Welcome to this Seminar

The Institute for Behavior Change is a nonprofit 501 (c) (3) foundation dedicated to providing EPSDT and other behavior support services to children. Visit us on the web at www.ibc-pa.org

Hello, I'm Steve Kossor, the Executive Director of the Institute for Behavior Change.

We're here today at the Children's Behavioral Health Center outside of Coatesville, Pennsylvania to have a seminar concerning "EPSDT" services, which are federally mandated treatment services for children, and the "Wraparound" philosophy of treatment which has unfortunately become confused with EPSDT services in the minds of a great many people.

It is my hope that EPSDT services will become more widely available to children throughout America, because in my experience, they are the single most effective means of delivering mental health and behavior support services to children.

I hope you enjoy the program, and that you'll contact the Institute for Behavior Change with your questions, afterward.

Thank you.

The Children's Behavioral Health Center is located about 30 miles West of Philadelphia and about 10 miles north of the Maryland border, where we provide free psychological evaluations to any Pennsylvania child under the age of 21 who has a behavioral or mental disability but who does not yet have Medical Assistance (Medicaid) benefits.

Our values:

Tell the truth

Be thankful

Help others

Share fairly

Move forward

a Federal **Entitlement**

vs.

a Treatment Philosophy

Steven Kossor, Licensed Psychologist
www.ibc-pa.org

The title of today’s presentation is “EPSDT versus Wraparound – a Federal Entitlement versus a Treatment Philosophy.” Further information about the EPSDT system and “wraparound” service philosophy can be found at the website of the Institute for Behavior Change: **www.ibc-pa.org** where the presenter of today’s program, Licensed Psychologist Steven Kossor, is the founder and Executive Director.

(the first Johnson Administration)

14th Amendment to the Constitution

All US citizens **[of any age]** *shall have* *equal protection under the law.*

rich or **poor**
rich or **poor**
rich or **poor**
rich or **poor**
rich or **poor**

The EPSDT system grew out of the American belief that all citizens are entitled to "certain inalienable rights," conferred by our Constitution.

Among these are life, liberty and the pursuit of happiness, for example.

When federal legislators create new programs for US citizens, they must do so within the boundaries set by the Constitution. One of the rights conferred by the US Constitution through the 14th Amendment is the right to "**equal protection under the law.**"

In the United States, we have a legislative history and a philosophy of government, dating all the way back to **18**68. saying that all US citizens, **regardless of their age**, and **regardless of their level of income**, are entitled to receive **equal benefit** and **equal protection** under the laws created by the United States government.

It's up to the Supreme Court to interpret the meaning of the 14th Amendment, but the **concepts** behind it are alive and well throughout the EPSDT regulations, as we shall see.

1965 (the second Johnson Administration)

"A great society protects its weakest members."

Medicaid is created as a joint federal and state program to finance health care treatment for diagnosed, episodic illness in low-income individuals.

It has no specific standards related to children.

In 1965, almost 100 years after the 14th Amendment was ratified, President Lyndon Baines Johnson was famous for declaring *"A great society protects its weakest members."* This declaration of a so-called "Great Society" was the foundation for the creation of **Medicaid.** In the words of the legislators who created it, *Medicaid is created as a joint federal and state program to finance health care treatment for diagnosed, episodic illness in low-income individuals."*

Notice that it had **no specific standards** related to children in **1965**.

1965

Medicaid:

To provide **Medically Necessary** treatment to those who need it.

Requires no Federal Reauthorization.

It's forever.

In 1965, Medicaid was created to provide Medically Necessary treatment to those who need it.

It requires no Federal Reauthorization, like the *Individuals with Disabilities Education Act* that requires periodic reauthorization by congress.

Medicaid is [functionally] **forever.**

Is it *Reasonable?*

Is it *Necessary?*

Is it *Appropriate, according to evidence-based practices?*

Then it's ***Medically Necessary.***

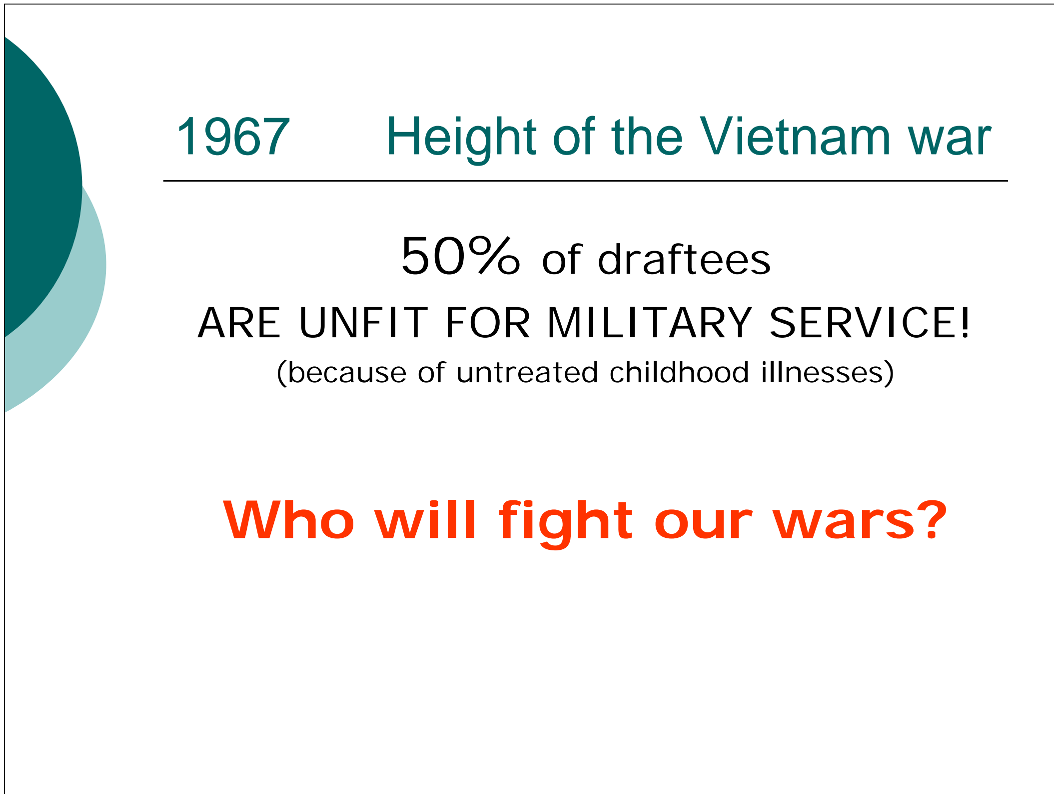
Each state is permitted to create its own variation on the federally-defined theme of what constitutes "medically necessary" treatment. Some create more obstacles to Medicaid and EPSDT services than others, but the right prescriptive language can overcome most obstacles.

