DHS Responses to Public Comments Regarding Therapy Manual and Related Changes in other Provider Manuals

Becky Carney

Comment: Becky called as an advocate for pediatric therapists. They are requesting that an occupational therapy assessment be added to the list of Medicaid approved tests.

Response: Thank you for your comment. This revision to the Therapy Manual and related changes in other provider manuals are being made to bring consistency to all Medicaid manuals containing therapy rules. DHS will continue to work with the Therapy Association and other stakeholders to consider your comment.

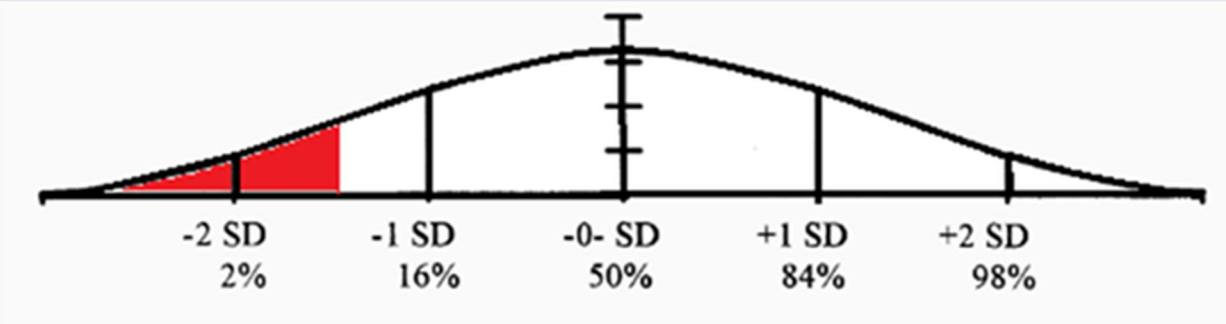
Ashlen Thomason, Ph.D., CCC-SLP, Speech-Language Pathologist, Audiology/Speech Pathology Department, Arkansas Children's Hospital

Comment: I am reaching out in an effort to get much-needed changes for the speech therapy qualification guidelines for patients who stutter (Section 214.400, D, 5, "Fluency"). The guidelines for qualification are quite problematic. In short, the guidelines do not make sense relative to the types of tests that are given to people who stutter, resulting in many people who stutter unjustly not qualifying for therapy.

There are only two accepted tests for Fluency: Stuttering Severity Instrument- Third Edition (SSI-3) or newer and The Test of Childhood Stuttering (TOCS) (listed mistakenly as the 'Test for Childhood Stuttering' in the present manual). The current guidelines state that patients are eligible for therapy based on standard scores of -1.5 SD greater below the mean from two tests.

The Stuttering Severity Instrument-Third Edition and 4th Edition are standardized on a disordered population, making severity comparisons within the 1% of people who stutter, not a comparison of that 1% of stutterers to the general population of fluent speakers; thus, this test does not yield any sort of standard score that is compared to a mean. Obviously, a score of -1.5 SD below the mean does not even exist for this test. The edition of the therapy manual before the one updated in 7/2018 was accompanied by a FAQ addendum; in that addendum, someone asked how to interpret the SSI-3/4 since there is no standard score. The manual indicated that in lieu of a standard score, clients in the moderate range and beyond will qualify. There are two problems with that "moderate" solution to the standard scores problem. 1) The SSI-3/4 manuals specify that the severity labels "were selected as logical but not mathematical" and directs clinicians to look at the available means and standard deviations for the subtests are the total scores at each level. 2) Only accepting this arbitrarily labeled "moderate" or greater, means that only the worst among the stuttering population will get treatment.

Current guidelines for other communication disorders with tests comparing them to the general population accept the bottom 5th percentile of performance for that domain of communication:



Taking the 1% of people who stutter, placing them on their own bell curve, categorizing them based on non-mathematical labels, and only accepting “moderate” or greater consistently results in people with average range stuttering compared to other disordered people who stutter to not qualify for therapy services:

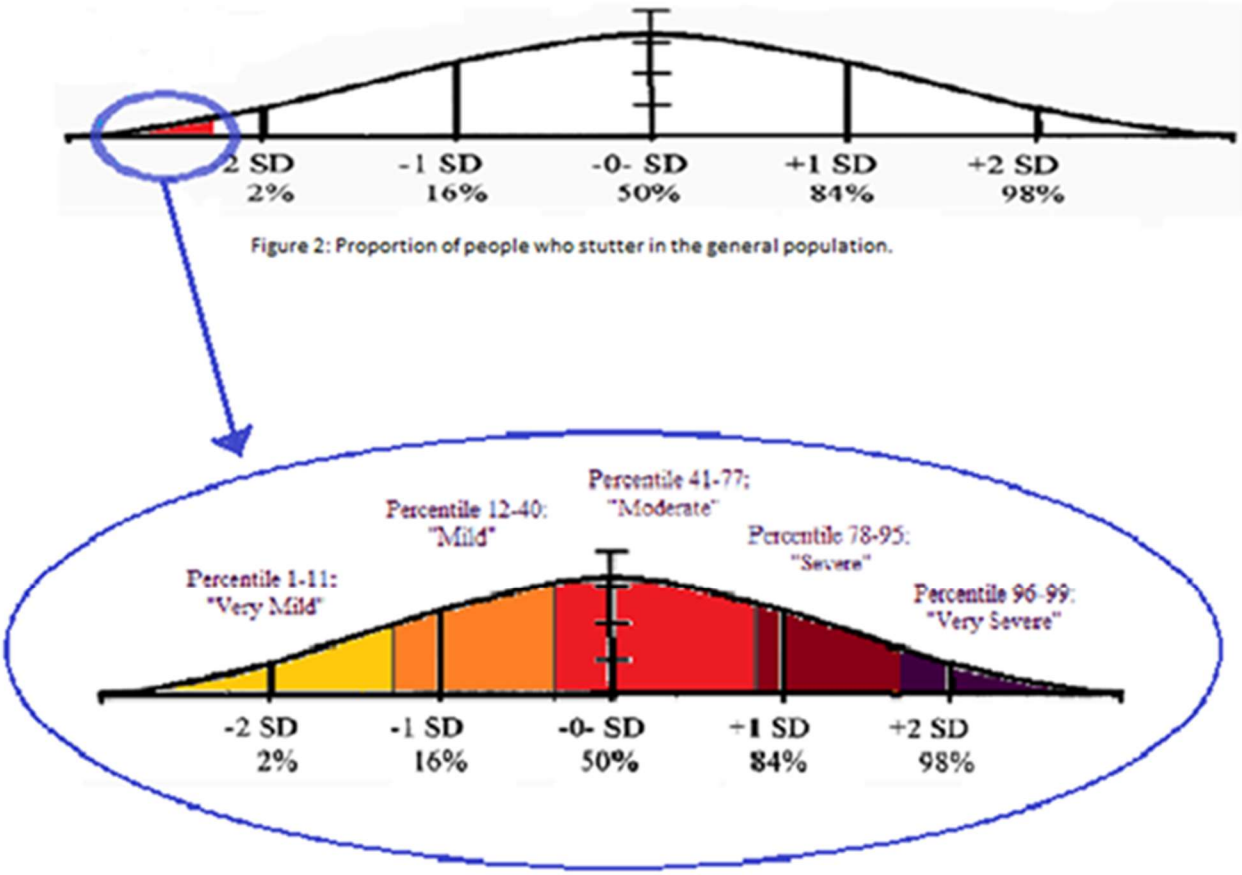


Figure 2: Proportion of people who stutter in the general population.

