July 31, 2014

DHS Response to Public Comments on 1915(i) State Plan Amendment (SPA) for Autism Early Intensive Developmental and Behavioral Interventions (EIDBI)

On June 2, 2014, DHS posted a draft 1915(i) plan to provide Early Intensive Developmental and Behavioral Interventions (EIDBI) for children with autism spectrum disorder (ASD). The posted EIDBI plan incorporated input from the large and diverse community of autism stakeholders in Minnesota who were engaged through an intentional and extensive stakeholder input process. This document summarizes the public comments which were received within the 30-day public comment period beginning on June 2nd and ending on July 2, 2014 and is required by state law. More than 100 pages of comments were received from 29 individuals and organizations, including parents and family members, interested parties, advocacy and professional organizations, lead agencies, counties and managed care organizations, and individual providers. The public comments ranged from general and specific support for the EIDBI benefit to specific questions and detailed comments and recommendations. General comments are presented first, followed by comments relating to specific topic areas in the order that they appear in the federal plan. DHS considered all comments and incorporated those with direct application and revised the EIDBI plan accordingly. DHS submitted the MN 1915i State Plan Amendment for the Autism Early Intensive Developmental and Behavioral Interventions to CMS on July 18, 2014. The "Responses to Comments" below specify what was changed in the plan in response to the public comments. It also includes DHS' responses to the summary of all the comments submitted.

Specific Comments In Support of the EIDBI Benefit

Many comments expressed support for the following features of Minnesota's EIDBI benefit.

- Development of services specifically designed to treat ASD.
- Expanding the scope and options for autism treatment approaches
- Equity across fee-for-service and managed care coverage
- Broadening of provider standards and qualifications and recognition of ASD-specific certifications
- Parental involvement and family/caregiver training and counseling
- Payment for staff supervision
- The key role and need for independent, ASD specific care coordination

General Comments:

(1) COMMENTS: A number of comments related to the state developing coverage of the EIDBI benefit under both **EPSDT** and 1915(i) to facilitate broader and possibly earlier access to treatment.

RESPONSE: DHS reviewed and weighed the options for developing Minnesota's Early Intensive Developmental and Behavioral Intervention (EIDBI) benefit and determined that the 1915i structure provided the best option for autism treatment services in an effective, intensive, coordinated way to meet the needs of children from birth to 18 years of age with ASD. This plan focuses on addressing the unique constellation of behavioral challenges of children with ASD, provided in an intensity of treatment and in a comprehensive child and family-centered manner that allows for optimal long-term outcomes. EPSDT requires that the service be open to diagnoses other than ASD which may have a budget impact and require legislative changes to the EIDBI benefit. DHS has and will continue to explore all options, examine the impact of new guidance from CMS, and gather information from other states to understand and integrate this information into best practices for services for individuals with ASD. DHS will continue to consult with CMS and our ASD stakeholder community to address these issues in the best manner possible for children with ASD and their families.

(2) COMMENTS: Many comments related to provider capacity concerns including expanding of culturally competent providers.

RESPONSE: DHS recognizes this concern and has made several changes to the 1915i EIDBI benefit to address this issue and facilitate expansion of provider capacity. Changes were made to the provider qualification and standards section, specifically regarding required hours of "expertise and training in ASD" to make it easier to qualify as a provider and facilitate access to qualified EIDBI providers particularly for providers from multi-cultural communities.

In the "Conflict of Interest" Section, DHS also added the following language: "*The Department will continuously evaluate gaps in capacity, provider shortages and wait times from diagnosis to treatment and establish steps to address these barriers to access for medically necessary treatment."*

The "System Improvement" section also now states:
The Department is taking a number of steps to assure reasonable access for children with ASD and their families including:

1) *Increasing the number of providers with diverse linguistic or cultural backgrounds by:*
   - *Increasing multicultural outreach to diverse and underserved populations;*
   - *Expanding provider training regarding cultural competence;*
   - *Collaborating with other state agencies; and*

