SENATE
STATE OF MINNESOTA
EIGHTY-NINTH SESSION

S.F. No. 2751

(SENATE AUTHORS: CARLSON, Lourey and Clausen)

DATE	D-PG	OFFICIAL STATUS
03/14/2016	5043	Introduction and first reading Referred to Health, Human Services and Housing
04/06/2016		Comm report: To pass as amended and re-refer to Finance

A bill for an act

relating to human services; modifying certain provisions governing autism early intensive intervention benefit; amending Minnesota Statutes 2014, section 256B.0949, subdivisions 2, 3, 4, 5, 6, 7, 8, 9, by adding subdivisions.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2014, section 256B.0949, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For the purposes of this section, the terms defined in this subdivision have the meanings given.

(b) "Agency" or "provider agency" means the legal entity that is enrolled with Minnesota health care programs to provide EIDBI and that has the legal responsibility to ensure that its employees or contractors carry out the responsibilities defined in this section. The definition of provider agency includes licensed individual professionals who practice independently and act as a provider agency.

~~(b)~~ (c) "Autism spectrum disorder ~~diagnosis~~" or "ASD" is defined ~~by diagnostic code 299~~ in the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

(d) "ASD and related conditions" means a condition that is found to be closely related to autism spectrum disorder and may include but is not limited to autism, Asperger's syndrome, pervasive developmental disorder-not otherwise specified, fetal alcohol spectrum disorder, Rhett's syndrome, and autism-related diagnosis as identified under the current version of the DSM and meets all of the following criteria:

(1) is severe and chronic;

(2) results in impairment of adaptive behavior and function similar to that of persons with ASD;

(3) requires treatment or services similar to those required for persons with ASD;

(4) results in substantial functional limitations in three core developmental deficits of ASD: social interaction; nonverbal or social communication; and restrictive, repetitive behaviors or hyperreactivity or hyporeactivity to sensory input; and may include deficits in one or more of the following related developmental domains:

(i) self-regulation;

(ii) self-care;

(iii) behavioral challenges;

(iv) expressive communication;

(v) receptive communication;

(vi) cognitive functioning;

(vii) safety; and

(viii) level of support needed; and

(5) is not attributable to mental illness as defined in section 245.462, subdivision 20, or an emotional disturbance as defined in section 245.4871, subdivision 15. For purposes of item (vii), notwithstanding section 245.462, subdivision 20, or 245.4871, subdivision 15, mental illness does not include autism or other pervasive developmental disorders.

~~(c)~~ (e) "Child" means a person ~~under~~ up to, but not including, the age of ~~18~~ 21.

~~(d)~~ (f) "Commissioner" means the commissioner of human services, unless otherwise specified.

(g) "Comprehensive multidisciplinary evaluation" or "CMDE" means a comprehensive evaluation of a child's developmental status to determine medical necessity for the EIDBI benefit based on the requirements in section 256B.0949, subdivision 5.

~~(e)~~ (h) "Early intensive developmental and behavioral intervention benefit" or "EIDBI" means ~~autism treatment options~~ intensive interventions based in behavioral and developmental science~~, which may include modalities such as applied behavior analysis, developmental treatment approaches, and naturalistic and parent training models~~ that include the services covered under subdivision 11.

~~(f)~~ (i) "Generalizable goals" means results or gains that are observed during a variety of activities over time with different people, such as providers, family members, other adults, and children, and in different environments including, but not limited to, clinics, homes, schools, and the community.

(j) "Individual treatment plan" or "ITP" means the person-centered, individualized written plan of care that integrates and coordinates child and family information from the

comprehensive multidisciplinary evaluation for a child who meets medical necessity for the early intensive developmental and behavioral intervention benefit. An individual treatment plan must meet the standards in section 256B.0949, subdivision 6.

(k) "Legal representative" means the parent of a person who is under 18 years of age, a court-appointed guardian, or other representative with legal authority to make decisions about services for a person. Other representatives with legal authority to make decisions include but are not limited to a health care agent or an attorney-in-fact authorized through a health care directive or power of attorney.

~~(g)~~ (l) "Mental health professional" has the meaning given in section 245.4871, subdivision 27, clauses (1) to (6).

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 2. Minnesota Statutes 2014, section 256B.0949, subdivision 3, is amended to read:

Subd. 3. **~~Initial~~ EIDBI eligibility.** This benefit is available to a child enrolled in medical assistance who:

(1) has ~~an autism spectrum disorder~~ a diagnosis of ASD or a related condition that meets the criteria of subdivision 4;

(2) ~~has had a diagnostic assessment described in subdivision 5, which recommends early intensive intervention services~~ is medically stable; ~~and~~

(3) ~~meets the criteria for medically necessary autism early intensive intervention services.~~ does not need 24-hour medical or nursing monitoring or procedures; and

(4) received a comprehensive multidisciplinary evaluation as described in subdivision 5 that recommends EIDBI services based on medical necessity criteria published by the commissioner.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 3. Minnesota Statutes 2014, section 256B.0949, is amended by adding a subdivision to read:

Subd. 3a. **Culturally and linguistically appropriate requirement.** The child's and family's primary spoken language, culture, preferences, goals, and values must be reflected throughout the process of diagnosis, CMDE, ITP development, progress monitoring, family or caregiver training and counseling services, and coordination of care. The qualified CMDE and QSP must determine the most effective way to adapt the evaluation, treatment recommendations, and ITP to the culture, language, and values of the child and family. A language interpreter who is fluent in both languages, with training or knowledge

of related diagnostic and medical treatment terminology, must be provided when the child or child's legal representative is not able to speak, read, write, or understand the English language at a level that allows the child or child's legal representative to interact with the CMDE, QSP, or a level I, level II, or level III treatment provider. The language interpreter must be fluent in both languages, with training or knowledge of related diagnostic and medical treatment terminology.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 4. Minnesota Statutes 2014, section 256B.0949, subdivision 4, is amended to read:

Subd. 4. **Diagnosis.** (a) A diagnosis must:

(1) be based upon current DSM criteria including direct observations of the child and ~~reports~~ information from parents or primary caregivers; ~~and~~

(2) be completed by either (i) a licensed physician or advanced practice registered nurse or (ii) a mental health professional~~.~~; and

(3) meet the requirements of Minnesota Rules, part 9505.0372, subpart 1, items B and C.