The TOCS does indeed include an Index Score that compares children who stutter to children who do not stutter. The index score for a child who stutters is consistently -1.5 SD below the mean (generally <58, given the low incidence of stuttering). However, the TOCS also provides a severity label, again comparing children who stutter to other children who stutter. Clinicians interpreting the present guidelines consistently report that they cannot take a child with "mild" range stuttering on the TOCS because of the severity label, despite the fact that the child's index score is in the severe range. As someone who has given the TOCS hundreds of times, I find that despite it being normed on children who were as young as 4-years of age, 4 and 5-year old children have trouble validly participating in many of the testing tasks (e.g. rapid naming of pictures, imitating complex sentence structures, answering story prompts like "Describe the alien."). If a child can get through the hoops of being among the worst on the SSI-4, then they must also fully participate in the TOCS and get a score at or above the moderate range.

There is a caveat in the current guidelines, likely included in the last edition to try to counteract the aforementioned issues in the guidelines: "When -1.5 SD or greater is not indicated by both of these tests, descriptive data from an affect measure and/or accepted clinical procedures can be used to support the medical necessity of services." I perform stuttering evaluations on around 75 children per year. I consistently get calls for parents saying that they cannot get therapy for their because the school or clinic thinks that the child does not meet Medicaid guidelines for services, despite my extensive descriptions of the child's need for therapy. SLPs are scared to taking these patients, receiving an audit, and being denied reimbursement.

Response: Thank you for your comment. This revision to the Therapy Manual and related changes in other provider manuals are being made to bring consistency to all Medicaid manuals containing therapy rules. DHS will continue to work with the Therapy Association and other stakeholders to consider your comment.

Comment: I feel like the following edit to the guidelines would provide an evidence-based and just solution to fix this ongoing blunder in the manual and to get patients who stutter they therapy that they need:

FLUENCY: At least one norm-referenced, standardized test with good reliability and validity, and at least one supplemental tool to address affective components. Eligibility for fluency therapy will be based upon either a standard score within 1.0 standard from the mean or greater on the standardized test or an index score -1.5 SD below the mean comparing people who stutter to people who do not stutter. Exceptions to this scoring will be provided to patients whose scores are lower than within 1.0 SD from the mean or have an index score higher than -1.5 SD below the mean for:

Children within three years of stuttering onset who exhibit two of the following risk factors for persistent developmental stuttering:

- Family history of stuttering in a first or second-order relative
- Males

- Steady or increasing stuttering severity as compared to stuttering severity at onset
- Dysfluencies of three or more units, present 7-months past onset
- Dysfluencies accompanied by secondary characteristics, present 7-months past onset
- Aberrant phonations (blocks or prolongations), present 7-months past onset

School-aged children and adults whose standard scores are within 1.0 standard deviation from the mean or greater when their speech sample is gathered from additional functional speaking tasks.

Response: Thank you for your comment. This revision to the Therapy Manual and related changes in other provider manuals are being made to bring consistency to all Medicaid manuals containing therapy rules. DHS will continue to work with the Therapy Association and other stakeholders to consider your comment.

Comment: These proposed changes to the guidelines solve a few problems:

By changing the guidelines to one standardized test, a clinician does not have to give the TOCS to a 4 or 5-year old who cannot participate in higher-level language tasks.

The SSI-3/4 will be interpreted with statistically derived means and standard deviations, not the non-mathematically-derived severity labels. The SSI-3 and 4 have a table in the manual (Table 5) that provides means and standard deviations that indicate an average range of stuttering as compared to other people who stutter. Thus, people with average range stuttering as compared to other people who stutter will qualify.

Children who have “below average” stuttering are still at risk for stuttering persistence into adulthood. Longitudinal evidence indicates that plenty of children with mild range stuttering grow up to stutter, and a child’s best shot at remediation from childhood stuttering is treatment within the first three years after stuttering onset. Including evidence-based risk factors from these longitudinal studies allows for these children who have high risk for persistent stuttering to get the services they need.

School-age children, teens, and adults with persistent stuttering (will continue throughout the lifespan) who exhibit “below average” stuttering in a one-on-one clinical setting with a clinician often exhibit more severe stuttering for functional speaking tasks (e.g. presentations, reading aloud in class, phone calls to unfamiliar people, job interviews, etc.). Allowing a clinician to use severity data with a speech sample gathered from a functional speaking task gets those clients the therapy they need to learn compensatory strategies to be more fluent in those situations.

Response: Thank you for your comment. This revision to the Therapy Manual and related changes in other provider manuals are being made to bring consistency to all Medicaid manuals containing therapy rules. DHS will continue to work with the Therapy Association and other stakeholders to consider your comment.

Angela Anderson

Comment: Hello,

I am a Speech-Language Pathology graduate student, and I am reaching out to you so that you all will consider changes for the speech therapy qualification guidelines for patients who stutter (Section 214.400, D, 5, "Fluency"). The guidelines are unclear concerning the types of tests that people who stutter receive, resulting in many people who stutter unjustly, not qualifying for therapy.

As a future SLP, I feel like the following edit to the guidelines would provide an evidence-based and just solution to fix this ongoing blunder in the manual and to get patients who stutter they therapy that they need:

FLUENCY: At least one norm-referenced, standardized test with good reliability and validity, and at least one supplemental tool to address affective components. Eligibility for fluency therapy will be based upon either a standard score within 1.0 standard from the mean or greater on the standardized test or an index score -1.5 SD below the mean comparing people who stutter to people who do not stutter. Exceptions to this scoring will be provided to patients whose scores are lower than within 1.0 SD from the mean or have an index score higher than -1.5 SD below the mean for:

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- Family history of stuttering in a first or second-order relative
- Males
- Steady or increasing stuttering severity as compared to stuttering severity at onset
- Dysfluencies of three or more units, present 7-months past onset
- Dysfluencies accompanied by secondary characteristics, present 7-months past onset
- Aberrant phonations (blocks or prolongations), present 7-months past onset

School-aged children and adults whose standard scores are within 1.0 standard deviation from the mean or greater when their speech sample is gathered from additional functional speaking tasks.

Response: Thank you for your comment. This revision to the Therapy Manual and related changes in other provider manuals are being made to bring consistency to all Medicaid manuals containing therapy rules. DHS will continue to work with the Therapy Association and other stakeholders to consider your comment.

Comment: These proposed changes to the guidelines solve a few problems:

By changing the guidelines to one standardized test, a clinician does not have to give the TOCS to a 4 or 5-year old who cannot participate in higher-level language tasks.

The SSI-3/4 will be interpreted with statistically derived means and standard deviations, not the non-mathematically-derived severity labels. The SSI-3 and 4 have a table in the manual (Table 5) that provides means and standard deviations that indicate an average range of stuttering as compared to other people who stutter. Thus, people with average range stuttering as compared to other people who stutter will qualify.

Children who have "below average" stuttering are still at risk for stuttering persistence into adulthood. Longitudinal evidence indicates that plenty of children with mild range stuttering grow up to stutter, and a child's best shot at remediation from childhood stuttering is treatment within the first three years after stuttering onset. Including evidence-based risk factors from these longitudinal studies allows for these children who have high risk for persistent stuttering to get the services they need.

School-age children, teens, and adults with persistent stuttering (will continue throughout the lifespan) who exhibit "below average" stuttering in a one-on-one clinical setting with a clinician often exhibit more severe stuttering for functional speaking tasks (e.g. presentations, reading aloud in class, phone calls to unfamiliar people, job interviews, etc.). Allowing a clinician to use severity data with a speech sample gathered from a functional speaking task gets those clients the therapy they need to learn compensatory strategies to be more fluent in those situations.

The world is in a strange and unusual time, and we, as clinicians, should do all that we can to edify and serve everyone to the best of our abilities. The outlined changes may seem small to you, but they could change someone's life, even in a pandemic. Thank you for your consideration and time.

Response: Thank you for your comment. This revision to the Therapy Manual and related changes in other provider manuals are being made to bring consistency to all Medicaid manuals containing therapy rules. DHS will continue to work with the Therapy Association and other stakeholders to consider your comment.