In 1965, the definition of "Medical Necessity" was very simple: Is it reasonable? Is it necessary? and Is it appropriate, according to evidence-based practices?

If so, then it's Medically Necessary, under the 1965 Medicaid statute.

Each state is permitted to create its own variation on the federally-defined theme of what constitutes "medically necessary" treatment.

Some states create more obstacles to Medicaid and EPSDT services than others, but the right prescriptive language can overcome most obstacles.



In 1967, during the height of the Vietnam war, it was discovered that **half** of the children appearing at military induction centers (draft boards) were **unfit for military service.**

They were unfit because of undiagnosed and untreated childhood illnesses.

This sent shock waves through the halls of Congress, as the legislators asked ***Who will fight our wars?***

If HALF of our children are unfit for military service, due to undiagnosed and untreated childhood illnesses, ***something <u>must</u> be done!***

And that's the climate and rationale that EPSDT services were born into. All the way back in **1967.**

For children under 21 years of age:

Question: *Is it intended to correct or ameliorate defects & physical & mental illnesses and conditions discovered by the screening process**?***

Yes? Then it's **"Medically Necessary."**

Each state is permitted to create its own version of the "medically necessary" treatment definition, but all states are required to comply with the federal EPSDT standard in order to continue accessing federal Medicaid funds.

EPSDT services were created to provide Early, Periodic Screening, Diagnosis and Treatment for children under 21 years of age. A very important **new definition** of "Medical Necessity" was created just for the EPSDT program:

A simple question is asked: *Is it intended to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening process?*

If the answer to that question is "yes." then it is **Medically Necessary**. In other words: **If it helps, then it's Medically Necessary**, according to the EPSDT regulations.

The word **"ameliorate"** means **"to prevent"** or **"reduce,"** so the new definition for Medical Necessity that was created by the EPSDT program includes **prevention** *as well as* **corrective** treatments. Although each state can create its own version of the "medically necessary" treatment definition, **all states** are *required* to comply with the federal EPSDT standards. These standards require that services must be ***"sufficient in amount, duration and scope to reasonably achieve their purpose"*** (as defined by the **prescriber**, not a government employee or Managed Care Organization's "reviewer"). Those standards can be found in Title 42 of the Code of Federal Regulations, Chapter IV Part 440. Let's look carefully at that now….

- Treatment AND **Prevention** services
- Physical, Speech & Related Therapies
- Hearing Services
- Eye Examinations & Eyeglasses
- Durable Medical Equipment
- Home, Residential & Inpatient Care
- Dental Care
- Other Services (including **mental health care**)

The remainder of this presentation will focus on the *mental health and Behavioral Health Rehabilitation Services* that can be delivered to disabled children through the EPSDT system. See 42 USC §1396d (r) 5.

This presentation will focus now on just the "**Behavioral Health Rehabilitation Services**" aspect of EPSDT, but EPSDT covers so much, much more, as you can see.

The following text appeared on the **Health Resources and Services Administration** (**HRSA**) website on 6/3/2007, regarding "**Medical Necessity"** under EPSDT

(See http://www.hrsa.gov/epsdt/medical.htm for the complete document):

*"In a report prepared for the federal Health Care Financing Administration (HCFA), now known as the Centers for Medicare and Medicaid Services – CMS), Rosenbaum and Sonosky described the EPSDT **medical necessity** standard as follows:*

While there is no federal definition of preventive medical necessity, federal amount, duration and scope rules require that coverage limits must be sufficient to ensure that the purpose of a benefit can be reasonably achieved… Since the purpose of EPSDT is to prevent the onset or worsening of a disability and illness in children, the standard of coverage is necessarily broad… the standard of medical necessity used by a state must be one that ensures a sufficient level of coverage to not merely treat an already-existing illness or injury but also, to prevent the development or worsening of conditions, illnesses, and disabilities."

Definitions
For purposes of this subchapter—

(a) Medical assistance

The term "medical assistance" means payment of part or all of the cost of the following care and services ...

(if provided in or after the third month before the month in which the recipient makes application for assistance) ...

for individuals who are—

(i) under the age of 21, or, at the option of the State, under the age of 20, 19, or 18 as the State may choose,
...

Where does EPSDT law "live?"

The Social Security Act is the "big umbrella" **statute** under which **Medicaid** exists (see http://www.ssa.gov/OP_Home/ssact/title19/1902.htm to start your review; EPSDT is covered at 1905a (r) 5).

EPSDT is a mandatory part of **Medicaid**. EPSDT **regulations** are found at 42 CFR Part 440.40 (see http://www.access.gpo.gov/nara/cfr/waisidx_02/42cfr440_02.html).

