DHS-8601B-ENG 11-24

Legislative Report

EIDBI Licensing Recommendations

Disability Services Division

January 2025

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ဟ်သူဉ်ဟ်သး. နမ့်၊လိဉ်ဘဉ် တၢ်မၤစၢၤကလီလၢ ကကျိးထံလံာ်တီလံာ်မီတဖဉ်အဃိ, ကိးနီဉ်ဂံၢ်လၢ အအိဉ်ဖဲတၢ်လွံၢ်နၢဉ် လၢတၢ်ဖိခိဉ်အပူၤတက့ၢ်. Karen

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Baldarî. Ger ji bo wergerandina vê belgeyê hewcedariya we bi alîkariya belaş hebe, ji kerema xwe bi hejmara li qutiya jorîn re telefon bikin. Kurdish Kurmanji

Hoȟpíŋ. Tóháŋ waŋží thí wíyukčaŋpi kiŋ yuhá níyuŋspe héčha čhéya, lé tkíčhuŋ kiŋ k’é náŋpa opáwiŋyaŋ. Lakota

ເອົາໃຈໃສ່. ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອຟຣີໃນການຕີຄວາມເອກະສານນີ້, ໃຫ້ໂທຫາເບີທີ່ຢູ່ໃນປ່ອງຂ້າງເທິງ. Lao

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Mah Biz’sin’dan.
Keesh’pin nan’deh’dam’mun chi’wee’chi’goo’yan chi’nis’too’ta’man oo’weh ooshii’be’kan.
Ishi’kidoon ah’kin’das’soon ka’ooshi’bee’kadehk ish’peh’mik ka’shi ka’ka’kak. Ojibwe

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LB (7-24)

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I. Executive summary

The Early Intensive Developmental and Behavioral Intervention (EIDBI) benefit was created in 2013, initially to serve children with autism spectrum disorder (ASD) and related conditions up to age 18; the benefit was subsequently expanded to serve young people up to age 21 who are enrolled in a Minnesota Health Care Program (MHCP) such as Medical Assistance or MinnesotaCare. It is estimated that roughly 1.9 percent of 4-year-old children (or one in 53 4-year-old children) in Minnesota have ASD.[1] There is significant need for EIDBI services and a shortage of providers available to provide needed services.

The Minnesota Department of Human Services (DHS) licenses or certifies several different provider types. Members of the community identified a need for a service specific to ASD around 2012. In response, DHS collaborated closely with community providers, partners and families to develop the EIDBI service. The Legislature authorized DHS to seek federal approval and implement EIDBI however a licensing framework was not included. This has left EIDBI agencies neither licensed nor certified, leading to concerns about monitoring the quality, safety and integrity of services provided. These concerns were exacerbated by the pandemic, when site visits which help ensure at least minimum provider enrollment standards are met were put on hold. DHS recognizes how vital EIDBI services are for children and families. The goal of this study is to identify solutions to these concerns while balancing access, equity and safety.

This report draws on both an environmental scan of similar licensed DHS providers and an extensive engagement process with interested parties, as well as data provided by DHS, to inform recommendations. The scan of licensed DHS providers shows that licensed providers are required to comply with significantly more fundamental program requirements to ensure client safety and monitored for their compliance against these requirements.

This report includes a set of recommendations to put EIDBI provider agencies on a path toward licensure as expeditiously as possible as well as recommendations for interim measures to improve program integrity and compliance. Proposed recommendations include an approach to establishing licensure of EIDBI provider agencies that would incorporate clinical oversight from DHS to evaluate various aspects of provider agency operations and delivery of medically necessary services. Proposed topics to be included in a system of licensure include the following nine areas:

- Health and safety standards.
- Investigating, reporting and acting on alleged violations of program standards.

[1] Minnesota Autism Developmental Disability Monitoring Network

- Administrative and clinical structure.
- Supervision standards.
- Caseload limits.
- Treatment modalities and provider qualifications.
- Initial and ongoing training.
- Verifying licensure and/or certification and scope of practice.
- Removing providers from MHCP enrollment based on inactivity.

These recommendations are made in the context of soaring growth in the number of enrolled EIDBI provider agencies and substantial increases in client participation and program costs. Implementation of these recommendations will accomplish three things:

- Protect the interests of children being served through the EIDBI benefit.
- More clearly inform prospective and current operators of EIDBI provider agencies what their responsibilities are.
- Put safeguards in place that will provide stronger accountability for state and federal funds invested in these vital services.

II. Legislation

Laws of Minnesota 2023, chapter 61, article 1, section 63.

EARLY INTENSIVE DEVELOPMENTAL AND BEHAVIORAL INTERVENTION LICENSURE STUDY.

(a) The commissioner of human services must review the medical assistance early intensive developmental and behavioral intervention (EIDBI) service and evaluate the need for licensure or other regulatory modifications. At a minimum, the evaluation must include:
1) an examination of current Department of Human Services-licensed programs that are similar to EIDBI;
2) an environmental scan of licensure requirements for Medicaid autism programs in other states; and
3) consideration of health and safety needs for populations with autism and related conditions.

(b) The commissioner must consult with interested stakeholders, including self-advocates who use EIDBI services, EIDBI providers, parents of youth who use EIDBI services and advocacy organizations. The commissioner must convene stakeholder meetings to obtain feedback on licensure or regulatory recommendations.

III. Introduction

This report explores the need for licensure of EIDBI provider agencies. It is the third in a series about EIDBI services commissioned by DHS at the direction of the Legislature. The first report, completed by Community Research Solutions, included a scan of other DHS licensed programs and their required standards. It also incorporated information about other states' Medicaid services for youth with autism and related conditions. The second report, completed by Courageous Change Collective, summarized an extensive engagement process for interested parties involving EIDBI providers and family members of children participating in EIDBI services. The findings from these first two reports are summarized at the outset of this report as well as referenced in other relevant sections.

Purpose of report

This report explores the need for licensure of EIDBI provider agencies. The report explains why licensure is needed and how it would address numerous emerging challenges across EIDBI provider agencies. It provides background information about the EIDBI benefit and program growth. It provides recommendations to the Legislature and DHS to establish licensure addressing at least nine core areas as well as a description of the timeline and resources that would be needed to do so. The document also recommends the Legislature and DHS take interim steps to improve oversight of EIDBI provider agencies until licensing can be implemented.

The report was required under Laws of Minnesota 2023, chapter 61, article 1, section 63. It was prepared by Katie Burns 10,000 Lakes Consulting under contract with the Minnesota Department of Human Services.

IV. An overview of work to date

Environmental scan of DHS licensed programs

The environmental scan of other DHS licensed programs includes summarized information about the following licensed providers:

- Outpatient mental health
- Center-based child care
- Family child care
- Adult day center
- Foster care
- Home and community-based services
- Children's residential facilities.

While insights and details are shared throughout this report in various relevant sections, a clear take away from the scan of DHS licensed programs is that licensed providers are required to meet an array of standards to provide services and their compliance with those standards is monitored and enforced through licensing. By comparison, EIDBI provider agencies are held to comparatively fewer standards and DHS lacks authority and appropriate staffing to enforce compliance with those existing standards.

Summary of provider and family engagement process

The engagement process, conducted by Courageous Change Collective, gathered feedback from two important partners: providers of EIDBI services and professionals in related fields as well as families and caregivers of children with autism and related conditions. The engagement process occurred over four months with substantial outreach. Courageous Change Collective facilitated six focus groups involving 75 providers; 114 providers responded to surveys. Four focus groups were held for family and caregiver representatives involving 35 participants; 52 families submitted survey responses.

The goals of the engagement process were to identify what is working well with EIDBI services; what areas of EIDBI services need improvement; solicit input on key topics that could potentially be addressed as part of licensure; and document concrete suggestions for improvement.

Families expressed appreciation of EIDBI services and the difference those services made in the lives of their children. They also expressed a need for more support; parents and guardians spend enormous time and energy navigating systems for coverage of EIDBI services and finding care. They voiced concern about lack of effective collaboration between providers and schools, often finding themselves as the coordinator between the two and reluctance on the part of schools for more active support of needed services.

As part of the feedback process, providers expressed their support for DHS establishing clear standards for EIDBI agencies. They particularly voiced support for physical health and safety standards as well as caseload limits. Other providers felt that clearer guidance from DHS would help new providers establish themselves successfully.

Some interested parties expressed reservations about a potential system of licensing because of its inherently more structured and defined approach to oversight of services. They are concerned the EIDBI care system may become too rigid if EIDBI becomes too regulated; other interested parties expressed concern that licensing officials might have inconsistent expectations. Regulations might especially be challenging for providers from underserved communities that face cultural and linguistic barriers to providing services. Interested parties also express concern about DHS administrative capacities and processes to support existing provider enrollment processes; they would like to know DHS is better positioned to support providers through state-required processes before going down the path of licensure where greater interaction will need to occur between DHS and providers.

Families noted the licensing process can take a lengthy time and that requirements for completing documentation and going through the licensing process might become a barrier to providers. They also expressed concern about when licensors would conduct site visits to evaluate services and whether this process might interrupt the provision of high-quality services. Families in rural areas are concerned about measures that might exacerbate the severe shortage of provider centers in outstate Minnesota. They wondered whether the licensing rules would result in accreditation requirements or required hours for staff training. Families were skeptical about whether state officials who would be involved in creating the licensing rules have any experience as EIDBI providers. Families would like any potential licensing process to be a collaborative one between individual providers, agencies and the Department of Human Services. They think it is critical for providers to have an opportunity to provide input and inform both any initial licensing process as well as changes into the future.

Limitations of licensing

It should also be noted that licensing would address many issues explored during the engagement process, but not all of them. Licensing typically is a tool for establishing minimum standards across provider agencies, which is critical. However, licensing will not address issues such as effective coordination of services with schools, which is a significant issue for families and providers. Licensure will help DHS to identify and potentially prevent program integrity issues; however, even licensing cannot eliminate the risk of some program integrity concerns.

V. Why should DHS license EIDBI provider agencies?

EIDBI is an outlier among other Minnesota Health Care Programs for its lack of licensure of provider agencies in comparison to similar other human services providers that offer intensive intervention services in centers, clinics and other community-based settings to vulnerable populations. Licensing provides a toolkit of potential approaches for responding to, addressing and escalating concerns based on the severity and chronicity of issues occurring. Licensing helps to ensure program quality by establishing “the threshold or floor of quality below which no program should be permitted to operate.”[2]

Because EIDBI provider agencies are not licensed, they are subject only to minimal health and safety standards unless they happen to be licensed as a different kind of provider entity (which might be the case, for example, if the provider agency also offers certain community-based mental health services). Staff are not required to participate in continued training and education to stay current on developments in this evolving field. This is out of step with other types of human services programs and concerning because of the complex needs of the population being served.

The population of young people served by the EIDBI benefit are a vulnerable population. The average age of children receiving EIDBI services is currently 8.8 years old[3]. Some participants are non-verbal. Children with ASD or related conditions are more prone to behaviors that could put them in danger, such as wandering or running away. Provider agencies serving children with ASD and related conditions need facility safety standards and procedures in place to address these concerns.

Because EIDBI provider agencies are not licensed, DHS has no authority and processes to conduct maltreatment investigations. A recorded incident of maltreatment of a 3-year-old child participating in EIDBI services occurred at a provider agency in May 2024[4] and raised concerns. The child was repeatedly forcefully pushed to the ground by an employee on her first day of unsupervised interactions with children. That employee was subsequently charged with malicious punishment of a child after the incident. DHS had no authority to send its own investigators to this EIDBI provider agency.

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[2] Fiene, Richard. National Association for Regulatory Administration. “Licensing Measurement and Program Monitoring Systems” webinar.

[3] DHS data, October 2024.

[4] CBS News. “Video shows toddler repeatedly thrown to the ground at Minnesota autism center.” May 3, 2024.

When a program is licensed, DHS has processes in place to triage a complaint and determine who should follow up on the report along with standard timelines, depending on the nature of the report. This is a different and more focused process operationally than for unlicensed programs.

This also provides greater opportunity for DHS to identify concerns that may, for example, involve a larger provider organization with locations scattered across different counties. When concerns are investigated by a centralized, statewide entity such as DHS, there are opportunities to "connect the dots" across various complaints to see they are associated with a single provider organization. An ability to see these types of patterns provides DHS staff an opportunity to view these complaints with heightened concern and escalate investigating and responding to them accordingly.

EIDBI services are in high demand and the program is growing in all critical dimensions – the number of children and young people being served; the number of provider agencies and individual providers enrolling to provide services through MHCP; as well as both average and total costs.

Local and national media have reported federal and state regulators are investigating EIDBI providers. The Federal Bureau of Investigation began investigating potential EIDBI provider fraud concerns at least as early as June 2024.[5]

The Star Tribune reported that, as of mid-September 2024, the Minnesota Department of Human Services' Office of Inspector General (OIG) had 29 open investigations underway of EIDBI service providers for review of fraud or abuse of Medicaid funds. In addition, among recently completed investigations, the state is in the process of recovering more than $86,000 from an Edina-based provider and both recovered $192,000 from and levied a $5,000 fine against a provider located in St. Paul.[6]

In addition to the recovered payments, the OIG has withheld payments to seven providers over the past six years: five due to credible fraud allegations, one because a provider refused to give DHS access to records and one to safeguard the public welfare and MHCP.[7]

While there is a significant shortage of individual providers, the number of EIDBI provider agencies enrolled as MHCP providers has more than quadrupled since 2020. As the number of agencies enrolling has increased, average costs per service and total program costs have grown exponentially.

