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DEPARTMENT OF HUMAN SERVICES

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 2022

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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 44 children[1] 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.

The most recent report from the Minnesota Autism Developmental Disabilities Monitoring (MN-ADDM) network in Hennepin and Ramsey counties found approximately 1 in 36 or 2.8 percent of 8-year-old children were identified with ASD. MN-ADDM data also examines data by race and gender.

Among children identified with ASD who had IQ information available, 29% also had intellectual disability. About 45% of children identified with ASD received an evaluation by age 3. Even though ASD can be diagnosed as early as age 2, about half of children were not diagnosed with ASD until 5 years and 3 months. Minnesota has the latest age of diagnosis of all the ADDM sites in the United States. 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 critical early intervention services.

MN-ADDM began gathering data on 4-year-olds in the most recent study. The data in Hennepin and Ramsey counties found approximately 1 in 44 or 2.3 percent of 4-year-olds were identified with ASD. MN-ADDM data also examines data by race and gender, which showed racial differences. As MN-ADDM continues to track this data, more themes will be become clearer.

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

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[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

(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 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 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 health care professionals is associated with a later age at diagnosis (Daniels and Mandell, 2014)[6].

Table 1: Children under 21 with ASD enrolled in Medicaid as of June 1, 2022

Race/Ethnicity	FFS	MCO	Total
Asian	539	562	1,101
Black	2,108	1,980	4,088
Hispanic	788	1,444	2,232
Native American	479	649	1,128
White	6,025	5,678	11,703
Unknown	2,168	4,843	7,011
Totals	12,107	15,156	27,263

[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

[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.

During the past several years, DHS and its partners have worked to increase access to intervention services and supports for children with ASD and their families. This included the first ever Minnesota Autism Resource Symposium to support families, professionals and other interested parties. The symposium was an interagency event hosted by DHS and the Minnesota departments of Health, Education and Employment and Economic Development. The University of Minnesota Institute on Community Integration and other community organizations were key partners in the event as well.

Table 2: EIDBI recipients by race/ethnicity and pay system

Race/Ethnicity	FFS	MCO	Total	Percentage of EIDBI recipients
Asian	123	32	155	4.3
Black	664	207	871	24.4
Hispanic	119	72	191	5.3
Native American	60	56	116	3.3
White	969	237	1,206	33.7
Unknown	585	453	1,038	29.0
Totals	2,520	1,057	3,577	100.0

The Minnesota Department of Health launched Help Me Connect, which aims to increase access to health care services to ensure screening, identification and referral for young children.

The COVID-19 pandemic affected all Minnesotans in various ways, but for families of young children who were socially isolated during their early developmental years, it has led to increase for evaluations. Long waitlists for evaluations delay access to services. Although the number of EIDBI provider organizations has increased, workforce shortages were further exacerbated by the pandemic. Workforce issues limit the number of children who can be served in EIDBI, which leads to additional delays in accessing early intervention.

Wilder Research and DHS worked together to create the following resources. We recently expanded and translated these resources for use by state agencies, providers and others to share information with families of a child with ASD.

This year DHS has focused on disseminating these resources to early childhood educators, pediatric care coordinators, pediatricians and others who interact with families when concerns are first identified. These resources include:

- 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 a 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).
- 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 options 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 people who found it difficult to know which services or supports would best meet the needs of the child and build off their strengths. The online autism services navigation tool and referral form 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 also available in Hmong, Somali and Spanish. MCOs, families, case managers and others can also find EIDBI providers throughout Minnesota using this map.

DHS also developed a self-paced online course: Coordinating services and supports for a child with ASD or related conditions. This course helps participants differentiate between EIDBI, Children's Therapeutic Services and Supports (CTSS) and other services for children with ASD and related conditions.

The following materials could also be useful for providers and families:

- Developmental, Social-Emotional, and Autism Spectrum Disorder Screeningin Early Childhood (PDF), a screening fact sheet for physicians
- Centers for Disease Control and Prevention Autism Spectrum Disorder website
- Minnesota Department of Health Recommended Screening Instruments webpage
- Minnesota Autism Resource Portal website
- Minnesota Autism Resource Portal Facebook page

Additionally DHS has worked to provide ongoing training resources for providers to decrease the impact of the provider shortage and COVID:

- Telehealth for Early Intervention training provides an overview of the benefits and barriers of providing early intervention autism services via telehealth. The training reviews services offered via telehealth, how to prepare for the session and what to expect.
- DHS partnered with the care coordinators community of practice and Minnesota Department of Health to present Identifying Autism Spectrum Disorder (ASD) and Accessing Services: What Care Coordinators Need to Know to more than 700 care coordinators. We recorded the presentation for others to view.
- A podcast created with the Center for Inclusive Childcare to help support child care providers who serve children with autism and their families. Young Children with Autism – What Does the Label Really Mean: Part 1 provides an overview of autism spectrum disorder and some early signs to watch for as parents and professionals care for young children. Minnesota Autism Resource Portal Part 1 highlights the Minnesota Autism Resource Portal and the resources it provides to professionals and parents.