Theresa Warner, B.A., Graduate Student in Speech-Language Pathology, University of Arkansas for Medical Sciences

Comment: To whom it may concern,

My name is Theresa Warner, and I am a graduate student in Speech-Language Pathology at the University of Arkansas for Medical Sciences. I have been informed that a new Medicaid manual for Occupational, Physical, Speech Therapy services is in the process of being edited, and I am reaching out to express my concerns regarding the speech therapy qualification guidelines for

patients who stutter (Section 214.400, D, 5, “Fluency”). The current guidelines for qualification are problematic to say the least, and result in many people who stutter’s being excluded from therapy unjustly.

There are only two accepted tests under current Medicaid guidelines for fluency: the Stuttering Severity Instrument – Third Edition (SSI-3) or newer, and the Test of Childhood Stuttering (TOCS). Under current guidelines, a patient is eligible for therapy based on a standard score of -1.5 SD or greater below the mean from two tests. This is problematic for several reasons. First, the SSI-3 and SSI-4 are standardized on a disordered population, not a representative sample, meaning that the comparisons are within people who already stutter and not to fluent speakers. Thus, a score of -1.5 SD below the mean does not exist for this test, as there is no mean to which it is compared. Instead, the authors of the manual instruct that clients in the moderate range and beyond will qualify in lieu of a standard score. This is troubling as the labels are somewhat arbitrarily selected, and furthermore it means that only the worst among the stuttering population will get treatment. This is unjust, as even a “mild” stutter is still disordered speech and can have a huge impact on the client’s life. Current guidelines for other communication disorders compare them to the general population, not a disordered subset of the population. It is important that fluency guidelines be changed to be more fairly in line with other communication disorders.

Unlike the SSI-3 and 4, the TOCS does include an index score that compares children who stutter to children who do not stutter. However, the TOCS also provides a severity label which compares only children who stutter to each other. This leads clinicians to reject children who score in the severe range due to their severity label’s being only “mild.” Additionally, the TOCS is difficult for young children (4 and 5) to validly complete, adding an additional hurdle to their access to therapy.

Response: Thank you for your comment. This revision to the Therapy Manual and related changes in other provider manuals are being made to bring consistency to all Medicaid manuals containing therapy rules. DHS will continue to work with the Therapy Association and other stakeholders to consider your comment.

Comment: Due to the aforementioned problems, an evidence-based, fair correction to the manual is needed in order to ensure that patients who stutter get the therapy they need. These are the proposed changes:

FLUENCY: At least one norm-referenced, standardized test with good reliability and validity, and at least one supplemental tool to address affective components. Eligibility for fluency therapy will be based upon either a standard score within 1.0 standard from the mean or greater on the standardized test or an index score -1.5 SD below the mean comparing people who stutter to people who do not stutter. Exceptions to this scoring will be provided to patients whose scores are lower than within 1.0 SD from the mean or have an index score higher than -1.5 SD below the mean for:

Children within three years of stuttering onset who exhibit two of the following risk factors for persistent developmental stuttering:

- Family history of stuttering in a first or second-order relative
- Males
- Steady or increasing stuttering severity as compared to stuttering severity at onset
- Dysfluencies of three or more units, present 7-months past onset
- Dysfluencies accompanied by secondary characteristics, present 7-months past onset
- Aberrant phonations (blocks or prolongations), present 7-months past onset

School-aged children and adults whose standard scores are within 1.0 standard deviation from the mean or greater when their speech sample is gathered from additional functional speaking tasks.

Response: Thank you for your comment. This revision to the Therapy Manual and related changes in other provider manuals are being made to bring consistency to all Medicaid manuals containing therapy rules. DHS will continue to work with the Therapy Association and other stakeholders to consider your comment.

Comment: These changes would resolve several ongoing problems:

By changing the guidelines to one standardized test, a clinician would not be forced to give the TOCS to a young child who cannot validly participate in order to qualify them.

The SSI-3/4 would no longer be interpreted by non-mathematical severity levels but instead by statistically-derived means, which are provided in the testing manual by the authors.

Children who have “below average” stutter can still be at risk for stuttering persistence into adulthood. Children who exhibit a high risk for persistence based on evidence from longitudinal studies should not be denied access to the services they need.

Older children, teens, and adults with persistent stuttering who exhibit “below average” stuttering in a clinical setting may exhibit more severe stuttering in necessary tasks for their daily lives. Allowing a clinician to gather a speech sample from a functional speaking task would allow these clients access to the therapy they need in order to participate more fully in their lives.

I urge you to adopt the proposed changes and correct an error that has unfairly impacted children who stutter in Arkansas for too long. Thank you for your consideration.

Response: Thank you for your comment. This revision to the Therapy Manual and related changes in other provider manuals are being made to bring consistency to all Medicaid manuals containing therapy rules. DHS will continue to work with the Therapy Association and other stakeholders to consider your comment.

Joyce Bobo, B.S., Speech-Language Pathology Graduate student, 2nd Yr., University of Arkansas for Medical Sciences, College of Health Professions

Comment: The current Medicaid guidelines do not fairly represent the population of children who stutter. The current interpretation/labels are preventing many children who stutter from receiving speech language pathology services to increase their speech communication and positively impact their quality of life. Children who stutter are at risk for negative impacts on their social, emotional health and well-being and academic and professional successes.

There are only two accepted tests for Fluency: Stuttering Severity Instrument- Third and Fourth Editions (SSI-3/4) and The Test of Childhood Stuttering (TOCS). Both of these tests provide severity labels comparing children who stutter to other children who stutter which does not fairly represent/interpret the range of severity in relation to typical fluent speakers. In addition, the TOCS is difficult for young children, age 4 and 5, to fully participate in many of the testing tasks.

Response: Thank you for your comment. This revision to the Therapy Manual and related changes in other provider manuals are being made to bring consistency to all Medicaid manuals containing therapy rules. DHS will continue to work with the Therapy Association and other stakeholders to consider your comment.

Comment: The following corrections to the current guidelines are recommended:

FLUENCY: At least one norm-referenced, standardized test with good reliability and validity, and at least one supplemental tool to address affective components. Eligibility for fluency therapy will be based upon either a standard score within 1.0 standard from the mean or greater on the standardized test or an index score -1.5 SD below the mean comparing people who stutter to people who do not stutter. Exceptions to this scoring will be provided to patients whose scores are lower than within 1.0 SD from the mean or have an index score higher than -1.5 SD below the mean for:

Children within three years of stuttering onset who exhibit two of the following risk factors for persistent developmental stuttering:

- Family history of stuttering in a first or second-order relative
- Males
- Steady or increasing stuttering severity as compared to stuttering severity at onset
- Dysfluencies of three or more units, present 7-months past onset
- Dysfluencies accompanied by secondary characteristics, present 7-months past onset
- Aberrant phonations (blocks or prolongations), present 7-months past onset

School-aged children and adults whose standard scores are within 1.0 standard deviation from the mean or greater when their speech sample is gathered from additional functional speaking tasks.

Response: Thank you for your comment. This revision to the Therapy Manual and related changes in other provider manuals are being made to bring consistency to all Medicaid manuals containing therapy rules. DHS will continue to work with the Therapy Association and other stakeholders to consider your comment.

Comment: These proposed changes to the guidelines will solve a few problems:

By changing the guidelines to one standardized test, a clinician does not have to give the Test of Childhood Stuttering (TOCS)to a 4 or 5-year old who cannot participate in higher-level language tasks.

The Stuttering Severity Instrument- 3rd & 4th Editions (SSI-3/4) will be interpreted with statistically derived means and standard deviations, not the non-mathematically derived severity labels. The SSI-3 and 4 have a table in the manual (Table 5) that provides means and standard deviations that indicate an average range for stuttering as compared to other people who stutter. Thus, people with average range stuttering as compared to other people who stutter will qualify.