(b) Additional ~~diagnostic~~ assessment information may be considered to complete a diagnostic assessment including ~~from~~ specialized tests administered through special education evaluations and licensed school personnel, and from professionals licensed in the fields of medicine, speech and language, psychology, occupational therapy, and physical therapy. A diagnostic assessment may include treatment recommendations.

EFFECTIVE DATE. This section is effective January 1, 2017.

Sec. 5. Minnesota Statutes 2014, section 256B.0949, subdivision 5, is amended to read:

Subd. 5. ~~**Diagnostic assessment**~~ **Comprehensive multidisciplinary evaluation (CMDE).** ~~The following information and assessments must be performed, reviewed, and relied upon for the eligibility determination, treatment and services recommendations, and treatment plan development for the child:~~

~~(1) an assessment of the child's developmental skills, functional behavior, needs, and capacities based on direct observation of the child which must be administered by a licensed mental health professional, must include medical or assessment information from the child's physician or advanced practice registered nurse, and may also include observations from family members, school personnel, child care providers, or other caregivers, as well as any medical or assessment information from other licensed professionals such as rehabilitation therapists, licensed school personnel, or mental health professionals; and~~

~~(2) an assessment of parental or caregiver capacity to participate in therapy including the type and level of parental or caregiver involvement and training recommended.~~

(a) A CMDE must be completed to determine medical necessity of EIDBI services. The CMDE must be administered by a qualified CMDE provider. The CMDE must include and document information from medical and mental health professionals.

(b) The qualified CMDE provider must:

(1) be a licensed physician or advanced practice registered nurse or a mental health professional or a mental health practitioner who meets the requirements of a clinical trainee as defined in Minnesota Rules, part 9505.0371, subpart 5, item C;

(2) have at least 2,000 hours of clinical experience in the evaluation and treatment of children with ASD or equivalent documented course work at the graduate level by an accredited university in the following content areas: ASD diagnosis, ASD treatment strategies, and child development;

(3) be able to diagnose, evaluate, or provide treatment within the provider's scope of practice and professional license; and

(4) have knowledge and provide information about the range of current EIDBI treatment modalities recognized by the commissioner.

(c) The CMDE must include and document the following:

(1) information from a diagnostic assessment that meets the definition under subdivision 4;

(2) information gathered from family members and primary child care providers;

(3) a face-to-face assessment of the child's degree of severity of core features of ASD and related conditions, as well as other areas of functional development, including cognition, learning and play, social or interpersonal interaction, verbal and nonverbal communication, self-care, behavioral challenges and self-regulation, safety, and level of support needed;

(4) a review and consideration of diagnostic and other related assessment information from other qualified or licensed health care or other professionals working with the child, including medical and pharmacological information from a licensed physician or advanced practice nurse; the child's rehabilitation therapists; licensed school personnel; and other mental health professionals;

(5) referrals to other needed clinical, medical, educational, rehabilitation, or social services;

(6) parent or caregiver preferences for involvement in child treatment that takes into account the family's culture, language, goals, and values;

(7) discussion with the child and family of the options and recommendations for the type and level of parent or caregiver training and preferred involvement in the child's treatment;

(8) discussion with the child and family of the recommendations for EIDBI medical necessity, including recommendations for a minimum and maximum range of suggested EIDBI treatment intensity;

(9) discussion with the child and family of all EIDBI treatment modality options recognized by the Department of Human Services available at the time of the CMDE, including differences in how the treatment modalities are implemented;

(10) summary of information provided to the child's legal representative in a manner in which they understand the results and recommendations and can make informed decisions about treatment options. This may include a coordinated conference, as requested by the parent;

(11) determination regarding how frequently to monitor the child's progress if monitoring is required more frequently than every six months; and

(12) determination of the most effective way to adapt the recommendations of the CMDE to the culture, language, and values of the family irrespective of where the child and family are from.

(d) The CMDE must be updated after each 12 months of treatment, or more frequently as determined by a qualified CMDE provider. The CMDE update must:

(1) consider the provider agency's progress evaluation results and make a determination of the child's progress toward achieving generalizable and functional goals contained in the treatment plan;

(2) identify any significant changes in the child's condition or family circumstances;

(3) document and provide rationale for any recommended changes in EIDBI services, including the need for continuation or discontinuation of medically necessary EIDBI; and

(4) be submitted to the commissioner in a manner determined by the commissioner for the authorization of EIDBI services.

EFFECTIVE DATE. Paragraph (b) is effective the day following final enactment. Paragraphs (a), (c), and (d) are effective August 1, 2016.

Sec. 6. Minnesota Statutes 2014, section 256B.0949, subdivision 6, is amended to read:

Subd. 6. **Individual treatment plan (ITP).** (a) The qualified EIDBI professional who integrates and coordinates child and family information from the CMDE and progress-monitoring process to develop the ITP must develop and monitor the ITP.

(b) The ITP reflects the values, goals, preferences, language, and culture of the child's family and specifies the medically necessary treatment and services, including baseline data, primary goals and target objectives, progress-monitoring results and goal mastery data, and any significant changes in the child's condition or family circumstances. Each child's ~~treatment plan~~ ITP must ~~be~~:

(1) be based on the diagnostic assessment and CMDE summary information specified in subdivisions 4 and 5;

(2) be consistent with the person-centered planning and service delivery requirements in subdivision 6a and be individualized based on the child's developmental status and identified needs, interests, values, preferences, culture, and language;

(3) identify desired outcomes of the child and the child's legal representative;

(4) specify target objectives for the treatment period that are functionally and developmentally appropriate and work toward generalization across people and environments for best possible participation in home, school and community life;

(5) identify level of family caregiver training and counseling;

(6) be delivered in a manner individualized to the child and family to ensure skills transfer to the parent or caregiver;

~~(2) coordinated~~ (7) identify and coordinate with other services the child and family are receiving, including medically necessary occupational, physical, and speech and language therapies, special education, social services, and other services the child and family are receiving; and

(8) integrate current services the child is receiving into treatment recommendations.

