. The purpose of the testing is not only to determine whether a child has dyslexia but is to rule out other problems." The people conducting these evaluations must be adequately trained to rule out other disorders as well as evaluating the impact of other issues that can impact learning (ADHD, intellectual or developmental disabilities, etc.). Although a formal measure of intelligence is not always thought of (by some) as an integral

part of a comprehensive evaluation for dyslexia, dyslexia is considered a learning disability, and included in the definition of learning disability is that there are deficits in one or more areas of cognitive processing. Most intelligence measures include areas of basic cognitive processing, which are linked to various academic areas (including basic reading and reading fluency [dyslexia]). Specialized graduate level training and licenses are required for this type of assessment. Additionally in the definition used by the International Dyslexia Association, "…difficulties typically result from a deficit in the phonological component of language that is often unexpected in relation to other cognitive abilities…." How do we know that unless we assess those areas? Assessment of these processes must be completed by those with appropriate training and licensure.

6.03 NOTE: Where does this belong? Move to 6.01?

9.00 Dyslexia Specialist. Needs clarification to distinguish this position from that in 3.04.

9.01.1.2 Screening. Which screening: initial, Level I, Level II?

10.0 Typo. Should be 10.00.

13.00 Dyslexia Resource Guide. How do these people get on the committee?

Question: How are parental consents being handled throughout this process? (Keep in mind that many of the tests listed in the Level II Dyslexia screening are considered "diagnostic" in nature even though they are listed under "screening" in the guide.)

03-06-2016 – Additional note: We attended ARMEA this past week. In one session, during a Q & A, the presenter, who is a well-known attorney in special education and 504 law, suggested that the move to a Level 2 Dyslexia Screening should be considered a 504 referral and the Level 2 Dyslexia Screening would be the resulting evaluation for consideration of 504 services, which would be the subsequent dyslexia therapy, if eligible.

[Note by ADE: Commenters also attached the Arkansas School Psychology Association's position statement regarding Qualifications to Conduct Psycho-educational/Psychological Evaluations in Arkansas Schools and Ark. Code Ann. § 17-19-307 entitled "Professional Titles" (regarding "psychological," "psychologist," and "psychology," etc.)]

Department Response:

Regarding Section 3.08, that language has been removed as it causes confusion (as opposed to clarity). The language in Section 3.05 mirrors the law. *See* Ark. Code Ann. § 6-41-602(5).

The ordering of the language in Section 6.00 mirrors the law. *See* Ark. Code Ann. § 6-41-604(a).

Commenters correctly recognize that Psychologists are not included under the law. Consequently, they are not included under Section 6.01.2.3, which mirrors the law. *See* Ark. Code Ann. § 6-41-604(a)(2)(C)(i)-(iv).

Regarding licensure comments, please see above the response to the 1/19/16 comment of Mary Bryant.

Comments considered. Non-substantive changes made.

Commenter: Tom Gattis, Superintendent, County Line School District (2/9/16)
Comment: I do believe the Dyslexia programs that were implemented in public schools last year are going to be beneficial for student success; however, it is costing districts several thousands of dollars each year to implement these programs, and we received only a modest increase in funding.
Department Response: ***Comment considered. No changes made.***

Commenter: Jennifer Dedman, Arkansas Public School Resource Center (2/16/16)
Comment:

3.03.6: This section may be improved by adding clarity that this reading instruction is a supplemental service/intervention in addition to the regular classroom reading instruction.

4.02: Consider adding the ability to "Understand the Text" (Reading Comprehension).

5.00: This section is missing recommendations of intervention for students identified with Level 1.

9.01 and 10.01: It is unclear whether each of these positions are required to be one Full Time Equivalent (FTE) or partial Full Time Equivalent positions. If they refer to full FTE, this appears to be an additional cost to the district of two employees with no supporting funding source.

13.02: Charter schools are not specifically represented on the committee. Consider adding an organization to represent this group of schools.

Department Response: ***Comments considered. No changes made.***

Commenter: Diane Zook, Arkansas State Board of Education (2/16/16)
Comment:

Section 3.047.1. EACH or ALL should not be taken out of the rules. If all (each and every) students aren't screened, the school has to get individual parental permission.

Section 4.03. NOTE: (the second sentence should read) DIBELS alone IS insufficient to determine…….

Sections 5.00 and 6.00. The deletion of steps needed/required under these sections make much of it misleading and stands the risk of violating the parents' rights under IDEA and 504. I believe this will be easily misunderstood by those in the schools.

Department Response:

Removing "all" from Section 3.07.1 provides consistency with other sections of the law and proposed rules, which do not require that all students be screened. For example, Section 4.00 requires with exceptions screening of K-2 students, as well as those in grades 3 and higher when a difficulty is noted.

Non-substantive change made to the "NOTE" following Section 4.03 to clarify that additional screening assessments will need be administered to measure components that are not measured by DIBELS or the equivalent screener.

Comments considered. Non-substantive changes made.

COMMENTS FROM THE PUBLIC COMMENT HEARING (2/2/2016)

Commenter: Amber Jones
Comment: Concerned about words "specialist" and "therapist" in rules, and these people not being trained in Orton-Gillingham Program. Concerned that K-2 students are not being screened in a specific time frame; rules read sometime during year, and it needs to be done prior to end of year, as there are students who have not yet been screened. Overall lack of knowledge by school staff about dyslexia even though purportedly had training. Overall lack of fidelity in OG programs implemented by school staff. Would like teachers to be board certified in the science of reading. Overall lack of enforcement by schools and ADE. Children are suffering needlessly because of this "watered-down" law.
Department Response: The law does not vest the Arkansas Department of Education with enforcement authority.

Comments considered. No changes made.

Commenter: Scott Gann, Arkansas Dyslexia Support Group
Comment: Has dyslexic child who he needed to be pulled out of public school to get the proper services. This law is pretty good, but it is not being enforced. ADE tells parents it is not an enforcement agency, and he does not understand when they enforce every other rule he seems to read about in the newspaper. Also concerned about Section 7.01 where fidelity was removed and uses words like "may include." These kids need help; not "may" need help.
Department Response:

Section 7.01 (which includes "may" and in which "fidelity" was removed) mirrors the law. *See* Ark. Code Ann. § 6-41-605(a).

Regarding enforcement authority, please see above response to the 2/2/16 comment of Amber Jones.

Comments considered. No changes made.

Commenter: Dallas Green, Arkansas Dyslexia Support Group

Comment: Has nineteen-year-old son who has dyslexia. Since first grade, one of largest schools in state told her they knew nothing about dyslexia. Law passed in 2013; too late for her son. College he attended that had dyslexia program did not work out; now he works two jobs. Discussed her interaction with school/teachers during her son's career. Graduated with a 2.8 GPA, but reads on a 3rd grade level. Now in 2014, daughter, who is four, is in pre-K and something is "not right" with her. Mother asked pre-K teacher whether she thought her daughter was dyslexic; teacher said she doesn't know anything about dyslexia (although law has been passed). There is so much science out there on the issue. Said her group (Arkansas Dyslexia Support Group) travels to schools in Arkansas, and they don't know when they'll do screen or what screen to use. Unorganized. Schools don't know what to do with students with dyslexia: no information going out; no training. Said a superintendent said can't diagnose dyslexia until there's an autopsy. We are 49th in the country. Teachers have told her that it's her fault her kid can't read, but 70% overall can't read on grade level. Excited about law but who is going to enforce it. Told the school is going to enforce it; do you think the schools are going to "kill" themselves? Many gaps: the school may or may not use fidelity. Who is going to enforce? Someone needs to tell psych examiners to quit telling kids they are "retarded." That's what psych examiners all around the State are telling kids.
Department Response: Regarding enforcement authority, please see above response to 2/2/16 comment of Amber Jones.

Comments considered. No changes made.

Commenter: Sarah Jane Luckey, Retired Arkansas Teacher
Comment: Still teaches children with dyslexia to read. Has worked with kids who need to test in small settings; tested same kids year after year, and wondered why the [special education] students never were able to read the test. Dyslexia is "elephant in the room." Must teach students in a way they can learn. Until colleges start to teach teachers how to teach students with dyslexia to read, we're still going to be 68% below grade level. ADE gives "lip service." Need to do whatever it takes to teach our students with dyslexia to read. Visited one school where staff member said screened students and turned in results but hadn't heard a word. Another just finished a reading specialist degree, but barely had word mentioned of dyslexia in her training. Thirty-five dyslexia research centers associated with universities that use our tax dollars; they know what to do and "we" know what to do. We are not going to get there by watering dyslexia law down; it must be beefed up. Leaving to go to school that is dragging its feet by following the IDEA and providing student with FAPE; our one in five students with dyslexia are not getting FAPE.
Department Response: ***Comments considered. No changes made.***

Commenter: Mary Beth, Teacher in 2nd Largest School District in Arkansas
Comment: Forced to become a teacher because her child was denied FAPE in public school. Teachers tried and cared, tutored him into having an anxiety attack, but not trained in dyslexia. ADE should get teachers all of the professional development it can on Orton-Gillingham research based, scientifically proven reading methods. Don't leave it up to an educational co-op; don't make it a choice but a requirement. ADE issues report cards; tells parents to see if schools are doing their jobs. No one is holding schools accountable. 68% of students are reading below proficient. 20% of those students are dyslexic. 80% of students in special education can get out of SPED if teachers are trained in Orton-Gillingham Method. Method school chooses must be done with fidelity and have fidelity parameters. ADE needs to make rules a lot stronger. Pulled her child out of school (2nd grader) because concerned about possible suicide in the future due to anxiety (after reading a statistic on suicide). Pulled him out and is teaching him herself. Thank goodness for Susan Barton. There are budget surpluses and NSL funds that need to be used because the money is there. Have to hold superintendents accountable; teacher bonuses come out of same fund, so that is a conflict of interest. Appeal to ADE and ask them to beef up the rule. Need to take out words like "may" in Section 7. It's a slap in the face not to follow the law. There must be an enforcement tool; when schools don't report accurate numbers to ADE, there has to be follow up. Not enough just to report. When ADE sees low numbers they know school districts are not screening. Appeal to ADE to follow its own rules and enforce them the best they can.
Department Response:

Section 7.01 (which includes "may") mirrors the law. *See* Ark. Code Ann. § 6-41-605(a).