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[5] Winter, Deena. "FBI investigates Minnesota autism centers, which have exploded in growth since 2018: DHS studying whether it should begin licensing autism facilities." Minnesota Reformer. June 18, 2024.

[6] Van Berkel, Jessie. "Minnesota Medicaid fraud investigators examining more autism service providers." Star Tribune. Sept. 18, 2024.

[7] Winter, Deena. "FBI investigates Minnesota autism centers, which have exploded in growth since 2018: DHS studying whether it should begin licensing autism facilities." Minnesota Reformer. June 18, 2024.

Although the number of children being served through EIDBI is also increasing, the degree of increase is not keeping pace with the significant increase in program costs. A system in which provider agencies are licensed would give DHS additional capacity and set protocols to address program integrity concerns.

DHS sees indications that capacities for appropriate clinical oversight of services are under strain.

A number of individual providers with the qualifications needed to oversee services appear to be simultaneously employed by a large number of agencies. At a certain point, it is difficult to appropriately monitor clinical services of individual providers if a care supervisor is attempting to do so across a large number of individual providers or across too many provider sites.

The rapid increase in the number of EIDBI provider agencies and individuals enrolling to serve children with ASD and related conditions has led to some operational inconsistencies. Some providers who participated in the interested party engagement process indicated they need more direction from DHS and that some EIDBI provider policies are not clear to them. While some providers report challenges with the DHS provider agency enrollment process, it is crucial to address these challenges to ensure that newly enrolled agencies are fully operational and prepared to deliver high-quality services.

When provider agencies complete the enrollment process, they are listed as MHCP providers in DHS' provider directory. The issue of providers completing enrollment, but not becoming operational, results in a provider directory including providers that don't offer services. This is a frustration to families searching for providers for their children. The provider directory also includes providers who no longer offer services, which is also frustrating to families. DHS' current process for enrolled providers does not allow for providers to be removed when they are inactive over a lengthy period. DHS currently requires EIDBI providers to revalidate their enrollment every five years. Under current process, providers are only removed from the provider directory if they fail to revalidate their enrollment or if DHS has other grounds to remove them. This means both providers who never became operational or who are dormant linger on the MHCP provider directory for a lengthy period before they are removed.

DHS staff report some basic components of business operations are lacking among some EIDBI provider agencies. For example, staff have called the phone number listed for an agency only to have someone answer the phone in a manner that suggests the phone number is a personal phone rather than that of a professional client-serving agency. Similarly, some EIDBI provider agencies lack websites or have providers who use email addresses that appear to be personal email addresses. The use of personal email addresses for conveying protected, sensitive health information to families or other providers is a serious concern. Provider agencies should have basic components of a professional business in place, such as a business phone number, a business website and business email addresses for their employees that allow employees to communicate via secure email. The presence of these business tools conveys a minimally expected level of professionalism to families and other providers.

Some EIDBI treatment protocols call for up to 40 hours per week of intensive services. A child receiving that level of services in a center-based environment is essentially spending at least as much time at a provider agency as a child enrolled in full-time day care. The lack of more rigorous controls around this program has some concerned that a portion of provider agencies may be acting more as daycare operators, but bill for more expensive EIDBI services instead without providing medically necessary services.[8] To the extent this is true, this is a disservice to families seeking services and an egregious form of provider fraud.

Licensing will help ensure higher quality of services by creating standards and enforcing compliance with them, which will likely lead to better outcomes for the children being served.

While EIDBI services are clearly needed by families, this high growth program needs additional guardrails and oversight. Unless the concerns described in this report are concretely addressed through a clear system of standard-setting and enforcement of those standards through licensure, these issues are likely to continue to grow in scale.

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[8] Winter, Deena. "FBI investigates Minnesota autism centers, which have exploded in growth since 2018: DHS studying whether it should begin licensing autism facilities." Minnesota Reformer. June 18, 2024.

VI. Background

Evolution of EIDBI services in MHCP

The EIDBI benefit was created in 2013, initially to serve children with ASD and related conditions up to age 18; the benefit was subsequently expanded to serve young people up to age 21. There is significant need for EIDBI services and a shortage of providers available to provide needed services.

Minnesota is unique among states for allowing a variety of treatment modalities to be offered as part of the EIDBI benefit. Most states rely solely on Applied Behavioral Analysis (ABA), which is widely recognized as the gold standard for care of children with ASD. It is the most rigorously tested and evidence-based intervention and is recognized by the Surgeon General[9] and the National Institute for Mental Health (NIMH)[10] as the most effective approach for treating ASD. Other key organizations, such as the American Academy of Pediatrics[11], the Centers for Medicare & Medicaid Services[12] and the Behavior Analysis Certification Board[13] also recognize ABA as an effective, evidence-based treatment approach. ABA also has the most extensive education and experience requirements for providers as compared to other treatment modalities.

In addition to ABA, Minnesota permits the following modalities to be used in MHCP:

- Developmental, Individual Difference, Relationship-based (DIR)/Floortime model.
- Early Start Denver Model (ESDM).
- PLAY Project.
- Relationship Development Intervention (RDI).
- Early Social Interaction (ESI).

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[9] U.S. Department of Health and Human Services. (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services

[10] National Institute of Mental Health. (2021). Autism Spectrum Disorder: *Treatments and Therapies*. Bethesda, MD: NIMH.

[11] American Academy of Pediatrics. (2020). Autism Spectrum Disorder: Guidelines and Standards. *Pediatrics*, 145 (Supplement 1), S1-S11.

[12] Centers for Medicare & Medicaid Services (CMS). (2014). *Clarification of Medicaid Coverage of Services to Children with Autism*. Baltimore, MD.

[13] Behavior Analyst Certification Board (BACB). (2022). *Professional and Ethical Compliance Code for Behavior Analysts*.

Current status of EIDBI licensure, certification and accreditation in Minnesota

It is important to understand the baseline of licensure and certification requirements in place for EIDBI providers in Minnesota:

- **Agencies offering EIDBI services are not licensed**. This report recommends DHS adopt a licensure framework for these agencies.
- **Individual providers are not currently required to be licensed**; however, this is changing effective Jan. 1, 2025, for the most highly credentialed individual providers offering Applied Behavioral Analysis (ABA) services. This includes board certified behavior analysts (practitioners with a master's degree) and board-certified behavior analysts – doctoral (practitioners with a doctoral degree).
    - The Minnesota Board of Psychology will manage the licensing process for these providers. Thirty-five states already required licensure of BCBAs[14] before Minnesota law was changed to require this.
    - This licensure process will increase oversight and regulation of professional and ethical standards of ABA practice, which should be helpful in ensuring and increasing fidelity of ABA service provision in the state.
    - DHS does not license individual providers practicing the other five permitted EIDBI treatment modalities and there are currently no plans to do so.
- **Individual providers may be certified to offer a variety of EIDBI treatment modalities** permitted to be used and billed under MHCP as noted above. Certifications are offered through private credentialing organizations or public entities and are distinct from licensure, which gives a provider authority to operate in a state or to provide services through a state Medicaid program. Certification means an individual has completed the requisite education and training requirements needed to meet that private organization's standards. It should be noted significant variation exists in the rigor of these professional organizations' standards, including those related to initial training to obtain certification, continuing education requirements, oversight protocols and ethical standards.
- **Licensing and/or certification for individual providers do not fill the gap of a lack of required licensure for EIDBI agencies.** Agencies employ individual providers and, under a licensing framework, would be held to a more robust set of standards around how they operate.
- **Accreditation by a credible external entity typically relies on more rigorous standards than licensing.** Effective licensing creates standard requirements to achieve at least a certain minimum level of program quality, whereas achieving accreditation from a respected external entity is generally indicative of meeting standards associated with higher levels of quality.

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[14] Licensure of Behavior Analysis in the United States, https://www.bacb.com/u-s-licensure-of-behavior-analysts/

- A national organization called the Autism Commission on Quality (ACQ) recently created an accreditation program provider agencies. Thirty I program sites across the nation have achieved accreditation through ACQ (none of those accredited agencies are located in Minnesota). Massachusetts recently took a significant step forward by requiring Medicaid managed care organizations in the commonwealth to contract only with accredited agencies to offer medically necessary services to children with autism and related conditions.[15]

[15] Oct. 1, 2024. "MassHealth Announces Accreditation Requirement for Applied Behavior Analysis Providers." https://autismcommission.org/press-release/20241001-masshealth-announces-accreditation-requirements-for-aba-providers/

How much EIDBI care is provided through MHCP?

This section of the report provides important baseline information about EIDBI service provision in Minnesota. It shares data provided by DHS about the following metrics:

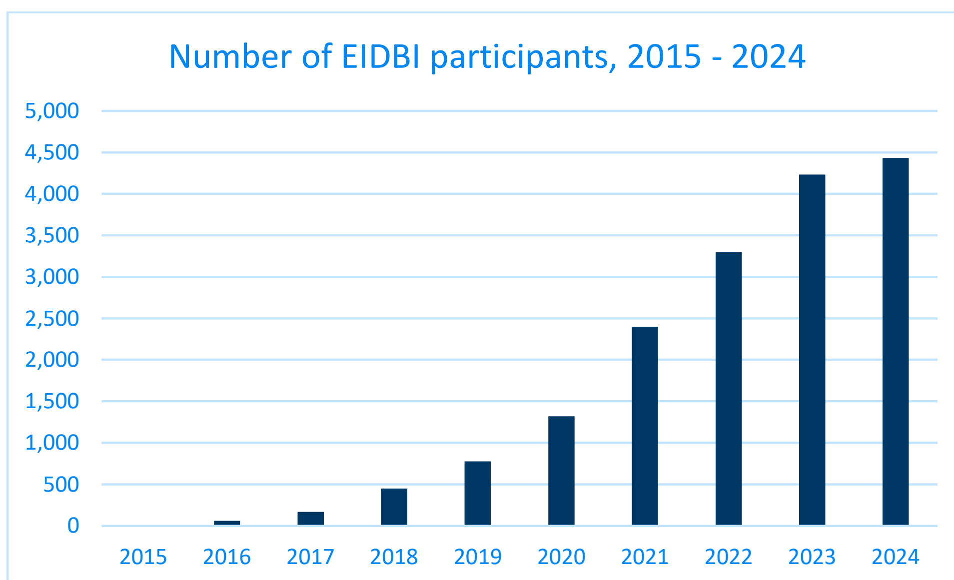
- Number of children receiving services.
- Number of service units billed on an annual basis.
- Number of units billed per client on an annual basis.
- Average annual spending per client per year.
- Units billed by provider type.
- Average cost of service over time.
- Number of EIDBI provider agencies over time.

All metrics show significant growth, which is to be expected when a new program is launched and in its early years of operation. It is important to understand information about increased program costs in the context of anticipated growth and participation in a relatively new benefit. It must be noted, however, this growth is occurring in a largely unregulated care system; this lends urgency to the need for licensure to safeguard program participant health and safety as well as to ensure program integrity.

Number of EIDBI clients served

As expected with a new program, the number of children receiving EIDBI services has grown significantly since the benefit became operational in 2015. In 2023, a total of 4,232 Minnesota children received EIDBI services as compared to 3,296 in 2022; this represents a 28 percent growth in the number of participants in a year and more than a tripling of program participants since 2020.

Figure 1: Number of EIDBI participants over time



Units of EIDBI services billed

The amount of care being provided is increasing over time as well on a per-client-served basis and in total. The number of total EIDBI service units billed annually has increased in part because of an increasing number of program participants each year as well as some success in addressing provider shortages. Strategies to allow alternative types of credentials to attract more care providers into the care system are working at least to some extent, particularly among EIDBI Level II providers.

