



Legislative Report

Report on barriers, strategies and effectiveness of practices in the identification of children between the ages of 1-3 with symptoms of autism spectrum disorder

Disability Services Division

August 2021

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I. Executive summary

The Minnesota Department of Human Services (DHS) developed this report in response to a legislative mandate ([Minn. Stat. §256B.69, subd. 32a](#)), requiring managed care organizations (MCOs) to submit the following information annually. The requirement allows DHS to monitor early screening, diagnosis and treatment services for young children with symptoms of autism spectrum disorder (ASD) served by the MCOs.

This report identifies barriers to screening, diagnosis and treatment of young children, ages 1-3. It also identifies strategies MCOs and county-based purchasing (CBP) plans use to address those barriers. It includes recommendations from each MCO about:

- How to measure and report on the effectiveness of the strategies to improve access for young children to periodic developmental and social-emotional screenings (as recommended by the Minnesota Interagency Developmental Screening Task Force)
- Diagnosis.

Treatment recommendations include:

- Training and education for providers on best practices in screening and diagnostic tools
- Training and education for parents and caregivers on typical developmental milestones and the early warning signs of ASD
- Culturally meaningful training and education on the early signs of ASD for parents and providers in their preferred language
- Efforts to build provider capacity to reduce wait times and improve timely access to services
- Increased coordination across education, health care, mental and behavioral health resources.

As public program providers, MCOs and county-based purchasing plans have an important role to play in the development of best practices in policies and procedures for screening, diagnosis and treatment of young children in Minnesota. It is also critical to involve other state agencies and multidisciplinary providers who are part of the system of care and supports for children with ASD. This report will provide further analysis and direction for improving timely access to services for young children with developmental concerns.

II. Legislation

The legislative authority requiring that MCOs report barriers to screening, diagnosis and treatment of young children between the ages of 1 and 3 is found in Minn. Stat. 2018, §256B.69, subd. 32a.

Initiatives to improve early screening, diagnosis, and treatment of children with autism spectrum disorder and other developmental conditions.

(a) The commissioner shall require managed care plans and county-based purchasing plans, as a condition of contract, to implement strategies that facilitate access for young children between the ages of one and three years to periodic developmental and social-emotional screenings, as recommended by the Minnesota Interagency Developmental Screening Task Force, and that those children who do not meet milestones are provided access to appropriate evaluation and assessment, including treatment recommendations, expected to improve the child's functioning, with the goal of meeting milestones by age five.

(b) The following information from encounter data provided to the commissioner shall be reported on the department's public Web site for each managed care plan and county-based purchasing plan annually by July 31 of each year beginning in 2014:

- (1) the number of children who received a diagnostic assessment;
- (2) the total number of children ages one to six with a diagnosis of autism spectrum disorder who received treatments;
- (3) the number of children identified under clause (2) reported by each 12-month age group beginning with age one and ending with age six; and
- (4) the types of treatments provided to children identified under clause (2) listed by billing code, including the number of units billed for each child.

(c) The managed care plans and county-based purchasing plans shall also report on any barriers to providing screening, diagnosis, and treatment of young children between the ages of one and three years, any strategies implemented to address those barriers, and make recommendations on how to measure and report on the effectiveness of the strategies implemented to facilitate access for young children to provide developmental and social-emotional screening, diagnosis, and treatment as described in paragraph (a).

III. Introduction

Nationally, one in 54 children¹ has been identified with ASD, according to estimates from Centers for Disease Control and Prevention’s Autism and Developmental Disabilities Monitoring. The CDC defines ASD as “a developmental disability that can cause significant social, communication and behavioral challenges.”²

ASD usually appears during the first three years of a child’s life. Most parents first notice the loss of skills or developmental delays when their children are 15 to 18 months old. Even though researchers cannot point to one specific cause for ASD, research consistently suggests that early diagnosis and intervention offer the best chance for improving function and increasing the child’s progress and outcomes.

A recent study from the Minnesota Autism Developmental Disabilities Monitoring network in Hennepin and Ramsey counties found approximately 1 in 44 or 2.3 percent of 8-year-old children were identified with ASD. The average age of diagnosis was 4 years, 8 months. ASD may be diagnosed in children as young as 18 to 24 months; however, many children are identified when they enter school or when social demands exceed their skill levels. A delay in proper diagnosis results in a delay in accessing early intervention services.

Despite research indicating early intervention as best practice, for many children ASD is diagnosed several years after the appearance of symptoms (Mandell et al., 2009)³ and is often misdiagnosed (Mandell, Ittenbach, Levy & Pinto-Martin, 2007)⁴. Late diagnosis and misdiagnosis of ASD disproportionately affects children from culturally and racially diverse communities (Mandel et al., 2009; Mandell, Ittenbach, Levy & Pinto-Martin, 2007). In one study looking at 406 Medicaid-eligible children, researchers found African-American children were found to be 2.6 times less likely than white children to receive an autism diagnosis at their first specialty care visit (the most common misdiagnosis

¹ CDC. (2018). Prevalence of Autism Spectrum Disorder Among Children Aged 8 Years — Autism and Developmental Disabilities Monitoring Network, 11 Sites, United States, 2014. Accessed from <https://www.cdc.gov/mmwr/volumes/67/ss/ss6706a1.htm>

² CDC. (2016). Autism spectrum disorder. Accessed from <https://www.cdc.gov/ncbddd/autism/index.html>

³ Mandell, D.S. et al. (2009). Racial/ethnic disparities in the identification of children with autism spectrum disorders. *American Journal of Public Health*, 99(3), 493-498

⁴ Mandell, D.S, Ittenbach, R.F., Levy, S. E. & Pinto-Martin, J.A. (2007). Disparities in diagnoses received prior to a diagnosis of autism spectrum disorder. *Journal of Autism and Developmental Disorders*, 37(9), 1795-1802

for this population was ADHD) (Mandell, et al.). Children who are consistently seeing a primary care doctor are more likely to receive an earlier diagnosis of autism; children who switched pediatricians in their first five years of life had later diagnoses than their peers (Daniels and Mandell, 2014)⁵. Studies have found that seeing a greater number of physicians or other healthcare professionals is associated with a later age at diagnosis (Daniels and Mandell, 2014)⁶.

A strong evidence base shows disparities in the age at which white children and Black, Indigenous and children of color are diagnosed with autism spectrum disorder (Daniels and Mandell, 2014; Fountain et al., 2011; St. Amant et al., 2018)^{5,7,8}. There are a variety of hypotheses as to why this difference exists, all of which are related to social, economic and cultural factors; there is no evidence suggesting that autism prevalence varies by race (Burkett, Morris, Manning-Courtney, Anthony, and Shambley-Ebron, 2015)⁹.

During the past several years, DHS and its contractors asked stakeholders about access to intervention services and supports for children with ASD and their families. Wilder Research and DHS worked together to create the following resources. Recently these resources were expanded and translated for use by state agencies, providers or other stakeholders to share information with families of a child with autism:

- The [First Steps: Pathway to learning, playing and growing, DHS-6751L \(PDF\)](#) provides a summary of key developmental milestones that babies and toddlers should be achieving. It also has tips, tools and guidance to help your child's development. In addition, it describes what resources are available to parents and caregivers who have questions or concerns about their child's development. The First Steps: Pathway to learning, playing and growing document also is available in [Hmong \(PDF\)](#), [Somali \(PDF\)](#), [Karen \(PDF\)](#), [Oromo \(PDF\)](#), [Russian \(PDF\)](#), [Vietnamese \(PDF\)](#) and [Spanish \(PDF\)](#).