Regarding enforcement authority, please see above response to 2/2/16 comment of Amber Jones.

Comments considered. No changes made.

Commenter: Mary Beth Wallace, Harrisburg School District, Speech-Language Pathologist and Board Certified Teacher
Comment: Been on forefront in her district; wants to put forth the success of this law if done with fidelity. Son 7-8; good at math (95th percentile), but in 35th percentile in reading. Paid for son to have tutoring he needed; son made 3 years' growth in 6 months with the appropriate intervention. Has a good teacher, but she did not embrace multi-sensory education. Worked with 16-year-old in a juvenile detention center reading at a pre-primer level. Connections is better for younger kids, but recommended Barton for him (due to his age). It is not expensive; no excuse for "may be" multi-sensory. Do something (some program) with fidelity and integrity. The 16-year-old is now reading. Her son now reads with fluency after one year of intervention. Reaches out to ADE to put some

structures in place because "they [school districts/teachers] are starting from scratch and building nowhere" and an accountability piece is falling through. Too much work for the one person doing it at her district. Her school is doing it with fidelity and committed to it. Not enough "feet on the ground"; not enough trained interventionists. "May" and "possibly" in Section 7 needs to be beefed up; needs to be no wiggle room.
Department Response: Regarding use of "may" in Section 7, please see above response to 2/2/16 comment of Mary Beth, Teacher in 2nd Largest School District in Arkansas.

Comments considered. No changes made.

Commenter: Joyce Elliott, Arkansas Senate
Comment:

Every time something is stricken and replaced with other words, wants to make sure she understands why. Page 3, at top where talk about delivered with fidelity, that is reference to everything we do. Started working on this issue in 2010, law in 2011 not successful because fiscal impact showed between $4 and $11 million dollars; but it wouldn't be that much but for a huge lack of understanding. In drafting the current law, got everyone in room to figure out how can we do this and make sure kids learn to read within the confines of what we have now and not make excuses about we don't have the time or the resources. Everyone who is fighting the law now was in the room and was agreeing to what was put on paper, but now there is an enforcement problem of people not doing what they are supposed to do. But main thing, whatever we agreed to do would be done with fidelity; that's why it appears so much throughout the law. In one place "fidelity" is stricken, and in others it is not. Commenter is assuming that's because overall fidelity is intended. Would like clarification. *See* 3.03.4.

Section 3.04.1, regarding person reading "a professional at each educational service coop or school district who has expertise and is working toward an endorsement or certification." Understands that's like what we do for provisional teachers or people working toward certification. Understand we don't have work force right now, but this is something we need to do with fidelity, which is make sure individuals are working toward getting the expertise, and it's not just words on paper. If we don't do this with fidelity, we won't have people in four years. Parents are reporting nothing is happening, but other schools are going right ahead and doing it. Doesn't understand the disconnect between some schools saying they don't know how to follow the rules while others are getting it done. Many of the schools that are getting it done are often the smaller, more challenged schools. Have heard horrific stories from the larger schools that are not getting it done, and fidelity is a word they've never heard of.

Section 3.08: Ongoing problem. Definition of "programs approved or defined by the Department" means one determined by school

district to meet all required components. Lovely idea, but something needs to be in rules giving someone the final say. Would hope every school district would do this but there is ample evidence that it won't. ADE needs to provide direction: does it need legislation to be an enforcer? Some school districts do only what they have to do; it is a significant problem. Wants ADE guidance; does there need to be another law?

Page 5: 4.02 Notes has not marked out "fidelity," just noting that it is there.

DIBELS: Some districts where superintendents and supervisors still telling folks they have to screen every child every year for dyslexia. Don't know how to make this any clearer. They are screening using DIBELS or some equivalent that is required by this law and is brand new. Adds to confusion: nothing new about it; it was already there. DIBELS screening is a starting place in helping kids with dyslexia or markers of any reading issue.

Page 6, 4.045, reading that students with existing diagnosis of dyslexia are exempt from screening. If student has a diagnosis, it's going to have to be accepted by the school; maybe that needs to be clarified at this point in the rules.

Section 6.02, a school district "shall consider" the diagnoses. Reads shall consider recognizing that a diagnosis might not be acceptable in a valid way. This was a compromise. This section needs to be beefed up, because school district could say it has considered the diagnoses and "bye." Can't be this lackadaisical. Suggests language: if district considers a diagnosis and decides not to accept it, then (1) need to make sure they explain to parent why that diagnosis or evaluation was not accepted; and (2) needs to be some way for parents to have some appeal, at least to the school board.

Section 7.01. Use of "may." The "may" came about because of a question: if a student is dyslexic, does s/he need all of the listed interventions, or just some? May have to follow up, as answer is crucial to "may." If "may" remains, add "but shall include all appropriate interventions" after "may include the following instructional approaches." Need to be assured that people cannot argue that "may" means they don't have to do it.

Page 9, top of page "receive training and certification from program approved by the department," raised question in her mind, if ADE can approve which programs are okay, why cannot we enforce whether a school district is using a program that is appropriate and meeting kids' needs. If it is about legislation, tell us that.

Section 8.01 school districts "shall annually report," need definition for school district as to what they are going to report and what it will look like. Needs to be how many were in school district, how many were screened, how many got intervention; otherwise no point of reference to know what report could mean.

Last page, 11.01.2 "the science behind teaching a student who is dyslexic" [which is struck through], commenter recalls that evidence-based interventions are going to include that. Commenter wants ADE to think about whether this is correct.

Section 12.0, struck "students at risk for dyslexia and related disorders," don't remember if there is a definition for "related disorders"; know supposed to be thinking about kids with dysgraphia and dyscalculia. Want to follow up with ADE about this.

Department Response:

The term "fidelity" was stricken from the proposed rules only in those instances where it was removed from the law. *See* Section 7.01 ("fidelity" removed in Act 1268 of 2015, codified as Ark. Code Ann. § 6-41-605). The same is true with the term "may" in Section 7.01.

Regarding frequency of screening, please see above the response to the 1/19/16 comment of Mary Bryant (each student, who does not fall into an exception, must be screened in kindergarten, in the first grade, and in the second grade; beyond as well when a difficulty is noted).

Non-substantive change made to Section 4.05 to clarify that a student with an existing diagnosis of dyslexia is exempt only if the school district is providing interventions to the student.

Non-substantive change made to Section 6.03 to clarify that if a school district does not provide intervention based upon the diagnosis, it must notify the student's parent or guardian of its reasoning. Also, non-substantive change made to "NOTE" in Section 2.02 to clarify that in addition to a school district's continuing obligations under the IDEA, it also must continue to meet its obligations under § 504 of the Rehabilitation Act, as amended. Both the IDEA and § 504 provide due process when parents/guardians disagree with a school district decision regarding the provision of services required under those laws.

Non-substantive change to Section 7.01 to clarify that although all interventions listed in Sections 7.01.1 through 7.01.4 need not be provided, services provided must include those the school district deems appropriate.

Regarding enforcement authority, please see above response to 2/2/16 comment of Amber Jones.

Section 8.01 refers readers to the Dyslexia Resource Guide, which instructs how to report through APSCN and what information must be entered.

Section 12.00 mirrors the law (*see* Ark. Code Ann. § 6-41-609).

Comments considered. Non-substantive changes made.

Commenter: Karen Marriott, Parent

Comment: Discussed her "story and struggles." Has a wonderful daughter who is 8, as well as an adopted son. Also has been a foster parent. Starting in 2012, daughter started kindergarten. Doing great. Spring she was excelling and bright, but she was struggling. Started sight

words and spelling words, and mother told teacher something not right; she was struggling. Asked teacher if she was dyslexic; teacher said no, she'll grow out of it. Same story in first grade. Second grade, doing DIBELS, did tutoring other children at school, tutors her own at home. Mother told teacher she saw a disconnect; teacher said intervention specialist would watch her and continue to test her. Child had problems with classes and homework, lack of focus, frustrated, caused "breakdowns." Mother paid to have daughter tested; found OTVs, sensory deficits, working memory problems, ADHD, dysgraphia, dyslexic tendencies; disconnect between oral and written skills. Met with school, they told mother they could not give child accommodations because she was too smart and would be an unfair advantage, even though she has a neurological disorder. Daughter is A-B student because of mother's tutoring. School put her into dyslexia intervention program where she is receiving Orton-Gillingham, and she is making progress. Interventionist tutors commenter so commenter (mom) can continue working with her daughter at home. Writing skills below average. Paid personally for various therapies. Rule is "skinny, itty bitty"; so much needs to be fleshed out and filled in. Accountability, fidelity, integrity. Needs to be enforced.
Department Response: Comments considered. Although commenter considers proposed rules "skinny, itty bitty," further clarification, guidance, and instruction is provided in the Arkansas Dyslexia Resource Guide, which can be accessed through the ADE's website. For clarity, Section 1.03 added to rules to ensure that readers are on notice of the Dyslexia Resource Guide and where it can be found.

Comments considered. Non-substantive change made.