The slide shows the language of the Social Security Act (also referred to as "42 CFR §1396a" that created "Medical Assistance" as part of the Medicaid statute in 1967. This is the **law** in all 50 states.

Notice that it permits children to receive Medical Assistance benefits (funding for necessary treatment) for up to **three months** <u>before</u> they are determined to be *eligible* for Medical Assistance.

In other words, **the federal Medicaid statute** permits children to receive Medical Assistance benefits for up to **three months** *before* they get official approval for the Medicaid benefits that they are eligible for, because of a disabling condition. Pennsylvania complies with this federal law (no surprise there, right?). It's called the "**presumptive eligibility**" standard.

(r) Early and periodic screening, diagnostic, and treatment services

(5) Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, **whether or not such services are covered under the State plan.**

Nothing in this subchapter shall be construed as limiting providers of early and periodic screening, diagnostic, and treatment services to providers who are qualified to provide all of the items and services described in the previous sentence or as preventing a provider that is qualified under the plan to furnish one or more (but not all) of such items or services from being qualified to provide such items and services as part of early and periodic screening, diagnostic, and treatment services.

Here is the actual language that mandates **EPSDT mental health treatment services** in all 50 states. They're called "**Behavioral Health Rehabilitation**" services in Pennsylvania and are described more thoroughly at **42 USC Chapter IV 440.130**.

Notice that it specifies the definition of "Medical Necessity" and says that the treatment services must be provided **"whether or not such services are covered under the State plan."** The term **"Medical"** in the Medicaid statute refers to the services provided by a **licensed practitioner of the healing arts** (psychologists and psychiatrists are **always** covered, and in some states, social workers).

In other words, it doesn't matter whether the prescribed services are part of any "State plan" for its residents – **all** Medicaid recipients under the age of 21, regardless of the state in which they live, are entitled to these EPSDT "Behavioral Health Rehabilitation" services.

EPSDT service providers **do not** have to deliver the *full range* of EPSDT services. This means that **licensed psychologists** can participate in the EPSDT system to deliver "Behavioral Health Rehabilitation" services **without** having to also provide dental, or hearing or vision or medical services.

42 CFR Chapter IV Part 440.130

(a) ''**Diagnostic services**,'' except as otherwise provided under this subpart, includes any medical procedures or supplies recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, to enable him to identify the existence, nature, or extent of illness, injury, or other health deviation in a recipient.

(c) ''**Preventive services**'' means services provided by a physician or other licensed practitioner of the healing arts within the scope of his practice under State law to

(1) Prevent disease, disability, and other health conditions or their progression;

(2) Prolong life; and

(3) Promote physical and mental health and efficiency.

(d) ''**Rehabilitative services**,'' except as otherwise provided under this subpart, includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level.

This slide shows that **Behavioral Health Rehabilitation Services** MUST be available, according to the **mandatory** federal Medicaid statute, **in every state in the nation.**

This is where Pennsylvania got the mandate and the authority to create what they call "**Behavioral Health Rehabilitation Services**" as part of the EPSDT (Medicaid) program.

Every other state could, <u>and should</u> implement the exact, same BHRS programs as those implemented in Pennsylvania under this Statute because:

- They are **effective** and **cost-efficient** when implemented properly **under the direct supervision and control of *licensed professional psychologists***
- **Licensed psychologists** are *"qualified practitioners of the healing arts"* in every state where Medicaid is administered.

Any state that hasn't yet implemented these BHRS programs can be **compelled to** with relative ease, because

- these programs have been implemented **successfully** and **cost-efficiently** in Pennsylvania by the staff of **the Institute for Behavior Change** since **1997.**

EPSDT services <u>must</u> be provided,
to children enrolled in Medicaid
whether or not the services are
provided for in the State Plan.

EPSDT services <u>must</u> be provided
in every State.
in every State.
in every State.
in every State.

Since **1989**, Congress has affirmed that EPSDT services must be made available to children in all 50 states, and Washington DC, Puerto Rico, the Virgin Islands, and Samoa.

Under Medicaid Law and the Individuals with Disabilities Education Act (IDEA), **Medicaid**, *not the school system* must pay for covered services to a child, *even when these services have been found necessary and included in the child's Individual Education Plan (IEP) or Individual Family Service Plan (IFSP).* Behavioral Health Rehabilitation Services (BHRS) can **always** be provided to a child during school hours if it is needed and prescribed by a licensed practitioner of the healing arts (just like *medication* to treat a physical or mental illness), **whether or not** the child has a 1:1 aide provided by the school district.

See 42 U.S.C. § 1396b(c) and §612(a)12) of the amendments of 1997 to IDEA, 20 U.S.C. §1400

See also the Bazelon Center for Mental Health Law Policy Analysis #5 (1997): **Defining Medically Necessary Services to Protect Children** available at **www.bazelon.org**

EPSDT services <u>must</u> be provided at no cost to Medicaid <u>children</u> who are <u>disabled</u>

rich or **poor**.

This is the 14th Amendment and OBRA '89 in Action.

Pennsylvania is one of 37 states that do not measure the "assets" of children who are applying for Medicaid – **their family's income doesn't count.**

Pennsylvania is also one of a few states which does not "count" the income of the family to determine Medicaid eligibility for disabled children.

A disabled child in Pennsylvania is considered "a family of one" if the words "DISABLED CHILD ONLY" are printed on the application for Medicaid (Medical Assistance) benefits.

Almost EVERY disabled child is eligible for Medicaid…

The disabled CHILD is the recipient of Medicaid, so

the disabled *CHILD's* income must be used to determine Medicaid eligibility.

Medicaid is available to fund the treatment needs of virtually every disabled child in America, rich or poor,
even if the 14th Amendment didn't exist.