• *Collecting and evaluating EIDBI service access data for different racial/ethnic groups.*
(3) COMMENTS: Comments expressed a concern that availability of this new benefit would lead to reductions in **existing benefits.**
RESPONSE: As required by federal law, determination of eligibility for 1915(i) services will not prevent any Medicaid-eligible child, whether eligible for 1915(i) or not, from accessing medically necessary state plan services. However, DHS anticipates that the EIDBI services covered under this plan will be more medically appropriate for some children than the services that are currently covered under Minnesota's regular Medicaid plan, and that availability of EIDBI will reduce the need for some currently covered services.
(4) COMMENTS: Some comments asked DHS to consistently use **the term "habilitative/rehabilitative therapists**" to refer to occupational therapists, physical therapists, and speech-language pathologists.
RESPONSE: The plan has been revised to either use the entire list of therapists or to use the term "habilitative/rehabilitative therapists."
(5) COMMENTS: One comment recommended **use of live links** when citing other documents or sources of law.
RESPONSE: Statutory references have been removed from the plan. Live links are not available as yet for Minnesota's State Plan. The referenced section of the state plan (definition of MH professional) was copied into public comment version of the plan.
(6) COMMENTS: One comment asked about the term "Licensed psychological practitioner" in the list of Mental Health Professionals.
RESPONSE: This is part of a reference to an existing part of the State Plan which includes a category which is no longer used by the Board of Psychology. This category will be removed whenever this part of the State Plan is updated.
(7) COMMENTS: Two comments recommended a **definition of the term "Individual Treatment Plan (ITP**)".
RESPONSE: As indicated in the plan, the ITP is different from the Individual Service Plan (ISP). Federal 1915i requires an ISP; it does not require an ITP. State law authorizing EIDBI requires an ITP. Changes in the plan were made to help to distinguish the two terms however further definition of the ITP will be done as part of the state's provider manual and is not required for the plan that is submitted to CMS.
(8) COMMENTS: Some comments incorrectly assumed that the plan covers **speech therapy, physical therapy and occupational therapy**, since these therapists are listed among the possible qualified providers of EIDBI treatment. Based on this assumption, commenters questioned why these therapists should be supervised by individuals who are not licensed therapists in their field of practice, and why EIDBI provisions would apply to these therapies.
RESPONSE: The various therapists are included as possible qualified EIDBI providers, if other requirements such as expertise and

training in ASD or ASD specific certifications are met (see Provider Qualifications section). Speech therapy, physical therapy and occupational therapy as services in and of themselves, are outside the scope of this plan, therefore provision of these therapies is not governed by this plan.

(9) COMMENTS: Some comments recommended that the EIDBI benefit conform with the **Standards of Practice for Applied Behavior Analysis** in Minnesota, as developed by the MNABA.

RESPONSE: DHS staff have reviewed the standards for applicability, and have included many of them in the plan. The proposed EIDBI benefit reflects, for the first time, recognition of ABA as well as other treatment modalities as distinct and medically necessary covered service. The ASD Advisory Council, clinical/professional focus group and other constituent input groups have included recommendations from ABA and other certified professionals that are now recognized in the new EIDBI benefit. This input will continue to be sought as DHS develops greater details of the provider qualifications and other standards of practice.

Implementation and Access – Managed Care vs Fee-for-service Coverage

(10) COMMENTS: Some comments expressed support for the plan's provision for **equity across fee-for-service and managed care** coverage, but with concerns about actual implementation.

RESPONSE: DHS is working closely with the managed care entities to assure equity in coverage, access and implementation. As provided in the "System Improvement" section of the plan, DHS will compare service provision for children on fee-for-service and managed care by:

- Collecting data from the time of the comprehensive multi-disciplinary evaluation to treatment; and
- Collecting data on the intensity, frequency and duration of EIDBI services provided.

The language in this section and the Distribution of State Plan HCBS Operational and Administrative Functions section has been strengthened to make it clear that EIDBI will be available to all eligible children receiving Medical Assistance coverage through fee-for-service and managed care in an amount, duration, and scope that is equal.

(11) COMMENTS: One comment asked whether DHS could enroll all kids with ASD into **fee-for-service (FFS) instead of managed care** in order to assure equal access.

RESPONSE: Under Minnesota law, children who are certified disabled are excluded from managed care and are on FFS. There are no specific exclusions or provisions for children with ASD not to be enrolled in managed care unless they are certified disabled.