⁵ Daniels, A. & Mandell, D. (2014). Explaining differences in age at autism spectrum disorder diagnosis: A critical review. *Autism*, 18(5), 583-597.

⁶ Ibid.

⁷ Fountain, C., King, M., & Bearman, P. (2011). Age of diagnosis for autism: Individual and community factors across 10 birth cohorts. *Journal of Epidemiology and Community Health*, 65(6), 503-510.

⁸ St. Amant, H., Schragger, S., Pena-Ricardo, C., Williams, M., & Vanderbilt, D. (2018). Language barriers impact access to services with autism spectrum disorders. *Journal of Autism and Developmental Disorders*, 2018(48), 333-340.

⁹ Burkett, K., Morris, E., Manning-Courtney, P., Anthony, J., & Shambley-Ebron, D. (2015). African American families on autism diagnosis and treatment: The influence of culture. *Journal of Autism and Developmental Disorders*, 2015(45), 3244-3254.

- The [Next Steps: Pathway to services and supports for a child recently identified with ASD, DHS-6751J \(PDF\)](#) helps parents and caregivers understand options for their child in the year after diagnosis. The Next Steps: Pathway to services and supports for a child recently identified with ASD document also is available in [Hmong \(PDF\)](#), [Somali \(PDF\)](#), [Karen \(PDF\)](#), [Oromo \(PDF\)](#), [Russian \(PDF\)](#), [Vietnamese \(PDF\)](#) and [Spanish \(PDF\)](#).
- The [Pathway to ASD services and supports, DHS-6751 \(PDF\)](#) helps parents and caregivers navigate what options are available to their child in the years that follow. The Pathway to ASD services and supports document also is available in [Hmong \(PDF\)](#), [Oromo \(PDF\)](#), [Somali \(PDF\)](#), [Russian \(PDF\)](#), [Vietnamese \(PDF\)](#), [Karen \(PDF\)](#) and [Spanish \(PDF\)](#).
- The [Next Stage: Pathway to Transition and Long-Term Services and Supports for ASD, DHS-6751K \(PDF\)](#) outlines resources available to young adults and adults as they transition into independent living and the work world. The Next Stage: Pathway to Transition and Long-Term Services and Supports for ASD document also is available in [Hmong \(PDF\)](#), [Karen \(PDF\)](#), [Oromo \(PDF\)](#), [Russian \(PDF\)](#), [Somali \(PDF\)](#) and [Spanish \(PDF\)](#).
- The [Navigating Autism Supports and Services: A guidebook for parents and caregivers, DHS-8129 \(PDF\)](#) is a helpful resource to walk through the process of accessing services and supports step by step. The guidebook is also available in [Hmong \(PDF\)](#), [Somali \(PDF\)](#) and [Spanish \(PDF\)](#).

DHS created additional resources in response to feedback from stakeholders who identified struggles in knowing which services or support will best meet the needs of the child and build off their strengths. The [online autism services navigation tool](#) is available for case managers, social workers and other professionals to help them make accurate and appropriate referrals to early intervention services and supports based on the needs of the child and family. The services and supports people access depend on the person, their current needs and preferences. The tool does not replace the need for formal assessments and evaluations. Instead, it helps people to connect to the right services at the right time. It is meant to be referred back to as the child ages or their needs change. The navigation tool is being translated into Hmong, Somali and Spanish.

DHS also develop a [self-paced, online coordinating services and supports for a child with ASD or a related condition course](#). This course helps participants differentiate between EIDBI, Children’s Therapeutic Services and Supports (CTSS) and other services for children with ASD and related conditions.

Additionally, the following materials could also be useful for stakeholders:

- [Screening fact sheet for doctors and pediatricians \(PDF\)](#)
- [Centers for Disease Control and Prevention Autism Spectrum Disorder website](#)
- [Minnesota Department of Health Recommended Screening Instruments webpage](#)
- [Minnesota Autism Resource Portal website.](#)

Another result of this engagement process was a report to the Legislature in December 2012 titled [A Report on Early Intervention Services for Minnesota’s Children with Autism Spectrum Disorders](#). The report includes a section of stakeholder responses highlighting key characteristics of effective early intervention services broken down into 11 categories. Three of those categories relate to the information MCOs are required to provide under Minn. Stat. §256B.69, subd. 32a. Each of these categories includes comments (identified below by section name) that relate to practices the MCOs have in place or are trying to implement, but have encountered barriers to implementation:

- Early Means Early:
 - Early screening and diagnosis are the keys to effective intervention.
 - Early intervention has been found to be the most effective. It is also often easier for children to access services at a younger age and to receive those services in their home or other natural environments.
 - Providers need a more accessible and systematic process for conducting screening and diagnostic assessment.
- Individualized to unique needs:
 - Providers will show respect for the unique needs, values and perspectives of the person with ASD and his or her family.
 - Providers will design programs around the specific needs of the person with modifications that match their spectrum profile, age and developmental stage. They will use individualized motivational strategies and behavioral and developmental support systems.
 - Providers will deliver services in the home or in a center, depending on the child’s needs.
- Data-driven with frequent, ongoing assessment:
 - Providers will identify best practices to track progress toward positive outcomes for each child receiving early intensive intervention services.

DHS has a number of data sources that describe characteristics of children with an ASD. But it does not have information – beyond claims data – about the screening process used by each MCO, the barriers they encounter, and the strategies they use to ensure children have access to appropriate care. The information from MCOs allows DHS, during this reporting cycle, to better understand what is occurring. It also helps to raise awareness for future work, to develop and improve early access to screening, diagnosis and treatment, especially for children who do not meet milestones.

For the eighth year, MCOs met their Families and Children Contract obligation by providing the requested information (see questions 1 to 7) on implementing strategies to reduce barriers to screening, diagnosis and treatment for children, ages 1-3.

Additionally this year, MCOs provided information about member use of the [Early Intensive Developmental and Behavioral Intervention \(EIDBI\) benefit](#). The EIDBI benefit is Minnesota’s Medicaid early intervention service for children with ASD and related conditions. The benefit was passed into law in 2013 and has undergone many changes over the years. These changes have resulted in increased usage of the benefit. The purpose of the EIDBI Benefit is to provide medically necessary early intensive intervention for people with ASD and related conditions, as well as:

- Educate, train and support their parents and families
- Promote people’s independence and participation in family, school and community life
- Improve long-term outcomes and the quality of life for people and their families.

MCOs also reported relevant data and demographics (see questions 8-10) for children accessing these services. Below are the MCO responses.

IV. Questions and responses

Question 1: What social-emotional and developmental screening tools are being used by pediatric and family practice clinics for children, ages 1-3?

The Minnesota Interagency Developmental Screening Task Force recommends the following [developmental and social-emotional screening instruments](#) for use in Minnesota programs that provide screening for children from birth to 5 years old. The task force approved this list in July 2018 and will update the list as it reviews new or revised developmental screening instruments and in response to statutory, rule or regulatory changes that affect comprehensive screening programs in Minnesota.