~~(3) family-centered;~~

~~(4) culturally sensitive; and~~

~~(5) individualized based on the child's developmental status and the child's and family's identified needs.~~

~~(b)~~ (c) The ~~treatment plan~~ ITP must specify the primary treatment goals and target objectives, including baseline measures and projected dates of accomplishment. The ITP must include:

~~(1) child's goals which are developmentally appropriate, functional, and generalizable;~~

~~(2) treatment modality;~~

~~(3) treatment intensity;~~

~~(4) setting; and~~

~~(5) level and type of parental or caregiver involvement.~~

(1) the measurable and observable criteria for identifying when the desired outcome is achieved and how data shall be collected;

(2) the projected starting date for implementing the services and the date by which progress toward accomplishing the outcomes shall be reviewed and evaluated;

(3) the treatment method to meet the goals and objectives, including:

(i) frequency, intensity, location, and duration of each service provided;

(ii) level of parent or caregiver training and counseling;

(iii) any changes or modifications to the physical and social environments necessary when the services are provided;

(iv) any specialized equipment and materials required;

(v) techniques that support and are consistent with the child's communication mode and learning style; and

(vi) names of staff with overall responsibility for supervising staff and implementing the service or services;

(4) an updated review according to subdivision 7 every six months or more frequently if indicated on the CMDE;

(5) discharge criteria that shall be used and a defined plan to assist the child and the child's legal representative to transition to other services. The plan shall include:

(i) protocols for changing service when medically necessary;

(ii) how the transition will occur;

(iii) time allowed to make the transition. Up to 30 days of continued service is allowed while the transition plan is being developed. Services during this period shall be consistent with the ITP from when the notice of need for transition until services are terminated; and

(iv) how the parent or guardian will be informed of and involved in the transition.

~~(c)~~ (d) Implementation of the ~~treatment~~ ITP must be supervised by a qualified supervising professional ~~with expertise and training in autism and child development who is a licensed physician, advanced practice registered nurse, or mental health professional~~ (QSP).

~~(d)~~ (e) The ~~treatment plan~~ ITP must be submitted to the commissioner for approval in a manner determined by the commissioner for this purpose.

~~(e)~~ (f) Services authorized must be consistent with parent or caregiver preferences for treatment, the child's CMDE recommendations, and approved ~~treatment plan~~ ITP.

(g) Services included in the ~~treatment plan~~ ITP must meet all applicable requirements for medical necessity and coverage.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 7. Minnesota Statutes 2014, section 256B.0949, is amended by adding a subdivision to read:

Subd. 6a. **Person-centered planning requirements.** (a) The provider must provide services in response to the identified needs, interests, preferences, and desired outcomes of the child and the child's legal representative as specified in the ITP and recommended in the CMDE and in compliance with the requirements of this section.

(b) Services must be provided in a manner that supports the preferences of the child and the child's legal representative, consistent with the principles of:

(1) person-centered service planning and delivery that:

(i) identifies and supports what is important to the child and the child's legal representative, including preferences for when, how, and by whom treatment is provided; and

(ii) respects each child's history, dignity, and cultural background;

(2) self-determination that supports and provides:

(i) opportunities for the development and exercise of functional and age-appropriate skills, decision making and choice, personal advocacy, and communication; and

(ii) the affirmation and protection of each child's civil and legal rights; and

(3) service delivery that supports, promotes, and allows:

(i) inclusion and participation in the child's community as desired by the child and the child's legal representative in a manner that promotes the skills that enable the child to interact with children without disabilities to the fullest extent possible and supports the child in developing and maintaining a role as a valued community member;

(ii) opportunities for self-sufficiency as well as developing and maintaining social relationships and natural supports; and

(iii) a balance between risk and opportunity, meaning the least restrictive supports or interventions necessary are provided in the most integrated settings in the most inclusive manner possible.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 8. Minnesota Statutes 2014, section 256B.0949, is amended by adding a subdivision to read:

Subd. 6b. **Coordination with other benefits.** (a) Services provided under this benefit do not replace services provided in a child's individualized education plan. Each child's ITP must document that EIDBI services coordinate with, but do not include or replace special education and related services defined in the child's individualized

education plan when the service is available under the Individuals with Disabilities Education Improvement Act of 2004 through a local education agency.

(b) The commissioner shall integrate medical authorization procedures for this benefit with authorization procedures for other health and mental health services and home and community-based services to ensure that the child receives services that are the most appropriate and effective in meeting the child's needs.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 9. Minnesota Statutes 2014, section 256B.0949, subdivision 7, is amended to read:

Subd. 7. ~~**Ongoing eligibility**~~ **Progress evaluation monitoring.** (a) ~~An independent~~ A progress evaluation ~~conducted by a licensed mental health professional with expertise and training in autism spectrum disorder and child development~~ must be completed after each six months of treatment, or more frequently as determined by the ~~commissioner~~ qualified CMDE provider, to determine if progress is being made toward ~~achieving~~ targeted functional and generalizable goals ~~and meeting functional goals contained~~ specified in the ~~treatment plan~~ ITP. Based on the results of progress monitoring and evaluation, the ITP must be adjusted as needed and must document that the child continues to meet medical necessity for EIDBI or is referred to other services.