Conflict of Interest Standards

(12) COMMENTS: Some comments expressed support for the proposed **conflict of interest standards** while others expressed concern that the standards might limit the pool of available providers, thus reducing access to the service.

RESPONSE: The EIDBI plan has addressed the provider capacity issue vs. the conflict of interest issue within the limits of the federal 1915i standards. Generally, 1915i requires a complete separation of evaluation and treatment providers. Many comments were in support of this separation. DHS has clarified this section to describe the current statewide shortage of willing and qualified professionals, thus making a case for the need to allow the same agency to provide both evaluation and treatment, as long as the functions are separated within the agency, and until there are sufficient willing and qualified providers within the geographic area.

(13) COMMENTS: Some comments stated that treatment providers would be the most knowledgeable about the client, and thus in the best position to evaluate needs and progress. Other commenters, especially parents, disagreed and indicated a preference for an independent evaluator.

RESPONSE: DHS agrees that information from a child's existing providers should be a critical part of the child's documentation of needs and progress. However, existing providers may not be aware of other areas outside their scope of practice. They may also have a conflict of interest in the recommendations and may inadvertently limit options for child and family. DHS supports the requirements in the MN state law and in federal 1915(i) regulations requiring an independent evaluation of progress including treatment recommendations.

Number Served

(14) COMMENTS: Some comments expressed concern that the **projected numbers served** would be a cap, and they questioned whether the projections were too low.

RESPONSE: 1915i does not allow states to place a cap on numbers served. The numbers in the plan are projections, not limits. The numbers are based on historical utilization of CTSS services.

Eligibility

(15) COMMENTS: Many comments expressed support for the required comprehensive multi-disciplinary evaluations (CMDE), individual service plans (ISP) and care consultation for each child, but also **concerns were expressed about delays in receiving treatment** if CMDE, ISP and care consultation created barriers to access.

RESPONSE: DHS has carefully reviewed all eligibility requirements in this plan and has worked to streamline the requirements wherever possible. As a result of these comments, language has been added in the CMDE section clarifying and encouraging use of all prior assessments including diagnosis information to avoid unnecessary duplication and delays in access to services. Language has also been added to the section which defines responsibility for plan of care development: "If the independent CMDE provider is

willing and qualified to carry out the duties of a care consultant, they can develop, monitor and update the ISP." Corresponding changes have been made in the section which defines who can provide ISP development and monitoring. This will allow one provider to do both the CMDE and the ISP development.
(16) COMMENTS: One comment asked "How will the Department of Human Services **support families who want to access the MA** Autism benefit in applying for MA or connecting them with places for assistance?" The commenter was particularly concerned about families facing language, cultural or socio-economic barriers, and asked whether children would have to be certified as disabled.
RESPONSE: DHS shares and has worked to address these concerns. Children will not have to be certified disabled to be eligible for this benefit. DHS will continue to work to provide assistance in understanding of and facilitate access to the EIDBI benefit and other services necessary for care of a child with ASD for cultural and ethnic communities.
(17) COMMENTS: Many commenters asked that **EIDBI be funded while the comprehensive multi-disciplinary evaluation (CMDE) and individual service plan (ISP) are being completed**.
RESPONSE: DHS explored options in this regard. Much parent education and child treatment probing takes place during the CMDE process, however providing treatment before medical necessity is determined is not an option under the 1915i requirement. It is also important to assure that the treatment provided is appropriate to the child and addresses the need. The CMDE process and requirement does not affect a child's eligibility for other existing benefits such as CTSS, speech therapy and occupational therapy. The CMDE often includes initial significant parent education and evaluation of specific treatment modalities.
(18) COMMENTS: One commenter asked for clarification regarding the **allowable time period for presumptive eligibility** for the CMDE.
RESPONSE: The plan has been amended to clarify that the federally allowed 60-day presumptive eligibility period for the CMDE begins with the first day a billable CMDE service is provided.
(19) COMMENTS: One commenter recommended **deletion of the requirement for modality to be specified** in the CMDE. The commenter was concerned that this might require a new CMDE whenever a new modality is determined to be more appropriate.
RESPONSE: The plan has been amended to delete this requirement.
(19) COMMENTS: One commenter recommended clarification of the **role and qualifications of the medical professional in the CMDE**. The proposed plan stated that the CMDE was the responsibility of a medical professional and a mental health professional, and implied that both professionals had to have expertise and training in ASD. The commenter felt that this was unrealistic and