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 public 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 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 ninth 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 the MCOs provided information about member use of the Early Intensive Developmental and Behavioral Intervention (EIDBI) Benefit. DHS is monitoring use of EDIBI within both Minnesota fee for service Medicaid and MCO plans.

DHS meets with the MCOs monthly in a workgroup to ensure that they continue to make progress.

MCO provider data indicates a racial discrepancy that does not exist in the fee for service Medicaid side. Through the work group, DHS and MCOs are working to improve racial equity among children who use the 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 use 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 C&TC Clinic Settings (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).

Some MCOs reported use of the following screening tools: Survey of Wellbeing of Young Children (SWYC); Early Screening Profiles (ESP); First STEPS 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

The ASQ3 and ASQSE-2 are the most commonly used screening tools used, but clinics also report using the SWYC (Milestones, BPSC, PPSC, Parent Concerns) and the M-CHAT-R.

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

Itasca County clinics provide screenings at well-child checkups starting at nine months of age. In Itasca County most clinics use the Modified Checklist for Autism in Toddlers (M-CHAT), Parents' Evaluation of Developmental Status (PEDS) screen, the Ages and Stages Questionnaire (ASQ) and ASQ:SE. One clinic uses the M-CHAT at nine months and again at 18 months and the PEDS screen at nine months to assess developmental milestone benchmarks. At 24 months, providers use the Age and Stages Social/Emotional Questionnaires (ASQ/ASQ:SE) and repeat the M-CHAT for comparison.

Medica

Medica audits providers for evidence of use of validated screening tools but did not provide the results of that audit to DHS. They did state that their tools are supported by accreditations such as American Academy of Pediatrics, or supported by Bright Futures.

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. South Country Health Alliance follows 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 use 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.

United HealthCare

Surveillance and developmental screening at recommended intervals of age, social-emotional screening beginning at 6 months of age, continuing every 6 months through 2 years of age, and then yearly autism spectrum disorder (ASD) screening at 18 and 24 months of age should be done as part of child and teen checkups.

Screening tools include the following:

- The Modified Checklist for Autism in Toddlers Revised (M-CHAT-R/F) (www.mchatscreen.com).
- Survey of Well Being of Young Children Screener (SWYC)
- Ages and Stages Questionnaires, 3rd ed. (ASQ-3)
- Battelle Developmental Inventory 3rd ed.
- Screening Test, Developmental Brigance Early Childhood Screens III 2013
- Developmental Indicators for Assessment of Learning, 4th ed. (DIAL-4)
- Parents' Evaluation of Developmental Status (PEDS) 2012
- Ages & Stages Questionnaires: Social- Emotional, 2nd ed. (ASQ:SE-2) 2015.

These are examples of social-emotional and developmental screening tools but is not a comprehensive or exhaustive list.

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

Social-emotional and developmental screenings for children ages 1-3 are conducted in the following settings. All are reimbursable as health care services.

- Child and teen checkup and well child visits in a clinic setting
- Family home visits
- Acute office visits specifically for the developmental of social emotional condition
- Early childhood center (Head Start)
- Screenings conducted via telemedicine – follows same reimbursement as if in-clinic/onsite (though most clinic systems do all or most well-child visits in person)

Hennepin Health

- Primary care, pediatric, and family practice and FQHCs. Screenings are reimbursed in all of these settings.

Itasca Medical Care

- Itasca County's main school district (ISD 318) has an autism specialist and early childhood programs, including Head Start and Invest Early. Upon enrollment into the programs, the social-emotional and developmental screening for children from birth to 7 years old is completed. This screening is free to anyone and is not billed to or reimbursed by any health insurance. The ISD 318 school psychologist provides formal testing utilizing the Autism Spectrum Rating Scale and Autism Diagnostics Observation Scale with the help of parents and teachers to give an educational diagnosis. Referrals can be made to the school district at birth to 3 years old. This can give an educational diagnosis of autism, so a referral must also be made for a medical diagnosis. Starting at 4 months old, ASQs are sent in the mail every four months and ASQ:SE are sent every six months, for parents to complete. This occurs from birth to age 3.
- Healthy Families Itasca, a home visiting program for first time, pregnant moms who qualify for WIC, provides an evidence-based parenting curriculum through intensive home visiting. This program is available until the child turns 3 years old. ASQ and ASQ:SEs are administered in this program and referrals can be made.
- Help Me Grow is a free service offered by Itasca County Public Health and offers many relevant resources. If there is a noted concern or delay on either scale, children may be referred to their primary care provider, a network EIDBI provider or an out-of-network EIDBI provider for additional screening. Screenings are reimbursable when completed by a clinic or licensed psychologist. In some cases, telemedicine via interactive video may be used for certain services.