Children who have “below average” stuttering, are still at risk for stuttering persistence into adulthood. Longitudinal evidence indicates that plenty of children with mild range stuttering grow up to stutter, and a child’s best shot at remediation from childhood stuttering is treatment within the first three years after stuttering onset. Including evidence-based risk factors from these longitudinal studies allows for these children who have high risk for persistent stuttering to get the services they need.

School-age children, teens, and adults with persistent stuttering (will continue throughout the lifespan) who exhibit “below average” stuttering in a one-on-one clinical setting with a clinician often exhibit more severe stuttering for functional speaking tasks (e.g. presentations, reading aloud in class, phone calls to unfamiliar people, job interviews, etc.). Allowing a clinician to use severity data with a speech sample gathered from a functional speaking task gets those clients the therapy they need to learn compensatory strategies to be more fluent in those situations.

If you need additional references to studies and testing manuals to support the information provided, please don’t hesitate to ask me. I look forward to your attention in this matter. Thank you for your consideration in providing fair representation of Arkansans who stutter and their families seeking help. Respectfully,

Response: Thank you for your comment. This revision to the Therapy Manual and related changes in other provider manuals are being made to bring consistency to all Medicaid manuals containing therapy rules. DHS will continue to work with the Therapy Association and other stakeholders to consider your comment.

Lori Tankersley, MSOTR/L, Occupational Therapist

Comment: To whom it may concern:
I have worked in outpatient and school based pediatrics for 16 years. In this time, I have completed numerous evaluations on a variety of ages, diagnoses, and levels of complexity. I am writing today out of concern for the new complexity code changes. It has been my experience that pediatric OT evaluations, even for noncomplex cases, require an hour on average and can take up to an hour an a half to complete administration in order to complete an thorough assessment of a child's needs. The thought that evaluations could consistently be completed in 30 minutes is completely inaccurate. I hope you will take this into account when determining changes to complexity codes. Thank you

Response: Thank you for your comment. DHS is currently completing research at this time and will be working with the Therapy Association to address any questions related to complexity coding. Providers will be notified if changes are required.

Leah Lowe PT, DPT, PhD, ABPTS Pediatric Certified Specialist, PT #2916

Comment: To whom it may concern:

The functional terminology and designations included in the proposed complexity codes are rooted in the International Classification of Functioning, Disability and Health (ICF). I could not agree more with a transition to this method of conceptualizing the functioning of our patients. With any transition to a new conceptual system, however, careful thought and attention must be given to the practical nature of its application.

I would first like to submit that I enthusiastically agree with the Joint Statement on Therapy Evaluation Coding from the Arkansas chapter of the American Physical Therapy Association, the Arkansas Occupational Therapy Association, and the Arkansas Speech-Language-Hearing Association. The joint statement from these representative groups clearly outlines the difficulty in applying a one-size-fits-all element of time to these patient evaluations—a difficulty encountered by Medicare providers leading CMS to conclude that provider time is the same no matter the complexity of the patient.

As a physical therapist, I utilize a thorough history and examination to determine the strengths and needs of the patient before me. As a physical therapy educator, I teach students to utilize a thorough history and examination to determine the strengths and needs of the patient before them. The ICF provides a valuable framework for making clinical decisions related to assessment and measurement, a key element of a successful therapy evaluation. The ICF framework not only assists in organization of the physical examination techniques, but also in appropriate utilization of interview questions and other self- or caregiver-report instruments.

For example, to adequately examine and evaluate a 2-month-old infant with possible torticollis, even one who is by the end of the process deemed to be a patient with moderate complexity, the necessary history and examination procedures take more than the allotted 30 minutes of time. The therapist must carefully assess body systems with focus on body structures and functions including: body symmetry, screening for hip dysplasia, cervical ROM measured specifically with an arthrodial protractor, palpation (specifically of neck musculature), assessment of craniofacial asymmetries, tone, reflexes, visual tracking, skin fold assessment for skin integrity, strength, and pain.

The therapist must carefully assess body systems with focus on activity limitations including: Utilization of standardized testing based upon the age and presentation of the child. For a 2-month-old, the Test of Infant Motor Performance is evidence-based and the recommended assessment in the published Clinical Practice Guidelines. This is a lengthy test with 42 items. Additional, observation of gross motor skill acquisition as needed.

The therapist must carefully assess body systems with focus on participation restrictions including: This information is collected through a thorough interview with the caregiver exploring participation restrictions related to eating, sleeping, and the baby's ability to self-soothe.

The therapist must take a very skilled approach to the history for this patient to determine contextual factors associated with the case including environmental factors, personal factors, and/or comorbidities including: mother's pregnancy history, delivery history, family history of potentially related diagnoses, and additional medical reports and imaging findings.

The method described above is evidence-based, recommended in the Clinical Practice Guidelines for this patient population, and deeply rooted in the ICF. To perform this initial examination appropriately for any child with this health condition, regardless of determined complexity, a physical therapist will need more than 45 minutes. Therapists need adequate time not only to meet the needs of standardized testing to explore activity limitations and participation restrictions, but also to perform the appropriate measurements and assessments to determine the presence or absence of body structure and function impairments.

Arkansas therapy providers are well-educated and capable of meeting the challenges of Arkansas Medicaid evaluation requirements. As noted in the joint statement from the therapy associations, we support the continued use of stringent assessment guidelines to ensure clear documentation of need and to promote professional integrity of our programs. To continue to meet these criteria, adequate time is critical.

I ask you to reference the practical requests submitted via the joint statement from the therapy associations for consideration. These recommendations remove the unrealistic time limits associated with the codes and instead reflect the nature of examination and evaluation in the pediatric setting.

Thank you for your time and consideration of this matter. Together, we can better serve the children of our state. Sincerely,

Response: Thank you for your comment. This revision to the Therapy Manual and related changes in other provider manuals are being made to bring consistency to all Medicaid manuals containing therapy rules. DHS will continue to work with the Therapy Association and other stakeholders to consider your comment.

Mary Winkelman

Comment: Good afternoon,

I have some concerns about the Medicaid guidelines for fluency. I have heard a new Medicaid manual for Occupational, Physical, and Speech Therapy Services is in process of editing. I am concerned that some significant and necessary changes for speech therapy qualification guidelines for patients who stutter (Section 214.400, D, 5, "Fluency") will not take place. The current guidelines for qualification are extremely problematic. The guidelines do not make sense regarding the types of tests given to people who stutter. This will result in many people who stutter unjustly not qualifying for therapy.

There are only two accepted tests for Fluency right now. One is the Stuttering Severity Instrument-Third Edition (SSI-3) or newer and The Test of Childhood Stuttering (TOCS). The SSI-3 test is standardized on a disordered population. This makes severity rating comparisons within 1% of people who stutter, not a comparison of the 1% of stutterers to the general population fluent speakers. Thus, this does not give any sort of standard score compared to a mean. The current guidelines state that patients are eligible for therapy based on standard scores of -1.5 SD greater below the mean from two tests. The manual indicates that in lieu of a standard score, clients in the moderate range and beyond will qualify. There are two problems with that "moderate" solution to the standard scores problem. 1) The SSI-3/4 manuals specify that the severity labels "were selected as logical but not mathematical" and directs clinicians to look at the available means and standard deviations for the subtests are the total scores at each level. 2) Only accepting this arbitrarily labeled "moderate" or greater, means that only the worst among the stuttering population will get treatment.

Thus is we are placing the 1% of people who stutter on their own bell curve and categorize them based on non-mathematical labels, we then have a skewed view of the results. Someone with a "moderate" or greater can result in them being in a moderate range, when in fact, they are in great need of services due to their disfluency. This is because they are only compared to the 1% of people who stutter. So only those who stutter that score the lowest are getting services, when in fact, those who score average need services.