(b) The progress evaluation must be overseen and signed by the qualified supervising professional. The progress evaluation must include:

(1) the treating provider's report;

(2) parental or caregiver input;

(3) an ~~independent~~ observation of the child which ~~can~~ must be performed by ~~the child's~~ a QSP or a level I or level II treatment provider and may include observation information from licensed special education staff or other licensed health care providers;

(4) documentation of current level of performance on primary treatment goal domains including when goals and objectives are achieved, changed, or discontinued;

(5) any significant changes in the child's condition or family circumstances;

~~(4)~~ (6) any treatment plan modifications and the rationale for any changes made including treatment modality, intensity, frequency, and duration; and

~~(5)~~ (7) recommendations for continued treatment ~~services~~.

(c) Progress evaluations must be submitted to the commissioner in a manner determined by the commissioner for ~~this purpose~~ the reauthorization of EIDBI services.

(d) A child who continues to ~~achieve generalizable goals and~~ make reasonable progress towards treatment goals as specified in the ~~treatment plan~~ ITP is eligible to continue receiving ~~this benefit~~ EIDBI services.

(e) A child's treatment shall continue during the progress evaluation using the process determined under ~~subdivision 8, clause (8)~~ this subdivision. Treatment may continue during an appeal pursuant to section 256.045.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 10. Minnesota Statutes 2014, section 256B.0949, subdivision 8, is amended to read:

Subd. 8. **Refining the benefit with stakeholders.** The commissioner must ~~develop the implementation~~ refine the details of the benefit in consultation with stakeholders and consider recommendations from ~~the Health Services Advisory Council,~~ the Department of Human Services ~~Autism Spectrum Disorder~~ Early Intensive Developmental and Behavioral Intervention Benefit Advisory Council, ~~the Legislative Autism Spectrum Disorder Task Force,~~ the EIDBI learning collaborative, and the ASD Interagency Task Force of the Departments of Health, Education, Employment and Economic Development, and Human Services. ~~The commissioner must release these details for a 30-day public comment period prior to submission to the federal government for approval.~~ The ~~implementation~~ details must include, but are not limited to, the following components:

(1) a definition of the qualifications, standards, and roles of the treatment team, including recommendations after stakeholder consultation on whether board-certified behavior analysts and other ~~types of~~ professionals certified in other treatment approaches recognized by the Department of Human Services or trained in autism spectrum disorder and child development should be added as ~~mental health or other~~ professionals ~~for~~ qualified to provide EIDBI treatment supervision or other functions under medical assistance;

(2) ~~development of initial,~~ refinement of uniform parameters for comprehensive multidisciplinary ~~diagnostic assessment information~~ evaluation and ~~progress evaluation~~ ongoing progress-monitoring standards;

(3) the design of an effective and consistent process for assessing parent and caregiver ~~capacity~~ preferences and options to participate in the child's early intervention treatment and efficacy of methods ~~of involving the~~ to involve and educate parents and caregivers in the treatment of the child;

(4) formulation of a collaborative process in which professionals have opportunities to collectively inform provider standards and qualifications, standards for a comprehensive, multidisciplinary ~~diagnostic assessment~~ evaluation; medical necessity determination; efficacy of treatment apparatus, including modality, intensity, frequency, and duration; and ~~progress evaluation~~ progress-monitoring processes ~~and standards~~ to support quality improvement of ~~early intensive intervention~~ EIDBI services;

(5) coordination of this benefit and its interaction with other services provided by the Departments of Human Services, Health, Employment and Economic Development, and Education;

(6) evaluation, on an ongoing basis, of ~~research regarding the~~ program EIDBI outcomes and efficacy of treatment ~~modalities~~ methods provided to children under this benefit; and

(7) determination of the availability of ~~licensed physicians, nurse practitioners, and mental health professionals~~ qualified EIDBI providers with necessary expertise and training in autism spectrum disorder and related conditions throughout the state to assess whether there are sufficient professionals ~~to require involvement of both a physician or nurse practitioner and a mental health professional~~ to provide timely access and prevent delay in the CMDE diagnosis and treatment of ~~young children, so as to implement subdivision 4, and to ensure treatment is effective, timely, and accessible; and~~ ASD and related conditions.

~~(8) development of the process for the progress evaluation that will be used to determine the ongoing eligibility, including necessary documentation, timelines, and responsibilities of all parties.~~

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 11. Minnesota Statutes 2014, section 256B.0949, subdivision 9, is amended to read:

Subd. 9. **Revision of treatment options.** (a) The commissioner may revise covered treatment options as needed based on outcome data and other evidence. EIDBI treatment methods approved by the Department of Human Services must:

(i) cause no harm to the individual child or family;

(ii) be provided in an individualized manner to meet the varied needs of each child and family;

(iii) be developmentally appropriate and highly structured, with well-defined goals and objectives that provide a strategic direction for treatment;

(iv) be regularly evaluated and adjusted as needed;

(v) be based in recognized principles of developmental and behavioral science;

(vi) utilize sound practices that are replicable across providers and maintain the fidelity of the specific approach;

(vii) demonstrate some level of evidentiary basis;

(viii) have goals and objectives that are measurable, achievable, and regularly evaluated to ensure that adequate progress is being made;

(ix) be provided intensively with a high adult-to-child ratio;

(x) include active family participation in decision-making, knowledge and capacity building, and developing and implementing the child's ITP; and

(xi) be provided in a culturally and linguistically appropriate manner.