Commenter: Melissa Hannah, Speech-Language Pathologist and Certified Academic Language Therapist
Comment: Visited with school (third time) where a child is receiving dyslexia services. Thought meeting went well, but dyslexia interventionist decided student did not need Tier III intervention. Teacher doing everything she can, but feeling like a failure. Had unproductive meetings regarding child. Child had two comprehensive evaluations from two unrelated agencies confirming child had dyslexia, but school district required more testing. Today in third meeting, psychological examiner who attended third meeting thought child was receiving services recommended in the first meeting [move to Tier III], but child was not. Then notified student was receiving the right intervention, but why then were they meeting and another test being required? Not a quick fix, but have to recognize that what we're doing now is not right. Our programs—dyslexic and otherwise—are not supported with scientific data, but beliefs and opinions. Reading is not a natural process. Alphabetic writing system is not learned simply from exposure to print. Spoken and written language are different. Most important skill in early reading is the ability to read single words completely, accurately, and fluently. Context is not the

primary factor in word recognition, only effective 10% of the time, yet it is the first strategy we teach. Interventions are very systematic, can't just "sprinkle in" some multi-sensory stuff. Teachers may attend an Orton-Gillingham training and "check, we meet the law." But then they aren't doing it with fidelity. Science of reading has proven three areas of brain must work together for a child to learn to read. Two of those areas do not activate or underactivate for children with dyslexia, and unless they have the right multi-sensory intervention, they will not activate. The interventions we do now with RTI are a "little band-aid." When kids reach middle school, they fall all to pieces because they can't read textbooks. Such a gap in the amount of information teachers need; they do not know. Not teachers' fault, "we" failed the teacher because she doesn't have the knowledge or training she needs. Districts will only train teachers when "we" come and force the issue. Twenty percent of children are dyslexic, but we are failing 68% of students. If we would just provide the right kind of instruction, only the dyslexic kids would need intervention. When kids cannot read, their futures are limited.
Department Response: ***Comments considered. No changes made.***

Commenter: DeeDee Cain, Arkansas Dyslexia Support Group, UCA
Comment: Commenter is dyslexic, as are her mother, sister, and three-year-old child. We will not back down. This law will be enforced. "We" roll up into schools constantly, which schools tell parents to read to their kids. Public education system failed her daughter miserably. Her teachers were fantastic, because commenter hand-picked them all until she was in 4th grade. Not diagnosed with dyslexia until 11th grade. We have this law because special education was not doing what it was supposed to do. Commenter is special education teacher. Systemic problem (across U.S.) is that it is a "wait to fill" program; you can never get out of a "wait to fill." Commenter never dismissed a child from SPED. Was never trained to teach these kids. Only way this will stop is at the university level. At UCA, students cannot graduate without learning the science of reading. Most other states require this. We got a "big fat zero" on the NAEP for not having a test for the science of reading. If you pay enough money and go to enough school, you can call yourself anything. But if you don't know the science of reading, you cannot teach children to read. Reading recovery is not going to teach children to read. Have to know the science behind reading to teach all students, not only those with dyslexia. We are failing children. People can get a dyslexia endorsement in our universities without ever learning the science of reading. We need to quit blaming parents. We need to jump in and fix the problem. If you had cancer, would find a good doctor; you wouldn't have a janitor perform a mastectomy on you. No matter who you are or how many degrees you have, if you don't know the science of reading, don't talk to me about teaching reading. Cuba's literacy rate is 97%, so don't talk about the "poverty brain." The "poverty brain," like the "dyslexia brain," responds

to intervention. We have to help the teachers whose hands are tied at their schools. It is so sad what has happened; we have to do better by our kids. It is embarrassing. There's a way to fix this, and we all have to be willing to admit that what we do is not right.
Department Response: ***Comments considered. No changes made.***

Commenter: Debbie Miller, Conway School District, Director of Instructional Services
Comment: Her school district has worked so hard over past years regarding dyslexia. We *are* working together. Needs teachers to have a master's degree in reading. At Rotary, a man (15 years ago) was upset because students don't write well in the cursive, and that teaching reading is not "rocket science." She disagreed and said that it IS rocket science. We have children falling through the cracks, but her school district is working diligently. There are a lot of districts doing tremendous things. There is a gap in learning by teachers, administrators, speech pathologists, but they need time. Teachers have to be taught in the universities, such as foundational pieces of reading. This doesn't happen overnight. Let's work together.
Department Response: ***Comments considered. No changes made.***

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

In Rule 3.08, defining "Program approved or defined by the Department," did the Department intend to allow a "school district" to determine whether a program meets all required components? Or was it for the Department to determine, as the term itself suggests? **RESPONSE:** The statute clearly identifies the components that must be included in a Dyslexia program. ADE does not identify specific approved programs, but defines approved programs as those programs the district has determined meets the requirements of the statute. The district must ensure the interventionists are trained and practice the program with fidelity. **FOLLOW-UP NOTE:** Section 3.08 was stricken by the Department post-comment, as explained in its response to another commenter above.

Section 6.03 appears to mirror Ark. Code Ann. § 6-41-604(b)(2) in requiring that a school district *shall* consider the diagnosis and provide district-deemed-appropriate interventions. The post-comment revision, however, seems to suggest that a district may simply choose or opt not to provide intervention. Under what circumstances might a district choose or opt not to provide intervention, or even be allowed to do so, where it appears that the statute requires it to provide those services it deems appropriate? Does the revision contemplate that the district is not providing intervention services because it did not deem them appropriate? **RESPONSE:** We added the language in yellow ("If the school district

does not provide intervention . . .") as the result of a comment made by Senator Elliott, who was the law's sponsor. In her comment, Senator Elliott expressed concern that although the statutory language required a school district to "consider" the diagnosis, it did not require the school district to provide interventions if the school district didn't feel any interventions were appropriate. ("A school district shall consider the diagnosis and provide the students with interventions *determined to be appropriate by the school district* . . ." [emphasis added]). Senator Elliott thus recommended: (1) if no interventions are provided, the school district needed to explain to parent/guardian why the diagnosis or evaluation was not accepted; and (2) that there needed to be some way for parents to have some appeal, at least to the school board.

The language in yellow was added to Section 6.03 of the Rules to address this concern. First, language was added to clarify that if the school district did not provide intervention based on the diagnosis, it must notify the student's parent or guardian of its reasoning. Second, we revised the "NOTE" in Section 2.02 to remind school districts that it had an obligation to follow (in addition to the IDEA, which provides all kinds of due process) Section 504 of the Rehab Act, which provides due process when a parent/guardian disagrees with a school district decision regarding the provision of services required under Section 504.

So to directly address your questions, the concern was that considering the way the law was written, a school district could "consider" the diagnosis but conclude that no interventions were appropriate, and thus not provide any. And that would be the end of the story. The language was added to make sure that such action would not be the end of the story.

The proposed effective date is pending legislative review and approval.

CONTROVERSY: When first issued in 2014, there was a lot of public comment, some of which was negative. But with changes in the law and the fact that these proposed rules mirror the law so closely, there may be less opposition.

FINANCIAL IMPACT: The minimum cost of the mandated dyslexia specialist to be employed at the Department of Education is approximately $60,000 for the current fiscal year and approximately $60,000 for the next fiscal year from general revenue.

LEGAL AUTHORIZATION: These rules implement Act 1268 of 2015, which modified and clarified the requirements relating to screening students for dyslexia by school districts. Pursuant to Ark. Code Ann. § 6-41-610(a), the Department of Education shall adopt rules to implement

Title 6, Chapter 41, Subchapter 6, Dyslexia and Related Disorders, of the Arkansas Code.

2. DEPARTMENT OF FINANCE AND ADMINISTRATION, OFFICE OF DRIVER SERVICES (Walter Anger and Paul Gehring)

a. SUBJECT: Implementation Date of the Arkansas Voluntary Enhanced Security Driver's License and Identification Card Act

DESCRIPTION: The Arkansas Voluntary Enhanced Security Driver's License and Identification Card Act was enacted in 2009 to bring Arkansas into compliance with the Federal REAL ID Act of 2005, which established minimum security standards for state-issued driver's licenses and identification cards and prohibits federal agencies from accepting for official purposes licenses and identification cards from states that do not meet these standards.

The rule states:

"The Director of the Arkansas Department of Finance and Administration ("Director"), pursuant to his authority under Ark. Code Ann. § 27-16-1212 does hereby issue the following rule:

The Director has determined that the voluntary enhanced identification and security features under Ark. Code Ann. § 27-16-1201 et seq. are necessary to ensure secure commerce and travel by Arkansas citizens within and throughout the State of Arkansas, the United States, and abroad;

The Director has determined that Congress has not repealed the REAL ID Act of 2005, Pub. L. No. 109-13; and

The date of implementation of the Arkansas Voluntary Enhanced Security Driver's License and Identification Card Act shall be October 1, 2016."

PUBLIC COMMENT: No public hearing was held. The public comment period expired on July 20, 2016. The Department received no comments.

The proposed effective date is October 1, 2016.

CONTROVERSY: This is not expected to be controversial.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: Arkansas Code Annotated § 27-16-1212 (3) specifically authorizes the Department of Finance and Administration to promulgate "a rule specifying the date of implementation of this subchapter [Voluntary Enhanced Security Driver's License and Identification Card]."

3. DEPARTMENT OF HEALTH, EMERGENCY HEALTH SERVICES (Robert Brech)

a. SUBJECT: Emergency Medical Services

DESCRIPTION: These rules add the Community Paramedic as a healthcare provider in the State of Arkansas. The proposed revisions to the Emergency Medical Services Rules and Regulations are as follows:

- Definitions.