- [All Instruments at a Glance \(PDF\)](#) lists all recommended developmental and social-emotional screening instruments by type, age, multiple languages (yes/no), and program.
- [Instruments at a Glance for Minnesota Clinics and Providers \(PDF\)](#) lists a subset of recommended screening instruments that are more practical for use in primary care clinics.

According to participating MCOs, the most commonly used developmental screening tools conducted by parent report were the Ages & Stages Questionnaires: 3rd edition (ASQ-3) and the Parent Evaluation of Developmental Status (PEDS).

The most commonly used developmental screening tools conducted by observation were: the Battelle Developmental Inventory, Second Edition (BDI-2); the Bayley Scales of Infant and Toddler Development, Third Edition (Bayley-3); the Brigance Early Childhood Screens (BECS); the Developmental Indicators for Assessment of Learning, Fourth Edition (DIAL-4); and the Early Screening Inventory-Revised (ESI-R). Less commonly used observational screening tools included the Minneapolis Preschool Screening Instrument, Revised (MPSI-R).

The most commonly used social-emotional screening tools were the Ages & Stages Questionnaires: Social-Emotional (ASQ-SE) and the Modified Checklist for Autism in Toddlers (M-CHAT). Less commonly used social-emotional screening tools used were the Brief Infant Toddler Social Emotional Assessment (BITSEA) and the Pediatric Symptom Checklist (PSC).

None of the MCOs reported any use of the following screening tools: Survey of Wellbeing of Young Children (SWYC); Early Screening Profiles (ESP); FirstSTEPS Screening Tool; Infant Development Inventory (IDI); Child Development Review Parent Questionnaire (CDR-PQ); and Denver II. These instruments do not meet the [instrument review criteria outlined by MDH](#). We do not recommend these instruments for use in Minnesota's screening programs and do not approve them for use in Minnesota's Early Childhood Screening program. We recommend programs that use these instruments change to a [recommended observational screening tool](#).

For more information about the screening instruments, see [MDH's Developmental and social-emotional screening of young children \(0-5 years of age\) in Minnesota webpage](#).

Blue Plus

Pediatric & Family Practice Clinics do not use a single uniform screening tool. Acceptable tools can include:

- Developmental screening instruments (Parent report):
 - Ages & Stages Questionnaire, Third Edition (ASQ–3)
 - Parents' Evaluation of Developmental Status (PEDS)
- Developmental screening instruments (Observational):
 - Battelle Developmental Inventory, Second Edition (BDI–2)
 - Bayley Scales of Infant and Toddler Development, Third Edition (Bayley–3)
 - Brigance Early Childhood Screens Three (BECS)
 - Developmental Indicators for Assessment of Learning, Fourth Edition (DIAL–4)
 - Early Screening Inventory, Revised (ESI–R), 2008 Edition
 - Minneapolis Preschool Screening Instrument, Revised (MPSI-R) 2015
- Social-emotional instruments:
 - Ages & Stages Questionnaires: Social-Emotional (ASQ-SE2)

HealthPartners

HealthPartners does not require prior authorization of EIDBI services for children 1-3, therefore we [HealthPartners] do not know all the tools which may be used by these provider types. We do know, however, that, per the C&TC Periodicity Schedule, many providers use ASQ and ASQ-SE for the developmental and social emotional screenings.

Hennepin Health

- Developmental screening instruments (Parent report):
 - Ages & Stages Questionnaire, Third Edition (ASQ–3)
- Social-emotional instruments:
 - Ages & Stages Questionnaires: Social-Emotional (ASQ-SE)
 - Modified Checklist for Autism in Toddlers (M-CHAT)

Itasca Medical Care

In Itasca County, the majority of clinics continue to utilize the:

- Developmental screening instruments (Parent report):
 - Ages & Stages Questionnaire, Third Edition (ASQ–3)
 - Parents’ Evaluation of Developmental Status (PEDS)
- Social-emotional instruments:
 - Ages & Stages Questionnaires: Social-Emotional (ASQ-SE)
 - Modified Checklist for Autism in Toddlers (M-CHAT)

PrimeWest

PrimeWest Health facilitates the following screenings that are available for children ages 0-3, and requires that providers complete these at every well-child visit or child and teen checkup (C&TC). The screenings are added to members’ electronic medical records (EMRs) as applicable.

- Developmental screening instruments (Parent report):
 - Ages & Stages Questionnaire, Third Edition (ASQ–3)
 - Parents’ Evaluation of Developmental Status (PEDS)
- Developmental screening instruments (Observational):
 - Battelle Developmental Inventory, Second Edition (BDI–2)
 - Bayley Scales of Infant and Toddler Development, Third Edition (Bayley–III) Screening Test
 - Brigance Early Childhood Screens (0 – 35 months, 3 – 5 years, K & 1)
 - Developmental Indicators for Assessment of Learning, Fourth Edition (DIAL–4)
 - Early Screening Inventory, Revised (ESI–R), 2008 Edition
 - Minneapolis Preschool Screening Instrument, Revised (MPSI–R)
- Social-emotional instruments:
 - Ages & Stages Questionnaires: Social–Emotional (ASQ:SE)
 - Brief Infant Toddler Social Emotional Assessment (BITSEA)
 - Modified Checklist for Autism in Toddlers (M-CHAT)

South Country Health Alliance

South Country Health Alliance does not require providers to use a specific social-emotional and developmental screening tool. We [South Country Health Alliance] follow the guidance for tools as listed in the DHS Provider manual which may include the following screening programs:

Developmental screening instruments (Parent report)

- Ages and Stages Questionnaire (ASQ-3)
- Parents Evaluation of Developmental Status (PEDS)

Developmental screening instruments (observational)

- Battelle Developmental Inventory 2nd Editions (BDI-2)
- Bayley Scales of Infant and Toddler Development, 3rd ed. (Bayley-III)
- Brigance Early Childhood Screen III
- Developmental Indicators for Assessment of Learning 4th edition
- Early Screening Inventory, Revised (ESI-R)
- Minneapolis Preschool Screening Instrument, Revised (MPSI-R)

Social-Emotional screening instruments

- Ages and Stages Questionnaire: Social-Emotional, 2nd ed (ASQ: SE-2)
- Pediatric Symptom Checklist (PSC)

UCare

UCare does not require providers to utilize a specific socio-emotional and developmental screening tool. UCare encourages providers within our network to use one of the screening tools recommended by the Minnesota Interagency Developmental Screening Task Force. Providers have the ability to access screening and recommended instrument information from the MDH website ([Developmental and social-emotional screening of young children \(0-5 years of age\) in Minnesota](#)). Providers are also encouraged to visit the DHS website ([Children's Mental Health Screening](#)) for information on early childhood screenings and C&TC.

Question 2: In what settings are social-emotional and developmental screenings conducted for children ages 1-3? In which of these settings are screenings reimbursable as health care services?

The most common settings for social-emotional and developmental screenings are primary care clinics, certified behavioral health clinics or public schools. Many screenings are also conducted in the home in association with family home visits, which are reimbursable. The MCOs reimburse for screenings conducted by eligible licensed health-care professionals.