Medica

Pre-school screenings, pediatric appointments like well-child visits have required screenings for children ages 1-3. Screenings that take place in an office visit conducted by a licensed health professional are reimbursable as health care services.

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
- 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.

United HealthCare

The main settings for these screenings are primary care and pediatrician offices during child and teen checkups. Child and teen checkups are covered for members enrolled in PMAP and MNCare with United HealthCare Community Plan of Minnesota.

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 Comprehensive Multidisciplinary Disciplinary Evaluation (CMDE) for autism services.
- Blue Plus has case managers available to assist with questions or referrals to participating providers.

HealthPartners

Through discussions with providers, HealthPartners has identified the following barriers:

- Access to follow-up services – Shortage of children's mental health providers throughout state makes it difficult for children to receive services even after a referral, especially in more rural communities.
- 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.
- 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.
- Length of screening tools - The ASQ3 and the ASQSE-2 are lengthy forms. Most parents who are not sent these forms in advance find it difficult to fill the form out in the time they are waiting to be roomed. If they have more than one child with them the likelihood of them completing them goes down. When these are not completed the clinician cannot determine if follow-up is needed at the time of visits.
- Expense to providers of purchasing the screening tools (ASQ and ASQ-SE) especially for translated, electronic or online versions.

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
    - Speech, occupational, physical therapy
    - EIDBI services
    - If screenings are completed in a clinic setting, a referral to county public health (Hennepin County Child Access) is made.
    - No authorization is required for any of these services.

Itasca Medical Care

- If an early intervention assessment identifies a need for further evaluation, the primary care provider (PCP), school or other entity providing the assessment can make numerous referrals to other providers and programs.
- PCPs can make both social and clinical referrals. Clinically, the PCP can refer the child to a pediatric doctor who specializes in autism and offer additional referrals to services such as speech therapy, occupational therapy and physical therapy; non-PCP providers can provide referrals to the PCP or to social support services, clinics; and the Public Health Follow-Along Program may refer to the Help Me Grow program and notify the child's primary care provider.
- Referrals can be made by any entity to Behavioral Dimensions, a provider that offers intensive behavioral intervention. Referrals can be made by any entity to Itasca County Disability Resource Group, which was established by mothers to assists parents in accessing local, state and national resources.
- The school district's autism specialist becomes involved and acts as a coordinator to ensure services are established and maintained for the child.
- To receive a medical diagnosis for autism, residents of Itasca County may use any provider in DHS' statewide network.
- IMCare contracts with all local EIDBI providers in our service area and, to promote enrollee choice, allows the entire DHS EIDBI network to provide services to IMCare enrollees. IMCare does not restrict use or require prior authorization for any EIDBI services in or out of network.

Medica

- On the medical side, there are developmental screening tools that have recommendations for referrals based on the answers specific to the screening question. A provider will likely include the recommendations generated by the screening tool into the plan of care.
- On the behavioral health side, once MBH is notified or made aware of the referral need, MBH would refer family/child to a CMDE provider. CMDE is a specialty that can be filtered and searched on Live and Work Well. If the family is overwhelmed with the process and will benefit from assistance finding a CMDE provider, they would be referred for case management.

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 audiology 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.

United HealthCare

- If screenings are positive, it is important to make referrals for additional assessment as soon as possible for children to get a comprehensive medical evaluation, a mental health evaluation, or depending on the child's age, an educational evaluation.
- If indicated, timely referral for a Comprehensive Multidisciplinary Evaluation (CMDE) is appropriate and necessary. It is very important to get children further evaluation as soon as possible to determine whether Early Intensive Developmental Behavioral Intervention services are needed, and if so, to get them into those services as soon as possible. Children with autism and related conditions have much better outcomes when their diagnoses and treatment needs are identified and initiated sooner.

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 medical 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 in-network 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

- Parent/family under-engagement with primary care services.
- Additional social/cultural barriers to screening may be a factor with our member population.

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.
- Another barrier for screening is parent's lack of knowledge that screenings are available at no cost through the school district and their early childhood education programs.
- There are no barriers to initial referrals, as they can be made by anyone. Telehealth options are also available for certain services.