would be difficult to manage.
RESPONSE: The plan has been clarified to assure consistency with the 2014 legislative amendment which requires the CMDE to be completed by a mental health professional with the inclusion of medical information from a medical professional which could include the child's pediatrician. The plan was amended to make it clear that only the mental health professional had to have expertise and training in ASD and therefore the child's pediatrician is included in the qualified medical professional.
(20) COMMENTS: Many commenters recommended a five working-day **time limit for the state's review of medical necessity** and eligibility. Some commenters also asked that treatment be paid if the review process takes longer than 5 days.
RESPONSE: The timeline for medical reviews is governed by the current DHS medical review contract, which requires the contractor to complete prospective authorization requests within 10 business days of receipt. The current contract also provides an incentive payment to the contractor for months when the contractor completes authorization requests within 5 business days.
(21) COMMENTS: Two commenters recommended changing the **timeline for progress evaluations** to annually instead of every 6 months, and clarifying the role of the 6-month progress evaluations.
RESPONSE: The authorizing state legislation for EIDBI requires **progress evaluations every 6 months** or more frequently based on the child's individual service plan (ISP). Many treatment programs require progress evaluation more frequently than 6 months. The purpose of the 6 month progress review is to ensure that the child's treatment plan and goals and objectives are providing the right treatment and promoting adequate progress. This is especially important for very young children where the developmental window of opportunity is critical. Federal 1915i requires re-determination of **eligibility every 12 months** therefore the annual review is required to comply with federal requirements. The 6-month progress evaluations will be further defined in the state's provider manual.
(22) COMMENTS: Two comments expressed support for the plan's statement that "*no specific **standardized assessment** is required*" and mentioned the need for **culturally appropriate assessments**. One commenter recommended more standardization in the assessment tools used.
RESPONSE: DHS has, in part due to the developing nature of diagnostic standards for ASD, retained the statement about standardized assessments and has also included the following: "*The child and family's primary spoken language, culture and values must be considered throughout the diagnosis, CMDE, individual service plan (ISP) and individual treatment plan (ITP) development, progress monitoring, parent education and support services and coordination of care. A language interpreter must be provided when needed*." DHS will work with stakeholders to identify, improve upon and/or develop diagnostic standards with specific focus on culturally appropriate assessments.

(23) COMMENTS: One comment asked for clarification regarding the statement *"A **language interpreter** must be provided when needed."*
RESPONSE: Coverage for language interpreters is the same for all MA covered services and therefore is governed by general MA policy, not specific to the Autism benefit. All ASD providers must meet CLAS and Title VI standards for meaningful access to services.
(24) COMMENTS: One comment recommended that **play skills** be included in the assessment and criteria of medical necessity and eligibility for the benefit.
RESPONSE: The plan has been revised to include play skills in the evaluation and criteria for medical necessity determination.
(25) COMMENTS: One comment recommended that the eligibility criteria be revised to be **consistent with DSM-5** by referring to "occupational" areas of functioning.
RESPONSE: The plan has been revised as recommended.
(26) COMMENTS: One commenter recommended that the eligibility criteria be revised to remove the reference to **co-occurring intellectual disability and autism.**
RESPONSE: This reference is from DSM-5, and has been retained to ensure consistency with DSM-5 criteria.
(27) COMMENTS: Many commenters recommended that the target population definition be revised to remove "*The child must have the **developmental capacity** to participate in and benefit from the available interventions covered by the EIDBI benefit as determined by the CMDE."*
RESPONSE: DHS agreed that this was an immeasurable criteria and this statement has been removed from the plan.
(28) COMMENTS: One commenter recommended clarification of the **role and qualifications of the medical professional in the CMDE**. The proposed plan stated that the CMDE was the responsibility of a medical professional and a mental health professional, and implied that both professionals had to have expertise and training in ASD. The commenter felt that this was unrealistic and would be difficult to manage.
RESPONSE: The plan has been clarified to assure consistency with a 2014 legislative amendment which requires the CMDE to be completed by a mental health professional with the inclusion of medical information from a medical professional. The plan was also amended to make it clear that only the mental health professional had to have expertise and training in ASD.
(29) COMMENTS: Some comments recommended more detail regarding the **authorization criteria** that will be used to determine amount and type of treatment for each child.