In Pennsylvania and 37 other states, the **family's** income (the child's "assets") is not counted. There is no "asset test" for Medicaid eligibility in these states.

There is also an "income" test to determine eligibility for Medicaid. Your income must be near to (or below) the Federal Poverty Level (FPL). The limit varies from state to state.

However: Since the disabled **child** is the recipient of Medicaid benefits, the disabled **child's** income must be used to determine the child's eligibility for Medicaid benefits!

Since virtually every **child's** income is below the Federal Poverty Level, virtually every **child** is eligible for Medicaid, and certainly every **disabled** child!

EPSDT is "a program within a program"

"EPSDT is Medicaid's 'comprehensive and preventive child health program for individuals under the age of 21.' Designed to promote child health and development as well as treat diagnosed illness, EPSDT has a striking scope of coverage. Under EPSDT Medicaid children are entitled to health care screenings and access to all Medicaid-covered services they are found to need, regardless of any Medicaid benefit restrictions imposed on adult beneficiaries by their state. The range and depth of services provided under EPSDT, coupled with a **unique medical necessity standard**, has resulted in an unparalleled and comprehensive health benefit package for children."

National Health Policy Forum Issue Brief No. 819 November 20, 2006 www.nhpf.org

IMPORTANT: All of the references to **"EPSDT services"** in this presentation refer equally to **Behavioral Health Rehabilitation ("BHR") Services** because they are an inseparable **part** of EPSDT and Medicaid.

BHR services are covered under 42 USC Chapter IV Part 440.130 relating to "**Diagnostic**, **Preventive**, and **Rehabilitation**" services that exist within the EPSDT regulations.

Like the rest of the "Part 440" regulations, these are **mandatory** services within the EPSDT program, but not all states have yet included them in their implementation of EPSDT services. Eventually, someone will insist that BHR Services must be added to a State's implementation of the Medicaid regulations, and they will be installed there, too. It's inevitable. It's been happening in one state after another, in fact, as word gets out about the value and effectiveness of these "**BHR" Services.**

Citizens have been **successfully** challenging State implementations of the Medicaid statute since 1967 based on a lack of **access** to services, and a lack of **quality** services. They almost always win, because the federal Medicaid statute is so broadly defined as providing mandatory **preventive** as well as **treatment** and **rehabilitative** programs – *precisely* what BHR Services provide.

STATEMENT OF POLICY DEPARTMENT OF PUBLIC WELFARE
OFFICE OF MEDICAL ASSISTANCE PROGRAMS
[55 Pa. Code Chapter 1101] General Provisions

§1101.21a. Clarification Regarding the Definition of "Medically Necessary" – statement of policy.

A service, item, procedure or level of care that is necessary for the proper treatment or management of an illness, injury or disability is one that:

(1) Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.

(2) Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.

(3) Will assist the recipient to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the recipient and those functional capacities that are appropriate of recipients of the same age.

Pennsylvania, like all other states, must adhere to the federally prescribed definition of what constitutes "**Medically Necessary**" treatment.

In other words:

- if it **probably** will help to prevent the onset of a disability, **it's medically necessary.**
- if it **probably** will help to reduce or lessen the effects of a disability, **it's medically necessary.**
- if it **probably** will help a child achieve or maintain "maximum functional capacity" in daily activities, **it's medically necessary.**

This definition applies to "Behavioral Health Rehabilitation Services," just like all of the *other* EPSDT services.

Relationship between “levels of need” and PA DPW “medical necessity” criteria

The relationship between Appendix T and TSS Prescribing Practices: As preferred by MCOs vs. Appendix T-literate Practitioners

GAF (Axis V)	Severity Level	Appendix T level	Managed Care’s “standard” For TSS services	Appendix T “standard” For TSS Services
55-65	Mild	Level I	5 hours per week	5 – 100+ hours / week
45-54	Moderate	Level II	10 hours per week	5 – 100+ hours / week
30-44	Severe	Level III	15 hours per week	5 – 100+ hours / week
Below 30	Emergency	Level IV	> 20 hours per week	5 – 100+ hours / week

A child who is presently at functioning at “Level I” (**mild** disability) can require a ***great deal*** of professional support to **prevent** his/her deterioration to a greater level of need.

Since EPSDT is supposed to be a **preventive** service, it may be necessary for a licensed practitioner to prescribe a substantial amount of EPSDT BHR service, including “TSS” service, to a child at ***any*** “level” of need. Levels of need can change quickly and dramatically, as we all know, especially in children. Some professionals’ opinions are highly influenced by the preferences of their employer. Accordingly, the Pennsylvania Department of Public Welfare (DPW) “Medical Necessity” guidelines (Appendix T of the Health Choices RFP) do **NOT** specify *any* particular **amount** of “TSS” or other EPSDT BHR service that a child can receive based on his or her “level” of functioning.

Some people certainly disagree with this, but fortunately, they aren’t *allowed* to change State or Federal Medicaid regulations to impose inappropriate, arbitrary limits on a child’s **access** to EPSDT BHR services that have been prescribed by a licensed practitioner of the healing arts in the State, **especially** when the prescription is based on **research** (such as the Report of the *National Academy of Sciences* called Teaching Children with Autism, for example) and **current behavioral data**.

2005 The Deficit Reduction Act (DRA)

Children will… *"still be entitled to receive EPSDT benefits in addition to the benefits provided by the benchmark coverage..."*

The Centers for Medicare and Medicaid Services (CMS) "will not approve any state Medicaid plan that does not include the provision of EPSDT benefits."

CMS Administrator Mark B. McClellan, "Statement on EPSDT Coverage for Children Under 19," April 2006. Available at www.tilrc.org/Real%20Choice%20Website/epsdt0406htm.