Figure 2: Units billed by calendar year

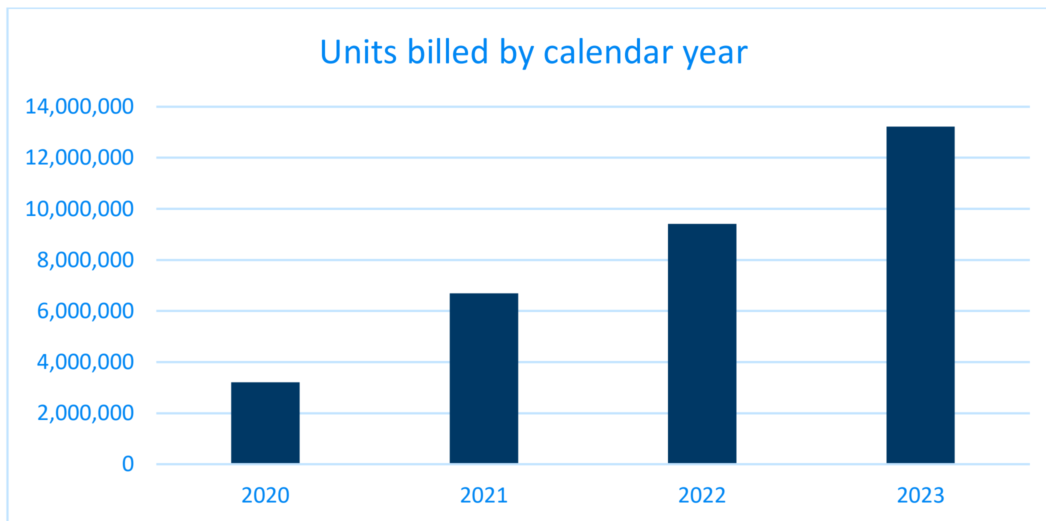
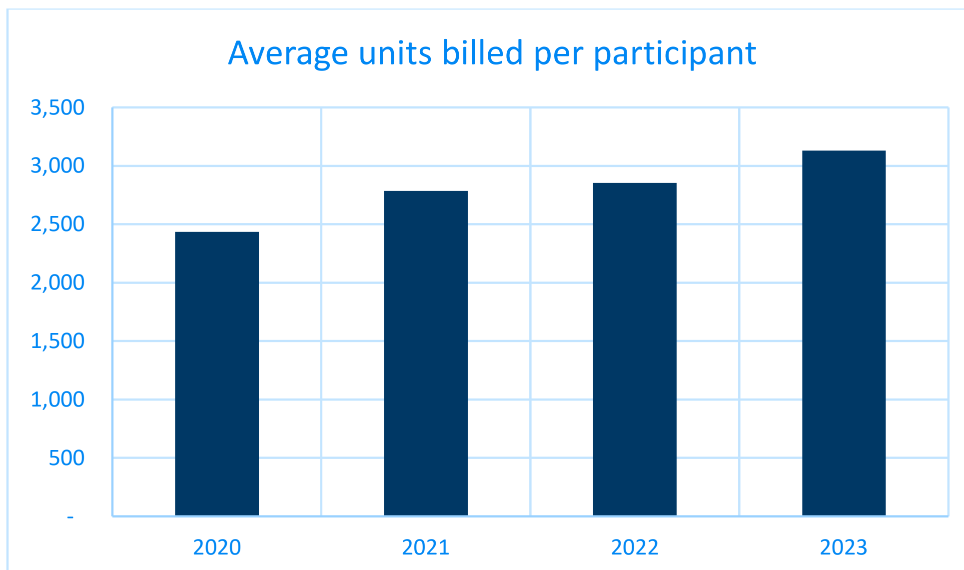


Figure 3: Average units billed per participant

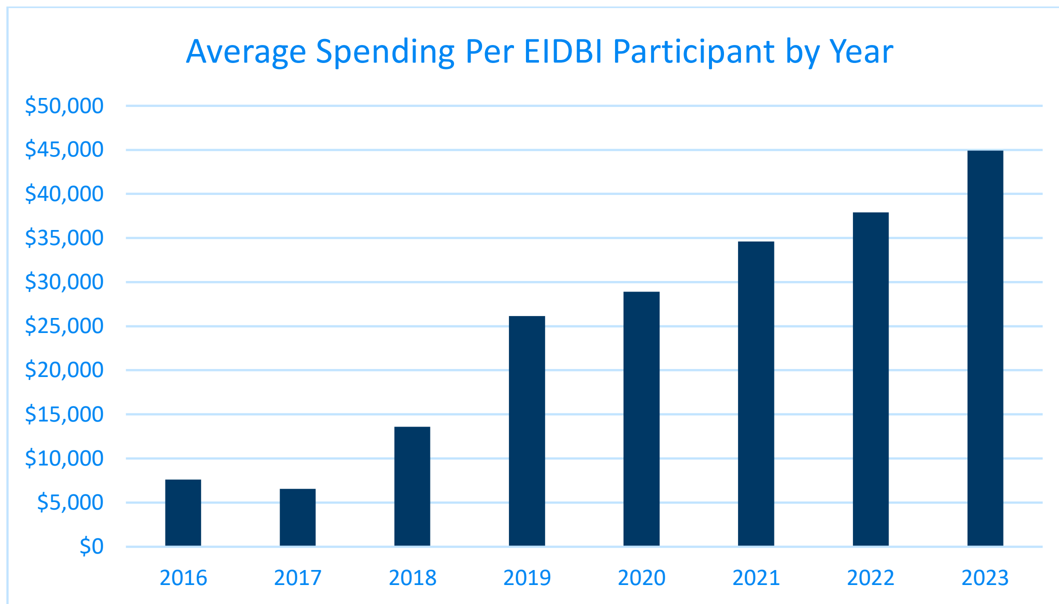


Examining the number of units of services billed per participant sheds light on treatment intensity. The average growth rate over a four-year period of the average number of units billed per participant is nearly 29 percent. While this is a significant increase, program growth as measured in number of participants served, total units billed and cost growth are all much higher.

Spending and cost growth

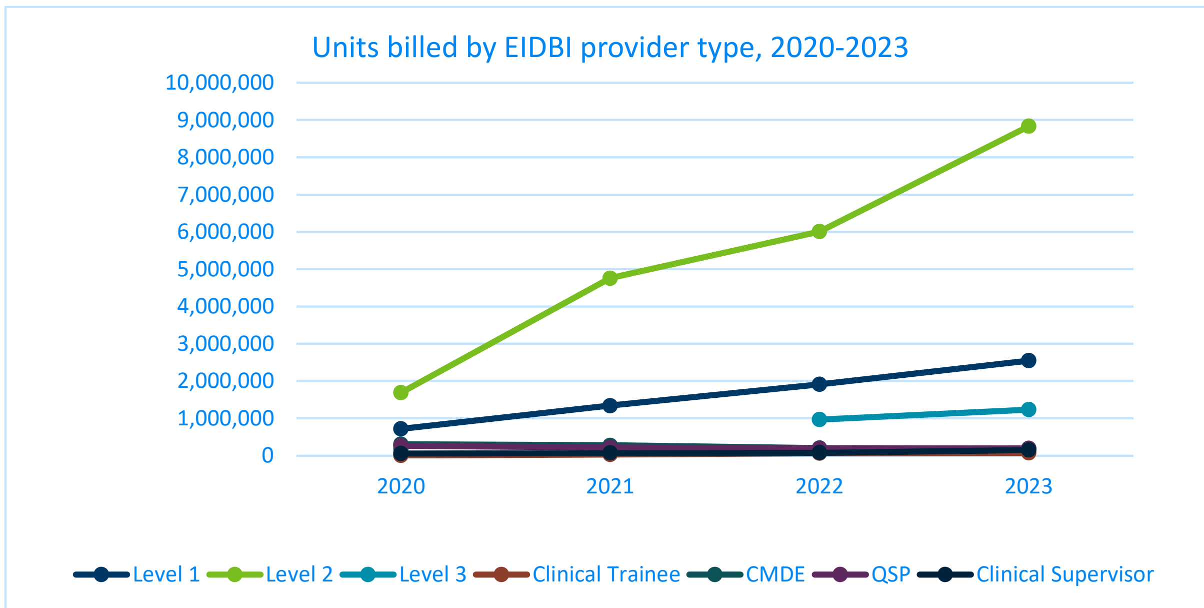
Average spending per EIDBI client served has increased sharply over the life of the program.

Figure 4: Average spending per EIDBI participant by year



To better understand what factors are contributing to cost growth, we looked at which provider types are billing for services and average cost growth as well as how these metrics are changing over time.

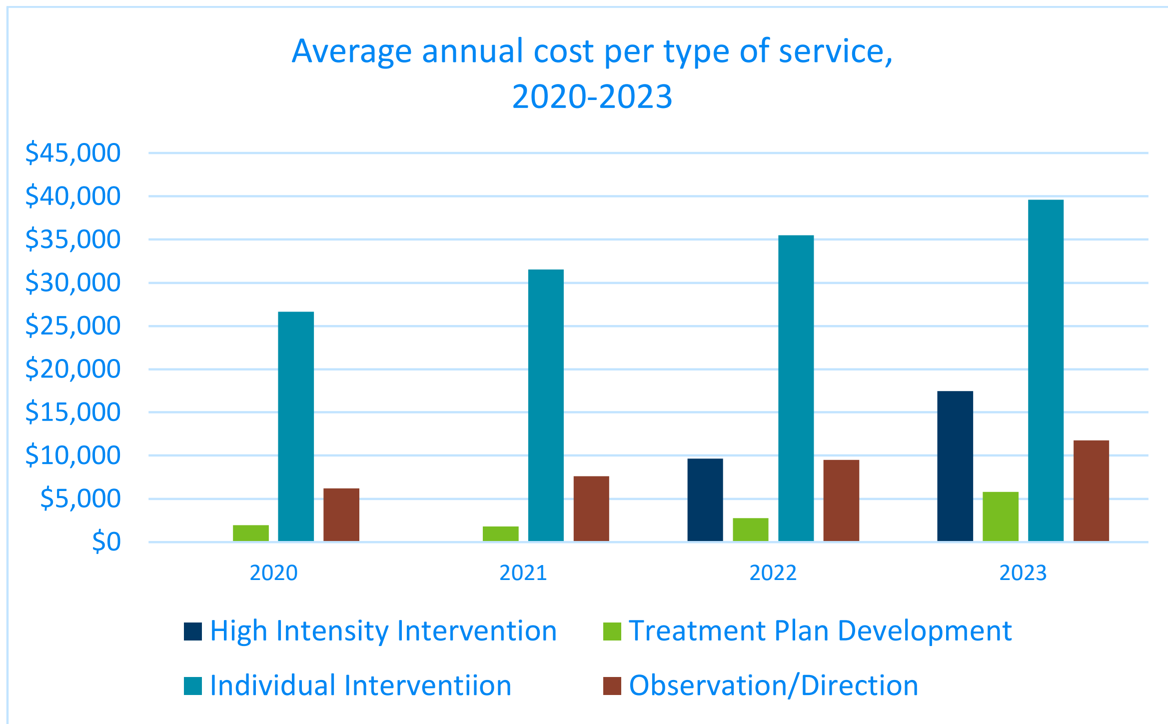
Figure 5: Units billed by provider type



As Figure 5 depicts, the sharpest increase in numbers of units billed has occurred among Level II providers. This has some impact on cost growth as more experienced Level II providers have higher payment rates as compared to Level III providers.

Average annual cost for certain types of EIDBI services have increased significantly over time. It should be noted there are logical reasons for average costs to increase, such as increases in payment rates. A significant occurrence in the evolution of the EIDBI program over time, for example, was the finalization of current procedural terminology (CPT) billing codes in 2018, which drove a jump in average cost in services.

Figure 6: Average cost per service, 2020-2023



Several average cost trends are noteworthy and merit additional examination, particularly in the context of growth in the number of EIDBI provider agencies; how many qualified supervising professionals (QSPs) and advanced certification providers are available to provide clinical supervision; and enormous growth in telehealth claims in the post-pandemic period:

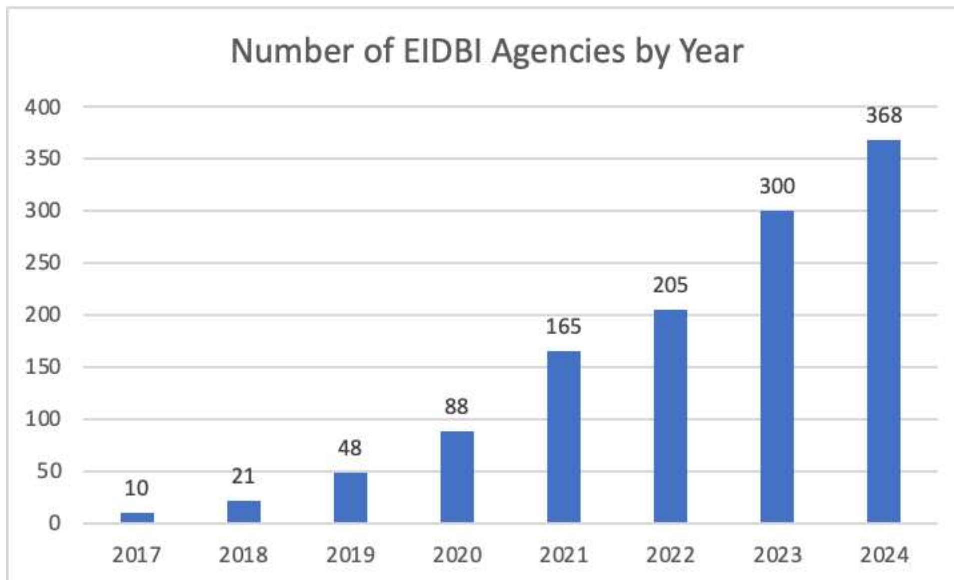
- The average cost for individual intervention services was almost $40,000 per client in 2023.
- The average cost of higher intensity interventions and development of individual treatment plans have grown substantially over the past several years. Average cost for individual treatment plans grew by 54 percent in 2022 and by 109 percent in 2023 as compared to prior year average costs. Average costs for high intensity interventions grew by 81 percent from 2022 to 2023.
- This growth in average cost has occurred when the number of claims made for services provided via telehealth have increased substantially as well. It should be noted growth in telehealth occurred following the COVID-19 pandemic, not during the pandemic. The number of claim lines for "out of home" telehealth services nearly tripled over a two-year period between January 2022 and January 2024.

EIDBI provider agencies

The number of EIDBI provider agencies enrolled as MHCP providers has more than quadrupled over a four-year period from 2020 through 2024.

To date in 2024, approximately 220 provider agencies have provided services and billed for them through MHCP. There are roughly 100 additional provider agencies enrolled through MHCP that are not billing for services. This is a very strong indication the provider agency is not actually providing services. This is a disconcertingly high percentage of EIDBI provider agencies (32 percent) that appear inactive in terms of providing EIDBI services.

Figure 7: Number of EIDBI provider agencies by year



Each provider agency must employ at least one QSP and advanced certification provider to provide clinical supervision for all care provided by less experienced providers at that location. The number of QSPs working in the state is not growing at nearly the same rate as the number of provider agencies. This means the workforce is being stretched over a larger number of EIDBI provider agencies.