- (Page 5, P. Community Paramedic): In this section we added the definition for Community Paramedic;
- (Page 5, P. Emergency Medical Service): In this section we updated the Emergency Medical Service to reflect urgent and non-urgent settings;
- (Page 6, P. Emergency Medical Services Personnel (EMSP): In this section we updated the Emergency Medical Service to reflect EMS Instructor Trainers;
- (Page 7, added Definition for Licensure):
- (Page 8, Medical Director (Community Paramedic Service): Added definition for Medical Director or the Community Paramedic Service;

- SECTION IV. GROUND AMBULANCE SERVICE LICENSURE CLASSIFICATION STANDARDS. Page 15-16
- In this section we added Licensed Community Paramedic Services shall have vehicles permitted at the Community Paramedic level. Only licensed Paramedic Services may operate a Community Paramedic Program or vehicles

- SECTION IV. GROUND AMBULANCE SERVICE LICENSURE CLASSIFICATION STANDARDS. Section B. Page 17 - 19
- Added General Standards for Community Paramedic Services

- SECTION IV. GROUND AMBULANCE SERVICE LICENSURE CLASSIFICATION STANDARDS. Section D. Page 19-20 Specific Standards
- Added Licensed Community Paramedic Services:

- SECTION IX. EDUCATION, TESTING AND LICENSURE OF PERSONNEL Page 43;
- Added Community Paramedic Service License

- SECTION IX. EDUCATION, TESTING AND LICENSURE OF PERSONNEL Page 44; Initial Licensure Requirements
- Community Paramedic

- SECTION IX. EDUCATION, TESTING AND LICENSURE OF PERSONNEL Page 52; Renewal Licensure Requirements
- Community Paramedic

- SECTION IX. EDUCATION, TESTING AND LICENSURE OF PERSONNEL Page 55 Lapsed Licensure Requirements
- Added lapsed license process for Community Paramedic

- SECTION IX. EDUCATION, TESTING AND LICENSURE OF PERSONNEL Page 57-8 Reciprocity Licensure Requirements
- Added reciprocity process for Community Paramedic

- SECTION XII. EMS EDUCATION PROGRAM REQUIREMENTS Page 61 Paramedic EMS Education Programs
- Added Community Paramedic

- SECTION XII. EMS EDUCATION PROGRAM REQUIREMENTS Page 63 Paramedic EMS Education Programs
- Added Community Paramedic

- SECTION XIII. EMSP EDUCATION STANDARDS AND LICENSURE REQUIREMENTS Page 67-68
- Added Community Paramedic Licensure Requirements

- Addendum 3 Detailed Experience (Added the Clinical phases of the Community Paramedic program shall consist of a minimum of 210 hours to include the following minimum patient contacts listed below)

PUBLIC COMMENT: A public hearing was held on August 1, 2016. The public comment period expired on August 1, 2016. The Department received the following comments:

COMMENTS:
Allan Usrey, Southern Paramedic:

The requirement of having to be a Nationally Registered Paramedic limits experienced Arkansas State registered Paramedics, to whom in the past were told they only needed to keep the National Certification if they were leaving the State, from being able to become Community Paramedics.

A requirement for becoming a Community Paramedic is to be PHTLS or ITLS certified but now with ATERF gone there is no funding for these certifications.

The 1 year time frame to become a Nationally Registered Paramedic is too short, and he would like to see it moved to 5 years to give the State of Arkansas time to possibly initiate the Mark King Initiative.

Will a State Paramedic be required to have 3 licenses to be able to practice as a Community Paramedic in the state?

RESPONSE:

The Community Paramedic License is strictly voluntary. Providers that want to become Community Paramedics must meet the requirements, curriculum and training set forth by the rules and regulations that were agreed upon by the Community Paramedic advisory committee.

The AEMTA and The ArAA have agreed to continue to fund these courses for the providers in the state.

Again, the Community Paramedic licensure is voluntary; no one has to become a community paramedic. Those who wish to must meet the requirements. The 1 year time frame was agreed upon by the Community Paramedic advisory committee, as ample time to achieve this requirement. Also, the Governor's Advisory Council agreed in its last meeting to take up the charge to approve the adoption of the Mark King Initiative.

Yes, Community Paramedics will be required to maintain an Arkansas Paramedics License, the National Registry License and the Arkansas Community Paramedic License.

The proposed effective date is February 15, 2017.

CONTROVERSY: This is not expected to be controversial.

FINANCIAL IMPACT: There will be a cost, but only to the individuals and services that want to participate in the Community Paramedic Program. There is no additional cost to the state.

LEGAL AUTHORIZATION: The purpose of this rule is to implement Act 685 of 2015. Act 685 establishes the licensure and definition of Community Paramedics in Arkansas. The Act also creates Arkansas Code Annotated § 20-13-1603 that gives the Emergency Medical Services Advisory Council the authority to adopt rules to implement the subchapter.

4. DEPARTMENT OF HEALTH, OFFICE OF ADMINISTRATION (Robert Brech)

a. SUBJECT: Advisory Board for Interpreters Between Hearing Individuals and Individuals who are Deaf, Deaf/Blind, Hard of Hearing and Oral Deaf

DESCRIPTION: The following revisions are proposed:

1. Clarify that for renewal, a signed renewal request, not a full application is needed. To carry out this rule change, a renewal request will be sent out with renewal notices each year.

2. Clarify what documentation must be submitted with the renewal request.

3. Create an "inactive status" for licensure, to prevent individuals who do not meet the continuing education requirements from reapplying for a new license. This would allow them to go on "inactive status," and to resume licensure, they will have to provide appropriate documentation of continuing education or continued credentialing.

4. The above changes were made for provisional licensure renewal as well.

5. Change the levels of practice a licensee can engage in based on his or her credential. These changes were made at the recommendation of an ad hoc committee composed of deaf citizens and practicing interpreters.

6. Update fees to clarify that there is a $35 non-refundable processing fee for initial, renewal, and reactivation applications.

PUBLIC COMMENT: A public hearing was held on July 25, 2016. The public comment period expired on July 25, 2016. The Department received the following comments:

COMMENT:
Nelvia Agnew, MSE, Licensed Interpreter:

I am writing to submit my comments in opposition of the proposed Amendments to the " Rules and Regulations Governing the Advisory Board for Interpreters Between Hearing Individuals and Individuals who are Deaf, Deafblind, Hard of Hearing, or Oral Deaf". My concerns are due to the changes proposed to "Section XI Summary of Credentials". The proposed changes seem to be focused on reducing the number of settings in which a licensed interpreter holding a QAST credential level of 3 or less may accept assignments. I believe the outcome of such a restrictive environment for QAST Levels 1-3 will be to greatly reduce the amount of effective communication available to individuals who are Deaf, Deaf-blind, Hard of Hearing or Oral Deaf.

First, as of April 29, 2016, there were 145 Licensed Interpreters in the State of Arkansas. (This information is from the website of the Advisory Board for Interpreters between Hearing Individuals who are Deaf, Deaf-blind, Hard of Hearing, or Oral Deaf). That is 145 individuals to accommodate all the Deaf, Deaf-blind, Hard of Hearing and Oral Deaf in 75 counties in the State of Arkansas. On average, this means only 2 licensed interpreters are available at any time per county. That number, of course, does not take into consideration those interpreters who are credentialed for and work solely in educational settings. It does not take into consideration those who are credentialed with national tests and/or have specialized training or higher levels for legal settings such as criminal or civil court cases or serious medical settings of a critical nature. It also does not take into consideration those who may work another job and provide interpreter services in their community as they are available to do so. As you can see, this number of 145 interpreters begins to shrink quickly when we look at those who are available. In reality, we have a very small number of licensed interpreters to cover the needs of Deaf, Deafblind, Hard of Hearing, and /or Oral Deaf in our state. In addition, this average of 2 interpreters available per county disregards the geographical distribution of licensed interpreters. Unfortunately, there are areas of the state where few, if any, interpreters are living in the geographical region. By further reducing the number of local interpreters available for many assignments, one greatly increases the costs to those who are providing the services. In addition, there may be a delay in the timely provision of services when an interpreter must be obtained from a long distance. When these costs double or triple due to travel, time and mileage, the costs will become an undue burden, and the interpreter services may likely not be provided to those who need them.

Secondly, one must ask why these rule changes are being proposed. What evidence of problems exists? Are there documented consumer complaints of ineffective communication being provided? If so, how many? How would the proposed changes prevent such complaints from occurring?

Among my colleagues I have heard a variety of rationales for greatly restricting the interpreter with a QAST Level of 3 or below. Some may suggest, for example, that a QAST Level 2, should not interpret in any medical situation. The "argument" as I have heard it, is that this person, according to the QAST testing criteria "achieved a 70-84%" on the performance test. The rationale is that a person who understood, for example, only 75% of the message should not be interpreting between a physician and a Deaf patient, since 25 % of the message is lost. Unfortunately, this argument shows a lack of understanding of the QAST itself, and does not take into consideration all the variables involved in accepting an interpreting assignment. One such variable is the limitation already placed on a QAST credentialed interpreter. Again , using our example, a QAST Level 2 has, by the credential – not the state license – a number of limitations. Among these are a limitation to "one-on one situations or limited group situations where communication CAN be interrupted occasionally for clarification. " In the QAST performance testing process, there is no allowance to request clarification. If during testing the interpreter "misses" a fingerspelled word or signed concept that is key to understanding the scenario, there is no provision to allow for interrupting and obtaining that important clarifying information. Obviously this will affect his/her overall performance on that specific test. This is the nature of testing. In the same manner, in the testing environment, the speed of communication is standardized, with the interpreter having no influence on how fast or slow communication is occurring. Again, this is the normal nature of testing, and such standardization is necessary for evaluation purposes. However, in a real life situation, such as the doctor/patient office visit often given in the argument, an interpreter can easily interrupt for clarification on a missed word or concept, from either party. In this one-on-one communication setting, all parties have some influence on the pace at which communication occurs, including the interpreter, without reducing the effectiveness of the communication.