The MCOs use programs such as Follow Along, Child & Teen Checkups, Help Me Grow, Family Home Visiting, Public Health and Woman and Infant Children (WIC) or other local programs to promote early social-emotional and developmental screenings.

MDH recommends the following programs: [Minnesota Early Childhood Screening program](#) is targeted for ages 3 to 4 years and is required before public school entrance. The [Follow Along Program](#) is a developmental-screening program targeted at Minnesota children ages birth to 36 months. Child and Teen Checkups (C&TC) is the Minnesota Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. For more information, visit [C&TC - Department of Human Services](#) or [C&TC - Department of Health](#). Newborns, children and adolescents through the age of 20 should get routine child and teen checkups. Family home visiting (FHV) is a voluntary, home-based service ideally delivered prenatally

through the early years of a child's life. It provides social, emotional, health-related and parenting support and information to families, and links them to appropriate resources.

Blue Plus

- The most common settings for these screenings are family practice clinics, primary care clinics, public health clinics and specialty clinics.
- These services are reimbursable as health care services in all of the above settings.

HealthPartners

- Child and teen checkup and well child visits in a clinic setting – reimbursable
- Family home visits – reimbursable
- Screenings conducted via telemedicine – follows same reimbursement as if in-clinic/onsite

Hennepin Health

- Screenings are completed in a variety of settings including primary-care, pediatric and family practice, Federally Qualified Health Clinics (FQHCs) and Hennepin County Public Health Clinics, and WIC clinics.
- Screenings provided by primary care, pediatrics, FQHC clinics and public health clinics are reimbursed.
- According to Hennepin County Public Health Department, screens done at the WIC clinic have reimbursement challenges.
- These are not documented in typical systems like electronic health records (EHRs); rather documented in SQL Server Integration Services (SSIS).

Itasca Medical Care

- Itasca County school districts' early childhood programs, including Head Start and Invest Early, complete the social-emotional and developmental screening for children birth to 7 years of age upon enrollment into the program. This screening is free to anyone and is not billed or reimbursed by any health insurance. The school psychologist can do formal testing, utilizing the Autism Spectrum Rating Scale and Autism Diagnostics Observation Scale (ADOS) with the help of parents and teacher. This can give an educational determination of ASD; a referral must be made for a medical diagnosis.
- Starting at 4 months of age, ASQs are sent in the mail every 4 months and ASQ:SEs are sent every 6 month for parents to complete. This goes up to age 3.
- We make referrals to Help Me Grow (school district birth to three program). Help Me Grow is administered through the local school districts and they complete a special education evaluation.

- Healthy Families Itasca-home visiting program for first time, pregnant moms who qualify for WIC. Evidence-based parenting curriculum, intensive home visiting. This program goes up to the child turning 3 years of age. ASQ and ASQ: SEs are administered in this program as well along with any necessary referral to Help Me Grow. This is a free service offered by the county. If there is a noted concern or delay on either scale, children may be referred to their primary care provider for additional screening or an out of network provider.
- Screenings are reimbursable when completed by a clinic or licensed psychologist (LP).

PrimeWest

Social-emotional and developmental screenings are reimbursed and conducted as health care services in clinical settings, including the following:

- Medical and behavioral health clinics
- Health Care Homes (HCH)
- Public Health outreach, including WIC; Family Home Visits; and Public Health nurse visits

South Country Health Alliance

Most commonly screenings are conducted and reimbursable in:

- Primary care clinics
- Pediatric clinics and specialty clinics
- Behavioral health clinics
- Public health departments.

UCare

- Based on claims data, social-emotional and developmental screenings are conducted in primary clinics, community health clinics, rural health clinics, schools and public health clinics.
- UCare reimburses eligible licensed health care professionals who perform C&TC visits as well as social-emotional and developmental screenings in settings where health care services are provided.

Question 3: What is the protocol for referral and diagnoses if the screening(s) are positive?

All of the MCOs identified some process for formally or informally sending children on to receive an assessment. Each MCO's protocol indicates whether or not a formal referral or prior authorization is required. Generally, a referral or prior authorization is not required to access most services if the screening is positive.

Each plan provides individualized services. The majority of plans indicated that whoever conducts the screening determines where the child should be sent for follow-up. Referrals often include Help Me Grow or a special education evaluation, Follow Along program, speech and language pathology, occupational therapy or physical therapy. If a diagnosis of ASD is suspected, the MCOs will often refer to a medical doctor or mental health professional to complete additional assessments, such as the comprehensive multi-disciplinary evaluation (CMDE).

Some of the plans have a process for follow-up to ensure the referrals are followed through with. We highly encourage this as there are often barriers to families accessing services and supports.

Blue Plus

- Individual clinics maintain their own internal referral protocols for positive screenings.
- Blue Plus does not require prior authorization, but highly encourages referrals to participating network providers.
- Blue Plus does not require prior authorization for the CMDE for ASD services.
- Blue Plus has clinical guides available to assist with questions or referrals to participating providers.

HealthPartners

- As a health plan, we [HealthPartners] are unable to speak to the provider protocols for referral and diagnoses if the screenings are positive as that is a provider-managed process. Additionally, with no prior authorization required for this age group, we don't have line of sight into these protocols.
- From a billing perspective for these processes, we expect providers to follow the DHS EIDBI billing requirements and C&TC.

Hennepin Health

- Depending upon where the screening was completed and following a parent/guardian discussion, the following referrals occur:
 - Mental health / behavioral health/ school districts/ Help Me Grow/ speech, occupational therapy/ physical therapy/ and EIDBI services
 - If screenings are completed in a clinic setting, a referral to county public health (Front Door Hennepin County) is made.
 - No authorization is required for any of these services.

Itasca Medical Care

- Through the assessment(s), if they determine a need for further evaluation, the clinics make a referral to a pediatric MD who has an interest in ASD and they are also referred to applicable therapies such as speech therapy, occupational therapy and physical therapy.
- Clinics may also refer to Itasca County's early childhood program or Help Me Grow program for additional support and services.
- Referrals are also made to Behavioral Dimensions, which is a business that provides intensive behavioral intervention.
- The Itasca County Disability Resource Group, which was established by mothers, assists parents in accessing area resources. The group has also created a resource book that includes local, state and nationwide resources for parents.
- If problems are identified by the Public Health Follow Along Program, they, too, can make a referral to the Help Me Grow program and notify the child's primary care provider.
- In order to receive the diagnosis for ASD, residents of Itasca County need to go to the metropolitan area or other out-of-network resource.

PrimeWest

- When a child has a positive screening, the primary care provider or public health nurse should refer the child for a comprehensive evaluation with a mental health professional specializing in young children and autism spectrum disorders.
- As soon as an infant/toddler under age 3 is suspected of having a delay or developmental disorder, the child should be referred immediately to Early Childhood Education Services. If the child demonstrates language delays, the child should undergo an audiologic evaluation.
- The primary care provider/public health nurse should schedule a follow-up visit within one month of the positive screen.

South Country Health Alliance

- Typically, a referral or prior authorization is not needed for most services.
- If the screening is positive, referrals could be made to a mental health professional for an extended diagnostic assessment, pediatric physician, EIDBI provider, Early Childhood Education Services or Help Me Grow programs.
- On a C&TC claim, the provider must indicate the referral codes (AV - patient refused referrals, ST - Referral to another provider for diagnostic or corrective treatment or scheduled for another appointment with screening provider for diagnostic or corrective treatment) for at least one health problem identified during an initial or periodic screening service, S2 - patient is currently under treatment for referred diagnostic or corrective health problems, NU – no referral made.