As of November 2024, 24 QSPs with out-of-state addresses were registered as MHCP providers, which raises concerns about how knowledgeable those QSPs are about care being provided at a Minnesota EIDBI provider agency (see Appendix 1 for additional details). Eleven of those out-of-state QSPs have an address in a bordering state of North Dakota, South Dakota, Iowa or Wisconsin, while the remaining 13 out-of-state QSPs report addresses as far away as Arizona, Florida, Texas and Georgia. While supervision may legally be provided via telehealth, if a QSP is literally never physically present at a care location, the overall quality of supervision is likely substantially weaker than when an advance certification provider is on site at least some of the time to observe daily clinical operations.

Information about the EIDBI Benefit

Types of EIDBI services

Providers may provide and bill for the following EIDBI services under MHCP:

Comprehensive multidisciplinary evaluation (CMDE)

The CMDE is a first required gateway to services for children with ASD or related condition and who are enrolled in MHCP. This is a diagnostic assessment conducted by a highly trained professional.

Individual treatment plan development and progress monitoring

An individual treatment plan (ITP) is developed for every participant of EIDBI services based on information gathered as part of the comprehensive multidisciplinary evaluation. It summarizes the overall goals and objectives that will be targeted throughout intervention services and specifies the type and intensity of services the child will receive. The ITP service also includes ongoing monitoring of the person's progress. A QSP must create the ITP for each child before a provider may begin to deliver services to that child. Level I and II providers may support the QSP in the initial development of the plan and, over time, in incorporating progress updates in the plan and updating it.

Coordinated care conference

A coordinated care conference is a voluntary meeting between the person who receives services, their family, EIDBI provider(s), other service professionals and/or other people the person/family requests. The purpose of the meeting is to review the comprehensive multidisciplinary evaluation (CMDE) or ITP and integrate and coordinate services across providers and service-delivery systems to develop and implement the ITP.

Intervention – individual, group and higher intensity

Interventions are the medically necessary, intensive and individually designed services delivered to children to achieve goals established as part of their treatment plan. These services may be offered on an individual basis to one child at a time; in a group setting involving two to eight children; or through a higher intensity mode, which may be needed for a child's or provider's safety or both. Higher intensity interventions are distinct because they involve two or more providers implementing therapy with a single child under the direction of an on-site (e.g., in person or via telehealth) and available QSP or Level I provider.

Interventions take place during a "session," which is a defined time period with a predetermined start and end time and involves only the delivery of covered EIDBI services.

Interventions may be delivered in a variety of settings, including in a center, clinic or office, the child's home or another community-based setting such as a school or park.

Intervention observation and direction

Given the varying levels of education and professional expertise of different levels of providers, observation and direction is needed to ensure treatment is being delivered consistent with established clinical protocols and to inform whether any modifications need to be made. This is a clinical service provided for the direct benefit of the person receiving services. A qualified provider offers these services by either working directly with the child (without another EIDBI provider present) to observe behavior changes or troubleshoot treatment or by joining the child and another EIDBI provider during a group, individual or higher-intensity intervention session.

Family or caregiver training and counseling

Family and caregiver training helps parents, caregivers and other family members to support a child receiving EIDBI services at home. Family/caregiver training may involve both direct and indirect activities. Direct family training and counseling includes activities such as spending time with the family/caregiver as they work to put the learned strategies in action to give feedback and support or providing instruction, modeling, feedback and role-playing strategies to teach skills and reduce unwanted behaviors. Indirect family training may include activities such as assisting a parent or caregiver to make calls to the person's case manager or schedule referral appointments or to set up environmental adaptations in a family home, such as visual cues, timers or safety equipment.

Telehealth

Certain EIDBI services may be provided through telehealth as clinically appropriate for the individual and family, including:

- The CMDE
- Coordinated care conferences
- Family/caregiver training and counseling
- ITP development and progress monitoring
- Individual intervention, group intervention and observation and direction.

Travel time

Travel time is covered when an EIDBI provider travels to either a person's home or to a community setting that is not an EIDBI office, center or clinic to deliver any of the following services:

- Family/caregiver training and counseling
- Intervention

- Observation and direction
- Coordinated care conference
- ITP progress monitoring

EIDBI agencies' responsibilities under current law

Although EIDBI provider agencies are not licensed, they are required to carry out certain responsibilities under Minnesota Statutes 256B.0949 to provide services to MHCP enrollees. Prospective owners and managers of EIDBI agencies must complete the MHCP provider enrollment process and demonstrate compliance with federal and state law related to EIDBI services. A complete list of EIDBI provider agency requirements is outlined in Appendix 2[16]. Without licensure, however, there is no mechanism for assessing or enforcing compliance with these standards.

Current process for enrolling as a MHCP EIDBI provider agency

Individuals interested in opening an EIDBI provider agency must successfully complete DHS' provider enrollment process. This involves submitting numerous forms, including an application form, a fee-for-service or HMO in-network provider agreement, disclosure of ownership and control interest form and a provider agency assurance statement to DHS for their review. DHS relies heavily on the provider agency assurance statement at this stage of the process. An agency must employ and list a QSP on the agency quality assurance statement and must pay an application fee. This information may be submitted through the Minnesota Provider Screening and Enrollment portal or by fax. At the individual provider level, Provider Enrollment staff check resumes to verify clinical staff have required degrees; however, they do not comb through resumes to determine whether staff have required field experience.

Providers must ensure a criminal background study using NETStudy 2.0 is completed for all individuals, including subcontractors, volunteers and temporary staff, who will have direct contact with people receiving services or their legal representatives.

Once the application is complete and DHS has finished its review, DHS conducts a site visit within 60 days. The pre-enrollment site visit is quite limited in scope and very different than a licensing site visit. During the pre-enrollment site visit, DHS checks to ensure a physical location exists where services will be provided; verifies ownership and control of the provider entity; and calls the listed QSP to verify the QSP is employed at the provider agency at that specific address. If the provider passes the site visit, the provider becomes an enrolled MHCP provider and is listed in the MHCP provider directory.

[16] Minnesota Statutes 256B.0949

The provider will be considered enrolled for a five-year period, regardless of whether they begin to provide or maintain EIDBI services.

Providers report mixed experiences in working through MHCP provider enrollment processes. The high number of agencies enrolling each month suggests the process is not unduly burdensome. Many providers, however, say the process is confusing and doesn't sufficiently help providers understand what their obligations are either to complete the enrollment process or to get their new center up and running successfully. Providers are also concerned about antiquated technology, such as use of fax machines and what they perceive as slow response times from DHS.

Provider qualifications

DHS specifies roles for both provider agencies and five individual types of providers with varying levels of qualifications and responsibilities in providing EIDBI services. Those individual provider types include CMDEs, QSPs and Level I, II and III providers. CMDEs are not required to be affiliated with a provider agency; however, all other types of providers must be employed by an agency to provide and bill for services. A description of each provider type and requisite qualifications for each are included in Appendix 3.

VII. Issues and recommendations

This next section of the report turns to nine topic areas that should be addressed as part of a licensure process. Each section below explains the topic and provides recommendations on the issue.

Recommendation Topic #1: Health and safety standards for various treatment settings

Health and safety standards include a variety of topics, including sanitation, security, fire safety, medication administration and safeguards against abuse of children receiving services. As compared to licensed DHS programs, EIDBI provider agencies lack required health and safety standards. We strongly recommend that DHS establish such standards for EIDBI provider agencies.

Because of the variety of settings in which EIDBI services are delivered, we recommend proposed health and safety standards to be tailored to the environment in which services are provided. Centers and clinics should be held to a different set of health and safety standards than a home-based environment, which is, of course, in the purview of parents and legal guardians. Individual providers working in both center-based and home settings should also have some safety standards for their benefit.

Facility standards for other licensed programs typically include the following requirements[17]:

- Maintain equipment, vehicles, furniture, supplies and materials in good condition.
- Comply with all applicable state and local fire, health, building and zoning codes.
- Ensure that areas used by participants are free from debris, loose plaster and peeling paint.
- Be kept clean and free from accumulated dirt, grease, garbage, mold and infestations.
- Install handrails and nonslip surfaces on interior and exterior runways, stairways and ramps.
- Keep stairways, ramps and corridors free of obstructions.
- Shield or enclose heating, ventilation, air conditioning units and other hot surfaces and moving parts of machinery.
- Keep exterior stairs and walkways free of ice and snow.
- Maintain a comfortable indoor temperature.
- Keep outside property free from debris and safety hazards.

EIDBI agencies providing center-based services should also be required to abide by these same standards.

[17] Holm–Hansen, Cheryl. “Minnesota EIDBI Benefit Set: Review of human services licensing guidelines.” February 2024.

Table 1: Health and safety standards established for EIDBI in comparison to licensed DHS programs[18]

Health and safety topic	EIDBI	Outpatient mental health[19]	Center child care	Family child care	Adult day center	Foster care	HCBS	Children's residential
Medication administration	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Transportation of participants	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Access to telephones	No	No	Yes	Yes	Yes	Yes	Yes	Yes
Emergency preparedness plan	No	No	Yes	Yes	Yes	Yes	Yes	Yes
Presence of pets/service animals	No	No	Yes	Yes	Yes	Yes	Yes	Yes
Access to first aid kit	No	No	Yes	Yes	Yes	Yes	Yes	Yes
Facility standards for maintenance and upkeep	No	No	Yes	Yes	Yes	Yes	Yes	Yes

[18] Holm–Hansen, Cheryl. "Minnesota EIDBI Benefit Set: Review of human services licensing guidelines." February 2024. (Table reproduced in its entirety).

[19] While there is less specific guidance in statute related to health and safety standards for outpatient mental health, there is a general requirement that programs have "policies and procedures to ensure the health and safety of each staff person and client during the provision of services, including policies and procedures for services based in community settings."

Health and safety topic	EIDBI	Outpatient mental health[19]	Center child care	Family child care	Adult day center	Foster care	HCBS	Children's residential
Guidelines for food provision and safety	**No**	**No**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Sanitation	**No**	**No**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Storage of dangerous items	**No**	**No**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**

The lack of health and safety standards is particularly disconcerting given that some children with ASD and related conditions are prone to wandering or running away; some may be nonverbal; and many children with ASD have other co-occurring conditions that necessitate administration of medication or potentially put them at greater health risk overall. Facilities should have at least some basic requirements in place to address these issues to protect children and youth receiving services.

Notably, EIDBI service providers involved in the engagement process recommended the establishment of such protocols. In the engagement process, providers gave concrete suggestions for ensuring the safety of children receiving EIDBI services. When asked how to protect children from abuse, providers suggested the following strategies[20]:

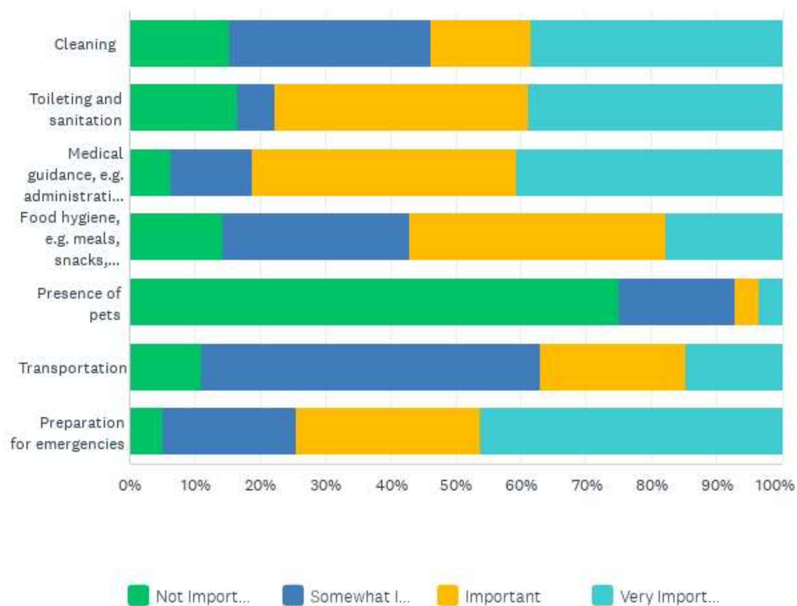
- Require all providers to participate in annual training and professional development focusing on abuse, mandated reporting, alternative restrictive methods and crisis intervention.
- Establish regulatory standards regarding abuse prevention, including credentials, caseload limits, supervision requirements and protocols for identifying, reporting and addressing instances of abuse.
- Require greater oversight of centers and staff (role of supervisors, observation of staff, drop-in site inspections).
- Implement a DHS recertification process, which consists of assessing sites, observation and document review regularly.
- Hire licensed providers who successfully pass background checks and reflect the families served to investigate abuse complaints. Be sure to incorporate caregivers' feedback and communication.

[20] Courageous Change Collective. EIDBI Licensure Study Stakeholder Engagement Report. August 2024.

Although provider agencies are required to conduct background studies on all employees who will have direct contact with children receiving services, DHS does not monitor whether this is happening because EIDBI provider agencies are unlicensed. In a licensing review, DHS licensors conduct an on-site visit, request to see a provider roster of employees and check to see whether people who have contact with clients have passed a background check. Under a system of licensure, DHS has authority to levy fines against a provider for failure to meet these requirements and can take other steps depending on the severity and chronicity of the concerns. For example, a situation in which a very few employees have not undergone a background check would be addressed differently than a facility where the owner and/or most staff had not had a background check conducted. Without licensure, no DHS staff are on site to monitor, much less enforce, this critical safety issue.

More than 70 percent of providers involved in the engagement process said it was either “important” or “very important” for health and safety standards to address medical guidance, toileting and sanitation and preparation for emergencies. At least 50 percent of providers said it was “important” or “very important” for standards to be established for food hygiene and cleaning protocols. Fewer providers were as concerned with standards related to transportation (roughly 35 percent) or the presence of pets (less than 10 percent).