On the other accepted test – The Test of Childhood Stuttering (TOCS) – The TOCS does indeed include an Index Score that compares children who stutter to children who do not stutter. The index score for a child who stutters is consistently -1.5 SD below the mean (generally <58, given

the low incidence of stuttering). However, the TOCS also provides a severity label, again comparing children who stutter to other children who stutter. Clinicians interpreting the present guidelines consistently report that they cannot take a child with "mild" range stuttering on the TOCS because of the severity label, despite the fact that the child's index score is in the severe range. According to the Medicaid guidelines right now, if a child has a "mild" rating, but is in the severe range with their index score, they do not qualify when clearly there is difficulty shown. This needs to change and not be based just on the "severity label". We are missing people that would benefit from services.

Response: Thank you for your comment. This revision to the Therapy Manual and related changes in other provider manuals is being made to bring consistency to all Medicaid manuals containing therapy rules. DHS will continue to work with the Therapy Association and other stakeholders to consider your comment.

Comment: We need an evidence-based solution to fix this injustice to people who stutter. Here are some edits and proposed changes for an update on fluency qualifications in the Medicaid manual.

FLUENCY: At least one norm-referenced, standardized test with good reliability and validity, and at least one supplemental tool to address affective components. Eligibility for fluency therapy will be based upon either a standard score within 1.0 standard from the mean or greater on the standardized test or an index score of -1.5 SD below the mean comparing people who stutter to people who do not stutter. Exceptions to this scoring will be provided to patients whose scores are lower than within 1.0 SD from the mean or have an index score higher than -1.5 SD below the mean for:

Children within three years of stuttering onset who exhibit two of the following risk factors for persistent developmental stuttering:

- Family history of stuttering in a first or second-order relative
- Males
- Steady or increasing stuttering severity as compared to stuttering severity at onset
- Dysfluencies of three or more units, present 7-months past onset
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School-aged children and adults whose standard scores are within 1.0 standard deviation from the mean or greater when their speech sample is gathered from additional functional speaking tasks.

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By changing the guidelines to one standardized test, a clinician does not have to give the TOCS to a 4 or 5-year old who cannot participate in higher-level language tasks.

The SSI-3/4 will be interpreted with statistically derived means and standard deviations, not the non-mathematically-derived severity labels. The SSI-3/4 have a table in the manual (Table 5) that provides the means and standard deviations that indicate an average range of stuttering as compared to other people who stutter. Thus, people with average range stuttering as compared to other people who stutter will qualify.

Children who have "below average" stuttering are still at risk for stuttering persistence into adulthood. Longitudinal evidence indicates that plenty of children with mild range stuttering grow up to stutter, and a child's best shot at remediation from childhood stuttering is treatment within the first three years after stuttering onset. Including evidence-based risk factors from these longitudinal studies allow for these children who have high risk for persistent stuttering to get the services they need.

School-age children, teens, and adults with persistent stuttering (will continue throughout the lifespan) who exhibit "below average" stuttering in a one-on-one clinical setting with a clinician often exhibit more severe stuttering for functional speaking tasks (e.g. presentations, reading aloud in class, phone calls to unfamiliar people, job interviews, etc.) Allowing a clinician to use severity data with a speech sample gathered from a functional speaking task gets those clients the therapy they need to learn compensatory strategies to be more fluent in those situation.

I hope this helps and sheds light on a change we need to have in the Medicaid manual in order to provide services to people who stutter. We are missing the mark with the current qualifications and they should be adjusted to accommodate an accurate and evidence-based approach for approving services to this population. Knowing the persistence risk factors for those who stutter is key in identifying those in need of the services and adjusting the standardization will provide the necessary changes. Please reach out with any questions, and I will do my best to address them. Thanks,

Response: Thank you for your comment. This revision to the Therapy Manual and related changes in other provider manuals are being made to bring consistency to all Medicaid manuals containing therapy rules. DHS will continue to work with the Therapy Association and other stakeholders to consider your comment.

Hannah Pelton, B.S.E., University of Arkansas for Medical Sciences, College of Health Professions, Communication Sciences and Disorders

Comment: To whom it may concern,

I have heard that a new Medicaid manual for Occupational, Physical, Speech Therapy Services is in the process of editing. I am reaching out to you in an effort to get much-needed changes for the speech therapy qualification guidelines for patients who stutter. The guidelines for qualification are quite problematic. Essentially, the current guidelines do not make sense to the types of tests that are given to people who stutter; resulting in many of them not qualifying for services when they should.

There are only two accepted tests for Fluency: Stuttering Severity Instrument- Third Edition (SSI-3) or newer and The Test of Childhood Stuttering (TOCS). The current guidelines state that patients are eligible for therapy based on standard scores of -1.5 SD greater below the mean from two tests.

Response: Thank you for your comment. This revision to the Therapy Manual and related changes in other provider manuals are being made to bring consistency to all Medicaid manuals containing therapy rules. DHS will continue to work with the Therapy Association and other stakeholders to consider your comment.

Comment: I feel like the following edit to the guidelines would provide an evidence-based and just solution to fix this ongoing problem in the manual and to get patients who stutter they therapy that they need:

Minimum of one norm-referenced, standardized test with good reliability and validity, and at least one supplemental tool to address affective components. Eligibility for fluency therapy will be based upon either a standard score within 1.0 standard from the mean or greater on the standardized test or an index score -1.5 SD below the mean comparing people who stutter to people who do not stutter. Exceptions to this scoring will be provided to patients whose scores are lower than within 1.0 SD from the mean or have an index score higher than -1.5 SD below the mean for:

Children within three years of stuttering onset who exhibit two of the following risk factors for persistent developmental stuttering:

- Family history of stuttering in a first or second-order relative
- Males
- Steady or increasing stuttering severity as compared to stuttering severity at onset
- Dysfluencies of three or more units, present 7-months past onset
- Dysfluencies accompanied by secondary characteristics, present 7-months past onset
- Aberrant phonations (blocks or prolongations), present 7-months past onset

School-aged children and adults whose standard scores are within 1.0 standard deviation from the mean or greater when their speech sample is gathered from additional functional speaking tasks.

I hope this helps to give some insight on the current problem for fluency assessment as well as a proposed change. Best,

Response: Thank you for your comment. This revision to the Therapy Manual and related changes in other provider manuals are being made to bring consistency to all Medicaid manuals containing therapy rules. DHS will continue to work with the Therapy Association and other stakeholders to consider your comment.

Sarah McCarley

Comment: Hi,

I am reaching out to you regarding the qualifications that individuals who stutter must meet to receive services, (Section 214.400, D, 5, "Fluency"). The guidelines that are set are not inclusive enough to provide services to all of of your patients who suffer from the life altering communication impairment that is stuttering. As an establishment concerned with the care of it's customers I wanted to bring this error to your attention so that it could be rectified to better serve those who depend on you.

There are only two accepted tests for Fluency: Stuttering Severity Instrument- Third Edition (SSI-3) or newer and The Test of Childhood Stuttering (TOCS) (listed mistakenly as the 'Test for Childhood Stuttering' in the present manual). The current guidelines state that patients are eligible for therapy based on standard scores of -1.5 SD greater below the mean from two tests.

The Stuttering Severity Instrument-Third Edition and 4th Edition are standardized on a disordered population, making severity comparisons within the 1% of people who stutter, not a comparison of that 1% of stutterers to the general population of fluent speakers; thus, this test does not yield any sort of standard score that is compared to a mean. Obviously, a score of -1.5 SD below the mean does not even exist for this test. The edition of the therapy manual before the one updated in 7/2018 was accompanied by a FAQ addendum; in that addendum, someone asked how to interpret the SSI-3/4 since there is no standard score. The manual indicated that in lieu of a standard score, clients in the moderate range and beyond will qualify. There are two problems with that "moderate" solution to the standard scores problem. 1) The SSI-3/4 manuals specify that the severity labels "were selected as logical but not mathematical" and directs clinicians to look at the available means and standard deviations for the subtests are the total scores at each level. 2) Only accepting this arbitrarily labeled "moderate" or greater, means that only the worst among the stuttering population will get treatment.