UCare

- The majority of developmental problems for children age 1-3 years old are identified during primary care or pediatrician visits.
- If a pediatrician or primary care physician requests an evaluation by a mental health professional or other specialist, no referral from UCare is required.
- The member or guardian may also self-refer and has the ability to go directly to the provider of their choice.
- If requested, UCare can assist the member or family with finding a provider and scheduling an appointment through UCare's Access Line.
- A positive screen would suggest a referral to a provider that could complete a CMDE and make a determination about the initiation of EIDBI services. This assistance can be provided to the member or the member's healthcare practitioner.

Question 4: What barriers has the MCO identified to providing screening, diagnosis and treatment to children, ages 1-3?

The MCOs have listed several barriers to providing screenings, diagnosis and treatment to children ages 1 to 3. One of the most commonly reported barriers is that families struggle to identify the early signs of ASD. It is a common misconception that an educational determination is sufficient to access services and supports. Providers also report that families are reluctant to follow up on referrals or accept that their children are experiencing developmental delays. English-language learner families may be additionally affected by screening tools that are not adapted to reflect their language, cultural values and customs.

Providers struggle to cover the cost of purchasing and training staff on ASD-specific screening and diagnostic assessment tools. Providers also struggle to complete a thorough assessment during a typical well-child checkup. A formal medical diagnosis from a mental health professional or a medical doctor who specializes in diagnosing ASD is required to access many services. Although it is recommended that a child receive a formal diagnosis, families should be encouraged to receive the educational evaluation that has no cost to them. Children are often able to access supports through their local school district within 30 to 45 days.

Lack of coordination between service providers and all payment plans often leaves families to coordinate services on their own. There are also barriers to exchanging and sharing information between mental health professionals and the primary care providers.

There is a shortage of qualified providers in the state who are specially trained to provide ASD screenings, diagnosis and treatment to meet the high demand for services. The shortage of providers means long waiting lists or the child does not receive services at the intensity that is recommended.

The shortage of qualified providers disproportionately affects rural Minnesota where families are often forced to move or travel a great distance to access services and supports.

These barriers make it especially important to work on one of the strategies that the health plans are implementing; namely, to ensure that clients receive child and teen checkups (C&TC) and are aware that this service is provided to them at no cost. In addition, the proposed strategies to address these barriers should be targeted across state agencies, counties and MCOs.

Blue Plus

- Educating families on where and how to get screenings.
- Providers also struggle with the time it takes to incorporate these screenings into their visit.
- Access to mental health providers that specialize in early childhood treatment can also be a barrier for timely services.

HealthPartners

- Duplication of services - screenings are conducted in various settings including the clinic, school districts, home visits and early childhood facilities.
- Expense to providers of purchasing the screening tools (ASQ and ASQ-SE) especially for electronic or online versions.
- Clinic workflow – clinics must adjust their workflows for certain ages to do screening as well as account for timing of collecting and evaluating the results from the parent reported tools.
- Visit time – some providers feel there is not enough time in a standard well child/C&TC visit to fully discuss the results of a developmental or social emotional screen.
- Access to follow-up services – Shortage of children’s mental health providers throughout the state makes it difficult for children to receive services even after a referral, especially in more rural communities.

Hennepin Health

- Lack of understanding of importance of C&TC screening.
- Time to follow up, information sharing and potential for duplication.
- Lack of knowledge of billing and reimbursement coding by public health and providers.
- Cultural barriers related to the social-emotional screening. Some families are reluctant to accept referrals for follow up of social-emotional delays.

Itasca Medical Care

- The primary barrier identified by providers is parent/caregiver's reluctance to accept that their child is experiencing significant delays in their social-emotional functioning and/or overall developmental delays.

- Providers also indicate that parents have a misconception of the early signs of ASD.
- In addition, Itasca County does not have local access to diagnostic specialists. Many of the primary care providers are not comfortable making a diagnosis of ASD and local mental health providers do not provide diagnostic services for ASD. Currently Itasca County has one provider that utilizes applied behavioral analysis (ABA); however, they have limitations as to how many cases they can take. Additional local providers are needed to better serve this population.
- Another barrier for screening is parents' lack of knowledge that screening is available at no cost through the school district's early childhood education program. Anyone can make a referral to the program so there is no barrier associated with that.
- The primary barrier is that it takes a lot of time before a medical diagnosis is made as they have to go to the metropolitan area. However, in the meantime they would have an educational diagnosis, which does allow the parent/ child(ren) to receive services.
- Lack of EIDBI providers in the plan area.

PrimeWest

- Identified barriers to screening include primary care providers indicating a lack of time during visits to conduct a thorough screening when combined with all other expectations of a well-child visit.
- In addition, rural areas are lacking in specialty early childhood behavioral health providers. The distance to specialty providers can potentially cause transportation challenges for the authorized guardian(s), and wait times to see providers can be long (this includes rural providers).

South Country Health Alliance

Barriers include:

- Members electing to not bring their children in for well-child checks and other screening opportunities (i.e., early childhood screening) as recommended.
- Potential cultural barriers as identified in utilization data (i.e., Hispanic members completing 6 or more well child visits within 15 months of birth are at a lower percent than for white members).
- Lack of time for providers to complete appropriate screenings during visits.
- Rural areas lack access to specialty providers including early childhood mental health and EIDBI services.
- Parents may have a difficult time distinguishing between what is normal development for their child and what may be impaired development, which would trigger them to ask for help.

UCare

There are numerous barriers for children to receive socio-emotional and developmental screenings, diagnosis and treatment. UCare has identified the following barriers that may affect our members:

- **Fragmentation:** The service system from primary care to mental health professionals is fragmented. Often, families are left to coordinate services on their own while trying to deal with the personal and financial stress of the child's condition. Additionally, there is reluctance to exchange information between mental health professionals and primary care.
- **Lack of resources:** The demand exceeds the available resources and many providers do not have the adequate equipment for assessment and treatment via telehealth in the areas of treatment where telehealth would be appropriate. Professionals skilled in the screening, diagnosis and treatment of children below the age of three are primarily located in the metro area, Duluth and Rochester. This results in barriers in accessibility of services for families seeking screening, diagnosis and treatment for the affected child.
- **Inadequate data:** Although there is data on members who receive a socio-emotional and developmental screening, this data does not include screenings by providers who do not submit data claims to MCOs. There is also inadequate data regarding the number of members evaluated by a mental health professional as a result of a positive socio-emotional and developmental screening
- **Language/cultural barriers:** Families who do not read or speak English as their primary language may have difficulties understanding information on screenings and developmental disorders. Some screening tools may not be adapted to reflect cultural differences and norms of such families and children. These families may also struggle with understanding how to access healthcare.
- **Stigma:** Families may be reluctant to discuss and seek help for developmental issues due to stigma surrounding developmental disorders and mental health. Families may have a fear of telling healthcare professionals about the challenges in caring for children with developmental disorders in the home.

Question 5: What strategies has the MCO implemented, or will it be implementing to facilitate access to periodic developmental and social-emotional screening(s), diagnosis and treatment for young children, ages 1-3?