Figure 8: Health and safety issues prioritized by EIDBI providers



Recommendation Topic #2: Investigating, reporting and acting on alleged violations of program standards

It is important to ensure DHS has the authority and tools necessary to conduct proper oversight of EIDBI provider agencies and individual EIDBI providers. Among other issues, DHS currently has no authority to conduct investigations related to alleged child maltreatment incidents. This authority would be provided through licensure or provisional licensure. Licensing would also require more upfront assessment of potential providers and their level of preparedness to offer services and an easier process by which to work with providers on corrective action plans or require them to stop offering services if necessary.

DHS needs both to be able to establish standards related to ethical conduct, data privacy, health and safety and other program standards and the tools to investigate, report and act – swiftly, if necessary – on violations of these standards.

Similarly, a licensing system could create professional obligations for individual EIDBI providers to report alleged violations of program standards directly to DHS. DHS has processes in place to accept, triage and investigate complaints involving service providers it licenses. The same level of established protocols does not exist when providers are unlicensed.

Recommendation Topic #3: Administrative and clinical infrastructure

This section of the recommendations includes proposed requirements for centers related to administrative and clinical infrastructure to support provision of EIDBI services. This includes considerations related to health records; staff support for core administrative and clinical functions; and some basic business operations.

Health records

EIDBI provider agencies are already required to maintain a health record for every person receiving services from that agency and for every service that individual and their family receives. There is no oversight process in place, however, to assess whether such records are being maintained.

Each client's health system record should include foundational information, including:

- Personal information for the person and their legal representative.
- Contact information for the QSP and other primary treating provider(s), including phone numbers.
- Completed, signed and current CMDE.
- Completed, signed and current ITP and progress monitoring.

- Documented preferences of the parent(s) and/or primary caregiver(s) for EIDBI services, including their level of involvement, as identified in the ITP.
- Plan for how to provide clinical supervision and observation and direction to individual providers, when required and as identified in the ITP.
- Progress monitoring notes, data and summary results.
- Information about other services the person or legal representative receives.
- Transition and termination plan, as identified in the person’s ITP.
- Signed DHS forms required for each client related to client rights and responsibilities and provider agency responsibilities.
- Case notes.
- Incident reports.

MHCP-enrolled providers may maintain their health record systems either in a paper format or electronically. Electronic health records (EHRs), while more expensive, have numerous benefits. EHRs designed to support EIDBI services prompt particular questions related to treatment of ASD and related conditions. Some EHRs might be integrated across health care provider systems, giving an opportunity to have an integrated electronic medical record for the client. This report does not recommend provider agencies be required to have an electronic medical record because of the expense of such systems. Imposition of such a requirement could be a barrier to entry for operators of EIDBI centers. However, families might be interested to know about whether a provider uses an electronic health record system.

There are no clear standards for how individual providers who work in client homes – and especially for individual providers who work exclusively in client homes – maintain client records. This is even more of an issue if the provider agency does not have an electronic health record system. To the extent providers have any paper documents, those need to be stored in a locked agency environment rather than in the provider's car or the provider's home. Electronic files need to be stored exclusively on an agency’s secure system rather than possibly stored on a personal laptop.

DHS could also strengthen use of nonelectronic health record systems by creating a template for case notes for providers to use if they are maintaining client case notes in manual health record systems. Such templates would be helpful because they would include standardized fields for providers to complete.

As noted above, case notes are one of the items to be included in a client’s health record. A provider is required to complete a case note for every service provided to a child or the child’s family, which should provide a rich data source about services delivered to the child over time.

Table 2: Required contents of a case note[21]

Required contents of case notes	Potential applicable additional information
• Person's name. • Type of service provided (e.g., individual or group intervention, observation and direction, parent training). • Name, title (e.g., QSP, level I) and signature of the provider who delivered the service. • Date the service was provided. • Date the provider added the documentation in the person's health service record. • Session start and stop times. • Summary of the person's progress or response to treatment and any changes in the treatment or diagnosis.	• Coordination with or referrals to other professionals, including each professional's name and date of contact. • Current significant events the person might be experiencing. • Documentation of supervision. • Emergency interventions used. • New behaviors or symptoms. • Parent/primary caregiver concerns. • Protocol modification. • Summary of treatment effectiveness, prognosis, discharge planning, etc. • Test results and medications.

As part of a system of licensure, DHS should have staff with clinical qualifications visit provider agencies; pull a random set of sample files; and assess whether the provider agency is maintaining these types of records. The required contents are a baseline foundation of information about whether provider agencies are ensuring the creation and ongoing maintenance of detailed client files as required, which are needed to ensure a given individual provider understands what services a client needs. This is important across all EIDBI provider agencies, especially given concerns about potential program integrity issues and to provide a baseline assessment of the degree to which medically necessary services are being provided. This type of monitoring would also be helpful on a topic covered later in this report related to ensuring providers are operating within their scope of practice.

Staff capacity for core clinical and administrative functions

Under current program requirements, QSPs must be employed by the agency with whom they work. There are no limits on the number of provider agencies employing the same supervisory provider at the same time. This is emerging as a potential problem as DHS is seeing more supervising providers affiliated with multiple provider agencies or provider agency locations. It is not surprising this is occurring given the significant growth in number of provider agencies enrolling in MHCP; provider agencies are required to have a QSP to become enrolled and there is not proportionate growth in the number of highly trained clinicians to staff all of the new agencies.

[21] Early Intensive Development and Behavioral Intervention Manual - Health service records.

This is a potentially concerning indicator that some supervisory providers might be attempting to provide clinical supervision to too many clients, staff and/or at too many sites. DHS should establish limits related to the number of agencies and/or sites with which a single provider may be employed.

This issue requires substantial exploration and input from interested parties, with consideration given to striking a balance between preserving access (especially in rural areas and underserved communities) and establishing a reasonable maximum number of agencies employing the same QSP and/or advanced certification provider.

Given the numerous responsibilities of EIDBI provider agencies, DHS should also consider requiring provider agencies to have some administrative staff capacity to support the provision of medically necessary services. Mental health provider agencies are required to designate a coordinator, a manager and a compliance officer. DHS should consider requiring EIDBI agencies to have similar types of positions or roles in the agency. Licensing standards should also dedicate at least a portion of a staff person's time (or, for larger centers, requiring a full- time position) to human resources functions. This type of capacity is essential.

DHS should also consider requiring provider agencies to have dedicated support for billing and authorizations. This type of work involves a particular skill set and, importantly, would both help free up provider time to offer services and have another individual be involved manage billing and authorizations. This type of role within an EIDBI provider agency could also manage enrollment and credentialing issues. That capacity is especially helpful for new EIDBI providers without the staff capacity, skill set or time to review enrollment and credentialing requirements and follow the steps. This is even more necessary if a provider wishes to be credentialed with private health insurance agencies and managed care organizations. Each have different credentialing, billing and authorization requirements. This may also be a useful internal control at the EIDBI provider agency level.

Client service support tools

Provider agencies should be required to establish fundamental components necessary for client service, including a functional website, dedicated agency and employee phone numbers and a secure business email system for both sending and receiving communications.

Recommendation Topic #4: Supervision standards

EIDBI services – regardless of treatment modality – are offered by individual providers with varying degrees of experience and professional qualifications. Advanced certification providers need to offer clinical leadership, support and training for less experienced staff. In this tiered staffing model, the services provided by less experienced providers must be monitored by more experienced providers to ensure fidelity with treatment standards and protocols. This supervisory role is critical in the provision and oversight of high quality EIDBI services.

This is also a method by which more highly trained providers can monitor progress of children and youth receiving services to ensure the recommended treatment is effective. Given the shortage of providers, this model of care also extends the reach of available providers while – with proper safeguards – ensures that less experienced providers receive appropriate supervision.

The tiered staffing model has many advantages and can create a pipeline for staff to come into and advance within their position and within an organization as they become more experienced. Advanced certification providers can help train other staff on evolving evidence-based practices. This structure can help create more sustainable organizations with highly competent staff who are supported in their work and have a clear career path with opportunities for advancement, which is essential in a field where staff turnover and “burn out” are common.

Effective supervision is a central component of the tiered staffing model. However, without a system of licensing, DHS has only limited requirements[22] related to how frequently QSPs and advanced certification providers must supervise the care offered by less experienced providers. Providers participating in the engagement process recommended establishing more comprehensive requirements related to clinical supervision. DHS does have guidelines related to clinical supervision, which include the following:

DHS recommends each Level II and Level III provider receive at least one hour of direct clinical supervision per month and additional supervision as required by the EIDBI provider’s enrolled level or professional license/board. This minimal recommended amount of supervision is most likely less than the Behavior Analyst Certification Board (BACB) standards suggest, depending on how many hours the Level II or Level III provider is working. The BACB standards suggest that one to two hours of supervision should be provided for every 10 hours of direct treatment using the ABA modality. This level of recommended supervision would include both direct (observing a staff member providing intervention services to a child) and indirect activities, such as facilitating a team meeting, reviewing case notes and data or role playing a new intervention. Table 3 translates the BACB guidelines on clinical supervision intensity for ABA services to staff working various numbers of hours each week.

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[22] Under DHS provider shortage variance standards, a Level II provider must receive observation and direction from a QSP or Level I provider at least twice per month until they meet 1,000 hours of supervised clinical experience under the variance one standard or receive observation and direction from the advanced certification provider at least once per week until they meet 1,000 hours of clinical experience under the variance two standard.

Table 3: Translating BACB clinical supervision guidance into monthly comparative benchmarks

Number of hours per week a Level II or III provider provides direct care	Recommended supervision of ABA services per week and per month
30	3-6 hours per week 12 – 24 hours per month
20	2-4 hours per week 8-16 hours per month
10	1-2 hours per week 4-8 hours per month

The BACB suggests that one full-time (meaning working 40 hours per week) board certified behavior analyst might be able to provide 100-150 hours of case supervision each month to support 500-1,500 hours per month of direct treatment. According to the BACB Practice Guidelines, multiple factors affect the number of hours of supervision a BCBA may provide. Those factors range from characteristics about the individual provider (such as level of experience) to support from the provider agency (for example, the degree to which the agency provides administrative support for billing – which, by extension, allows a QSP to spend more of their time on providing supervision), to the needs of individual children receiving treatment. For example, whether the children whose care is being supervised have other co-occurring conditions; where those children are in the treatment process; and/or whether the children are experiencing other changes, such as a divorce of their parents.

While it might be important to provide some flexibility around supervision standards, it is also clear there should be some upper limits around the number of supervisory hours a single QSP may realistically provide.

Supervision provided on site vs. through telehealth

In addition to establishing more specific limits on supervision, we recommend that DHS establish a standard for a portion of supervisory time that must be conducted on site and in person. DHS is seeing some QSPs and advanced certification providers with out-of-state addresses, which raises questions about whether that individual provider is ever on site to meet staff in person, see the facility's environment, conduct some supervision in person and have an overall handle on how the center is run on a day-to-day basis.

This lack of on-site supervision might also occur with advanced certification providers in Minnesota. Supervision may be provided remotely through telehealth, which is essential in the context of provider shortages and especially in rural Minnesota. This report does not recommend eliminating supervision by telehealth; it does, however, recommend that some portion of supervisory time be spent on site at each site and conducting supervision in person at each site where a QSP is employed. There are differences in what a QSP can observe about an EIDBI provider center and its staff if the QSP is never on site.

Recommendation Topic #5: Caseload limits

DHS has no requirements related to the maximum number of clients to be served by a single provider or at each agency and/or location. These numbers might reasonably vary for a number of reasons, including the number of children receiving treatment by a particular location overall; the number of staff and, in particular, the number of supervisory staff employed at each provider agency location; whether children receive the treatment on site vs. at home or in a different community-based setting; and the number of children on site at any one time. It is notable that provider agencies participating in the engagement process recommended establishment of caseload limits.

Options for such limits might include the following approaches:

- Establishing an upper limit on total number of children to be served at a single provider location for center-based services at any one time (for example, physically on site at one time or total patient count at any one time).
- Formalizing a specific upper limit on the ratio of one staff person providing group intervention services to multiple children at any one time, which permit a provider to bill for group interventions involving between two and eight children. While this is already required for billing purposes, it is not otherwise noted as a program requirement or caseload standard.
- Establishing a specific caseload limit for the number of children served in a home and/or community-based setting by a specific provider

Comprehensive programs typically involve 30 to 40 hours of therapy per week, often with clients who have more significant support needs. In this type of program, the BACB recommends a BCBA should manage six to 12 clients. Focused programs, alternatively, involve fewer therapy hours, typically 10 to 25 hours per week and address more specific areas of need (e.g., social skills, communication). In this type of program, a BCBA should manage 10 to 15 clients. We recommend that DHS adopt these standards for caseload size.

Recommendation Topic #6: Treatment modalities and provider qualifications

Minnesota's EIDBI benefit is considerably more flexible than other states when it comes to the types of treatment modalities that may be used and billed for under the EIDBI benefit. Most states permit only applied behavior analysis, while Minnesota allows several additional treatment modalities. The full list of billable treatment modalities permitted under MHCP include:

- Applied behavior analysis (ABA)
- Developmental individual-difference relationship-based model (DIR/Floortime)
- Early start Denver model (ESDM)
- PLAY project
- Relationship development intervention (RDI)
- Early social interaction (ESI).

State statute also permits DHS to adopt revised treatment modalities provided the modalities meet certain criteria, including being evidence-based, individualized and developmentally appropriate among other criteria[23]. Should DHS wish to revise any of the allowed treatment modalities, the department must provide public notice of any proposed changes and conduct a 30-day public comment period on the proposal.