Another variable is the experience and knowledge of the individual interpreter. The QAST interpreter is required to earn a minimum of ten (10) Continuing Education units annually. These may be in a variety of interpreting areas. One interpreter may focus on educational topics. Another may focus on medical settings and terminology. Yet another may focus on business and employment topics. Each of these may have the same "QAST level", but have widely different abilities in terms of settings in which they could effectively provide interpreting services. Additionally, each interpreter who holds the QAST credential may have entered the field at a different stage of his/her own life experience. Some may be recent high school graduates. Other may be professionals in another field who became interested when working with a member of the Deaf Community. Yet others may have pursued concentrated interpreter

training programs. These are a few of the many reasons that each licensed interpreter is also required to know and follow the Code of Professional Conduct , which guides the individual interpreter in determining which assignments and settings are appropriate for his/her level of skills and abilities. The QAST interpreter first passes a written test to ensure he/she has basic knowledge and understanding of this code.

Finally, Arkansas licensed interpreters at all levels have demonstrated satisfaction of a standard of knowledge and practice as well as a commitment to providing effective communication by pursuing credentials (often requiring regular re-evaluations), by obtaining annual continuing education units (CEU's) for the renewal of both credentials and license, and for many, by participating in professional interpreter organizations which share a commitment to providing quality interpreting services. They often bear the cost of these workshops, travel, testing, and fees in order that they can provide interpreting services in their communities to those who require them. Licensed interpreters are expected to practice within the guidelines of their Professional Code of Conduct. Severely limiting the settings in which an interpreter may provide services will, I believe, further reduce the already small number of interpreters available in many of our Arkansas communities and put an undue burden on those who seek to provide interpreting services to their patients, clients, and/or other consumers of services. Licensure is required in Arkansas and ensures a minimum standard of practice. Credentials used for licensure already have limitations and recommendations for practice areas connected to them. Individual interpreters are expected to follow their Code of Professional Conduct. I ask you to vote against the proposed rule changes that will severely limit the availability of licensed interpreters to serve those who require interpreting services.

RESPONSE:

Thank you for your comments. The Advisory Board for Interpreters between Hearing Individuals and Individuals who are Deaf, Deafblind, Hard of Hearing or Oral Deaf (the Advisory Board) created a Subcommittee to review the levels of licensure required to practice in different settings. The Subcommittee included interpreter agency representatives from around the state. It was felt that these individuals would best understand the settings where interpreters work and the skill levels needed for those settings. That Subcommittee met several times and considered many of the same factors you raised, including the lack of interpreters in the State. Ultimately, the Board feels that it is not necessarily better to have an unqualified interpreter rather than no interpreter at all. When there is an interpreter it is often assumed that communication is taking place. However, this may be far from true when that interpreter is not appropriately qualified. Your comments will be

considered going forward to determine if some flexibility is needed to accommodate those in rural areas without easy access to qualified interpreters. It should also be noted that Video Remote Interpreting Services can be used when a qualified interpreter cannot be found. When the Advisory Board addresses this issue in the future, it would appreciate input and participation from the interpreting community.

COMMENT:
Jeffrey McCrary, Licensed Interpreter:

Proposed amendments to the Rules and Regulations Governing the Advisory Board for Interpreters Between Hearing Individuals and Individuals who are Deaf, Deafblind, Hard of Hearing, or Oral Deaf

SECTION XI – Summary of Credentials:

If you look at the proposed rules, under XI - Summary of Credentials, where are RID levels and past certifications in Section D? RID has exempted themselves from the list in Section D. RID has different levels (or past certifications) also. These should be included on the list in Section D.

I have no problem with setting out in the rules which interpreting assignments individuals are allowed to do, which I personally believe is a very prudent thing to do, however the interpreting assignment list should apply to all, not just State certified interpreters only. It should also include National certified interpreters.

Section D needs to contain the levels or past certifications of RID, or it should be deleted and we all go by Section A only.

A better approach would be what Texas has done. They have a more extensive list than ours on interpreting assignments and have a wonderful chart. The advisory board should adopt these rules.

Below is the Texas Chart and jobs you are allowed to perform. The list is more comprehensive than Arkansas' list. All Arkansas would have to do is add QAST levels to the chart. QAST 1 would go in category A, QAST 2 in category B, QAST 3 in category E, and QAST 4-5 in category H.

(The List of Situations and Recommended Interpreter Certification Levels for the BEI in Texas was included in the email and considered by the Agency.)

RESPONSE:

Thank you for your comments. Please see the response to the above comments. The Advisory Board reviewed the BEI list of recommended certification levels, but did not feel that it addressed the concerns in

Arkansas. Review of practice settings and certification levels is ongoing and the Advisory Board will continue to look at this issue. When the Advisory Board addresses this issue in the future, it would appreciate input and participation from the interpreting community.

The proposed effective date is December 1, 2016.

CONTROVERSY: This is not expected to be controversial.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: Arkansas Code Annotated § 20-14-809 states that the State Board of Health shall adopt rules to implement the subchapter [Interpreters between Hearing Individuals and Individuals who are Deaf, Deafblind, Hard of Hearing, Oral Deaf].

Specifically, Ark. Code Ann. § 20-14-805 (b)(2) authorizes the Advisory Board for Interpreters between Hearing Individuals and Individuals who are Deaf, Deafblind, Hard of Hearing, Oral Deaf to "review and recommend to the Department of Health criteria for issuance and renewal of licenses for licensed qualified interpreters."

Additionally, A.C.A. § 20-14-806 (a)(5) authorizes the Department of Health to "establish reasonable fees for licensure and renewal of licensure."

5. DEPARTMENT OF HEALTH, OUTBREAK RESPONSE SECTION (Robert Brech)

a. SUBJECT: Reportable Disease

DESCRIPTION: These are changes to the Rules and Regulations Pertaining to Reportable Disease – Mandatory Reportable Disease List They are being revised to update the Mandatory Reportable Disease List to ensure that public health officials in Arkansas have information needed to monitor the occurrence and spread of diseases.

Proposed Changes

The department proposes the following to maintain agreement with the recommendations of the Council of State and Territorial Epidemiologists, an independent body of medical and epidemiological experts that recommends which diseases the Centers of Disease Control and Prevention should include on the list of nationally notifiable diseases.

Clarifications Regarding Laboratory Submissions of High Consequence Pathogens:

The department intends to require that available cultures or clinical samples from all emerging disease agents be sent to the Arkansas Department of Health's Public Health Laboratory for confirmation and further characterization. This includes the following infections or conditions: anthrax, botulism, and chemical agents of terrorism, novel coronavirus (MERS or SARS), novel influenza virus, plague, poliovirus, Q fever, smallpox, tularemia, typhus, viral hemorrhagic fevers, and other emerging threat agents. This has generally not been an issue, but some large reference labs have refused to submit tularemia isolates to the ADH because the previous language in the rule was vague.

Among 'Any infectious cause of encephalitis' which is reportable, the department proposes specifically adding California serogroup viruses which were recently added to the nationally notifiable disease list.

With HIV reporting, the department specifies that all qualitative, quantitative, and genotyping tests, even those that detect no virus, are required to be reported. This is necessary to improve case management of persons with HIV and to identify persons who are lost to care as early as possible.

Diseases Newly Required to be Reported to Agree with the Nationally Notifiable Disease List

Chikungunya
Any elevated heavy metal test in blood (e.g.: mercury, arsenic, cadmium)
Melioidiosis (*Burkholderia mallei*)
Vancomycin resistant *Staphylococcus aureus*
Zika virus

Diseases Removed from Requirement to be Reported:

Vancomycin Intermediate Staphylococcus aureus
(Note: Vancomycin resistant Staph aureus is still required to be reported and isolates are required to be submitted.)

Diseases Downgraded from Immediate Reporting to Routine (within 24 hours) Reporting:

Pertussis

Change in Laboratory Submission Requirements:

Invasive *Streptococcus pneumonia* isolates will no longer need to be submitted to the ADH lab, unless upon request. Due to increasing use of culture independent stool pathogen testing among labs/providers, clarification was needed so stool samples would still be submitted for testing.

Change in Ophthalmia Neonaturum Requirements:

The department struck the requirement to provide erythromycin eye ointment to infants at birth. This is because the incidence of ophthalmia neonaturum has dropped to historically low rates and the risks of treatment may outweigh the benefit of universal prophylaxis.

PUBLIC COMMENT: A public hearing was held on August 11, 2016. The public comment period expired on August 11, 2016. The Department received no comments.

The proposed effective date is February 15, 2017.

CONTROVERSY: This is not expected to be controversial.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: Arkansas Code Annotated § 20-7-109 (a)(1)(A) authorizes the State Board of Health to make all necessary and reasonable rules and regulations of a general nature for the protection of the public health and safety.

6. STATE HIGHWAY AND TRANSPORTATION DEPARTMENT (Rita Looney and Keli Wylie)

a. SUBJECT: Rules for Design-Build Contracts

DESCRIPTION: These rules describe the Arkansas State Highway Commission's procedures and regulations for the procurement of qualification-based design-build and design-build finance services as well as agreements for concession. Design-build is an alternate method of delivery for construction projects that combines the design, construction, and other related services into a single contract.

These rules establish the optional two-step procurement process which seeks to identify the most qualified firm to perform the services necessary to complete a design-build project. This two-step process consists of a Request for Qualifications whereby interested firms may submit their qualifications for consideration as a proposer for the project and a Request

for Proposals whereby the most qualified firms may submit their proposals for the project.