The majority of MCOs use the C&TC as the main strategy for reducing barriers to screening, diagnosis and treatment. MCOs support the C&TC efforts by:

- Educating providers and members about screening tools and treatment options
- Providing incentives to providers for administering complete screenings
- Providing incentives to the member for completing the assessment.

Clinics are also working to implement strategies to expedite the screening process.

DHS encourages the MCOs to continue to use services such as C&TC coordinators to help families follow up on referrals and locate providers in their area. We recommend MCOs contact the family's [county or regional human services, social services or family services office](#) to get in touch with the local C&TC coordinator. The coordinator will also help arrange interpreter services and/or transportation.

There are C&TC coordinators in each county and tribal nation. Periodic examinations or screenings are delivered according to the [C&TC Schedule of Age-Related Screening Standards \(PDF\)](#), also known as the Periodicity Schedule. The C&TC program has brochures and information for families and providers that the MCOs may request and distribute to their members.

C&TC also provides training to primary care providers and clinic staff, local public health, Head Start, schools and other people who provide screening for children, adolescents and young adults in Minnesota. These trainings are offered in various locations throughout the state. To locate an upcoming in-person training opportunity or to request a training, see the [Child and Teen Checkups In-person Training registration & requests page](#). MDH, MDE and DHS periodically offer trainings for programs and staff that provide developmental and social-emotional screening services for Minnesota children. For more information, see the [Training Toolkit](#) for developmental and social-emotional screening and referral. This is a training curriculum resource for Minnesota's public screening programs to provide staff training on early childhood developmental and social-emotional screening, referral and linkage to services.

Minnesota recently redesigned and expanded the [Help Me Grow website](#). The updated website continues to connect children ages 0-5 to Early Childhood Special Education evaluations at local school districts.

The updated Help Me Grow website also provides families with additional resources and information. DHS, MDH and MDE will continue to educate MCOs and members on the features of the expanded Help Me Grow website.

Blue Plus

- Blue Plus feels our strongest vehicle for insuring and managing early screening of young children with autism or a potential autism diagnosis is our commitment to child and teen checkups. We support this screening effort by educating providers and incenting them for administering complete screenings.

- Members are also provided educational materials and incentives for completing child and teen checkups. We attend regional county child and teen checkup meetings to stay informed and utilize the information received from the counties regarding child and teen checkups to align resources for our members.
- Our aim is to increase engagement, so the members seek and receive care in the right place at the right time—including identifying the need for early intervention services for children at risk.
- Blue Plus has a pilot partnering with community health workers to provide education, connect resources and supports to members in diverse communities.
- By helping members to understand the importance of early screening, it will also facilitate access, referrals and follow-up treatment for young children.

HealthPartners

- Child and teen checkup clinic trainings – participate in MDH and county C&TC trainings with clinics to promote the use of screening tools.
- Children’s Health Initiative – HealthPartners is engaged in an enterprise-wide initiative to improve the health of children from prenatal to age 5. The three main areas of focus are to promote early brain development, provider family-centered care and to strengthen communities. One of the 10 priorities is Early Childhood Experience: screen every child for exposure to harmful events that might impact a child’s development. This includes developmental and social-emotional screenings. Reach out and Read is also within this initiative.
- Little Moments Count – HealthPartners launched a statewide initiative to improve early brain development through promoting reading, singing and talking to babies and young children. The initiative is in partnership with local public health agencies, community organizations and pediatric health care systems.
- Help Me Grow – HealthPartners employees and clinicians have been involved in the Help Me Grow work groups.

Hennepin Health

- Parent/family incentives for completing screening visits.
- Follow-up and sharing information with clinics.
- Quarterly meetings held with Hennepin County Public Health include topics like child and teen checkups.
- Removal of barriers (i.e., authorization requirements) for any therapy services, including EIDBI.

Itasca Medical Care

- IMCare utilizes the member and provider newsletters to educate members and providers about available screening options through public health's Help Me Grow program.
- IMCare's disease management coordinator partners with local educational groups such as Communities for Health and the regional C&TC to evaluate ways to further educate the community about available resources.
- IMCare has attempted to assist DHS in recruiting EIDBI providers by sharing information with providers who may meet criteria to become an enrolled provider through email and provider newsletters.

PrimeWest

- PrimeWest Health is working with providers to extend appointment times to allow time for adequate screening. PrimeWest Health facilitates the screenings that are available for children ages 0 – 3, and requires that providers complete these at every well-child visit/C&TC. The screenings are added to members' electronic medical records (EMRs) as applicable.
- PrimeWest Health assists members through a variety of strategies to facilitate access, such as but not limited to: assistance with scheduling appointments, assistance with transportation, care coordination, member/guardian education, reminder calls for members who are due for a C&TC, and a voucher program to encourage C&TCs.
- PrimeWest Health encourages and supports relationships between members and primary care providers that begin at birth. Our Bright Futures program is a collaborative endeavor that includes PrimeWest Health, our provider network, local county partners, and members under age 21 and their authorized representatives. This collaborative effort is integral in ensuring positive outcomes for children who may have special medical needs. Bright Futures promotes and facilitates care coordination of infants and children who are medically fragile, technology-dependent and who have high social risk factors while minimizing re-hospitalizations. In addition, the program strives to ensure that parents and other caregivers receive appropriate training and skills to feel confident providing care in a nurturing environment.
- PrimeWest Health is organizationally integrated with county agencies, including county Public Health and Human Services. Public Health is a provider of child and teen checkups (C&TCs), a visit during which a developmental and social-emotional screening is conducted. In 2020, as part of PrimeWest Health's recognition of the importance of C&TCs and related screenings and to improve our Healthcare Effectiveness Data and Information Set (HEDIS®) /Star Ratings, PrimeWest Health offered members/authorized representatives the opportunity to receive a \$50 gift card for members ages 12 – 21 who receive an annual C&TC .
- PrimeWest Health has contracted with all available EIDBI providers in our service area, as well as some in the surrounding areas.

South Country Health Alliance

- South Country Health Alliance educates and encourages members to stay on track with well child visits.
- South Country has member education and incentive programs to encourage regular well child visits.
- South Country is working to educate county partners and providers on EIDBI provider enrollment process and service benefits and how to obtain a CMDE.
- South Country attends public health C&TC meetings to review C&TC guidelines and best practices. C&TC visits include developmental and social-emotional screenings.
- Member online resource “Embracing Life” encourages and educates on C&TC, which includes gift card incentive upon completion of six well-care visits before 15 months of age
- Provider newsletter provides periodic updates and information/education on C&TC
- South Country’s partnership and collaboration with county Public Health and Human Services departments.
- Expanded use of telehealth/e-visits for communication between parents and their primary care provider.