Current guidelines for other communication disorders with tests comparing them to the general population accept the bottom 5th percentile of performance for that domain of

communication, and why should stuttering be treated any different when it has just as big of an impact on the individual as any other communication impairment would have?

Response: Thank you for your comment. This revision to the Therapy Manual and related changes in other provider manuals are being made to bring consistency to all Medicaid manuals containing therapy rules. DHS will continue to work with the Therapy Association and other stakeholders to consider your comment.

Comment: As a soon to be graduate of the UAMS Communication Sciences and Disorders program I am lucky enough to be learning under the best minds in my field and experts on every aspect of Speech - Language Pathology. We have spoken a great deal on the changes that should be made to the guidelines that would greatly improve the outlook for individuals with a stutter and here are our suggestions:

FLUENCY: At least one norm-referenced, standardized test with good reliability and validity, and at least one supplemental tool to address affective components. Eligibility for fluency therapy will be based upon either a standard score within 1.0 standard from the mean or greater on the standardized test or an index score -1.5 SD below the mean comparing people who stutter to people who do not stutter. Exceptions to this scoring will be provided to patients whose scores are lower than within 1.0 SD from the mean or have an index score higher than -1.5 SD below the mean for:

Children within three years of stuttering onset who exhibit two of the following risk factors for persistent developmental stuttering:

- Family history of stuttering in a first or second-order relative
- Males
- Steady or increasing stuttering severity as compared to stuttering severity at onset
- Dysfluencies of three or more units, present 7-months past onset
- Dysfluencies accompanied by secondary characteristics, present 7-months past onset
- Aberrant phonations (blocks or prolongations), present 7-months past onset

School-aged children and adults whose standard scores are within 1.0 standard deviation from the mean or greater when their speech sample is gathered from additional functional speaking tasks.

Response: Thank you for your comment. This revision to the Therapy Manual and related changes in other provider manuals are being made to bring consistency to all Medicaid manuals containing therapy rules. DHS will continue to work with the Therapy Association and other stakeholders to consider your comment.

Comment: These proposed changes to the guidelines solve a few problems:

By changing the guidelines to one standardized test, a clinician does not have to give the TOCS to a 4 or 5-year old who cannot participate in higher-level language tasks.

The SSI-3/4 will be interpreted with statistically derived means and standard deviations, not the non-mathematically-derived severity labels. The SSI-3 and 4 have a table in the manual (Table 5) that provides means and standard deviations that indicate an average range of stuttering as compared to other people who stutter. Thus, people with average range stuttering as compared to other people who stutter will qualify.

Children who have "below average" stuttering are still at risk for stuttering persistence into adulthood. Longitudinal evidence indicates that plenty of children with mild range stuttering grow up to stutter, and a child's best shot at remediation from childhood stuttering is treatment within the first three years after stuttering onset. Including evidence-based risk factors from these longitudinal studies allows for these children who have high risk for persistent stuttering to get the services they need.

School-age children, teens, and adults with persistent stuttering (will continue throughout the lifespan) who exhibit "below average" stuttering in a one-on-one clinical setting with a clinician often exhibit more severe stuttering for functional speaking tasks (e.g. presentations, reading aloud in class, phone calls to unfamiliar people, job interviews, etc.). Allowing a clinician to use severity data with a speech sample gathered from a functional speaking task gets those clients the therapy they need to learn compensatory strategies to be more fluent in those situations.

Thank you for taking these changes into consideration and working to provide the best services to those who depend on you.

Response: Thank you for your comment. This revision to the Therapy Manual and related changes in other provider manuals are being made to bring consistency to all Medicaid manuals containing therapy rules. DHS will continue to work with the Therapy Association and other stakeholders to consider your comment.

Jessica Mahoney

Comment: To Whom it May Concern:

I am writing with concern for the new Medicaid manual for Occupational, Physical, Speech Therapy Services. I am specifically concerned with the qualification guidelines for fluency. The requirements for qualification as they stand unjustly excluded children from services based on a problematic qualification process. We have a responsibility to the children of Arkansas and their access to services should not be denied on the basis of problematic testing procedures.

Guidelines require a standard score of -1.5 SD or greater below the mean from two tests in order to qualify. The Stuttering Severity Instrument - Third Edition (SSI-3) and the Test of Childhood Stuttering (TOCS) are the only two tests accepted for qualifying for services in the area of fluency. The issue is that the SSI-3 is an assessment that was standardized on a

disordered population. It was standardized on children who stutter, not on a typically developing population. Therefore, there is no meaningful comparison to a mean and no standard scores are yielded from this test. An addendum was added in an attempt to address this issue, resulting in a required "moderate" range or greater for qualification. This did not adequately pacify the problem as the severity labels for this test are not mathematically constructed. Sole acceptance of these non-mathematical severity labels is problematic because only the very worst of individuals who stutter will qualify for services. This is requiring individuals to be in the bottom 1%, whereas other communication disorders qualify individuals who fall into the bottom 5th percentile of performance. This discrepancy is unjust and results in a disproportionate exclusion of individuals who stutter from access to treatment. We must do better. Thank you for your time,

Response: Thank you for your comment. This revision to the Therapy Manual and related changes in other provider manuals are being made to bring consistency to all Medicaid manuals containing therapy rules. DHS will continue to work with the Therapy Association and other stakeholders to consider your comment.

Amanda Clark, Billing Supervisor / Health Information Systems Manager

Comment: We would like to make a couple of comments on the DHS/DDS—Rule Amendment for Occupational, Physical, and Speech-Language Therapy in regard to the SGD Evaluations. Thank you for giving us the opportunity to do so.

SGD Evaluations - Billing for required Occupational Therapist

In the Medicaid Manual for Occupational, Physical, Speech Language Services, section 215.000 B. 2. an occupational therapist is required to be part of the SGD Evaluation team, however only the speech therapist's time is currently billable.

The following description of billing an SGD evaluation in a hospital setting shows that in a hospital setting both the speech therapist and occupational therapist are reimbursed for their portion of the SGD Evaluation.

Please see page 19 & page 65
of https://medicaid.mmis.arkansas.gov/Download/general/comment/IPpckt-Therapy.pdf

The XIX (Medicaid) maximum is based on the current hourly rate for both disciplines of therapy involved in the evaluation process. The Medicaid maximum for speech-language therapy is $25.36 per (20 mins.) unit x's 3 units per date of service (DOS) and occupational therapy is $18.22 per (15 mins.) unit x's 4 units per DOS equals a total of $148.96 per hour.
Two (2) hours per DOS is allowed. This would provide a maximum reimbursement rate per DOS of $297.92.

We would like to propose that a code be identified (maybe the Re-evaluation code) or added to the Occupational, Physical, Speech Language Services Medicaid Manual that would allow the

occupational therapist to bill their portion of the ACD evaluation. If it is decided that adding a code is the best solution, an appropriate code might be 97755 Assistive technology assessment. 97755 Assistive technology assessment (e.g., to restore, augment, or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes.

Response: Thank you for your comment. This revision to the Therapy Manual and related changes in other provider manuals are being made to bring consistency to all Medicaid manuals containing therapy rules. DHS will continue to work with the Therapy Association and other stakeholders to consider your comment.

Comment: SGD Evaluations - Billing for proposed device trials requirement

On Page 33 and 34
of https://medicaid.mmis.arkansas.gov/Download/general/comment/IPpckt-Therapy.pdf

The following requirements have been added to perform a 4 week trial period with results added to the SGD Evaluation. The following (below) outlines the new requirements.

What CPT code will the speech therapists utilize to document the time they spend with the patient during the device trials, the outcome of which will be documented by the speech therapist within the SGD Evaluation?

Response: Thank you for your comment. This revision to the Therapy Manual and related changes in other provider manuals are being made to bring consistency to all Medicaid manuals containing therapy rules. DHS will continue to work with the Therapy Association and other stakeholders to consider your comment.