Medica

- We believe that parent/guardian education on developmental milestones that would support their decision to pursue screening from a provider, as well as provider time to get trained or train staff on using screening tools are barriers to screening, diagnosis and treatment to children ages 1-3.
- When providers are still using a paper process that administrative burden increases. The electronic screening tools have a cost and an implementation commitment.
- There are long wait lists for that initial CMDE evaluation, and again wait lists for specialty providers like ABA, and families may struggle to follow through with such lengthy wait times to get care.

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 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 3 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 health care.
- 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.

United HealthCare

Some parents may not have as much awareness or education about the developmental milestones to monitor that would help them identify concerns that need to be further evaluated. Many parents are busy and might have significant priorities they are trying to manage such as social and basic needs. There tends to be a lack of culturally appropriate and sensitive providers and processes. Many times the system is not equipped to best support all families and children. These are some of the barriers we have observed. Some barriers we have observed our members experiencing include:

- Lack of culturally appropriate providers, language barriers
- Transportation and childcare barriers
- Lack of appointment convenience
- Mistrust of medical system
- Lack of knowledge of well child medical needs.

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

HealthPartners has implemented the following strategies to facilitate access to periodic developmental and social emotional screening(s), diagnosis and treatment for young children ages 1-3:

- Child and Teen Checkup clinic trainings – we 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 enterprisewide initiative to improve the health of children from prenatal to age 5. The three main areas of focus are to promote early brain development, provide 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 affect a child's development. This includes developmental and social-emotional screenings. Reach out and Read is also within this initiative.
- Community partnership: 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.
- Community partnership: Help Me Grow - HealthPartners employees and clinicians have been involved in the Help Me Grow work groups.
- 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.

Hennepin Health

- Parent/family incentives for completing screening visits. PMAP well-child visits for children, ages 0-30 months, increased by 5% the PMAP and MinnesotaCare programs in 2021 through intensive phone outreach.
- Follow-up and sharing information with clinics.
- Quarterly meetings held with Hennepin County Public Health include topics like child and teen checkups.
- No authorization requirements for any therapy services, including EIDBI.

Itasca Medical Care

- IMCare works with multiple clinics, schools and agencies to ensure the availability of early screening, diagnosis, ongoing assessment and treatment for children with ASD between the ages of 1-3 years old.
- IMCare provides education in the enrollee and provider newsletters on EIDBI services, resources available and how to access them. Education provided through the newsletter has included available screening options through primary care providers (PCP) with Child and Teen Checkups (C&TC), social support services; Itasca County's school districts offer early childhood programs, including Head Start and Invest Early, Public Health Follow-Along Program, Healthy Families Itasca and WIC. IMCare also provides education to enrollees with resources through collaborative efforts with Itasca County Public Health; Itasca County School Districts; Itasca County Developmental Disabilities Unit; and the Itasca County Disability Resource Group, which was established by mothers to assist parents in accessing local, state and national resources.
- IMCare managed care nurses partner with local educational groups such as Communities for Health, Head Start Health Advisory Committee and the regional Child and Teen Checkups (C&TC) to evaluate ways to further educate the community about available resources.
- IMCare has shared information with providers who may meet criteria to become an enrolled provider through email and provider newsletters to assist DHS in recruiting EIDBI providers and has removed authorization requirements for EIDBI services, including CMDE, to allow members to access services in or out of network.

Medica

- Medica collaborates with providers on current availability. We promote education on the benefit of well-child visits that include early screening and intervention as appropriate.
- New in 2022 we are offering families developmental milestone education in the member handbook and in the birthday card they receive upon their child's first birthday.
- We have developed a strong working relationship with local Minnesota provider Fraser in an effort to minimize wait list impact, and while families are waiting for services we can connect them to therapists who can work with the family on skills and communication as a placeholder for more intensive services until they become available.

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.
- 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 phone outreach 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 . Providers may 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 in which 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.

United HealthCare

UHC plans to partner with DHS as part of the EIDBI workgroup and collaborate on efforts to work with providers to facilitate access to developmental and social-emotional screening, diagnosis, and treatment for young children. UHC Community Plan of Minnesota is a new health plan to this market as of Jan. 1, 2022, and is at the initial stages of getting some experience in Minnesota. This topic is extremely important and there is a lot of opportunity to get more young children screened, referred for evaluation and into EIDBI services. Our quality program includes the following initiatives that should help increase screenings and referrals for further diagnosis and initiation of needed treatment:

- Annual Well Visit incentive for children ages 3-21
- Incentives for completion of childhood immunizations
- Child and Teen Checkups Program
- Preventive visit reminder letter sent to children one month prior to their birthday
- Preventive visit email campaign sent to members with children ages 3-21
- Programs for providers to encourage general pediatric care: Incentive program for primary care practices designed to reward closure of clinical gaps for the child and adolescent well child visits (WCV).