So, let's look at the recent history of challenges to the federal mandate of EPSDT services. In 2005, a proposal to create "benchmark" coverage was advanced, but Congress warned that the EPSDT benefits must not be deleted if "benchmark" coverage is enacted in any state. The Centers for Medicare and Medicaid Services (CMS) specifically prohibited, in writing, *any interference with EPSDT services.*

The "track record" of challenges to the EPSDT statutes since 1967 is clear: The mandate for EPSDT services has **always** been upheld, **and strengthened**. That applies to Behavioral Health Rehabilitation (BHR) Services as well.

In 2005 another proposal was made (unsuccessfully) to place all BHR services under the control **only** of licensed professionals, who would be **obligated** to collect outcome data regarding treatment progress. ***Great idea!***

The Institute for Behavior Change has been **doing** both of these things **since 1997** and **supports** legislative efforts like this that are aimed at improving the quality of services delivered under the EPSDT regulations. There is no doubt that these are **good** ideas that will, hopefully soon, find their way into the EPSDT regulations.

DRA sponsors weigh in on EPSDT

Sen. Charles Grassley (R-IA), chairman of the Senate Committee of Finance, and **Rep. Joe Barton (R-TX)**, chairman of the House Committee on Energy and Commerce (Sponsors of the DRA) state in a 2005 letter to Health and Human Services Secretary Michael Leavitt that:

EPSDT benefits are *"not an option"* and that *"Congress intended to make no changes to EPSDT coverage."* They assert also that EPSDT remains "a *required benefit to all individuals under the age of 19 who have been determined eligible for Medicaid and, if the state elects to provide coverage up to the age of 21."*

Available at: www.senate.gov/~finance/press/Gpress/2005/prg033006b.pdf

Even die-hard conservatives have recognized the value of the EPSDT system.

Prevention is always better than correction after-the-fact, especially in the lives of children.

Behavioral Health Rehabilitation ("BHR") Services under EPSDT are the most **cost-efficient**, **effective means** of providing children with mental health and behavioral support services that has ever been devised.

As part of the EPSDT system, BHR Services *"are not an option"* and should be insisted upon by parents and advocates in **every** State where they do not already exist.

42 CFR Chapter IV Part 440.230

(b) Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.

(c) The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service […] to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition.

(d) The agency may place appropriate limits on a service based on such criteria as medical necessity or on **utilization control procedures**. **Here enters the MCO**

By 1997, States were awash in red ink over the Medicaid program. EPSDT services were costing a fortune – much more than anticipated.

But what to do. These services are **federally mandated**…. Every parent had the legal right to choose the provider of EPSDT services for their child, and there were some pretty unscrupulous people running around prescribing some pretty outrageous "services" – that **all** had to be paid-for under the EPSDT mandate.

The bright idea: A federal **waiver** of the "parental choice" provision of the Social Security Act was created, allowing Managed Care Organizations into the EPSDT system. We all know what "Managed Care" has done to the health care system. Hindsight is 20/20….

Despite all of their bluster and protest, **every** State and **every** Managed Care Organization is **obligated** to comply with the federal EPSDT statutes. **Period.** They just need to be shown **how** to do it **successfully** and **cost-efficiently.** Putting licensed professional psychologists in charge of BHR Services is a great way to improve quality and reduce costs, and that's where **the Institute for Behavior Change** comes in. We've been doing precisely that since 1997 and we want to help psychologists in other States to accomplish the same things….

Managed Care Organizations can create "networks" of providers to deliver EPSDT services, and can "close" those networks when they believe they have enough providers in them…

… but a professional service provider with expertise in an area that is not yet already well-represented in the network, (such as a psychologist who specializes in "developmental disability" or "mental retardation" or "autism") may be in a very strong position to lobby for admission to the network, even if it's been "closed."

The waiver of the **parent's right to choose a provider of EPSDT services** allows State and other governmental entities to permit Managed Care Organizations to create "networks" of providers.

Although "parental outreach" to advertise the availability of EPSDT services (this would include BHR services) has been **required** under EPSDT regulations since 1967 and **re-emphasized by Congress** in **1972**, **1981** and again in **1989**, most people remain unaware that EPSDT BHR services **exist,** that they **work,** and that they're **free**.

Government officials, Managed Care Organizations and their "in network" providers of EPSDT providers usually deny that any additional parental outreach efforts are necessary.

Use of the "parental outreach" EPSDT mandate should make it possible for more enterprising (and well-informed) new practitioners to enter "closed" networks.

EPSDT Outreach & Family Support

Outreach and family support requirements were added in **1972** and **1981** to promote access to EPSDT services….

Yet, far too few people know that:

EPSDT BHR services exist,

They're Free,

and they work!

To see if there is a need for EPSDT BHR services in a given area, use this simple two-step formula:

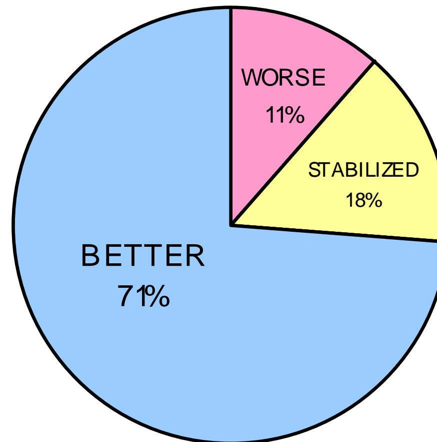
1. Count the population of children receiving Medicaid in a given area.
2. Multiply that number by 15% (a conservative estimate).

The result is the **minimum** number of children **on Medicaid** who ***qualify*** for mental health treatment services, **based on mental illness symptom prevalence** according to the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2006. SAMHSA has posited a rate as high as **20%**, in fact.

They Work!