(b) Before ~~the changes~~ revisions in Department of Human Services recognized treatment modalities become effective, the commissioner must provide public notice of the changes, the reasons for the change, and a 30-day public comment period to those who request notice through an electronic list accessible to the public on the department's Web site.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 12. Minnesota Statutes 2014, section 256B.0949, is amended by adding a subdivision to read:

Subd. 13. **Covered services.** (a) The following services are eligible for reimbursement by medical assistance under this section:

(1) EIDBI interventions are a variety of individualized, intensive treatment methods approved by the department that are based in behavioral and developmental science consistent with best practices on effectiveness. Services must address the participant's medically necessary treatment goals and be provided by an EIDBI supervising professional or a level I, level II, or level III treatment provider. Services are targeted to develop, enhance, or maintain the individual developmental skills of a child with ASD and related conditions to improve functional communication, social or interpersonal interaction, behavioral challenges and self-regulation, cognition, learning and play, self-care, safety, and level of support needed;

(2) EIDBI intervention observation and direction is the clinical direction and oversight by a QSP or a level I or level II EIDBI provider regarding provision of EIDBI services to a child, including developmental and behavioral techniques, progress measurement, data collection, function of behaviors, and generalization of acquired skills for the direct benefit of a child. EIDBI intervention observation and direction informs any modifications of the methods to support the accomplishment of outcomes in the ITP. Observation and direction provides a real-time response to EIDBI interventions to maximize the benefit to the child;

(3) CMDE is a comprehensive evaluation of the child's developmental status to determine medical necessity for EIDBI services and meets the requirements of subdivision 5. The services must be provided by a qualified CMDE provider;

(4) ITP development and monitoring is development of the initial, annual, and progress monitoring of ITPs. This service documents, provides oversight and on-going

evaluation of child treatment and progress on targeted goals and objectives, and integrates and coordinates child and family information from the CMDE and progress monitoring evaluations. The ITP must meet the requirements of subdivision 6. Progress monitoring must meet the requirements of subdivision 7. This service must be reviewed and completed by a QSP, and may include input from a level I or level II treatment provider;

(5) family caregiver training and counseling is specialized training and education a family or primary caregiver receives to understand their child's developmental status and help with their child's needs and development. This service must be provided by a QSP or a level I or level II treatment provider;

(6) coordinated care conference is a face-to-face meeting with the child and family to review the CMDE or progress monitoring results and to coordinate and integrate services across providers and service-delivery systems to develop the ITP. This service must be provided by a QSP and may include the CMDE provider or the level I or level II treatment provider;

(7) travel time is allowable billing for traveling to and from the recipient's home, a community setting, or place of service outside of an EIDBI center, clinic, or office from a specified location to provide face-to-face EIDBI intervention, observation and direction, or family caregiver training and counseling. EIDBI recipients must have an ITP specifying why the provider must travel to the recipient's home, a community setting, or place of service outside of an EIDBI center, clinic, or office; and

(8) medical assistance covers medically necessary services and consultations delivered by a licensed health care provider via telemedicine in the same manner as if the service or consultation was delivered in person. Coverage is limited to three telemedicine services per enrollee per calendar week.

(b) EIDBI interventions under paragraph (a), clause (1), include, but are not limited to:

(i) applied behavioral analysis (ABA);

(ii) developmental individual-difference relationship-based model (DIR/Floortime);

(iii) early start Denver model (ESDM);

(iv) PLAY project; or

(v) relationship development intervention (RDI).

(c) A provider may use one or more of the treatment interventions in paragraph (b) as the primary modality for treatment as a covered service, or several treatment interventions in combination as the primary modality of treatment, as approved by the commissioner. Additional treatment interventions may be used upon approval by the commissioner. A provider that identifies and provides assurance of qualifications for a

single specific treatment modality must document the required qualifications to meet fidelity to the specific model.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 13. Minnesota Statutes 2014, section 256B.0949, is amended by adding a subdivision to read:

Subd. 14. **Noncovered services.** The following services are not eligible for medical assistance payment as EIDBI under this section:

(1) service components of EIDBI simultaneously provided by more than one provider entity unless prior authorization is obtained;

(2) provision of the same service by multiple providers within the same agency at the same clock time;

(3) EIDBI provided in violation of medical assistance policy in Minnesota Rules, part 9505.0220;

(4) service components of EIDBI that are the responsibility of a residential or program license holder, including foster care providers under the terms of a service agreement or administrative rules governing licensure;

(5) adjunctive activities that may be offered by a provider entity but are not otherwise covered by medical assistance, including:

(i) a service that is primarily recreation oriented or that is provided in a setting that is not medically supervised. This includes sports activities, exercise groups, activities such as craft hours, leisure time, social hours, meal or snack time, trips to community activities, and tours, unless the activities in this item are primarily treatment oriented and provided pursuant to an ITP;

(ii) a social or educational service that does not have or cannot reasonably be expected to have a therapeutic outcome related to the child's diagnosis; or

(iii) prevention or education programs provided to the community;

(6) a service that is not identified in the child's ITP;

(7) a service provided pursuant to an ITP that has not been approved or updated as required by this section;

(8) a service not documented in the child's health service record or not documented in the manner required by this chapter or by Minnesota Rules, part 9505.2175;

(9) a service provided by an individual who does not meet the qualifications to render the service or by an individual for which the provider does not have documentation showing that the individual meets the required qualifications;

(10) a service that is primarily respite, custodial, day care, or educational;

(11) a service that replaces special education or related services defined in the child's individualized education plan (IEP) or individual family service plan (IFSP) when the service is available under the Individuals with Disabilities Education Improvement Act of 2014 through a local education agency;

(12) children's therapeutic services and supports reimbursed under section 256B.0943; or

(13) physical, speech, occupational therapies, or personal care assistance reimbursed under section 256B.0625.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 14. Minnesota Statutes 2014, section 256B.0949, is amended by adding a subdivision to read:

Subd. 15. **Service recipient rights.** (a) A child or the child's legal representative has the right to:

(1) participate in the development, implementation, and evaluation of all aspects of the child's and family's services;

(2) designate an advocate of the child's or the child's legal representative's choice to be present in all aspects of the child's and family's services at the request of the child's legal representative;

(3) know, in advance, the limits to services available from the provider to meet the child's and family's service and support needs, including limits in the knowledge, skills, and abilities of the provider agency;

(4) know the agency policy on assigning staff to individual children;

(5) know if the legal representative or another private party may have to pay for any charges;