UCare

UCare implements a number of strategies and interventions to facilitate access to periodic development and social-emotional screening(s), diagnosis, and treatment for young children age 1-3 years. In 2019, some of those activities included:

- Handing out C&TC periodicity schedules to members at health resource and screening fairs.
- Providing telephonic outreach by internal UCare staff to members to remind them about getting their C&TC visit and assisting them with scheduling when needed.
- UCare offers [member incentives](#) to encourage members to receive preventive health visits/screening and providers can participate in our Pay for Performance program to receive incentives for improving preventive health visit rates.
- UCare has a dedicated [C&TC chapter](#) in our Provider Manual where we encourage child and teen checkups and link to a variety of resources for C&TC, including the Dakota County C&TC billing grid and DHS and MDH C&TC websites.
- UCare publishes a provider newsletter ([health lines](#)) in which articles about C&TC screenings have been included to provide continuing education on C&TC, instructions on how to bill for services provided and the additional reimbursement available for screenings.
- UCare is currently working with a large pediatric health network to close health care gaps on well child visits by identifying screenings and immunization action lists for overdue patients.

- UCare also has a triage line to answer questions about treatment modalities, diagnoses and provider options. UCare's access line also helps schedule appointments and follows up with families about their appointment experiences to help facilitate a good provider/member fit.

Question 6: Pursuant to section 6.1.23 (C) (2) of the 2018 Families and Children Contract, what evaluation and assessment, including treatment recommendations, are provided to children who do not meet milestones?

The majority of MCOs report making referrals to medical or mental health professionals for additional assessments. Treatment recommendations often include physical therapy, educational services, occupational therapy, speech and language pathology, children's therapeutic services and supports (CTSS) and early intervention services provided the EIDBI Benefit.

Blue Plus

- Children with Blue Plus may be referred for additional assessments when developmental milestones are not being met.
- Children presenting with autism symptoms or related conditions may be referred for a comprehensive multi-disciplinary evaluation to determine best fit and intensity of needed services.
- Additional referrals may be made for physical therapy, occupational therapy and speech therapy as needed.

HealthPartners

- Evaluation and assessments are conducted by the provider community. As a health plan, we see referrals to EIDBI services for members to receive a comprehensive multi-disciplinary evaluation (CMDE) for assessment of additional services, referrals from primary care, and we know that members with autism spectrum disorder may work with our case managers who support in making referral to specialists.

Hennepin Health

- Potential treatment options are provided through school districts and public health clinics if accepted by parents/guardians.
- Treatment recommendations focused on developmental milestones, such as behavior and communication approaches, occupational therapy, speech therapy, sensory integration, dietary approaches, medications, complementary and alternative medicine.

Itasca Medical Care

- When a child is not meeting critical developmental or social-emotional milestones, providers are referring the child directly to the early childhood program or the Help Me Grow program.
- Once they are in the early childhood system, treatment may include speech therapy, physical therapy, occupational therapy and/or behavioral therapy.
- Home-based mental health services are also available for children who meet criteria. If the child meets criteria and enters into the program, ongoing assessments are conducted by the treatment team.
- An IMCare mental health provider, Children's Mental Health Services, is also located within the school and provides mental health support to individuals and in a group setting for those children who qualify.

PrimeWest

For children who do not meet milestones to have access to appropriate evaluation and assessment, including treatment recommendations to improve a child's functioning with the goal of meeting milestones by age 5, the following are possible treatment recommendations:

- DC 0-3R assessment (diagnostic assessments for additional mental health evaluation of infants and toddlers)
- Behavior and communication approaches
- Occupational therapy
- Sensory integration therapy
- Speech therapy, dietary approaches
- Medication
- Complementary and alternative medicine
- Early Intensive Developmental and Behavioral Intervention (EIDBI) services

South Country Health Alliance

For children who do not meet milestones, referrals may be made to:

- Providers for diagnostic or corrective treatment
- Early childhood education for evaluation
- Assessment for PT, OT and/or speech
- Mental health professionals
- Qualified mental health professionals for a CMDE for possible eligibility for EIDBI
- Dieticians for nutritional support

Referrals are not required to access these services. Members may also be referred back to the county for assistance with obtaining other necessary community-based services or resources. South Country ensures access to services and works with in and out of network providers to meet member need in the area of early screening, diagnosis, and treatment of autism and other developmental conditions.

UCare

- When children do not meet developmental milestones, the treatment recommendations would be determined by the screening tool and treatment guidelines. UCare supports the use of best clinical practices ([ICSI best practices](#) and [UCare](#) provider resource).
- As an integral part of UCare’s medical management of members, the UCare Special Health Care Needs (SHCN) program identifies people with special health care needs and assists identified members with access to care and monitors their treatment plan. Children ages 1-3 years old with a developmental disorder and in need of case management or assistance with finding a practitioner, and coordinating treatment are eligible to participate in the SHCN and/or mental health case management program.

Question 7: What are the recommendations of the MCO on how to measure and report on the effectiveness of the strategies implemented or to be implemented on facilitating access to developmental and social-emotional screening, diagnosis and treatment to children, ages 1-3?

The MCOs provided many recommendations to help address the identified barriers. Increasing awareness and education, both to providers and families, on the importance of regular screenings and checkups is one of the key recommendations. Additional data evaluation could be conducted to determine which areas of the state require more education to increase the rates of completing screening and assessments.

Many people are simply unaware of the benefits available to them through their health plans. The MCOs also recommended the use of multiple communication strategies to reach providers and members. In particular, they recommended communicating to families the early signs of ASD, where to access screening and diagnostic assessments, as well as the full range of treatment services and supports that are available to them. Finding effective ways to engage and communicate with English-language learner families is also critical.

The MCOs also recommend increasing coordination across agencies to ensure that the DHS, MDH and MDE are working together to ensure communication across service providers and coordinated services.

Efforts are being undertaken to help address the shortage of providers in Minnesota. For more information or to increase participation from the MCOs to help address the provider shortage, see the [Building EIDBI provider capacity webpage](#).

Blue Plus

- Strategies should include the continued education of enrollees regarding the importance of these screenings for early diagnosis and treatment.
- Provider adoption/screenings completed data could also be obtained through encounter data. The data could be used to identify possible areas for provider education as well as to identify how many children who receive these screens get connected to additional treatment services.

HealthPartners

- Measure access to services – DHS currently tracks the number of children accessing EIDBI and other treatment services
- Evaluate access to screenings – DHS can evaluate use of billing codes through encounter data for early childhood screenings
- Monitor the number of EIDBI and other child developmental specialist providers.

Hennepin Health

- Evaluation of claims information with the appropriate modifiers before intervention of strategies and after. Evaluating changes in services utilized for children diagnosed from 1-3
- Hennepin County Public Health worked with Assuring Better Child Health and Development (ABCD) to close the loop. ABCD is a proven, universal approach to screening young children in health care settings. ABCD works to increase health and developmental screening and referral rates for all young children by integrating routine screenings into well-child visits. This has been especially effective for children in the Minneapolis Public Schools (MPS). This allows the school district and the clinic to coordinate and make sure that the results of the ECSE assessment is shared with the medical provider. In addition, it allows for sharing information regarding referrals and the completion of further treatment. The MPS also keeps excellent records of referrals made and what intervention the child is receiving.

Itasca Medical Care

- IMCare would recommend working with the MDE on this issue as the early childhood program works with children who have a diagnosis of ASD throughout their school life, but can start as early as birth. These educational programs submit data to the MDE
- Another consideration is that once children are diagnosed with ASD, they typically obtain disability status and are no longer on a managed care program

- As a second option, collaboration with Public Health to monitor progress for those enrolled in the “Follow Along” Program, a comparison of ASQs to determine the improvement they've made in comparison to age-appropriate ratings.