300 Treatment records 2002-2006 Children ages 2-17

Overall Treatment Effectiveness



Once each week, the child's parent is asked to rate their child's level of involvement in "target behavior" (behavior "targeted" for improvement) on a scale from 1 to 10.

The **frequency** of the child's involvement in the behavior is measured, as well as the **severity** of the child's involvement in the "target behavior" using the same 10 point scale.

The question is posed by the child's **Behavior Specialist Consultant**, who has intimate familiarity with the child's treatment plan and the staff who are providing the EPSDT services.

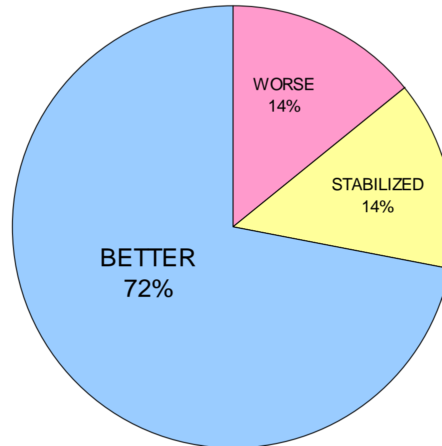
The average of these two ratings is computed, for each "target behavior" under study, and the result is graphed so that week-to-week changes can be seen easily.

All of the children in treatment were showing **significant** behavioral problems, with **deteriorating** behavioral profiles, prior to the start of EPSDT services. The pie chart shows the results of 300 "target behavior" treatment records between 2002 and 2006 for children between 2 and 17 years of age, with various diagnoses including autism, disruptive behavior disorders, ADHD and Pervasive Developmental Disorders. **71%** had lower involvement in "target behavior" and **18%** more showed no worsening of "target behavior" -- an overall **success rate** of 89% **in four months**.

They Work!

300 Treatment records 2002-2006 Children ages 2-17

Physical Aggression



Physical Aggression is one of five primary areas that the staff of the Institute for Behavior Change targets for intervention. Obviously, it is key to establishing age-appropriate peer relationships and safety in interpersonal relationships.

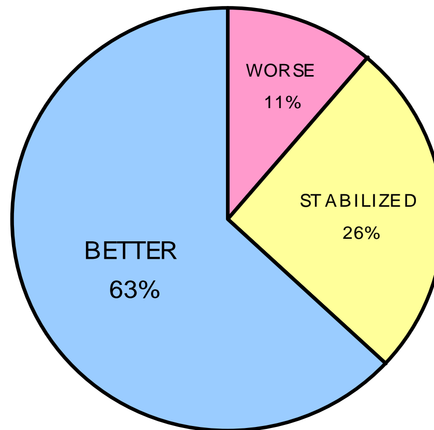
72% showed **less** physical aggression.

14% showed **no further deterioration** in regard to physical aggression.

Overall, **86% success** in response to EPSDT services in just **four months**, based on **parental assessment of progress.**

They Work!

300 Treatment records 2002-2006 Children ages 2-17



The ability to communicate effectively is central to the development of functional capacity in children. This is an area of primary concern to parents of children with Autism spectrum disorders, and rightly so. When approached from a behavioral perspective, communication deficits can be addressed successfully through the EPSDT system.

63% showed **less difficulty** with communication at an age-appropriate level.

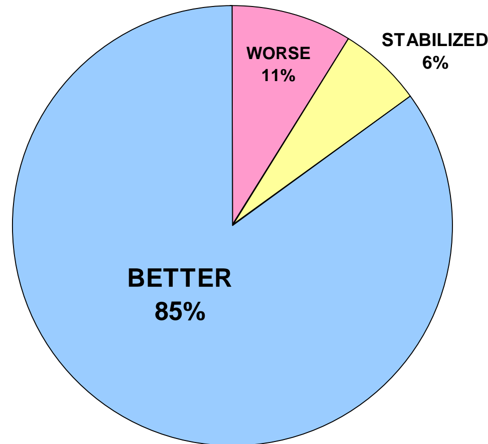
26% showed **no further deterioration** in communication skills.

89% success in addressing deteriorating communication skills, **in four months**, based on **parental assessment of progress.**

They Work!

300 Treatment records 2002-2006 Children ages 2-17

Lack of Safety Awareness



Impairment in safety awareness, including a lack of traffic safety, elopement risks (running away, leaving assigned areas without the knowledge of caretakers) creates terrifying scenarios for parents and the Institute for Behavior Change works with law enforcement authorities, community groups and teachers, as well as the child and his/her parents to implement successful training programs to improve the child's safety awareness.

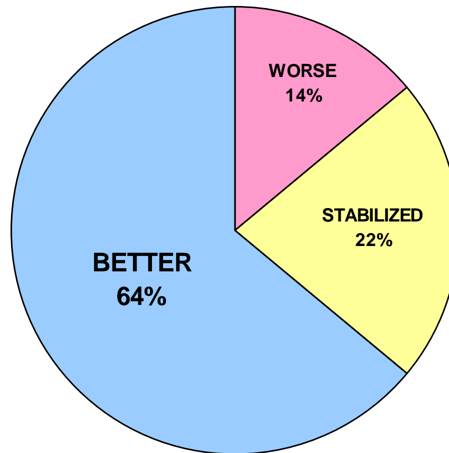
85% showed **better** safety awareness.

6% showed **no further deterioration** in environmental safety skills.

91% success in addressing environmental safety, **in four months**, based on **parental assessment of progress.**

They Work! 300 Treatment records 2002-2006 Children ages 2-17

Socialization Deficits



Improvement in socialization skills in children can be one of the most time-consuming and difficult undertakings in the field of children's mental health. It is central to the treatment of children with Autism and Pervasive Developmental Disorders. The Institute for Behavior Change specializes in this area of treatment.

64% showed **better** socialization skills.