(6) know the charges for services before the child or family receive services and receive advance notice if the charges change;

(7) know who shall pay for the services before services begin;

(8) know who is the qualified supervising professional with clinical responsibility for the child's ITP;

(9) know who to contact within the agency if the child or the child's legal representative has any concerns about the child's or family's services;

(10) receive a copy of the provider agency's admission criteria and policies and procedures related to temporary service suspension and service termination;

(11) receive reasonable accommodations to observe the child while receiving services;

(12) receive services from qualified and competent staff identified in the child's ITP;

(13) receive services in a manner that respects and takes into consideration the child's and family's culture, values, religion, and preferences;

(14) receive reasonable accommodations for observance of cultural and ethnic practices or religion;

(15) refuse or stop services and receive information about what might happen if the child or the child's legal representative refuses or stops services;

(16) access the child's and family's records as defined in federal and state law, regulation, or rule;

(17) be free from bias and harassment about race, gender, age, disability, spirituality, and sexual orientation;

(18) be free from physical, verbal and sexual abuse, and neglect;

(19) be free from restraint, time out, or seclusion, except when in imminent danger to self or others;

(20) be in the company of or under the supervision of a responsible adult at all times and ensure the hand-to-hand or eye-to-eye exchange of responsibility, as needed, from the staff member to the legal representative or adults designated by the child's parent or legal representative;

(21) be safe at all times;

(22) be treated with courtesy and respect;

(23) give or withhold written informed consent to participate in any research or experimental treatment without penalty or retaliation;

(24) have personal, financial, service, health, and medical information kept private;

(25) know if the provider agency gives the child's or family's private information to any other person or agency;

(26) assert all the rights in this subdivision without retaliation;

(27) receive respectful treatment of the child's or family's property;

(28) receive services in a clean and safe environment when the provider agency is the owner, lessor, or tenant of the property;

(29) receive a copy of the provider's written grievance policies and procedures;

(30) receive information about how to file a complaint regarding the child's or family's services, including how to file an appeal under section 256.045;

(31) receive contact information for disability advocacy services and the appropriate state-appointed ombudsman including the name, telephone number, Web site, e-mail, and street addresses;

(32) receive information about how to get a second opinion for medical necessity recommendations for EIDBI services and the child's ITP;

(33) receive prompt and reasonable response to questions and requests related to your child's or family's services;

(34) protect the recipient's personal privacy including, for children older than preschool, and younger children based on individual needs, the right to privacy when toileting and having personal cares performed; and

(35) receive notification from the provider agency within 24 hours if the child is injured while receiving services, including what occurred and how agency staff responded to the injury.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 15. Minnesota Statutes 2014, section 256B.0949, is amended by adding a subdivision to read:

Subd. 16. **Provider qualifications.** (a) "Level I treatment provider" means a person who is employed by an EIDBI provider agency and who:

(1) has at least 2,000 hours of supervised clinical experience or training in examining or treating children with ASD or equivalent documented course work at the graduate level by an accredited university in ASD diagnostics, ASD developmental and behavioral treatment strategies, and typical child development or an equivalent combination of documented course work or hours of experience; and

(2) has at least one of the following:

(i) a master's degree in behavioral health or child development or other fields including but not limited to mental health, special education, social work, psychology, speech pathology, or occupational therapy from an accredited college or university;

(ii) a bachelor's degree in a behavioral health or child development field from an accredited college or university and advanced certification in a treatment method recognized by the Department of Human Services; or

(iii) a board-certified assistant behavioral analyst with 4,000 hours of supervised clinical experience including meeting all registration, supervision, and continuing education requirements of the certification.

(b) "Level II treatment provider" means a person who is employed by an EIDBI provider agency and who has one of the following:

(1) a person who:

(i) has a bachelor's degree from an accredited college or university in a behavioral or child development science or allied field including but not limited to mental health, special education, social work, psychology, speech pathology, or occupational therapy; and

(ii) has at least 1,000 hours of clinical experience or training in examining or treating children with ASD or equivalent documented coursework at the graduate level by an accredited university in ASD diagnostics, ASD developmental and behavioral treatment strategies, and typical child development or a combination of coursework or hours of experience, or certification as a board-certified assistant behavior analyst from the National Behavior Analyst Certification Board or is a registered behavior technician as defined by the National Behavior Analyst Certification Board or is certified in one of the other treatment modalities recognized by the Department of Human Services;

(2) a person who:

(i) has an associate's degree in a behavioral or child development science or allied field including but not limited to mental health, special education, social work, psychology, speech pathology, or occupational therapy from an accredited college or university; and

(ii) has at least 2,000 hours of supervised experience in delivering treatment to children with ASD. Hours worked as a behavioral aide or developmental/behavioral support specialist may be included in the required hours of experience;

(3) a person who has at least 4,000 hours of supervised experience in delivering treatment to children with ASD. Hours worked as a mental health behavioral aide or developmental or level III treatment provider may be included in the required hours of experience;

(4) a person who is a graduate student in a behavioral science, child development science, or allied field and is receiving clinical supervision by a qualified supervising professional affiliated with an agency to meet the clinical training requirements for experience and training with children with ASD; or

(5) a person who is at least 18 years old and who:

(i) is fluent in the non-English language spoken in the child's home;

(ii) meets level III EIDBI training requirements; and

(iii) receives observation and direction from a qualified supervising professional or qualified level I developmental/behavioral professional at least once a week until 1,000 hours of supervised clinical experience is met.

(c) "Level III treatment provider" means a person who is employed by an EIDBI provider agency, has completed the DBSS level III training requirement, is at least 18 years old, and has at least one of the following:

(1) a high school diploma or general equivalency diploma (GED);

(2) fluency in the non-English language spoken in the child's home; or

(3) one year of experience as a primary PCA, waiver service provider, or special education assistant to a child with ASD within the previous five years.