RESPONSE: DHS has discussed authorization criteria and determination of amount and type of services with the ASD Advisory Council, the individual focus groups and the clinical/professional advisory group. These criteria are not required to be specified in the 1915(i) plan, and DHS will continue to involve stakeholders in these discussions
Person-Centered Planning
(30) COMMENTS: One commenter recommended changing a sentence on **person-centered planning** from "The PCP process identifies the functional developmental needs, abilities, preferences, interests, goals and health status of the child." to "The PCP process documents the functional developmental needs, abilities, goals, and health status of the child, as identified by the CMDE. The PCP process also identifies the child's preferences and interests, as well as the family's values, culture, language, preferences, needs, goals, capacity for involvement in the child's treatment, and formal and informal supports."
RESPONSE: DHS agreed with the improved language and has included this change.
(31) COMMENTS: One commenter recommended using the term "Community Plan", in place of **the term "Individual Service Plan".**
RESPONSE: DHS has retained the proposed terminology on the rationale since it is more consistent with the federal language and with other comparable requirements in state law and rule.
(32) COMMENTS: One commenter expressed concern about additional **workload on counties** to develop the required individual service plans and referred to this as an "unfunded mandate."
RESPONSE: DHS heard from stakeholders about the need for autism specific care coordination as well as the concern for adding additional professionals to coordinate care. Current case managers through Rule 185, Targeted Case Management or Waiver Case Management already develop individual service plans such as CSSPs or CSPs that can be used for the new EIDBI benefit. Additional ASD specific actives to coordinate care can be reimbursed through the new benefit. Families without current case management can choose an independent care consultant from a variety of professionals or through contracted case management agencies.
(33) COMMENTS: Some commenters recommended a more complete listing of all the steps that families would follow to access EIDBI.
RESPONSE: DHS is working to streamline the process as well as develop a **"road map"** for use by families and providers.
EIDBI Covered Services

(34) COMMENTS: Some commenters expressed concern about **identifying treatments by modality or brand**. Some suggested specific modalities that should be added.
RESPONSE: DHS feels that it is significant that Minnesota's MA program is, for the first time, recognizing ABA as well as other specific approaches as distinct treatment modalities known to benefit children with autism. At the same time, the plan has been clarified to add other modalities, followed by the statement "Because of the emerging nature of autism treatment, other effective interventions will be considered." See also the change under "Eligibility", removing specification of treatment modality from the determination in the CMDE.
(35) COMMENTS: Some commenters requested clarification of the statement "*EIDBI is not intended to supplant **services provided in school** or other settings or to be provided when the child typically would be in school but for the parent's choice to home school the child*." One of these commenters expressed concern that this might preclude provision of EIDBI during school hours.
RESPONSE: DHS has addressed and replaced the above statement as follows: *EIDBI is not intended to replace services provided in school or other settings. Each child's individual service plan (ISP) must document that EIDBI services coordinate with, but do not include or replace special education and related services defined in the child's individualized educational plan (IEP) when the service is available under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) through a local education agency. This provision does not preclude EIDBI treatment during school hours.*
(36) COMMENTS: Many comments questioned the specification of a range of **hours of service per week** in the definition of covered services. One commenter supported the inclusion of a specific range of hours.
RESPONSE: DHS has replaced the reference to average hours of service per week with the following: "*The total number of hours of intensive intervention is based on the individual needs of the child and takes into consideration other related services supporting the ISP that the child receives such as occupational therapy and speech therapy."*
(37) COMMENTS: One commenter requested deletion of the proposed **therapeutic preschool** category since this has not been found to be a workable model in CTSS.
RESPONSE: DHS explored this issue, agrees with the comment and has deleted this category.
(38) COMMENTS: Many commenters supported the inclusion of **Family/Caregiver Training** and Counseling. One commenter recommended that these services be delivered by an agency or provider separate from those providing services.
RESPONSE: The plan does not preclude a family from seeking these services from a separate provider.
(39) COMMENTS: Two commenters expressed the need for **culturally appropriate training** and other accommodations to assure