PUBLIC COMMENT: A public hearing was held on July 28, 2016. The public comment period expired on August 1, 2016. Public comments were as follows:

Richelle Brittain, Little Rock, AR

COMMENT: Section 2.1.2 states that these rules cover design-build-finance as well as design-build contracts; yet the only other place where financing is mentioned is in the definition of "Design-Build" in Section 3.6. Since the only project I understand AHTD to be pursuing as design-build (30 Crossing) is a design-build-finance plan, and since the financing component could be seen as back-door authority to incur debt (especially for a non-toll project like 30 Crossing), this omission is serious. Where is the financing component of these rules? **RESPONSE:** The AHTD staff has proposed the following change as a response to this comment:

3.6 Design-Build – is a qualification-based project delivery method in which design, construction, and other related services are contracted to a single entity known as the Design-Builder through a Design-Build Contract. Design-build-finance has been recognized in Ark. Code Ann. § 27-67-206 as a type of Design-Build that includes a financial services component and encompasses design-build-maintain, design-build-operate and other contracts that include financial services in addition to design and construction, including project financing, at-risk equity investment, operations, and/or maintenance of the project. ~~The term encompasses design-build-maintain, design-build-operate, design-build-finance and other contracts that include services in addition to design and construction, including project financing, at-risk equity investment, operations, and/or maintenance of the project.~~

COMMENT: Arkansas Constitution, Amendment 65 appears to authorize "revenue bonds" backed by non-tax revenue without voter approval, but only with legislative approval. (a) Is the definition of "revenue bonds" in Amendment 65 sufficient to include debt incurred via design-build-finance contracts? (b) Does this authorize AHTD to use any funds for design-build-finance contracts beyond those allowed by Amendment 20? **RESPONSE:** Arkansas Constitutional Amendment 65 is not applicable to the AHTD or ASHC. No further revisions are proposed to these rules.

COMMENT: While Arkansas Code § 27-67-206(j) authorizes AHTD to construct highways via design-build-finance contracts (and indeed these regulations), it does NOT appear to authorize the incurring of debt by

AHTD via such a contract. What statutory authority does AHTD have to incur debt under a design-build-finance contract (as opposed to a bond issue)? **RESPONSE:** The AHTD will remain in compliance with all state and federal laws regarding the distribution of funds pursuant to any design-build-finance contract. No further revisions are proposed to the rules.

COMMENT: While Section 3.6 defines "Design-Build" as including "design-build-maintain, design-build-operate, design-build-finance and other contracts that include services in addition to design and construction," Section 2 as a whole appears to limit the rules to design-build and design-build-finance contracts. Could Section 2 be clarified so as to include all of the "other contracts" included in Section 3.6? **RESPONSE:** Please refer to the definitions found in Section 3.6 in response to Comment No. 1. No further revisions are proposed to the rules.

COMMENT: Does the definition of "Design-Builder" in Section 3.8 include public entities of this or any other state? Though this may not fall under design-build, I believe it would be conceivable for AHTD to construct toll facilities as a partnership with a neighboring state's toll authority, such as the Northeast Texas Regional Mobility Authority (especially on the I-49 Red River Bridge as Bowie County, Texas is a member of that authority), North Texas Tollway Authority, or Oklahoma Turnpike Authority. Particularly if tolls become involved (given the recent backlash in Texas against privately operated toll roads), a "public-public partnership" may be preferable to a public-private partnership. **RESPONSE:** Section 3.8 only includes entities subject to the laws of the State of Arkansas. Toll projects would be subject to the statutory requirements of Ark. Code Ann. § 27-76-101, *et seq*. No further revisions are proposed to the rules.

Lane Construction Corporation of Fort Worth, TX

COMMENT: Section 7.1.2, page 5. Should shortlist no more than 3 firms. **RESPONSE:** It is not in the Department's best interest to create a limit at the rules level. Limits can be established in each project in the RFQ. No further revisions are proposed to the rules.

COMMENT: Section 7.3, page 6. General comment: Need more detail to include project understanding, organizational structure, applicable experience, resource availability, DB experience and financial ability. **RESPONSE:** Each contract will be project specific and additional details will be included in project specific documents. No further revisions are proposed to the rules.

COMMENT: Section 7.5.3, page 7. Only the shortlisted proposers should receive the RFP. **RESPONSE:** The definitions included in section 3 of the rules are sufficient to make this distinction. No further revisions are proposed to the rules.

COMMENT: Section 7.5.3.4, page 7. RFP evaluation process should include project understanding, anticipated complex problems, and design/construction QA/QC. **RESPONSE:** The DB Guidelines, the RFQ, and the RFP are more appropriate locations for these details. No further revisions are proposed to the rules.

COMMENT: Section 7.5.4, page 7. Add the DBE goals to the list of additional requirements. **RESPONSE:** A DBE goal may not be included in all DB Projects but will be clearly defined in the RFP when applicable. No further revisions are proposed to the rules.

COMMENT: Section 9. Add this section and title it "Protest Provisions" and then list what the provisions are. **RESPONSE:** The DB Guidelines are a more appropriate location for this detail. No further revisions are proposed to the rules.

The proposed effective date is October 3, 2016.

CONTROVERSY: This is not expected to be controversial.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: The State Highway Commission may establish written procedures and regulations for the procurement of: (1) qualification-based, design-build services and for administering design-build project contracts; (2) qualification-based, design-build finance services and for administering a design-build finance project contract; and (3) an agreement for a concession. Ark. Code Ann. § 27-67-206(j)(2)(A).

7. DEPARTMENT OF HUMAN SERVICES, BEHAVIORAL HEALTH SERVICES (Pam Dodson and Robbie Nix)

a. SUBJECT: Alcohol and Drug Abuse Prevention Rules of Practice and Procedure Manual Update 2016-01

DESCRIPTION: This updates the Rules of Practice and Procedure to coincide with requirements in the Division of Behavioral Health Services (DBHS) Request for Qualifications (RFQ) for Comprehensive Substance Abuse Services. This update is necessary so that the language in the Rules of Practice and Procedure for organizations funded by the DBHS mirrors

language in the RFQ for Comprehensive Substance Abuse Services. The RFQ instructs respondents to refer to the DBHS to refer to the DBHS Rules of Practice and Procedure manual so it is necessary that the language is consistent.

The proposed amendment clarifies that providers will receive payment from DBHS for necessary services billed to DBHS provided to individuals whose income is at or below 150% of the federal poverty level as issued in the Federal Register by the Department of Health and Human Services (HHS).

The proposed amendment also updates service definitions as well as updates Prevention Provider staff requirements to receive funding from DBHS to better align with best practices and national standards.

PUBLIC COMMENT: No public hearing was held. The public comment period expired on July 12, 2016. The Department received the following comments:

Question #1: Why move to 150% of the Federal Poverty Limit (FPL)? There are concerns about that level impacting clients receiving outpatient services.
Response: With the expansion of services allowable to be billed for by this change, the State must ensure appropriate utilization of services and that the amount of Federal Block Grant funding is not exceeded. The current funding for Substance Abuse Treatment services paid by the Division of Behavioral Health Services (DBHS) is based upon the 2006 Food Stamp Certification Basis of Income Scale. This is being amended to reflect current Federal Poverty Limit calculations.

Question #2: It appears that there is no longer the ability for programs to bill a client for some part of their service, that it is an all or nothing situation. They either qualify by meeting the standards for their services being paid through the division or they do not qualify?
Response: The Division of Behavioral Health Services (DBHS) will pay for individuals at or below 150% of the Federal Poverty Limit for Substance Abuse Services. Providers may collect payment from clients or third party sources over and beyond the DBHS contracted fee schedule for services provided to individuals who are above 150% of the Federal Poverty Level. All providers must submit information regarding their payment/collection system to DBHS.
Providers SHALL NOT charge or require payment for services provided to any client whose income is at or below 150% of the Federal Poverty Level as issued in the Federal Register by the HHS.

Question #3: It states in the proposed rules that Specialized Women's Services covers everything except day care. What happens to day care now with Specialized Women's Services? Not everybody seen qualifies for funding through DHS.
Response: This language is not changing in the proposed revision. The current way that day care is reimbursed in the proposed revision does not change.

Question #4: Care coordination was put under residential treatment services, but it is my understanding, that when we get paid for residential, it is an all-inclusive rate and care coordination is included under that rate and we can't bill for it separately?
Response: That is correct. Residential Services are paid on a per diem basis.

Question #5: Assuming this change is approved, when is the official start date for the changes?
Response: The effective date of the proposed changes is October 1, 2016.

The proposed effective date is October 1, 2016.

CONTROVERSY: This is not expected to be controversial.

FINANCIAL IMPACT: There is no financial impact. The manual changes do not impact the total amount of money available to providers for contracted services.

LEGAL AUTHORIZATION: The Department of Human Services is authorized to "make rules and regulations and take actions as are necessary or desirable to carry out the provisions of this chapter [Public Assistance] and that are not inconsistent therewith." Arkansas Code Annotated § 20-76-201 (12). In addition, A.C.A. § 25-10-129 (b) states that the Department of Human Services has the authority to promulgate rules, as necessary to conform to federal statutes, rules and regulations that affect current and future programs administered or funded by or through the department, as necessary to receive any current or future federal funds available to the department.

8. DEPARTMENT OF HUMAN SERVICES, COUNTY OPERATIONS (Dave Mills, item a; Lori Williams and Shirley Mason, item b.)

a. SUBJECT: Medical Services Policies B-315, F-180, Appendix P, and PUB-405

DESCRIPTION: This change clarifies the DHS Medical Services Policy Manual to bring it into compliance with federal and state law regarding institutional placement options, additional health insurance coverage, and premium amounts for the TEFRA program. These revisions are needed is to comply with Section 1902(e)(3)(B)(i) of the Social Security Act and TEFRA Waiver ID #11-W-00163/6.