(d) "Qualified supervising professional" or "QSP" means a person who is employed by an EIDBI provider agency and is:

(1) a licensed mental health professional who has at least 2,000 hours of supervised clinical experience or training in examining or treating children with ASD or equivalent documented course work at the graduate level by an accredited university in ASD diagnostics, ASD developmental and behavioral treatment strategies, and typical child development;

(2) a developmental or behavioral pediatrician who has at least 2,000 hours of supervised clinical experience or training in the examination or treatment of children with ASD or related conditions or equivalent documented coursework at the graduate level by an accredited university in the areas of ASD diagnostics, ASD developmental and behavioral treatment strategies, and typical child development.

(e) "Clinical supervision" means the overall responsibility for the control and direction of EIDBI service delivery, including individual treatment planning, staff supervision, progress monitoring, and treatment review for each client. Clinical supervision is provided by a QSP who takes full professional responsibility for the services provided by each of the supervisees. All EIDBI services must be billed by and either provided by or under the clinical supervision of a QSP.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 16. Minnesota Statutes 2014, section 256B.0949, is amended by adding a subdivision to read:

Subd. 17. **Provider agency responsibilities.** (a) The provider agency must:

(1) exercise and protect the client's rights;

(2) ensure services are client-centered and family-centered;

(3) ensure services reflect the values, preferences, culture, and language of the child and family;

(4) provide complete and current information in a manner that respects and takes into consideration the child's and legal representative's culture, values, religion, and preferences;

(5) allow people to make informed decisions concerning CMDE, treatment recommendations, alternatives considered, and possible risks of services;

(6) have a written policy that identifies steps to resolve issues collaboratively when possible;

(7) except for emergency situations, provide a minimum of two weeks' notice of transition from EIDBI services prior to implementing a transition plan with the family;

(8) use interpreters that are fluent in both languages and who have training or knowledge of necessary diagnostic and medical treatment terminology to convey the needed information to the child or the child's legal representative in a manner that allows informed consent by the child or the child's legal representative;

(9) provide notice as soon as possible when issues arise about provision of EIDBI services;

(10) provide the legal representative with prompt notification if the child is injured while being served by the provider agency. An incident report must be completed by the agency staff member in charge of the child. Copies of all incident and injury reports must remain on file at the provider agency for at least one year. An incident is when any of the following occur:

(i) an illness, accident, or injury which requires first aid treatment;

(ii) a bump or blow to the head; or

(iii) an unusual or unexpected event which jeopardizes the safety of children or staff including a child leaving the provider agency unattended;

(11) prior to starting services, provide the child or the child's legal representative written policy describing the provider's requirements about family participation, including the number of hours required and the consequences of inability to participate, if any; and

(12) prior to starting services, provide the child or the child's legal representative a plain-spoken description of the treatment method or methods that the child shall receive, including the staffing certification levels and training of the staff who shall provide the treatment or treatments.

(b) Within five working days of starting services and annually thereafter, provider agencies must provide the child, parent or legal representative with:

(1) a written copy of the child's rights and provider agency responsibilities;

(2) a verbal explanation of rights and responsibilities;

(3) reasonable accommodations to provide the information in other formats or languages as needed to facilitate understanding of the rights; and

(4) documentation in the child's file of the date that the child or the child's legal representative received a copy and explanation of the client's rights and responsibilities.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 17. Minnesota Statutes 2014, section 256B.0949, is amended by adding a subdivision to read:

Subd. 18. **Procedures when a child's rights are restricted.** Restriction of a child's rights under subdivision 15 is allowed only if determined necessary to ensure the health, safety, and well-being of the child, or to support the therapeutic goals in a child's ITP. Any restriction of those rights must be documented in the child's ITP. The restriction must be implemented in the least restrictive alternative manner necessary to protect the child and provide support to reduce or eliminate the need for the restriction in the most integrated setting and inclusive manner. The documentation must include the following information:

(1) the justification for the restriction based on an assessment of the child's vulnerability related to exercising the right without restriction;

(2) the objective measures set as conditions for ending the restriction;

(3) a schedule for reviewing the need for the restriction based on the conditions for ending the restriction to occur semiannually from the date of initial approval, at a minimum, or more frequently if requested by the child, the child's legal representative, if any, and case manager; and

(4) signed and dated approval for the restriction from the child or the child's legal representative, if any. A restriction may be implemented only when the required approval has been obtained. Approval may be withdrawn at any time. If approval is withdrawn, the right must be immediately and fully restored.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 18. Minnesota Statutes 2014, section 256B.0949, is amended by adding a subdivision to read:

Subd. 19. **EIDBI provider agency qualifications, general requirements, and duties.** (a) EIDBI agencies delivering services under this section shall:

(1) enroll as a medical assistance Minnesota health care programs provider according to Minnesota Rules, part 9505.0195, and meet all applicable provider standards and requirements;

(2) demonstrate compliance with federal and state laws and policies for EIDBI as determined by the commissioner;

(3) verify and maintain records of all services provided to the child or the child's legal representative as required under Minnesota Rules, parts 9505.2175 and 9505.2197;

(4) not have had a lead agency contract or provider agreement discontinued due to fraud, or not have had an owner, board member, or manager fail a state or FBI-based criminal background check while enrolled or seeking enrollment as a Minnesota health care programs provider;

(5) have established business practices that include written policies and procedures, internal controls, and a system that demonstrates the organization's ability to deliver quality EIDBI services; and

(6) have an office located in Minnesota.

(b) EIDBI agency providers shall:

(1) report maltreatment as required under sections 626.556 and 626.557;

(2) provide the child or the child's legal representative with a copy of the service-related rights under subdivision 15 at the start of services; and

(3) comply with any data requests from the department consistent with the Government Data Practices Act under chapter 13 and section 256B.27.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 19. Minnesota Statutes 2014, section 256B.0949, is amended by adding a subdivision to read:

Subd. 20. **Requirements for EIDBI provider agency infrastructure.** (a) To be an eligible provider agency under this section, a provider agency must have an administrative infrastructure that establishes authority and accountability for decision making and oversight of functions, including finance, personnel, system management, clinical practice, and individual treatment outcomes measurement. The provider agency must have written policies and procedures that it reviews and updates every three years and distributes to staff initially and makes available to staff at all times.