that Family/Caregiver Training and Counseling and other EIDBI services will be culturally appropriate. One commenter recommended **use of parents** from these communities to support other parents who have children with Autism.
RESPONSE: DHS is taking a number of steps to develop culturally appropriate training and other accommodations for culturally competent practices. The plan has been revised to require, as part of provider qualifications, training for autism service providers in culturally appropriate practices. DHS supports the proposed use of parents as facilitators and coordinators of EIDBI services, and will work with the Children's Mental Health Division and others as the Family Peer Specialist service is developed, to incorporate Family Peer Specialists into EIDBI.
(40) COMMENTS: Many commenters expressed concern about the definition of **care consultation**, and how that service would be provided. Many commenters felt that use of the care consultant should be optional. Others felt it was critical to the benefit and for families.
RESPONSE: The plan has been revised to clarify the difference between the care conference (which involves a team) vs ISP development, which is done by a care consultant. In response to the suggestion to make use of a care consultant optional, the plan has been clarified to allow a family to choose among a number of providers who will develop the ISP. Development of the ISP is required by 1915(i). The plan defines the ISP developer as a "Care consultant."
Provider Qualifications
(41) COMMENTS: Many commenters expressed support for the proposed requirement that providers have **specific training and experience with ASD** and child development, but with concerns that the proposed requirements may be too ambitious and unrealistic.
RESPONSE: DHS revised the ASD-specific requirements to reduce some of the required hours of experience and training, and to allow more flexibility between ASD training and ASD experience.
(42) COMMENTS: Two commenters indicated that speech therapists and occupational therapists should not be required to meet any additional qualifications over and above what is already required by their licenses.
RESPONSE: The EIDBI benefit provides autism specific treatment and requires expertise and training in ASD treatment and diagnostics that go beyond the licensure requirements for speech therapists, occupational therapists or special education. The EIDBI benefit does not replace or cover ancillary therapies; however those therapists who have additional ASD expertise and training may be qualified to provide the EIDBI treatment.
(43) COMMENTS: One commenter recommended development of **a license for BCBAs**.

RESPONSE: Development of a license for BCBAs is outside the scope of this plan and beyond the current state law. DHS will work with stakeholders including BCBAs and other licensed or certified providers to incorporate their credentials to meet the qualified professional provider standards and qualifications for the EIDBI benefit.

Participant-Direction of Services

(44) COMMENTS: Many commenters asked that the plan include a **self-directed option**.

RESPONSE: The EIDBI benefit is a medically necessary treatment and not based on a budget amount.

Quality Improvement Plan

(45) COMMENTS: Two commenters stated that the proposed plan to require an **annual ISP review** to authorize services is not consistent with the state law which requires that children can continue treatment services until the independent review agent makes a decision to authorize or deny continued service.

RESPONSE: We will work with providers to ensure that the ISP annual review is completed in a timely manner.

(46) COMMENTS: Two commenters asked that more **data elements** be included and defined, including specific data regarding access to professionals, age of diagnosis and beginning date and length of treatment, types of services provided by age and geographic location, number and results of appeals and treatment and service outcomes, and the time from when the child is identified as qualified for Early Intensive Developmental and Behavioral Interventions (EIDBI) to the time intervention actually begins.

RESPONSE: DHS will track and monitor this data as part of autism benefit operational measures and learning collaborative process.

Payment Rates

(47) COMMENTS: Several commenters asked for more information regarding payment rates. One commenter provided recommendations regarding payment rates, authorization procedures for simultaneous services, and recommendations to use payment structures to incent cost-effective services.

RESPONSE: DHS considered these recommendations as it developed the payment rates. Additional detail has been added to the plan. DHS will continue to consult with stakeholders to inform the development of the authorization process and procedures.

Misc.
DHS received several comments and suggestions about items unrelated to this state plan amendment, such as PCA services, day care and MnChoices.
REPONSE: These comments and suggestions are outside of the scope of this plan as it is defined in statute and regulation.