Not all approved modalities are being offered in Minnesota; three of them (Play Project, Early Start Denver Model and ESI) never have been. DHS could consider proposing removal of these from statute. The work needed to become certified in these approaches is substantially less than in ABA.

Other states have taken different approaches and many have not named specific allowable treatment modalities in statute. There are some disadvantages to naming specific modalities in statute, including that removing a modality requires a change in law.

Provider qualifications

The vast majority of Minnesota's EIDBI providers are certified in ABA. It should be noted that providers with advanced certification in modalities other than ABA are required to have substantially less education and training as compared to those with ABA credentials. While this report is not making specific recommendations to adjust any provider qualifications, this might be an area where DHS might consider developing quality metrics across various treatment modalities or agencies offering different approaches to care.

[23] Minnesota Statutes 256B.0949, subdivision 9.

Recommendation Topic #7: Training requirements for EIDBI provider agency staff

Training encompasses both initial competency-based standards and ongoing professional development activities for staff providing EIDBI services to clients. As compared to licensed providers, EIDBI provider staff are required to take substantially less training. This section of the report proposes that EIDBI agency staff should complete more initial and ongoing training than they are currently required to do as described below. These recommendations also propose that EIDBI agencies be required to establish a training plan for their employees, which helps employees anticipate required training and tracks whether employees complete required training. Documentation of the agency training plan and records of whether training was completed should be available during an on-site licensing review.

Initial basic training

EIDBI providers are required to take an initial on-line training offered through DHS after they complete the provider enrollment process. Their training requirements include the following topics:

- Their specific job responsibilities.
- Cultural Responsiveness in Autism Spectrum Disorder (ASD) Services.
- Vulnerable Adults Mandated Reporting (VAMR) online training and exam.
- Mandated Reporting Training – Minnesota Child Welfare Training Academy.
- Client rights and protections.
- Person-centered/family-centered care.
- State policy with respect to restraints, time out and seclusion.

DHS also strongly recommends all EIDBI providers take the following training:

- ASD Strategies in Action (especially helpful for providers on variances or with limited clinical experience and currently required for Level III providers).
- EIDBI 101: Overview of the Benefit (currently required for Level III providers).
- Coordinating Services and Supports for a Child with ASD or Related Conditions.
- Telehealth for Early Intervention.

Table 4 compares training requirements of EIDBI to those of other DHS licensed programs. It shows that EIDBI providers are required to take substantially fewer trainings when they are first hired by a center as compared to providers working in other types of licensed DHS programs. For example, operators of center-based child care are required to have initial training in a total of 14 areas, some of which overlap with EIDBI and some of which are different. Providers participating in the engagement process as part of this work supported expanding EIDBI provider training requirements, especially related to first aid/CPR and other training.

Table 4 : A comparison of topics required to be included in initial provider training across select DHS programs[24]

Orientation topics	EIDBI	Outpatient mental health	Center child care	Family child care	Adult day	Foster care	HCBS	Children's residential
Overview of agency and services	No	No	Yes	No	Yes	Yes	Yes	Yes
Specific job responsibilities	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Vulnerable adult/maltreatment of minors	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Drug and alcohol policies	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Emergency procedures/incident reporting	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Client rights and protections	Yes	Yes	No	No	Yes	Yes	Yes	Yes
Data privacy	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Health and safety procedures	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Professional boundaries	No	Yes	No	No	No	No	No	No
Behavior guidance standards	No	No	Yes	Yes	No	Yes	No	Yes
Infant safety guidelines	No	No	Yes	Yes	No	Yes	No	Yes

[24] Table 4 is taken in its entirety from Holm–Hansen, Cheryl. "Minnesota EIDBI Benefit Set: Review of human services licensing guidelines." February 2024.

Orientation topics	EIDBI	Outpatient mental health	Center child care	Family child care	Adult day	Foster care	HCBS	Children's residential
First aid/CPR	No	No	Yes	Yes	Yes	Yes	Yes	Yes
Child development	No	Yes	Yes	Yes	No	No	No	Yes
Proper use and installation of child restraint systems in motor vehicles.	No	No	Yes	Yes	No	No	No	Yes
Mental health (e.g., crisis response, de-escalation, suicide intervention)	No	Yes	No	No	No	No	Yes	Yes
Fetal alcohol spectrum disorders	No	Yes	No	No	No	Yes	No	No
Trauma-informed care/secondary trauma	No	Yes	No	No	No	No	No	Yes
Person-centered/family-centered care	Yes	Yes	No	No	Yes	Yes	Yes	Yes
Co-occurring substance use disorders	No	Yes	No	No	No	No	No	Yes
Culturally responsive treatment practices	Yes	Yes	Yes	Yes	No	No	Yes	Yes
Restraints, time out and seclusion	Yes	No	No	No	Yes	Yes	Yes	Yes
Allergy prevention and response	No	No	Yes	Yes	Yes	No	Yes	No
Activities of daily living (residential care)	No	No	No	No	Yes	Yes	Yes	Yes

Orientation topics	EIDBI	Outpatient mental health	Center child care	Family child care	Adult day	Foster care	HCBS	Children's residential
Medication administration	No	No	Yes	Yes	Yes	Yes	Yes	Yes
Strategies to minimize risk of sexual violence	No	No	No	No	No	No	Yes	Yes
Use of needed medical equipment	No	No	No	No	Yes	Yes	Yes	Yes

Ongoing training and professional development

Individual providers in other licensed programs are required to take between 18 and 24 hours of training each year to stay current on developments in their field and/or to take refresher training on key topics. EIDBI provider staff currently have no ongoing annual training requirements for EIDBI services (although some providers may have training requirements through their licensing or certification board). It is recommended that EIDBI providers also participate in 18-24 hours of annual training or have the option to demonstrate knowledge on the required topics to bypass the training requirement. This is especially important because some EIDBI treatment modalities require substantially less training to obtain initial certification, making ongoing training even more critical. Providers already completing training through their licensing or certification boards should be able to count that training, so long as they provide documentation of it to their provider agency. In addition to training requirements, foster care programs and home and community-based programs are required to conduct knowledge testing or direct observation of staff as part of ongoing performance evaluations.

Recommendation Topic #8: Verifying licensure and/or certification and scope of practice

EIDBI agencies should be required to collect and maintain documentation verifying licensure, certification or other credentials of individual providers employed by the agency. Agencies need to ensure staff have obtained the proper education and training required to provide clinical supervision or to provide other levels of EIDBI services.

During a licensing review, DHS should examine the agency's employee roster to ensure all providers – and especially those working in a supervisory capacity – have obtained and maintained the credentials necessary for their level and have completed a required background study.

Agencies should regularly update their employee rosters for MHCP provider enrollment records to ensure DHS has reasonably current information about individual providers and at which provider agencies they are employed.

Some level of clinical auditing is also recommended as part of a licensure process. This would help to ensure providers are working within their scope of practice and to ensure other aspects of care are being carried out as designed in the client's individual treatment plan. For example, a required component of a licensing review could be to pull a sample of patient records to do the following:

- Ensure an appropriate level of detail is being captured in a child's progress notes.
- Assess whether the services being delivered are consistent with the modality and intensity level (number of hours) recommended in the treatment plan.
- Monitor whether the child is making progress with the services being offered.
- Ensure appropriate clinical supervision is occurring by the right level of professional.

Recommendation Topic #9: Removing providers from MHCP provider directories and enrollment based on inactivity

Historically, DHS monitored activity levels of providers to keep the enrolled provider list more current with only active providers. If DHS noted a provider had not billed over a considerable period, DHS would reach out to the provider to inquire about their intent to provide services to MHCP enrollees and subsequently disenroll them if the provider did not respond to the inquiry. DHS has revisited that policy across all MHCP providers and no longer conducts this process.

DHS conducts a periodic revalidation process for MHCP providers. If a provider fails to participate in the revalidation process, they are removed from the provider directory. Every MHCP provider type is assigned a risk level that helps determine how frequently this revalidation process must occur. EIDBI providers are currently assigned a "moderate" risk level, which means that after the provider enrolls and a site visit is done, their revalidation process will occur every five years. More monitoring will occur if there are concerns about fraud.

Given some of the challenges with EIDBI provider agencies completing the enrollment process, but not becoming operational and billing for services, it might be helpful for DHS to revisit its internal process for removing inactive providers. One strategy, for example, would be to advise prospective providers that DHS anticipates active providers to bill for services and that providers may be disenrolled from MHCP if they haven't billed for any services over a considerable period. According to DHS data, approximately 100 out of 315 EIDBI provider agencies have not been associated with a claim for services in the past year. This means roughly 32 percent of all EIDBI provider agencies listed in the MHCP provider directory are not actively providing services.

Licensing would create tools for DHS to keep its roster and directory of enrolled providers current. Minnesota Statutes 245A.044 provides authority to close a provider's license if the commissioner determines that a licensed program has not been serving any client for a consecutive period of 12 months or longer.

VIII. Planning and implementing a system of licensure

Key questions

This section of the report identifies key questions policymakers would need to consider if the Legislature granted authority to DHS to create a system of licensure for EIDBI provider agencies. DHS has substantial experience in developing and implementing other systems of licensure that would inform how the agency could approach this work for EIDBI provider agencies.

Should DHS adapt an existing licensing framework or design a new approach for EIDBI agencies?

Minnesota Statutes, chapter 245A is the Human Services Licensing Act. This is the basis for all DHS licensed programs, of which EIDBI provider agencies would be a part should the Legislature decide to give DHS authority and resources to license them. This chapter covers all foundational components of licensure, including who must be licensed, the application procedures, general record keeping, change of ownership, sanctions and appeal rights and maltreatment reporting requirements for vulnerable adults and children. Additional chapters of Minnesota Statutes, chapter 245 have been created over time to specify licensing requirements applicable to certain providers.

Should the Legislature provide DHS authority to license EIDBI providers, a decision would need to be made on whether an existing framework (likely either 245D for home and community-based services or 245I for uniform service standards for mental health) can serve as the foundation for licensure or whether a wholly new licensing structure is needed.

EIDBI does not fit neatly into any existing licensing framework. Choosing either 245D or 245I as the basis for EIDBI licensure would be strongly preferable to child care licensing, as that work will move to the Department of Children, Youth and Families whereas programmatic leadership for MHCP remains at DHS.

Decision-making on this issue requires a more in-depth look at how closely EIDBI services compare to mental health services or home and community-based waiver services, especially, for example, on issues such as development of treatment plans or clinical supervision. Another consideration is that EIDBI services, designed to treat ASD and related conditions that are considered neurodevelopmental disabilities, are currently part of the Disability Services Division. This is the same division within DHS overseeing home and community-based services.

It might make more sense for EIDBI services to be licensed like mental health services; however, mental health service oversight occurs in the Behavioral Health Division. There is also an enormous amount of work being done related to uniform service standards licensing implementation and it is perhaps too much to add EIDBI provider agencies to that system of licensing.

In addition, incorporating licensure of EIDBI provider agencies into a mental health licensing framework might take longer to execute for EIDBI agencies given the significant work still needed to complete licensure for mental health service providers.

Given the issues being raised related to EIDBI services, it is important to move forward expeditiously, choose a path and ensure DHS has the resources to design and implement a new system.

Implementation timeframes for existing vs. new provider agencies

At present, there are almost 400 EIDBI provider agencies enrolled as MHCP providers of EIDBI services. That number is likely to grow over time and, if recent trends persist, might continue to grow rapidly. It is likely to be very challenging to bring all agencies under licensure at a single point in time as well as new EIDBI provider agencies. It might be helpful to establish criteria for prioritizing which agencies are required to obtain licenses first. For example, DHS could first require new EIDBI provider agencies to become licensed before becoming operational and then move on to existing EIDBI provider agencies (and, perhaps establishing additional categories or prioritization among existing agencies). For new providers, licensing typically occurs before provider enrollment. DHS should consider provisional licensure, while working toward a full licensure framework.

High level timeline to implement licensure

Development of licensure would be a complex undertaking that would occur over a multiyear period. The high-level steps that would need to occur for DHS to implement licensure include the following:

2025:

- Developing and implementing full licensure would take significant time and resources. It would take DHS at least two years to begin issuing licenses. The Legislature could create authority for a provisional license as an interim regulatory measure while full licensure is developed.
- The Legislature would need to provide DHS authority to license EIDBI provider agencies. The Legislature would also need to appropriate sufficient funding to DHS to support a design team process to develop detailed requirements and future funding to support staffing levels needed to implement licensure. This could potentially happen in the 2025 legislative session.
- DHS would need to engage providers, participants and other interested parties in specifying program standards to be used in the licensure process. DHS would likely need to hire a new FTE staff person and potentially a technical contract to lead this work. DHS could begin the process after the conclusion of the 2025 legislative session.