Comment: Will they use the 92507 Individual Speech Therapy code for this?

Response: Thank you for your comment. Codes and fees will be posted on the approved fee schedule for therapy allowed under the Medicaid State Plan.

Comment: Will there be any special requirements for obtaining a prescription / Extension of Benefits for this additional time?

Response: Thank you for your comment. It is unclear what you are referring to.

Comment: "The recommended SGD is prior authorized for purchase only after the client has completed a minimum of a

- four-week trial period that includes
- extensive experience with the requested system
- Data must be collected during the trial period
- document that the client can successfully use the recommended device.

- If the clinic cannot demonstrate successful use of the recommended device, subsequent trial periods with different devices shall occur until a device is identified that the client can successfully use.
- Information about the trial period must be documented in the evaluation report."

"The report must include information about the trial period documenting that the client could;

- successfully use the recommended device. This documentation must include information on
- length of trial,
- frequency of use of SGD,
- environments, activities and communication partners involved,
- access method(s) used,
- portability of the device,
- symbolic language system and rate enhancement used,
- number of symbols and layout of overlay used,
- a sample of language expressed,
- client's level of independence (prompting strategies) using the device and expressing various language functions, and a
- summary of baseline and end of trial data"

Response: Thank you for your comment. This revision to the Therapy Manual and related changes in other provider manuals are being made to bring consistency to all Medicaid manuals containing therapy rules. DHS will continue to work with the Therapy Association and other stakeholders to consider your comment.

David Ivers, J.D., VP for External Affairs & General Counsel, Easter Seals Arkansas

Comment: We appreciate the work that has gone into the proposed rules, including the removal of the IQ testing requirement for language therapy. Thank you.
Throughout the document the change was made to 2 units of evaluation per fiscal year. Does this mean that the two units can be billed on the same day?

When will therapy rates be increased? The rates have gone unchanged since 2008. During this 12 year period wages and costs have gone up significantly. Providers are now offering these services at a loss. It is very difficult to hire therapists when we cannot pay them near-market rates, particularly in rural areas. Therapists are choosing to work in other settings where they are paid more.

Also, please note that therapy rates and methodology are governed by the Arkansas Medical Society v. Reynolds Consent Decree. No changes can lawfully be made without the three plaintiff therapy associations and DHS reducing any agreement to writing and submitting an amendment to the Court.

Response: Currently there is a MUE edit barring 2 units from being billed on the same day. DHS continues to work with therapy associations to finalize an appropriate rate where one "unit" or one complexity evaluation is equivalent to the payment made to them today. All therapy services will be reviewed under the Governor's Executive Order. DHS is very familiar with the consent decree and is not violating it.

Ruth Giselle Barnice, B.S.

Comment: Hello,

My name is Ruth Barnice and I am conducting this email as a means of expressing some concerns about the current qualification guidelines for individuals who stutter (Section 214.400, D, 5, "Fluency"), according to the current Medicaid Manual for Occupational, Physical, Speech Therapy Services.

As someone who is active in the field of communication sciences and disorders, I am aware that this manual is in the process of editing and would like to contribute a general comment in favor of individuals who are being denied much-needed services.

Current qualification guidelines neglect the nature of the types of tests that are given to people who stutter, resulting in many people who stutter unsuitably not qualifying for therapy services.

There are only two accepted tests for Fluency: Stuttering Severity Instrument- Third Edition (SSI-3) or newer and The Test of Childhood Stuttering (TOCS) (listed mistakenly as the 'Test for Childhood Stuttering' in the present manual). The current guidelines state that patients are eligible for therapy based on standard scores of -1.5 SD greater below the mean from two tests.

While under current guidelines, only individuals who exhibit moderate to severe stuttering are eligible for services, this requirement does not take into account the fact that one of the accepted tests for fluency (SSI-3) has been normed on a disordered population (those who stutter). There are two problems with that "moderate" solution to the standard scores problem. 1) The SSI-3/4 manuals specify that the severity labels "were selected as logical but not mathematical" and directs clinicians to look at the available means and standard deviations for the subtests are the total scores at each level. 2) Only accepting this arbitrarily labeled "moderate" or greater, means that only the worst among the stuttering population will get treatment.

The TOCS does indeed include an Index Score that compares children who stutter to children who do not stutter. The index score for a child who stutters is consistently -1.5 SD below the mean (generally <58, given the low incidence of stuttering). However, the TOCS also provides a severity label, again comparing children who stutter to other children who stutter. Clinicians interpreting the present guidelines consistently report that they cannot take a child with "mild" range stuttering on the TOCS because of the severity label, despite the fact that the child's

index score is in the severe range. As someone who has given the TOCS hundreds of times, I find that despite it being normed on children who were as young as 4-years of age, 4 and 5-year old children have trouble validly participating in many of the testing tasks (e.g. rapid naming of pictures, imitating complex sentence structures, answering story prompts like "Describe the alien."). If a child can get through the hoops of being among the worst on the SSI-4, then they must also fully participate in the TOCS and get a score at or above the moderate range.

Several advocates for this population in the field of speech-language pathology have noticed the dis-service current guidelines pose for individuals whose quality of life would be significantly improved with appropriate speech-therapy services, but do not qualify.

Response: Thank you for your comment. This revision to the Therapy Manual and related changes in other provider manuals are being made to bring consistency to all Medicaid manuals containing therapy rules. DHS will continue to work with the Therapy Association and other stakeholders to consider your comment.

Comment: Some suggestions posed after several discussions about finding a solution for the discrepancy between qualification criteria and impairment degree in individuals who sutter. They are as follows:

FLUENCY: At least one norm-referenced, standardized test with good reliability and validity, and at least one supplemental tool to address affective components. Eligibility for fluency therapy will be based upon either a standard score within 1.0 standard from the mean or greater on the standardized test or an index score -1.5 SD below the mean comparing people who stutter to people who do not stutter. Exceptions to this scoring will be provided to patients whose scores are lower than within 1.0 SD from the mean or have an index score higher than -1.5 SD below the mean for:

Children within three years of stuttering onset who exhibit two of the following risk factors for persistent developmental stuttering:

- Family history of stuttering in a first or second-order relative
- Males
- Steady or increasing stuttering severity as compared to stuttering severity at onset
- Dysfluencies of three or more units, present 7-months past onset
- Dysfluencies accompanied by secondary characteristics, present 7-months past onset
- Aberrant phonations (blocks or prolongations), present 7-months past onset

School-aged children and adults whose standard scores are within 1.0 standard deviation from the mean or greater when their speech sample is gathered from additional functional speaking tasks.

These proposed changes to the guidelines solve a few problems: By changing the guidelines to one standardized test, a clinician does not have to give the TOCS to a 4 or 5-year old who cannot participate in higher-level language tasks.

Response: Thank you for your comment. This revision to the Therapy Manual and related changes in other provider manuals are being made to bring consistency to all Medicaid manuals containing therapy rules. DHS will continue to work with the Therapy Association and other stakeholders to consider your comment.

Comment: The SSI-3/4 will be interpreted with statistically derived means and standard deviations, not the non-mathematically-derived severity labels. The SSI-3 and 4 have a table in the manual (Table 5) that provides means and standard deviations that indicate an average range of stuttering as compared to other people who stutter. Thus, people with average range stuttering as compared to other people who stutter will qualify.

Children who have "below average" stuttering are still at risk for stuttering persistence into adulthood. Longitudinal evidence indicates that plenty of children with mild range stuttering grow up to stutter, and a child's best shot at remediation from childhood stuttering is treatment within the first three years after stuttering onset. Including evidence-based risk factors from these longitudinal studies allows for these children who have high risk for persistent stuttering to get the services they need.

Response: Thank you for your comment. This revision to the Therapy Manual and related changes in other provider manuals are being made to bring consistency to all Medicaid manuals containing therapy rules. DHS will continue to work with the Therapy Association and other stakeholders to consider your comment.