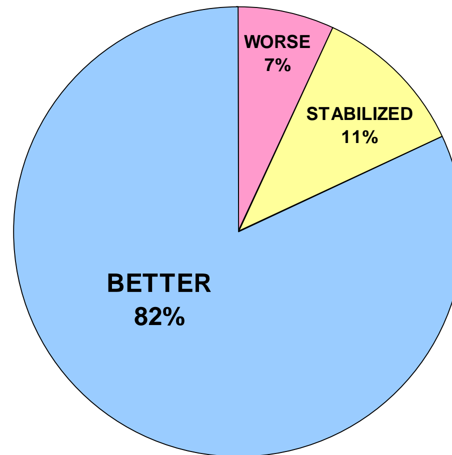
22% showed **no further deterioration** in socialization skills

86% success in addressing socialization skills, **in four months**, based on **parental assessment of progress.**

They Work!

300 Treatment records   2002-2006   Children ages 2-17

Noncompliance with Adult Prompts



If a child doesn't comply with adult prompts in school, the child can't learn. If the child doesn't comply with adult prompts at home, the child can't socialize safely with others. Children need to be responsive to adult prompts so that they can have access to the **teaching**, **training** and **support** of adults who care for them. This is a primary focus within the EPSDT behavioral health rehabilitation support program.

82% were more compliant with adult prompts.

11% showed no further deterioration in their responsiveness to adult prompts.

93% success in addressing responsiveness to adult prompts, **in four months**, based on **parental assessment of progress.**

treatmentplansthatworked.com

has more than 150 "treatment plans that worked" available on-line for download
– with the data that documents it.

A 2-year subscription with unlimited access (including *loads* of information on EPSDT and especially "BHR" mental health treatment services) is $65

If EPSDT BHR services are mandatory in all 50 states, Washington DC, Puerto Rico, the Virgin Islands and Samoa, and

if "Medically Necessary" treatment **must** be delivered under EPSDT to any child who needs it, and

if our treatment methods **work** and we can **prove it** with data collected *from the parents* of children who received our help, then

Our treatment methods **(Behavioral Health Rehabilitation Services)** can become "mandatory" in all 50 states, Washington DC, Puerto Rico, etc.

Any professional can download our "treatment plans that worked," with the data **proving** that they "worked," and the **treatments** described in those plans are **therefore** "medically necessary."

PA Medicaid (MA) Eligibility Screening

An evaluation by a licensed practitioner of the healing arts…

- Psychiatrist
- Physician
- Licensed Psychologist

and in Pennsylvania, the MA eligibility evaluation can be done by a

- School Psychologist

Since Pennsylvania **can be** a model for **all other states**, here's how EPSDT **Behavioral Health Rehabilitation Services** are being done here by the Institute for Behavior Change staff.

If the right person does it, this same MA Eligibility Screening can result in a:

Prescription for EPSDT services

Including "Behavior Specialist" and/or "Mobile Therapy" services

without having to ask anyone's permission (except the child's parent) and funded 100% by the State Department of Public Welfare under the Medical Assistance (Medicaid, EPSDT) program.

http://www.ssa.gov/OP_Home/ssact/title19/1905.htm

First, you establish whether or not the child is likely to be eligible for Medical Assistance (Medicaid) benefits in your state.

Most states have no "asset" test **(the child's family's income doesn't count).**

Pennsylvania and some other states determine eligibility on the basis of the **child's** income, and almost all children are below the Federal Poverty Level, **so they qualify.**

Any child who gets "SSI" benefits qualifies for Medicaid.

A person under the age of 19 (up to 21 in most states) with a condition that is listed in the Social Security disability "Blue Book" is considered a "disabled child" under Medicaid.

PA Prescriptions for EPSDT services

Behavior Specialist Consultant (BSC)
- licensed or unlicensed psychologist
- Masters or Doctoral degree "in a clinical field"
- One year of experience working with children
  - Philadelphia requires 2 years **post-graduate** experience

Mobile Therapist (MT)
- licensed or unlicensed psychologist
- Masters or Doctoral degree "in a clinical field"
- One year of experience working with children

BSC and MT providers are supervised closely each week by licensed psychologists at the Institute for Behavior Change in Pennsylvania.

See http://www.ibc-pa.org/job_descriptions.htm for more information.

"**Behavioral Health Rehabilitation Services**" in Pennsylvania include "Behavior Specialist Consultant" services and "Mobile Therapy" services. These **EPSDT services** have become confused in the minds of many people with so-called **"wraparound"** services. There are significant differences, as we shall see.

Most states that have responded to the EPSDT mandate for "preventive" and "rehabilitation" services that is found in 42 USC Chapter IV Part 440.130 have created "Mobile Therapy" services. However, "**Behavior Specialist Consultant**" and "**Therapeutic Staff Support**" services can *also* be created **in any state** under **EPSDT.**

If a licensed psychologist (or any other "licensed practitioner of the healing arts") **in any given state** prescribes "Behavior Specialist Consultant" or "Mobile Therapy" or "Therapeutic Staff Support" services, **under the EPSDT mandate** those services **must** be provided in that state, and funded through **Medicaid**, **whether or not those services are part of the "State plan."** This is especially true if treatment outcome data shows that these types of services **work** and that **they're cost-effective.**

This is *precisely* what the Institute for Behavior Change provides via its website and through **Treatmentplansthatworked.com.**

PA Interagency Team Meeting (ITM)

The Team:

A parent (preferably both)
The prescribing practitioner
A service provider representative
A County representative

1. The Team agrees with the prescription.
2. The Team signs necessary paperwork.
3. The EPSDT services start.

The procedures will vary from state-to-state, but the basic requirements are:

1. An evaluation by a licensed mental health professional, including a face-to-face visit with the child, finds a disability.