PUBLIC COMMENT: No public hearing was held. The public comment period expired on June 30, 2016. The Department received no comments.

The proposed effective date is October 1, 2016.

CONTROVERSY: This is not expected to be controversial.

FINANCIAL IMPACT: There is no financial impact.

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

b. SUBJECT: Low-Income Home Energy Assistance Program (LIHEAP) State Plan for FFY 2017

DESCRIPTION: The LIHEAP State Plan is required to be submitted on an annual basis to receive federal funding to operate the program.

The LIHEAP State Plan is updated to include Section 5 under Weatherization, the process for providing Training and Technical Services (T&TA) for the LIHEAP FFY 2017 State Plan.

PUBLIC COMMENT: Public hearings were held on July 11, 2016 in Springdale, July 12, 2016 in Batesville, July 13, 2016 in Prescott, and July 14, 2016 in Warren. The public comment period expired on July 30, 2016. The Department received no comments.

The proposed effective date is October 1, 2016.

CONTROVERSY: This is not expected to be controversial.

FINANCIAL IMPACT: The cost to implement the rule is $27,000,000 in federal funds for the current fiscal year and the same amount for the next fiscal year. For FFY 2016, the state will operate LIHEAP with $600,000 for administration and the same applies for FFY 2017. This is a portion of the 10% allowable for LIHEAP program administration.

LEGAL AUTHORIZATION: This rule is necessary for Arkansas to receive federal home energy assistance funds to assist low-income households with their home energy costs.

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

9. DEPARTMENT OF HUMAN SERVICES, FINANCE AND ADMINISTRATION

a. SUBJECT: Social Service Block Grant Pre-Expenditure Report for SFY July 1, 2015-June 30, 2016 Amendment #1

DESCRIPTION: Social Services Block Grant Pre-Expenditure report requires that a pre-expenditure annual report be submitted in order for the state to receive SSBG funds. Fund redistribution is requiring this amendment to be approved and filed.

The revisions will include updated contact information for the following titles: "Director for the Office of Finance and Administration" and "Assistant Director for the Office of Finance and Administration" as well as substantive changes to the following sections: "Fiscal Operations of the Arkansas SSBG Program," "Services and Activities of the Arkansas SSBG Program-Service Summary Sheet for the Division of Children and Families," "Services and Activities of the Arkansas SSBG Program-Summary Sheet for the Division of Youth Services," "Federal Reporting Form OMB No. 0970-0234-Estimated Recipients," and "Appendices-Certifications." These changes will update the policy to be in compliance with federal regulations for federal funds distribution.

PUBLIC COMMENT: No public hearing was held. The public comment period expired on August 5, 2016. The Department received no comments.

The proposed effective date is pending legislative review and approval.

CONTROVERSY: This is not expected to be controversial.

FINANCIAL IMPACT: There is no financial impact.

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

b. SUBJECT: Social Services Block Grant Pre-Expenditure Report for SFY July 1, 2016-June 30, 2017

DESCRIPTION: Social Services Block Grant Pre-Expenditure report requires that a pre-expenditure annual report be submitted in order for the state to receive SSBG funds. Fund redistribution is requiring this amendment to be approved and filed.

The revisions will include updated contact information for the following titles: "Director for the Office of Finance and Administration" and "Assistant Director for the Office of Finance and Administration" as well as substantive changes to the following sections: "Fiscal Operations of the Arkansas SSBG Program," "Services and Activities of the Arkansas SSBG Program-Service Summary Sheet for the Division of Children and Families," "Services and Activities of the Arkansas SSBG Program-Summary Sheet for the Division of Youth Services," "Federal Reporting Form OMB No. 0970-0234-Estimated Recipients," and "Appendices-Certifications." These changes will update the policy to be in compliance with federal regulations for federal funds distribution.

PUBLIC COMMENT: No public hearing was held. The public comment period expired on August 5, 2016. The Department received no comments.

The proposed effective date is pending legislative review and approval.

CONTROVERSY: This is not expected to be controversial.

FINANCIAL IMPACT: There is no financial impact.

LEGAL AUTHORIZATION: This rule is necessary to for Arkansas to receive federal funding. The Department of Human Services is authorized to "make rules and regulations and take actions as are necessary or desirable to carry out the provisions of this chapter [Public Assistance] and that are not inconsistent therewith." Arkansas Code Annotated § 20-

76-201 (12). Arkansas Code § 20-77-107 specifically authorizes the department to "establish and maintain an indigent medical care program."

10. DEPARTMENT OF HUMAN SERVICES, MEDICAL SERVICES (Michael Crump, items a, b, and c; Elizabeth Smith, item a; and Craig Cloud, items b and c)

a. SUBJECT: Rehabilitative Services for Persons with Mental Illness (RSPMI) Update #1-16

DESCRIPTION: These are revisions to Group Psychotherapy Code 90853. The purpose of the rule is to reduce the payment amount; reduce the maximum units billed per session; set the total maximum payment rate at $40 per day; and set a cap on the total units billed per year at 100 for the Group Psychotherapy Code 90853.

PUBLIC COMMENT: A public hearing was held on June 13, 2016. The public comment period expired on July 5, 2016. The Department received the following comments:

COMMENT:
One party requested that pursuant to Ark. Code Ann. §25-15-204(a)(2)(D) the state Medicaid agency identify the principle reasons for adoption of RSPMI 1-16.
RESPONSE:
The changes proposed in RSPMI 1-16 were submitted after analyzing a study performed by Advance Med, the Zone Program Integrity contractor for the State of Arkansas, which showed that the current rate structure, benefit limit, and total reimbursement for procedure code 90853 in Arkansas deviates significantly from surrounding states and Medicare. The current limits for the code allow for overutilization and improper use of group psychotherapy services in Arkansas. The overutilization and improper use of the code significantly impacts quality of care and Medicaid spending.

COMMENT:
Several parties submitted comments stating that the proposed changes to benefit limits would cause rapid deterioration among recipients and would result in increased hospitalizations, incarcerations, and homelessness.
RESPONSE:
The proposed changes allow recipients to receive all medically necessary care. If more than 100 units are required, the provider may request an extension of benefits. Beacon Health will review all extension of benefits requests. Extensions will be granted if the additional services are deemed to be medically necessary.

COMMENT:
One party commented that group therapy is an essential component of both adult and children's day rehabilitation programs and is the most cost effective means of providing care in this setting.
RESPONSE:
OMIG agrees that group psychotherapy is an essential component of both programs; however, the current rates and benefit limit allow for overutilization and improper use of group psychotherapy services. As providers may request an extension of benefits, recipients will be able to receive all medically necessary care.

COMMENT:
One party commented that there is no evidence that access to care was considered during the review process.
RESPONSE:
Access to care was considered and maintained in the proposed changes. An extension of benefits may be requested for recipients that require more than 100 units of services annually.

COMMENT:
One party inquired as to whether the 100 units of group psychotherapy would be part of the annual benefit package for Medicaid recipients that do not require prior authorization.
RESPONSE:
No, the 100 units of group psychotherapy will not be a part of the annual benefit package for RSPMI.

COMMENT:
One party inquired as to whether the reduction in daily maximum and annual units will be applicable to under 21 and adult populations.
RESPONSE:
Yes, the changes will be applicable to both populations.

COMMENT:
Several parties inquired as to the standard that would be used in the process for approving extension of benefit requests.
RESPONSE:
An extension of benefits will be granted if services are deemed to be medically necessary.

COMMENT:
One party commented that rates for states identified in the comparative analysis presented to the Health Care Task Force are lower because they allow mental health paraprofessionals to perform group psychotherapy.
RESPONSE:
Arkansas requires that mental health professionals perform group psychotherapy yet our rates exceed the rate at which surrounding states and Medicare reimburse those same professionals. Under Medicare, mental health professionals are reimbursed at a rate of $25.01 per session, while Arkansas currently reimburses at $55.20 per hour.

COMMENT:
Several parties commented that the structure of Arkansas' RSPMI program does not allow for the provision of necessary intensive mental health services that are available in other states. The party also commented that providers utilize 90853 for this perceived shortcoming.
RESPONSE:
Any use of a procedure code that deviates from its intended use as defined in Medicaid policy is improper. An array of services exists that can be utilized by mental health providers to provide viable alternatives to group psychotherapy. Those services include but are not limited to:

Day Treatment
Individual Therapy
MHPP Intervention
Pharmacological Management

COMMENT:
One party inquired as to what "activities" are being funded in Arkansas by 90853 that are being funded some other way by states included in the comparative analysis. The party also inquired as to how those activities are being funded in other states.
RESPONSE:
We can only comment as to the proper use of the 90853 procedure code. Any provision of services outside of the defined appropriate use in the RSPMI provider manual is improper, and should not be compared to other states. The commenter is requesting that the agency identify how an improper use of 90853 in Arkansas would be reimbursed in states identified in the comparison. The agency can only compare states by analyzing the proper use of 90853.

COMMENT:
One party inquired as to the professional qualifications required of those who provide group psychotherapy services in the states included in the comparative analysis.

RESPONSE:

Georgia- Group psychotherapy services must be provided by a psychologist.

Mississippi- Approved providers of group psychotherapy services include an individual with a masters degree and professional license (MD, DO, Ph. D, LCSW, LPC, PMHNP), certified mental health therapist, intellectual and disabilities therapist, or an addiction therapist

Alabama- Approved providers of group psychotherapy services include psychologists, professional licensed counselors, certified social workers, marriage and family therapists, psychiatric nurses, or an individual with a masters degree and has successfully completed a practicum towards their degree, six months of post masters level experience supervised by a masters level or above with 2 years of post-graduate clinical experience.