PrimeWest

PrimeWest recommendations:

- Improve or maintain screening scores
- Improve quality of life determination survey
- Increase provider satisfaction survey responses
- Increase percentage of members accessing EIDBI services post positive screen date
- Increase percentage of members accessing mental health treatment post positive screen date
- Increase percentage of members demonstrating continuous access to mental health services one year post diagnosis of mental health disorder (visits occur minimum of once every three months)
- Reduce appointment wait times for members who were triaged to a psychiatrist
- Decrease number of emergency room visits for behavioral and/or psychiatric diagnosis
- Decrease number of hospitalizations for behavioral and/or psychiatric diagnosis
- Decrease number of readmissions within 30, 60 or 90 days for behavioral and/or psychiatric diagnosis.

South Country Health Alliance

- Survey providers regarding barriers to accessing screening and treatment for this population
- Measure the number of emergency room visits for age 1-3 for behavioral diagnosis
- Measure member adherence to the recommended C&TC checkups
- Measure member diagnosis of autism within member population and age group.

UCare

- UCare monitors HEDIS rates for increases and to identify opportunities for improving C&TC. UCare follows DHS guidelines and continues to engage in the EIDBI workgroup in order to assess for additional implementation strategies related to increasing access.

Questions 8-10 Summarize CMDE data, demographics and average service utilization for children accessing EIDBI

Blue Plus

- CMDE outcome data collected includes the Summary Results for Autism Core Deficits, Related Conditions
 - Social Interaction, Social Communication and Restrictive
 - Repetitive Behaviors/Interests
 - Self-Care Skills
 - Interfering or Unwanted Behaviors
 - Expressive Communication; Receptive Communication
 - Cognitive Functioning
 - Safety
 - Learning/Play/Motor Skills
 - Behavior/Sensory Regulation
 - Parent/Caregiver Interview Results including Confidence; Stress; Perception of Quality of Life
 - Level of Support for: Social Communication; Restrictive, Repetitive Behaviors, Sensory Regulation
 - Identify if the child has an accompanying intellectual impairment and/or language impairment provider
 - This data could be used to identify possible areas for provider education as well as to identify how many children who receive these screens get connected to additional treatment services.
- 146 children received EIDBI services
- Children received an average of 428 hours of direct intervention a year
- Children received an average of 49 hours of group intervention a year
- Children and families received an average of 11.5 hours of family caregiver training a year.

HealthPartners

- Does not currently collect CMDE outcome data
- In 2020 dates of service, the demographics of HealthPartners members who received EIDBI services included ages ranging from 2-17, with an average age of 6 and mode of 4 years of age
- 77% of members (children) who received EIDBI services were male

- 42% of the children were white, 29% black or African American, 8% Asian or Pacific Islander, 4% American Indian or Alaskan Native, 4% Hispanic/Latino, and the remainder “other” or “unknown” (about 13%). Languages spoken other than English include Arabic, Oromo, Vietnamese, Somali and Spanish (two members or fewer of each of these).
- Children received an average of 361 hours of direct intervention a year
- Children received an average of 52 hours of group intervention a year
- Children and families received an average of 9 hours of family caregiver training a year.

Hennepin Health

- Does not currently collect CMDE outcome data
- Three children received the benefit
- There were not enough children receiving the benefit for a long enough period of time to determine adequate averages for services.

Itasca Medical Care

- There are no members receiving EIDBI or who completed CMDEs in 2020.

PrimeWest

- CMDE information is gathered on all members who are approved for EIDBI services. In 2020, nine members that had a CMDE completed had those results submitted for authorization of EIDBI services. PrimeWest is able to manually extract data from the CMDE, but does not currently require CMDE outcome data in an easily extractable format. The average score for Autism Core Deficits and Related Conditions and Additional Developmental Domains for these nine children was 22.3. The average score for Parent/Caregiver Informational Interview for these nine children was 5.2.
- 13 children received EIDBI services
- Children received an average of 533 hours of direct intervention a year
- Children received an average of 7 hours of group intervention a year
- Children and families received an average of 11 hours of family caregiver training a year.

South Country Health Alliance

- South Country has collected the scoring criteria data for each member receiving EIDBI services. South Country has a small number of members (four) participating in this service and has only been able to collect baseline data at this point in time.
- Children received an average of 398 hours of direct intervention a year.
- Children and families received an average of 48 hours of family caregiver training a year.

UCare

- UCare collects the CMDE data from providers only to facilitate the prior authorization process; the data is not aggregated in any fashion at this point.
- 73 children received EIDBI services
- Children received an average of 498 hours of direct intervention a year
- Children received an average of 59 hours of group intervention a year
- Children and families received an average of 16 hours family caregiver training a year.

V. Conclusion

The MCOs are implementing or have plans to implement strategies for overcoming barriers to screening, diagnosis and treatment (as required under Minn. Stat. § 256B.69, subd. 32a). Access to EIDBI services is increasing with more children accessing services in 2020 than ever before. Families, however, are still struggling to access appropriate services in a timely manner. This report identifies barriers and provides recommendations to address barriers to accessing early screening, diagnosis and treatment of ASD and related conditions. The recommendations include:

- Improve public awareness and education, including ASD early signs and symptoms through a variety of communication and outreach strategies targeting providers and others interacting with families
- Increase awareness and education to parents, caregivers and providers about the importance of early screening, effective screening tools, proper diagnosis and treatment
- Increase awareness and education to parents and caregivers about the services available through their current health plans
- Increase awareness of the C&TC trainings available, as well as the training toolkit and increase funding for effective screening tools to all providers
- Increase incentives for providers to implement recommended screening tools consistently and for families to follow through on screening appointments
- Identify best practices in screening and diagnostic tools used to identify children early in order to develop consistent practices across primary physicians and health-care providers
- Develop the workforce and increase access to providers who are trained to implement screening, diagnosis and treatment of ASD across a variety of settings.
- Improve communication, collaboration, coordination across educational, medical and human service providers and agencies
- Streamline the process for referrals and ensure that referrals are followed up on
- Increase awareness of the Follow Along, Child & Teen Checkups, Public Health and Woman and Infant Children programs to promote early social-emotional and developmental screenings
- Place a special focus on outreach and awareness of Help Me Connect
- Expand education to multicultural and linguistic communities about the importance of early screening and understanding of typical and atypical child development and resources available for treatment
- Ensure that current screening tools are adapted to the language, culture, values and customs of all families
- Eliminate barriers for all families, including but not limited to race, ethnicity, socio-economic status, geographic location, etc.
- Ensure that everyone in need of services has access to services.

As public program providers, MCOs and county-based purchasing plans have an important role to play in the development of best practices in policies and procedures for screening, diagnosis and treatment of young children in Minnesota. It is also critical to involve other state agencies and multidisciplinary providers who are part of the system of care and supports for children with ASD as identified in [Options for Coverage of Treatment for Autism Spectrum Disorders in Minnesota \(PDF\)](#) submitted by the Minnesota Department of Commerce to the Minnesota Legislature in September 2013.

Addressing the barriers that families and providers face requires a multifaceted, multiagency approach, including health, education, social services and public and private health coverage. The recommendations listed in this report should be the collaborative focus of all state agencies, providers, MCOs, counties and tribal nations.