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 (CMDE) 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 help 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.
- IMCare attempts to educate providers and members about EIDBI services through the newsletters and advisory committees to raise awareness surrounding this resource now that it has some availability in the region.

Medica

- On the medical side, there are developmental screening tools that have recommendations for referrals based on the answers specific to the screening question.
- The health plan relies on the provider to complete evaluation and assessment, including treatment recommendations, that is specific to each child seen in their practice. A provider will likely include the recommendations generated by the screening tool into the plan of care.
- On the behavioral health side, once MBH is notified or made aware of the referral need, MBH would refer family/child to a CMDE provider. CMDE is a specialty that can be filtered and searched on Live and Work Well. If the family is overwhelmed with the process and will benefit from assistance finding a CMDE provider, they would be referred for case management.

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 Clinical Practice Guidelines 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.

United HealthCare

If developmental milestones are not met and screenings administered are positive, it is important to make referrals for additional assessment as soon as possible for children to get a comprehensive medical evaluation, a mental health evaluation or, depending on the child's age, an educational evaluation. If indicated, timely referral for a Comprehensive Multidisciplinary Evaluation (CMDE) is appropriate and necessary.

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.
- Data about provider adoption and screenings completed 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
- Completion of well-child visits.

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 ABCD to Close the Loop. 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 medial 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

- Through coordination with screening staff in the school districts, public health agencies and PCP providers there is potential to report the number of referrals that were generated through the screening process and attempt to determine how many of those individuals that have received services.
- It also may be beneficial to do parent surveys to understand their perspective and to identify gaps in the process.

Medica

- Education for parents, education for providers and EHR support to build templates with best practice standards. Access to validated screening tools in advance of appointments available electronically.

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.

United HealthCare

- This annual EIBDI MCO report can be helpful to monitor year-over-year data. DHS has access to all MCO and FFS data and could run reports and analysis. Further, providers should be encouraged to analyze their own data.
- Providers are front and center and administer the screening, diagnosis and treatment. Primary care, pediatrician offices and EIDBI providers could all provide a wealth of information. It just depends on what is specifically being looked at.
- The UHC Community Plan of Minnesota is new and we do not have a lot of data yet for our Minnesota membership, but we plan to review data as we get more experience to understand the effectiveness of our strategies to encourage participation in early childhood checkups and screening, monitoring the rate of the developmental screening in the first three years of life and data on participation and closing clinical gaps.
- We will also continue to monitor the number of members who are getting CMDE evaluations and accessing EIDBI treatment.

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.
- 292 children received EIDBI services
- Children received an average of 416 hours of direct intervention a year
- Children received an average of 63 hours of group intervention a year
- Children and families received an average of 14.5 hours of family caregiver training a year
- Of children whose race/ethnicity was known 40% were Hispanic, Asian, Black or Indigenous and 60% were white

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% of the children were black or African American
- 8% of the children were Asian or Pacific Islander
- 4% of the children were American Indian or Alaskan Native
- 4% of the children were Hispanic/Latino
- The remainder of the children were “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

Itasca Medical Care

- IMCare did not have any claims for children under 6 years old. Members who had CMDEs and received EIDBI were too small to report unidentifiable data.

Medica

- At this time Medica has not received claims for CMDE procedure codes.

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.

United HealthCare

Data elements gathered from the CMDE include the following items:

- How would you rate caregivers in regards to their proficiency with treatment techniques with their child?
- What is the severity of social communication deficits?
- What is the severity of the social interaction deficits?
- What is the severity of Behavior Difficulties, i.e. restricted, repetitive patterns of behavior, interests, or activities?
- What is the severity of destructive or maladaptive behaviors such as aggression, self-injurious behaviors, or property destruction?

United HealthCare has served 13 children with average units being difficult to calculate as they have been in the Minnesota market for one quarter.

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; however, access to services by children served by MCOs is not keeping pace with those who use fee for service Medicaid.

Families are still struggling to access appropriate services in a timely manner. This becomes more apparent when looking at racial demographics. The MCOs' demographics show less service being provided to children who are BIPOC. 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
- Develop and create more formal ways to coordinate and support families from initial concern to accessing services
- 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
- 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 and coordination across educational, medical and human service providers and agencies using the collaboration resources
- 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, Infants and 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 communities with different cultures and languages 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.

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.