Comment: School-age children, teens, and adults with persistent stuttering (will continue throughout the lifespan) who exhibit "below average" stuttering in a one-on-one clinical setting with a clinician often exhibit more severe stuttering for functional speaking tasks (e.g. presentations, reading aloud in class, phone calls to unfamiliar people, job interviews, etc.). Allowing a clinician to use severity data with a speech sample gathered from a functional speaking task gets those clients the therapy they need to learn compensatory strategies to be more fluent in those situations.

I appreciate the interested parties for taking the time to read this message, and for seriously considering its content. These modifications have the potential to improve the lives of an innumerable amount of children, adolescents, and adults in the stuttering population. Thank you,

Response: Thank you for your comment. This revision to the Therapy Manual and related changes in other provider manuals is being made to bring consistency to all Medicaid manuals containing therapy rules. DHS will continue to work with the Therapy Association and other stakeholders to consider your comment.

ArkSHA: Arkansas Speech-Language-Hearing Association

Comment: To Whom it May Concern:

The following are changes that ArkSHA feels would better serve our clients and maintain an appropriate level of assessment and guidance for treatment.

By changing the guidelines to one standardized test, a clinician does not have to give the TOCS to a 4 or 5-year old who cannot participate in higher-level language tasks.

The SSI-3/4 will be interpreted with statistically derived means and standard deviations, not the non-mathematically derived severity labels. The SSI-3 and 4 have a table in the manual (Table 5) that provides means and standard deviations that indicate an average range of stuttering as compared to other people who stutter. Thus, people with average range stuttering as compared to other people who stutter will qualify.

Children who have "below average" stuttering are still at risk for stuttering persistence into adulthood. Longitudinal evidence indicates that plenty of children with mild range stuttering grow up to stutter, and a child's best shot at remediation from childhood stuttering is treatment within the first three years after stuttering onset. Including evidence-based risk factors from these longitudinal studies allows for these children who have high risk for persistent stuttering to get the services they need.

School-age children, teens, and adults with persistent stuttering (will continue throughout the lifespan) who exhibit "below average" stuttering in a one-on-one clinical setting with a clinician often exhibit more severe stuttering for functional speaking tasks (e.g. presentations, reading aloud in class, phone calls to unfamiliar people, job interviews, etc.). Allowing a clinician to use severity data with a speech sample gathered from a functional speaking task gets those clients the therapy they need to learn compensatory strategies to be more fluent in those situations.

Response: Thank you for your comment. This revision to the Therapy Manual and related changes in other provider manuals are being made to bring consistency to all Medicaid manuals containing therapy rules. DHS will continue to work with the Therapy Association and other stakeholders to consider your comment.

Comment: There are two key changes that have the potential to severely impact individuals needing speech generating devices in the state of Arkansas, as well as the ability of a licensed clinician to perform an evaluation:

Page 32, Section 215.000, Item B7: The team must evaluate use at least three ACD SGDs systems with different language/storage systems during the evaluation and these devices must not be from the same manufacturer or product line written documentation of each usage included in the ACD assessment.

Response: Thank you for your comment. This revision to the Therapy Manual and related changes in other provider manuals are being made to bring consistency to all Medicaid manuals containing therapy rules. DHS will continue to work with the Therapy Association and other stakeholders to consider your comment.

Comment: Page 32, Section 215.000, Item B8: The recommended SGD is prior authorized for purchase only after the client has completed a minimum of a four-week trial period that includes extensive experience with the requested system. Data must be collected during the trial period and document that the client can successfully use the recommended device. If the client cannot demonstrate successful use of the recommended device, subsequent trial periods with different devices shall occur until a device is identified that the client can successfully use. Information about the trial period must be documented in the evaluation report.

Response: Thank you for your comment. This revision to the Therapy Manual and related changes in other provider manuals are being made to bring consistency to all Medicaid manuals containing therapy rules. DHS will continue to work with the Therapy Association and other stakeholders to consider your comment.

Comment: We would like to comment on these two changes:

Relating to B7:

Seeks to undermine the clinical expertise and judgement as a licensed speech-language pathologist by forcing the use pieces of equipment you know do not satisfy the client's communication needs and, in fact, could be detrimental to language growth.

Requires the licensed speech-language pathologist to put your client through unnecessary device use, when there may have the clinical reasons supporting a particular language system. This will also slow the evaluation process, as there may not be equipment readily available from three different manufacturers.

Places an undue burden on the evaluator, to find equipment to perform evaluations and does not increase the rate at which you are reimbursed for such services.

Could detrimentally impact individuals needing communication devices and their families because of a delay in obtaining all the necessary equipment, etc., to perform the evaluation.

Other forms of durable medical equipment are not required to follow the same regulations (i.e., three different wheelchair manufacturers), needing a prescription for a drug does not require the trial of three different kinds, etc. What is proposed places an undue burden on multiple parties.

Response: Thank you for your comment. This revision to the Therapy Manual and related changes in other provider manuals are being made to bring consistency to all Medicaid manuals

containing therapy rules. DHS will continue to work with the Therapy Association and other stakeholders to consider your comment.

Comment: Relating to B8:

Adding the one-month trial period is good policy, and one that ArkSHA wholeheartedly supports. However, if this guideline will be mandated and a trial now required, B7 should not be made a requirement. The trial data will either support the recommendation or it will not, and, if it doesn't, the trial of a different device will be necessary.

Response: Thank you for your comment. This revision to the Therapy Manual and related changes in other provider manuals are being made to bring consistency to all Medicaid manuals containing therapy rules. DHS will continue to work with the Therapy Association and other stakeholders to consider your comment.

Comment: Now may also be a good time to provide comments on the long-standing Arkansas Medicaid requirement that an Occupational Therapist to be part of the AAC/SGD evaluation process, a requirement that many other states do not have:

Note item #B2 and #B5 in section 215.00. Many other states do not require a licensed therapist from another specialty. The treating speech-language pathologist, the expert in language, should be able to make a recommendation based on expertise and understanding of how language develops and how the SGD systems can meet the clients' needs. Inclusion of the OT in the process should be fashioned the same as it is for a physical therapist according to the guidelines: "a physical therapist should be added to the team if it is determined that there is a need for assistance in the evaluation as it relates to…" The same could be said for an OT: they may be added the team to assist with fine motor skills as those skills relate to use of the SGD however not required to be part of the team. Furthermore, B3 would be reworded and B5 would be struck down completely.

Thanks for your time and interest. The AAC evaluation process is an important to the members of ArkSHA.

Response: Thank you for your comment. This revision to the Therapy Manual and related changes in other provider manuals are being made to bring consistency to all Medicaid manuals containing therapy rules. DHS will continue to work with the Therapy Association and other stakeholders to consider your comment.

<u>Barbara Jones, M.S., CCC-SLP, Clinical Instructor, UAMS, College of Health Professions Speech and Hearing Clinic</u>

Comment: To whom it may concern,

I am alarmed that the state is considering limiting evaluations for therapies to two units. For our severely needy children, four units are seldom enough to cover the evaluations that we actually perform. To limit payment to two units will affect our ability to perform, analyze and

report on the communicative abilities of these children. Please consider continuing the four unit assignment in 2020.

Thank you for your kind attention to this matter.

Barbara Jones, M.S., CCC-SLP

Response: Thank you for your comment. DHS is currently completing research at this time and will be working with the Therapy Association to address any questions related to complexity coding. Providers will be notified if changes are required.

Stephanie Smith, with Easter Seals of Arkansas

Comment: I am not sure if this has already been addressed with the legal component of all of this, but any rate changes with therapy have to go through the consent decree. But rate changes and the procedure code and -- this was missed when the speech therapy codes were changed but cannot be missed again. So that needs to be addressed before we move forward. And if you need a copy of the consent decree, I can provide that to you.

Response: Thank you. We have copies of all consent decrees pertaining to Medicaid rates. Please see previous response to David Ivers above.