Tennessee- Approved providers of group psychotherapy services include psychiatrists (MDs), psychotherapists (PhDs), social workers (MSWs) with appropriate state licensure, nurse practitioners/clinical nurse specialists (APRNs/NPs) with special training and/or experience in psychiatric nursing beyond the standard curriculum, physician assistants (PAs), and other providers of mental health services including but not limited to professional counselors and marriage and family therapists licensed or otherwise authorized by the state in which they practice.

Louisiana- Group psychotherapy services may be provided by a licensed mental health practitioner. A licensed mental health practitioner is an individual who is licensed in the State of Louisiana to diagnose and treat mental illness or substance use, acting within the scope of all applicable State laws and their professional license. A LMHP includes individuals licensed to practice independently:

- Medical psychologists
- Licensed psychologists
- Licensed clinical social workers
- Licensed professional counselors

Licensed marriage and family therapists

Licensed addiction counselors

Advanced practice registered nurses – must be a nurse practitioner specialist in adult psychiatric and mental health, and family psychiatric and mental health, or a certified nurse specialist in psychosocial, gerontological psychiatric mental health, adult psychiatric and mental health and child-adolescent mental health and may practice to the extent that services are within the APRN's scope of practice

West Virginia- Qualifications to provide group psychotherapy services vary as the services are available through multiple MCO's which have different certification requirements. The certification requirements for the MCO's are as follows:

West Virginia Family Health: Group psychotherapy services may be provided by a psychiatrist, psychologist, or licensed therapist

The Health Plan: Group psychotherapy services may be provided by a psychiatrist, psychologist, social workers, and counselors or therapists.
Coventry: No specific certification requirements identified for group psychotherapy services
Unicare: No specific certification requirements identified for group psychotherapy services

COMMENT:
Several parties commented that OMIG's comparison of group psychotherapy policy and expenditures to surrounding states is inaccurate or incomplete.
Only one party identified a specific example of how another state Medicaid program differs from Arkansas. The party stated that Alabama was included in the comparative analysis, but suggested that the dollars paid amount for group psychotherapy services was incomplete because recipients receive services through the substance abuse treatment program in Alabama.
RESPONSE:
Alabama does, in fact, have a substance abuse treatment program through which recipients can receive group psychotherapy services. Under that program, group psychotherapy services are reimbursed through the 90853 procedure code. Claims billed under the 90853 procedure code in the Alabama substance abuse treatment program were included in the comparative analysis and reported to the Health Care Task Force.
Several parties commented that the proposed changes were arbitrarily selected and driven by budgetary considerations without giving consideration to the patient and possible repercussions.
Recipient benefits are always the focus of the state Medicaid program, it is imperative that recipients be able to receive necessary care and treatment. Overutilization and improper use of Medicaid benefits has a negative impact on the state's Medicaid spend and quality of care. Once this vulnerability in the Arkansas Medicaid program regarding procedure code 90853 was identified, it was evident that changes were required. A review of the Arkansas group psychotherapy benefit (procedure code 90853) along with a review of additional services available through the Arkansas RSPMI program was conducted and then compared to the group psychotherapy benefits available in other states. Not only was it clear the state was over utilizing the benefit, but also it was determined Arkansas was spending well above the norm. The current rate and benefit limit for procedure code 90853 allows for overutilization and improper use of group psychotherapy services. OMIG believes aligning the limits with the other states in our region is not detrimental to patients but provides more appropriate care for the patients.

COMMENT:
One party inquired as to whether the state Medicaid agency contends that RSPMI 1-16 is a reduction in provider payment or a payment restructuring that requires medical assistance access review pursuant to 42 C.F.R. §447.203 et seq,, and if an inquiry was conducted regarding how patient care would be affected by RSPMI 1-16. If not, what are the reasons for adopting this position?
RESPONSE:
42 C.F.R. §447.203 (b)(6) provides that the State shall submit an access review with any State plan amendment that proposes to reduce provider payment rates or restructure provider payments in circumstances when the changes could result in diminished access. The State contends that the changes in RSPMI 1-16 will not result in diminished access for recipients. Michael Harry, an attorney with the Bureau of Legislative Research, asked how the department settled on setting the yearly cap at 100 units. The Department responded by attaching a report furnished by AdvanceMed Corporation that analyzed Medicaid payouts for group psychotherapy in Arkansas and surrounding states. Also attached were two separate power point presentations compiled by the Office of the Medicaid Inspector General.

The proposed effective date is October 1, 2016.

CONTROVERSY: This may be controversial. It is likely that individual providers will identify the rules as possible barriers to treatment.

FINANCIAL IMPACT: There will be a total estimated savings of $27,078,000 in the current fiscal year ($8,185,679 in general revenue and $18,892,321 in federal funds) and $36,104,000 for the next fiscal year ($10,914,239 in general revenue and $25,189,761 in federal funds).

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

b. SUBJECT: Living Choices Assisted Living Waiver Renewal & Living Choices Assisted Living Update #2-15

DESCRIPTION: The Living Choices Assisted Living (LCAL) 1915(c) Medicaid Waiver is being renewed for a five-year period. The unduplicated annual cap will remain the same at 1,300. The point in time cap will increase from 1,000 to 1,200. There are no other changes being

made to the waiver. The LCAL Provider Manual is being amended to add new federal regulations found at 42 CFR 441.301(c)(4)-(5) regarding Home and Community-Based Settings.

PUBLIC COMMENT: No public hearing was held, however, comments were received during the public comment period that expired on November 21, 2015. The Department received the following comments:

a.) Herb Sanderson, State Director of AARP, submitted a letter opposing the removal of the cost of living adjustment from the waiver.

The Department responded as follows:

"We fully acknowledge your concern, but for now DHS is not committing to annual increases. During the next year, DHS will be reviewing the LCAL rate methodology, engaging stakeholders in the process, and amending the waiver as needed."

b.) Robert Wright stated concerns regarding that the waiver does not increase the unduplicated cap and that it doesn't allow for automatic rate increases each year. Also, that case management and care coordination should remain a function of the assisted living facility and that appropriate reimbursement should be provided.

The Department responded as follows:

"DHS fully acknowledges your concerns. DHS is not committing to an increase in the unduplicated cap or annual rate at this time. During the next year, DHS will be reviewing the unduplicated cap and the LCAL rate methodology, engaging stakeholders in the process, and amending the waiver as needed.

DHS originally intended for assisted living facilities to continue to provide case management, but due to the conflict-free case management regulations, CMS would not allow this. DHS has changed the waiver to state that case management is an administrative function performed by the DAAS RN."

The proposed effective date is December 1, 2016.

CONTROVERSY: This is not expected to be controversial.

FINANCIAL IMPACT: The estimated financial impact is $8,505 in the current fiscal year ($2,533 in general revenue and $5,972 in federal funds) and $611,417 in the next fiscal year ($184,831 in general revenue and $426,586 in federal funds).

The agency submitted the additional following information in answering the question concerning whether 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:

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

The purpose of increasing the point in time cap is to delay the need for a waiting list. If the cap is not increased, it is projected that a waiting list will be needed by June 2016.

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

The problem is the current point in time cap is too low to meet projected growth. Increasing the point in time cap is not required by statute. CMS does not require a point in time cap. The point in time cap is used as a management tool for the agency. DAAS seeks to delay the point in time cap without changing the unduplicated cap of 1,300. Due to the critical need for individuals in need of assisted living, individuals waiting on a slot for assisted living will most likely choose more costly nursing home care.

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

Individuals in need of assisted living services face a critical need for the service. It is often determined that the individual can no longer remain safely in their own home. The need for round-the-clock care is evident. If an individual in need of these services is faced with a lengthy wait for admittance in an assisted living facility because a waiver slot is not available, they will be forced to seek more costly care in a nursing facility. Medicaid mandates nursing facility care, so there are no caps on the number of individuals who can receive Medicaid in a nursing facility.

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

There are no statutory requirements for this change. The rules cost may decrease the need for nursing facility 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;

The state could keep the point in time cap at 1000. This will create a waiting list beginning June 2016. By delaying implementation of the waiting list, it will delay the need for more costly nursing home care.

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

N/A

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

N/A

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:

The waiver is renewed every 5 years and the cap will be reevaluated at that time.

(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.

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

This rule was subsequently filed as an emergency rule and reviewed and approved by the ALC – Executive Subcommittee and ALC. The emergency rule became effective on August 23, 2016. The emergency rule expires on November 20, 2016. The purpose of the proposed emergency rule is to comply with federal law, specifically 42 CFR 441.301 (c)(4)-(5), by renewing the existing Living Choices Medicaid

waiver as well as adding new regulations pertaining to Home and Community-Based Services (HCBS).

c. **SUBJECT: ARChoices Update #1-15**

DESCRIPTION: The changes follow:

201.010. Adds a new section which replicates the transition plan that was previously promulgated as part of the ARChoices waiver. This plan describes the transition of individuals from ElderChoices and Alternatives for Adults with Physical Disabilities to ARChoices in Homecare during 2016.

201.105. Adds language to clarify that providers must attend at least one training per year.

212.000 F. Corrects language describing when the eligibility begin date starts so that it matches other policies.

212.300 C. Clarifies how Attendant Care hours are authorized.

212.324. Deletes section on Hospice as it does not apply to ARChoices.

Various. Changes references to one hour billing units to 15 minute billing units throughout so that it matches current practice.

213.290. Clarifies current practices concerning billing for Environmental Modifications/Adaptive Equipment.

PUBLIC COMMENT: No public hearing was held. The public comment period expired on July 19, 2016. The Department received no comments.

The proposed effective date October 1, 2016.

CONTROVERSY: This is not expected to be controversial.

FINANCIAL IMPACT: There is no financial impact.

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

E. Adjournment.