(b) The administrative infrastructure written policies and procedures must include:

(1) personnel procedures, including a process for:

(i) recruiting, hiring, training, and retention of culturally and linguistically competent providers;

(ii) conducting a criminal background check on all direct service providers and volunteers;

(iii) investigating, reporting, and acting on violations of ethical conduct standards;

(iv) investigating, reporting, and acting on violations of data privacy policies that are compliant with federal and state laws;

(v) utilizing volunteers, including screening applicants, training and supervising volunteers, and providing liability coverage for volunteers;

(vi) documenting staff time in a manner that allows matching of staff time records with service delivery records;

(vii) documenting that staff meet the applicable provider qualification criteria, training criteria, and clinical supervision requirements; and

(viii) arranging for qualified backup staff when the usual staff is not available;

(2) fiscal procedures, including internal fiscal control practices and a process for collecting revenue that is compliant with federal and state laws;

(3) quality assurance procedures including an annual, confidential family survey of satisfaction with services provided, including cultural appropriateness of services provided;

(4) a limited English proficiency (LEP) plan in compliance with title VI of the Civil Rights Act of 1965;

(5) communication and language assistance in compliance with national standards for culturally and linguistically appropriate services (CLAS), as published by the United States Department of Health and Human Services; and

(6) a process to establish and maintain individual client records. The records must include:

(i) the child's personal information;

(ii) forms applicable to data privacy;

(iii) the child's diagnostic assessment, if available; comprehensive multidisciplinary evaluation under subdivision 5; updates to any assessments or the CMDE; and results of tests, ITP, progress monitoring, and individual service plan;

(iv) documentation of service delivery, including start and stop times for each service;

(v) telephone contacts;

(vi) discharge plan;

(vii) documentation of other services received by the child, to the extent known by the EIDBI provider agency;

(viii) documentation that the child or the child's legal representative received a copy of the service recipient rights described in subdivision 15; and

(ix) insurance information, if applicable.

(c) EIDBI provider agencies must develop a staff orientation and training plan that documents compliance with this paragraph. Required training includes:

(1) Culturally Relevant Direct Care Services in Diverse Populations training recognized by the Department of Human Services. This training must be completed by all EIDBI agency direct service staff and individual providers;

(2) EIDBI agency policies and practices training. This training must be completed by all EIDBI direct service staff and individual providers and must cover the following topics:

(i) agency or provider policies, standards, and responsibilities;

(ii) individual provider roles and responsibilities;

(iii) client rights required under subdivision 15;

(iv) person-centered planning and service delivery under subdivision 6a;

(v) data privacy and collection;

(vi) fraud detection and prevention;

(vii) infection control;

(viii) maintaining professional boundaries;

(ix) mandated reporting of suspected maltreatment or abuse;

(x) roles and responsibilities of team members;

(xi) service documentation requirements and expectations; and

(xii) procedures related to restriction of a child's rights under subdivision 16; and

(3) EIDBI level III basic training. This training must be completed by all level III providers within six months of the date of becoming an enrolled individual MHCP EIDBI provider and documented in the personnel file maintained at the enrolled agency. Level III training must include:

(i) an overview of the EIDBI benefit. This includes a history of the EIDBI benefit, purpose, eligibility, provider standards and qualifications, and department-recognized treatment methods;

(ii) orientation to ASD that covers the core features of ASD and related conditions and comorbid conditions, red flags for atypical development in children, and understanding and supporting individuals with ASD and related conditions, including strategies to address challenges in cognition, social interaction, communication, behavior and sensory regulation, and other key functional areas of development;

(iii) positive behavioral support strategies;

(iv) working with families and caregivers; and

(v) understanding and supporting the ITP.

(d) The training components in paragraph (c) may be developed and provided by the provider agency if the components meet the requirements of paragraph (c), if the provider's training is approved by the commissioner.

EFFECTIVE DATE. This section is effective August 1, 2016.

Sec. 20. Minnesota Statutes 2014, section 256B.0949, is amended by adding a subdivision to read:

Subd. 21. **Commissioner's access.** When the commissioner is investigating a possible overpayment of Medicaid funds, the commissioner must be given immediate access without prior notice to the provider during regular business hours and to documentation and records related to services provided and submission of claims for services provided. Denying the commissioner access to records is cause for immediate

suspension of payment and terminating the agency provider's enrollment according to section 256B.064.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 21. Minnesota Statutes 2014, section 256B.0949, is amended by adding a subdivision to read:

Subd. 22. **Provider shortage; commissioner authority for exceptions.** (a) In consultation with the EIDBI advisory council, the commissioner shall determine if a shortage of qualified providers exists. A shortage means a lack of availability of providers that results in the delay of access to CMDE diagnosis or treatment of children with ASD and related conditions. The commissioner shall consider geographic factors when determining the prevalence of a shortage. The commissioner may determine that a shortage exists only in a specific region of the state, multiple regions of the state, or statewide.

(b) If the commissioner determines that a shortage exists under paragraph (a), the commissioner, in consultation with the EIDBI advisory council, shall establish processes and criteria for granting exceptions under this subdivision. The commissioner may grant exceptions to the following requirements:

(1) QSP or a level I, level II, or level III treatment provider qualification criteria in subdivision 16; and

(2) CMDE requirements in subdivision 5.

(c) When the commissioner determines that a provider shortage no longer exists, the commissioner shall submit a notice to the chairs and ranking minority members of the house and senate committees with oversight over health and human services. This notice shall be posted for public comment for at least 30 days prior to the termination of the exception authority.

EFFECTIVE DATE. This section is effective the day following final enactment.