2026:

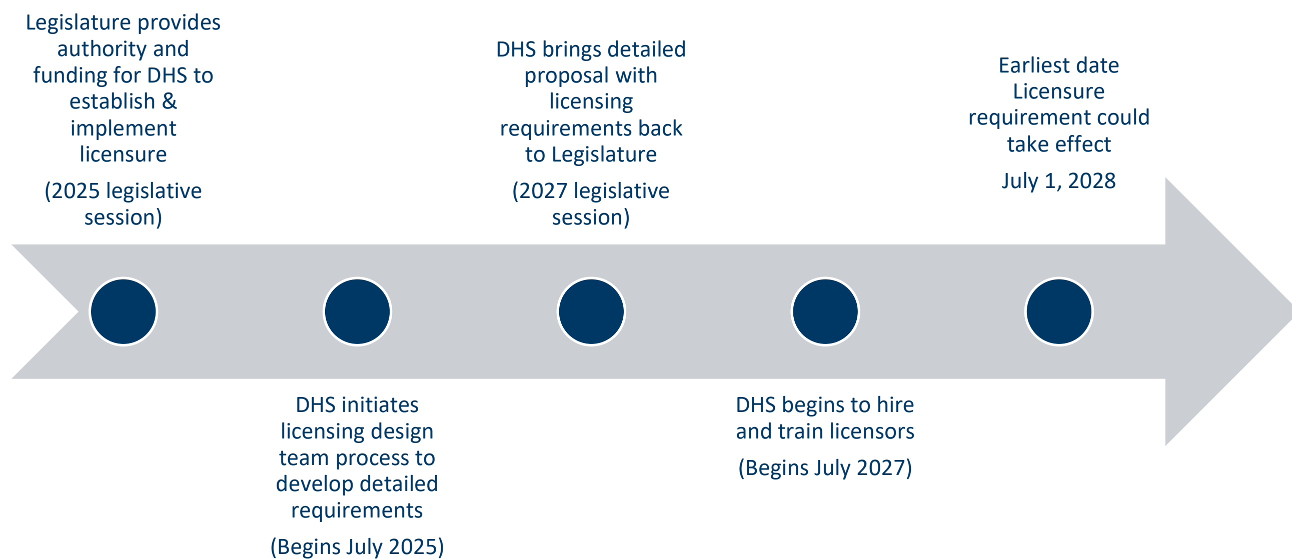
- DHS would continue its process of building detailed requirements with interested parties and develop a detailed legislative proposal for consideration in the 2027 legislative session.

2027:

- DHS would come back to the Legislature with a detailed set of proposed requirements for the 2027 session for the Legislature's consideration after the detailed public input process.
- If the Legislature approved the more detailed requirements and funding for additional FTEs to support licensure implementation, DHS could begin to hire and train new staff after the 2027 legislative session.
- In addition to hiring new staff, DHS and MNIT would need to work together to adapt the state's electronic licensing system to accommodate EIDBI provider agency licensing requirements.

2028:

- The earliest it would be feasible for the new licensure requirement to take effect would be July 1, 2028, and that timeline might be ambitious.



DHS resource needs to implement licensure

DHS would need significant resources to successfully implement a new licensing system for EIDBI provider agencies. A future system of licensure would involve several components:

- A web-based system by which a prospective provider locates necessary application materials and access to an electronic portal to submit completed forms and pay application fees. This portal exists and might need modification for EIDBI-specific protocols.
- DHS licensing staff reviewing applications and supporting materials to first determine if the application is complete and then to review the material.
- Prospective providers also will need to participate in a background study, ideally before they are able to enroll as MHCP providers.
- Licenses are typically issued after a licensing application has met requirements and no problematic issues surfaced during the background study process.
- An on-site licensing review typically occurs within the first year a program is open (but not before the program becomes operational).
- The on-site review would allow both licensing staff to perform most aspects of the review and program staff to monitor how clinical services are being provided through an examination of client files.

Policymakers would need to anticipate both one-time and on-going costs to implement and maintain licensing.

- One-time funding would be needed to pay for information technology systems development and infrastructure along with ongoing funding for maintenance; legal services; and support to engage external partners in designing licensing requirements. Additional FTEs would be required for background studies, program integrity, legal and data.
- Ongoing costs would include staffing to pay for new FTE positions. The Licensing Division would need an estimated 30+ full time equivalent (FTE) positions to implement licensure for EIDBI agencies. The Disability Services Division at DHS, which oversees the EIDBI benefit, would also need to hire additional program staff to conduct the clinical oversight components of site visits.
- Funding will be needed to support a design team process to put detailed licensing requirements together and to hire and train employees to carry out the licensing process. Given growth in the number of EIDBI provider agencies, a preliminary conservative estimate of the number of entities to go through a licensing process is 500.

It is important that any new system of licensure be based on electronic licensing systems rather than starting in a more manual, paper-based process and later migrating to electronic-based processes.

IX. Interim strategies to enhance oversight

Given it will take at least into mid-2028 to implement licensure, both the Legislature and DHS should also consider additional strategies for clarifying requirements for EIDBI provider agencies. Additionally the Legislature and DHS should consider creating a provisional license for EIDBI agencies as a way to enhance monitoring and compliance while a full license is developed. These strategies are in no way a substitute for licensure and should not be interpreted as such; however, to the extent that clarifications in the EIDBI statute could provide DHS a stronger basis for exercising its existing authorities, those measures would be useful steps. In addition, DHS should use its existing authorities more extensively to strengthen oversight of EIDBI provider agencies and staff.

Recommendations for DHS to consider include the following:

Provider enrollment

- Leverage existing authorities for MHCP provider enrollment processes to review EIDBI agencies as frequently as possible. Every MHCP provider type is assigned one of three risk levels (limited, moderate or high) that determines the frequency and methods by which the provider is monitored. EIDBI providers are currently assigned a “moderate” risk level, which means that after the provider enrolls and a site visit is completed, their reverification site visit will happen every five years. More monitoring will occur if there are concerns about fraud. DHS should revisit this risk designation and adjust the risk level for EIDBI providers from “moderate” to “high.” The impact of this change in designation would increase the frequency of reverification site visits from a five-year cycle to a three-year cycle.
- Redesignation of risk level to “high” risk would also leverage other types of monitoring, including criminal background checks using fingerprinting.
- Consider resequencing some aspects of the MHCP provider enrollment process for EIDBI agencies so that prospective agency operators take more training before being designated as an MHCP provider. This would help prospective providers be much more aware of what they are required to do, which should help inform decisions about whether they are prepared to own and operate an EIDBI agency. And, while the MHCP provider enrollment process should not be made unduly burdensome to applicants, inserting a value-added step in the process may help incent only those who are ready to take on the challenging work of running an EIDBI provider agency to complete the MHCP enrollment process. Owners and managing employees of personal care assistant agencies, designated as high-risk providers, are required to take a three-day Steps for Success orientation training.
- Consider revisiting current practice for inactive EIDBI provider agencies included in the MHCP provider directory with the goal of removing inactive providers from the provider directory. Given the high rate of inactive EIDBI provider agencies included in the MHCP provider directory

and the difficulty this creates for families searching for an EIDBI provider, DHS should consider reaching out to inactive provider agencies; ask them to respond affirmatively if they would like to continue their enrollment as MHCP providers; and disenroll them if DHS does not receive a response to its inquiry.

- This would help families looking for provider agencies to have a more current provider directory and, if the numbers of MHCP EIDBI provider agencies is reduced, would also help DHS have more accurate estimates of the number of EIDBI agencies that might seek licensure down the road and therefore a more accurate projection of DHS staffing needs to support that work.

Table 5: A comparison of MHCP screening actions by designated risk levels[25]

Provider Enrollment screening action	Risk level: Limited	Risk level: Moderate	Risk level: High
Provider-specific requirements verification	Yes	Yes	Yes
Licensure verification. if applicable	Not applicable currently to EIDBI agencies	Not applicable currently to EIDBI agencies	Not applicable currently to EIDBI agencies
Database checks to screen for potential issues (verify NPI and check HHS OIG exclusion list, excluded parties list system, death of individual with ownership or control interest, termination by Medicare or another state's program).	Yes	Yes	Yes
Unscheduled or unannounced site visits	No	Yes	Yes
Criminal background check (based on fingerprints)	No	No	Yes
Fingerprinting	No	No	Yes

[25] Minnesota Department of Human Services' website.

Program Integrity Oversight Division

- Analyze administrative and billing data to help identify potential program integrity concerns, such as managed care organization encounter data and fee-for-service billing data to identify unusual patterns, such as higher than normal billing of units or outliers on proportion of services billed as telehealth. These data points could be cross-referenced in a comparison of EIDBI agencies with out-of-state QSPs/advanced certification providers or with QSPs/advanced certification providers affiliated with multiple EIDBI provider agencies.
  - In the event concerns about specific provider agencies materialize in such analyses, DHS could conduct targeted site visits to EIDBI provider agencies to investigate their concerns. DHS could leverage other MHCP provider requirements when conducting targeted site visits or revalidation site visits and assess whether medical records are being maintained as required and whether services being delivered are outlined in a client's ITP.
  - DHS could consider whether there are opportunities to conduct prepayment review where they have particular concerns about an EIDBI provider agency.
- Consider whether working with managed care organizations and encounter data would provide any additional capabilities for monitoring for potential program integrity concerns.

Further leveraging current authorities to monitor EIDBI provider agencies will help assess current program integrity concerns and increase public confidence and trust in DHS' commitment to ensuring the services being provided are high-quality, regulated and safe for those in the community. These steps would also require additional resources for new FTE positions in the Program Integrity Oversight Division and provider eligibility and compliance to implement these strategies.

Legislative considerations

- The Legislature could consider adding some requirements to the EIDBI statute this session to specify that QSPs and advanced certification providers must live or have an office in Minnesota or a bordering state. The Legislature could also limit the number of EIDBI provider agencies with whom a single QSP or advanced certification provider may be employed by at the same time.

X. Conclusion and recommendation summary

This report strongly recommends the Legislature provide DHS the authority and resources to establish and implement EIDBI provider agency licensure. Stronger program requirements and enforcement mechanisms are needed to protect EIDBI client safety and well-being.

This report provides licensing recommendations in nine areas:

1. Health and safety standards

- Licensing standards should emphasize safety and prevention of abuse of children.
    - All providers should participate in annual training and professional development focusing on abuse, mandated reporting, alternative restrictive methods and crisis intervention.
    - Standards should establish protocols for identifying, reporting and addressing instances of abuse.
- A system of licensure should require EIDBI provider agencies to meet facility physical plant safety guidelines commonly applicable to other DHS licensed programs. Examples of these standards include the following:
    - Maintain equipment, vehicles, furniture, supplies and materials in good condition.
    - Comply with all applicable state and local fire, health, building and zoning codes.
    - Ensure that areas used by participants are free from debris, loose plaster and peeling paint.
    - Facilities should be kept clean and free from accumulated dirt, grease, garbage, mold and infestations.
- Facility standards should also address the potential for children with ASD and related conditions to wander or run away and how to safeguard against this potential while maintaining compliance with fire codes.
- Standards should also be in place related to medication administration, toileting and sanitation, preparation for emergencies, food hygiene, cleaning protocols and storage of dangerous items.
- Standards should be tailored for home environments and account for safety of individual providers working in client homes. In this type of environment, for example, it might be important to have policies related to pets as well as storage of dangerous items.

2. Investigating, reporting and acting on alleged violations of program standards

- DHS should establish standards related to ethical conduct, data privacy, health and safety and other program standards and the tools to investigate, report and act – swiftly, if necessary – on violations of these standards. This can be accomplished through licensing.
- DHS currently has no authority to conduct investigations related to alleged child maltreatment incidents and a licensing system needs to provide DHS this authority.
- A licensing system should create professional obligations for individual EIDBI providers to report alleged violations of program standards directly to DHS.
- Licensing provides an easier process by which to work with providers on corrective action plans, levy fines or require them to stop offering services if necessary.

3. Administrative and clinical infrastructure

Health records

- EIDBI provider agencies are required to maintain a health record for every person receiving services from that agency and for every service that individual and their family receives. This is critical information for treatment planning, clinical supervision and monitoring client progress. As part of a system of licensure, DHS should have staff with clinical qualifications visit provider agencies; pull a random set of sample client files; assess whether the provider agency is maintaining these types of records; and the extent to which these records document provision of medically necessary services.
- Clear standards should be established for how and where individual providers who work in client homes – and especially for individual providers who work exclusively in client homes – maintain and store client health records and ensure clinical supervisors have access to those records.
- DHS could also strengthen use of nonelectronic health record systems by creating a template for case notes for providers to use if they are maintaining client case notes in manual health record systems.

Clinical capacity

- Under current program requirements, QSPs must be employed by the agency with whom they work. There are no limits on the number of provider agencies employing the same supervisory provider at the same time. DHS should establish limits related to the number of agencies and/or sites with which a single provider may be employed.
- DHS should require QSPs to live or have an office in either Minnesota or a bordering state.

- DHS should specify that clinical supervision must include direct supervisory activities (and not just documentation review) for every client receiving EIDBI services.
- DHS should limit the amount of supervision that can be conducted solely be telehealth, while keeping in mind provider shortages in rural areas and underserved communities. Requiring some amount of on-site supervision is needed to ensure a QSP can see daily clinic operations in action and is able to observe how care is provided, physical facilities, etc.

Administrative capacity and business operations

- Given the numerous responsibilities of EIDBI provider agencies, DHS should also consider requiring provider agencies to have some administrative capacity to support the provision of medically necessary services:
    - Mental health provider agencies are required to designate a coordinator, a manager and a compliance officer. DHS should consider requiring EIDBI agencies to have manager and coordinator roles like those of mental health provider agencies. EIDBI provider agencies should also dedicate at least a portion of a staff person's time (or, for larger centers, require a full- time position) to human resources functions.
    - DHS should require EIDBI provider agencies to have dedicated support for billing, authorizations and provider credentialing.
    - Provider agencies should be required to establish fundamental components necessary for client service, including a functional website, dedicated agency and employee phone numbers and a secure business email system for both sending and receiving communications.

4. EIDBI provider agency staff training requirements

- EIDBI provider staff currently have fewer initial training requirements as compared to providers working in licensed programs. EIDBI providers should have stronger initial training requirements, including all current training requirements and training on at least the following topics:
    - Health and safety standards
    - Emergency procedures/incident reporting
    - Child development
    - Mental health
    - Medication administration
    - CPR/First aid.

- EIDBI provider staff currently have no annual ongoing professional development or training requirements. We recommend that EIDBI providers participate in 18-24 hours of annual training or have the option to demonstrate knowledge on the required topics to bypass the training requirement.

5. Supervision standards

- DHS should establish specific supervision requirements and specify that one to two hours of supervision should be provided for every 10 hours of direct treatment using the ABA modality.

6. Caseload limits

- DHS should establish limits on the number of clients a single BCBA can serve.
    - In a more intensive program where clients receive 30 to 40 hours of therapy per week, a BCBA should manage six to 12 clients.
    - In a focused program, through which clients participate in therapy 10 to 25 hours per week, a BCBA should manage 10 to 15 clients.

7. Treatment modalities and provider qualifications

- The Legislature should consider narrowing the list of approved modalities for EIDBI service provision in Minnesota. Not all approved modalities are being offered in Minnesota; three of them (Play Project, Early Start Denver Model and ESI) never have been. The work needed to become certified in these approaches is substantially less than in ABA.
- The vast majority of Minnesota's EIDBI advanced providers are certified in ABA. It should be noted that providers with advanced certification in modalities other than ABA are required to have substantially less education and training as compared to those with ABA credentials. While this report is not making specific recommendations to adjust any provider qualifications, this might be an area where DHS might consider developing quality metrics across various treatment modalities or agencies offering different approaches to care.

8. Verifying required qualifications and scope of practice

- Agencies should be required to collect and maintain documentation verifying licensure, certification or other credentials of individual providers employed by the agency:
    - During a licensing review, DHS should examine the agency's employee roster to ensure all providers – and especially those working in a supervisory capacity – have obtained the credentials necessary for their level and have completed a required background study.

- Agencies should regularly update their employee rosters for MHCP provider enrollment records to ensure DHS has reasonably current information about individual providers and at which provider agencies they are employed.
- We also recommend some level of clinical auditing as part of a licensure process. This would help to ensure providers are working within their scope of practice and to ensure other aspects of care are being carried out as designed in the client's individual treatment plan.

9. Removing inactive providers from MHCP provider directory

- Licensing should provide DHS specific authority for how to keep its provider roster more current for EIDBI provider agencies. Mechanisms should be available for removing inactive provider agencies from the MHCP provider directory while assuring due process considerations for providers.

Interim measures

DHS and the Legislature should also consider other interim measures they can take to improve oversight of EIDBI provider agencies until licensure can be implemented.

Recommendations for DHS to consider include the following:

- Leverage existing authorities for MHCP provider enrollment processes to review EIDBI agencies as frequently as possible. EIDBI providers are currently assigned a "moderate" risk level, which means that after the provider enrolls and a screening site visit is completed, their reverification site visit will happen every five years. DHS should revisit this risk designation and adjust the risk level for EIDBI providers from "moderate" to "high." The impact of this change in designation would increase the frequency of reverification site visits from a five-year cycle to a three-year cycle.
- Redesignation of risk level to "high" risk would also leverage other types of monitoring, including criminal background checks using fingerprinting.
- Consider resequencing some aspects of the MHCP provider enrollment process for EIDBI agencies so that prospective agency operators take more training prior to being designated as an MHCP provider.
- DHS should screen more specifically for whether EIDBI provider staff have attained requisite hours of experience needed for each provider level qualification. It should be noted this may be challenging to implement but is important in terms of understanding whether provider staff have the experience needed to qualify for the role.
- Consider revisiting current practice for inactive EIDBI provider agencies included in the MHCP provider directory with the goal of removing inactive providers from the provider directory.

- DHS should proactively analyze administrative and billing data to help identify potential program integrity concerns, such as managed care organization encounter data and fee-for-service billing data to identify unusual patterns, such as higher than normal billing of units or outliers on proportion of services billed as telehealth. These data points could be cross-referenced in a comparison of EIDBI agencies with out-of-state QSPs or advanced certification providers or with QSPs or advanced certification providers affiliated with multiple EIDBI provider agencies.
    - In the event concerns about specific provider agencies materialize in such analyses, DHS could conduct targeted site visits to EIDBI provider agencies to investigate their concerns. DHS could leverage other MHCP provider requirements when conducting targeted site visits or re-enrollment site visits and assess whether medical records are being maintained as required and whether services being delivered are outlined in a client's ITP.
    - DHS could consider whether there are opportunities to conduct prepayment review where they have particular concerns about an EIDBI provider agency.
    - DHS should consider whether working with managed care organizations and encounter data would provide any additional capabilities for monitoring for potential program integrity concerns.
- The Legislature could consider adding some requirements to the EIDBI statute this session to specify that QSPs and advanced certification providers must live or have an office in Minnesota or a bordering state. The Legislature could also limit the number of EIDBI provider agencies with whom a single QSP or advanced certification provider may be employed by at the same time.

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Appendix 1: Number of QSPs registered with out-of-state addresses by state

State	Number of QSPs providing supervision with registration address in that state
Arizona	2
Florida	2
Georgia	1
Illinois	1
Iowa	2
Massachusetts	1
Missouri	2
North Dakota	1
Oregon	1
South Dakota	1
Texas	1
Utah	1
Virginia	1
Wisconsin	7

Appendix 2: Current EIDBI agency requirements

Although EIDBI provider agencies are not licensed, they are required to carry out certain responsibilities under Minnesota Statutes 256B.0949 in order to provide services to MHCP enrollees:

- Enroll as a medical assistance MHCP provider according to Minnesota Rules, part 9505.0195 and Minnesota Statutes, section 256B.04, subdivision 21 and meet all applicable provider standards and requirements.
- Demonstrate compliance with federal and state laws for EIDBI service.
- Verify and maintain records of a service provided to the person or the person's legal representative as required under Minnesota Rules, parts 9505.2175 and 9505.2197.
- Demonstrate that while enrolled or seeking enrollment as an MHCP provider the agency did not have a lead agency contract or provider agreement discontinued because of a conviction of fraud; or did not have an owner, board member or manager fail a state or federal criminal background check or appear on the list of excluded individuals or entities maintained by the federal Department of Human Services Office of Inspector General.
- Have established business practices including written policies and procedures, internal controls and a system that demonstrates the organization's ability to deliver quality EIDBI services.
- Have an office located in Minnesota or a border state.
- Conduct a criminal background check on an individual who has direct contact with the person or the person's legal representative.
- Report maltreatment according to section 626.557 and chapter 260E.
- Comply with any data requests consistent with the Minnesota Government Data Practices Act, sections 256B.064 and 256B.27.
- Provide training for all agency staff on the requirements and responsibilities listed in the Maltreatment of Minors Act, chapter 260E and the Vulnerable Adult Protection Act, section 626.557, including mandated and voluntary reporting, nonretaliation and the agency's policy for all staff on how to report suspected abuse and neglect.
- Have a written policy to resolve issues collaboratively with the person and the person's legal representative when possible. The policy must include a timeline for when the person and the person's legal representative will be notified about issues that arise in the provision of services.
- Provide the person's legal representative with prompt notification if the person is injured while being served by the agency. An incident report must be completed by the agency staff member in charge of the person. A copy of all incident and injury reports must remain on file at the agency for at least five years from the report of the incident.
- Before starting a service, provide the person or the person's legal representative a description of the treatment modality that the person shall receive, including the staffing certification levels and training of the staff who shall provide a treatment.
- When delivering the ITP and annually thereafter, an agency must provide the person or the person's legal representative with:
    - A written copy and a verbal explanation of the person's or person's legal representative's rights and the agency's responsibilities.
    - Documentation in the person's file the date that the person or the person's legal representative received a copy and explanation of the person's or person's legal representative's rights and the agency's responsibilities.

- Reasonable accommodations to provide the information in another format or language as needed to facilitate understanding of the person's or person's legal representative's rights and the agency's responsibilities.

Appendix 3. EIDBI provider levels and required qualifications

Provider level	Required qualifications
CMDE	To qualify as a comprehensive multidisciplinary evaluation (CMDE) provider, a professional must meet all of the following requirements: 1. Be either: • A licensed physician, advanced practice registered nurse (APRN) or mental health professional as defined in Minn. Stat. §245I.04, subd. 6. • A mental health practitioner who meets the requirements of a clinical trainee as defined in Minn. Stat. §245I.04. 2. Have either: • At least 2,000 hours of clinical experience in the evaluation and treatment of people with autism spectrum disorder (ASD) and/or related conditions. • Completed the equivalent in graduate-level coursework (refer to equivalent coursework section) at an accredited college or university. Note: Coursework must be documented in one or more of the following areas: ASD or a related condition diagnosis, ASD or a related condition treatment strategies or child development. 3. Be able to diagnose, evaluate and/or provide treatment within their scope of practice and license.
Qualified supervising professional	To qualify as a qualified supervising professional (QSP), a person must meet all the following requirements: 1. Be employed by an EIDBI provider agency. 2. Be a physician, advanced practice registered nurse (APRN), developmental or behavioral pediatrician or licensed mental health professional as defined in Minn. Stat. §245I.04, subd. 2. 3. Have either: • At least 2,000 hours of clinical experience and/or training in the examination and/or treatment of people with autism spectrum disorder (ASD) or a related condition. • Completed the equivalent in graduate-level coursework at an accredited university (refer to equivalent coursework section).

Provider level	Required qualifications
	Note: Coursework must be documented in one or more of the following areas: ASD or a related condition diagnostic, ASD or a related condition treatment strategies or child development. 4. Be able to provide treatment within their scope of practice and license.
Level I	To qualify as a Level I provider, a person must meet both of the following requirements: 1. Be employed by an EIDBI agency. 2. Complete either: • At least 2,000 hours of clinical experience and/or training in the examination and/or treatment of people with autism spectrum disorder (ASD) or a related condition. Note: The provider may include hours worked as a mental health behavioral aide, mental health practitioner, personal care assistance (PCA) worker, EIDBI level II or level III provider or another role in a clinic or education setting as required hours of experience. • The equivalent in graduate-level coursework at an accredited university (refer to the equivalent coursework section on this page). Note: Coursework must be documented in one or more of the following areas: ASD or related condition diagnostics, ASD or related condition treatment strategies or child development. In addition to the above requirements, a person must meet at least one of the following requirements: 1. Have a doctoral or master’s degree from an accredited college or university in behavioral health, child development or a related field (e.g., mental health, special education, social work, psychology, speech pathology, occupational therapy, health science, education, sociology, nursing, human services, counseling, family studies). 2. Be a board certified behavior analyst-doctoral (BCBA-D) through the Behavior Analyst Certification Board Inc. (BACB). 3. Be a board certified behavior analyst (BCBA) through the BACB. 4. Be a qualified behavior analyst as defined by the Qualified Applied Behavior Analysis Credentialing Board. 5. Have a bachelor’s degree from an accredited college or university in behavioral health, child development or a related field (e.g., mental health, special education, social work, psychology, speech pathology, occupational therapy, health science, education, sociology, nursing, human services, counseling, family studies) and advanced certification in one of the DHS-recognized treatment modalities.

Provider level	Required qualifications
	6. Be a board certified assistant behavior analyst (BCaBA) through the BACB and have 4,000 hours of supervised clinical experience that meets all registration, supervision and continuing education requirements of the certification.
Level II	To qualify as a level II provider, a person must be employed by an EIDBI provider agency and meet at least one of the following sets of requirements: 1. Have a bachelor's degree from an accredited college or university in behavioral health, child development or a related field (e.g., mental health, special education, social work, psychology, speech pathology, occupational therapy, health science, education, sociology, nursing, human services, counseling, family studies) and meet at least one of the following requirements: a. Have at least 1,000 hours of clinical experience and/or training in the evaluation and treatment of people with ASD or a related condition. b. Have completed the equivalent in graduate-level coursework at an accredited university. Note: Coursework must be documented in one of the following areas: ASD or related condition diagnostics, ASD or related condition treatment strategies or child development. c. Be a board certified assistant behavior analyst (BCaBA) through the Behavior Analyst Certification Board, Inc. (BACB) d. Be a registered behavior technician (RBT) through the BACB e. Be certified in one of the other treatment modalities recognized by DHS 2. Have both: a. An associate's degree from an accredited college or university in a behavioral health, child development or a related field. b. At least 2,000 hours of supervised clinical experience delivering treatment to people with ASD or a related condition. 3. Have at least 4,000 hours of supervised clinical experience delivering treatment to people with ASD or a related condition. 4. Be both: a. A graduate student in behavioral health, child development or a related field b. Formally assigned by an accredited college or university to an EIDBI provider agency for clinical training with people with ASD or related conditions and receiving clinical supervision from a QSP affiliated with the agency. 5. Meet all of the following requirements: a. Be age 18 or older. b. Be fluent in a non-English language or be certified by a tribal government. 6. Complete the ASD Strategies in Action and EIDBI 101: Overview of the Benefit required trainings. a. Receive observation and direction from a QSP or qualified level I provider at least once per week until they meet 1,000 hours of supervised clinical experience.

Provider level	Required qualifications
	More flexible standards are required to qualify as a Level II provider under current provider shortage variance standards.
Level III	1. Be employed by an EIDBI provider agency. 2. Complete the Level III provider training requirements during the first six months of employment. 3. Be age 18 or older. 4. Meet at least one of the following requirements: a. Have a high school diploma or general equivalency diploma (GED). b. Be fluent in a non-English language or have a tribal nation certification. Have one year of experience as a primary personal care assistance (PCA) worker, community health worker, waiver service provider or special education assistant to a person with ASD or a related condition within the past five years.