2. A licensed mental health professional prescribes a treatment program that will probably reduce ("ameliorate") the condition identified in the evaluation.

3. The family is given a choice of providers of the treatment prescribed by the licensed mental health professional.

4. The family participates in the planning of the treatment program. The child participates actively in this process to the greatest extent possible.

5. A licensed mental health professional who is enrolled in the State Medicaid program supervises the delivery of the treatment services and collects outcome data.

6. The services rendered under the supervision of the licensed mental health professional are billed to and paid by the State Medicaid plan.

7. The child improves, as shown by the data collection process, or the treatment plan is amended so that the probability of improvement exists.

8. When the child attains age 21, or has improved sufficiently so that no EPSDT treatment remains necessary, the child is discharged from treatment.

PA Time Line |---x------------------|

Evaluation data is collected by a Psychologist's Assistant before the child meets the psychologist. The evaluation report is begun in draft format by the Psychologist's Assistant.

This data can be collected by mail, over the telephone, or by other correspondence.

Procedures may vary from state-to-state and from county-to-county, but since these are **EPSDT services** delivered under the federal **Medicaid** statute, State and County officials have **limited ability** to interfere with, impede or obstruct the process (restrict the "amount, scope and duration of services") without jeopardizing federal Medicaid funding **and** federal penalties related to interference with delivery of EPSDT services under **42 USC Chapter IV Part 440.230**

Under Medicaid *"services must be sufficient in amount, scope and duration to achieve their intended purpose."*

The licensed psychologist sees the child face-to-face and completes the evaluation by making diagnoses and recommendations for any necessary treatment, including EPSDT services. The psychologist also completes the child's initial Treatment Plan if EPSDT services are recommended.

The psychologist's final evaluation report can be written later.

By seeing the child face-to-face, and taking full responsibility for the content of the bio-psycho-social evaluation that finds the child to be a person with a disability who is in need of treatment, the licensed practitioner virtually guarantees that the child will be found eligible for the treatment services by a Managed Care Organization or other reviewer.

By personally participating in the development of the Treatment Plan, the validity of the Plan as a means of delivering the EPSDT services that are "prescribed" in the evaluation is assured.

Regulations do not require that the psychologist's evaluation report or "prescription" needs to be typewritten – handwritten and signed documents are permissible to "get things started" without unnecessary delay, with complete preparation of the child's clinical chart (including printed documents) within a reasonable period of time.

PA Time Line |-------------------x---|

If EPSDT services are prescribed, the Interagency Team meets to discuss and finalize the initial Treatment Plan.

Behavior Specialist Consultant and Mobile Therapy services can begin as soon as the Treatment Plan and other ITM documents are signed.

State or County officials may require the attendance of a “County representative” at the initial Interagency Team Meeting (or the signature of a designated County representative), but the signature of the State or County representative cannot be “unreasonably withheld.”

A competently presented prescription and treatment plan proposal by a licensed mental health professional at an Interagency Team Meeting that includes at least one parent if the family is intact (and the child whenever possible) will **almost certainly** be signed without protest by any State or County official to avoid jeopardizing Medicaid funding or other possible penalties related to 42 USC Chapter IV Part 440.230.

So, how long does all that take?

It can all be done in an hour.

If the psychologist's assistant collects data indicating that EPSDT service is *probably* going to be necessary, the ITM and face-to-face meeting with the psychologist can be scheduled at the same time (with sufficient advance notice to the County representative).

If the licensed psychologist meets the child face-to-face and immediately thereafter attends the ITM and drafts the initial Treatment Plan, all of the requirements for establishing the child's Medical Assistance eligibility, *and* for establishing the need for EPSDT services, have been accomplished.

The Institute for Behavior Change can show licensed psychologists in Pennsylvania how to conduct bio-psycho-social evaluations, design treatment plans that have a high probability of success, hold Interagency Team meetings, manage Managed Care Organizations, and otherwise navigate the waters of the EPSDT system that many people believe are "uncharted."

We have been doing this successfully for more than 10 years. We have the charts. We **made** them.

Based on our success in Pennsylvania, we believe that it is reasonable to believe that we may be able to help licensed psychologists in other states to achieve success in the EPSDT system. We would welcome the opportunity to try.

Realistically….

It can be done in a week.

Two, at the most.

It may take a little longer for the BSC or MT services to begin, because it sometimes takes a little while to recruit, train and schedule these EPSDT providers. Sometimes, it takes quite a while, unfortunately.

BSC and MT reimbursement rates haven't changed in Pennsylvania since **1992.**

Funding through the Medicaid system is notoriously limited. Some might say that the best way to kill Medicaid is to choke off its funding as conscientiously as possible. If you set the pay rate for a service in **1992**, and never change it (no cost-of-living adjustments, no adjustment for inflation, etc), eventually **nobody** will be able to work for that wage, right?

…They forgot about **College graduates in psychology** who aspire to be licensed mental health professionals, and **Graduate Students** who are **committed** to that goal. These people are **excellent** candidates for work in the human services field. They value "supervision" because they **need it** to get licensed someday.

They also need "internships" or "practicum" experience as part of their education, and virtually all of these "experiences" are unpaid. Offer **paid** internships or **paid** practicum experiences to Graduate Students, or meaningful work **under the supervision of a licensed psychologist**, to a college graduate in psychology and they'll **line up** for the opportunity, even if the pay is low. This is what we've been doing at the Institute for Behavior Change, and we work with some of the best providers of EPSDT service on earth. We'd like to help other psychologists do the same thing. It's *incredibly* rewarding to work every day with intelligent, motivated and innovative "new professionals."

What happens next?

The Behavior Specialist can start working:

- Fine-tuning the treatment plan
- Meeting with school people and other adults
- Meeting with parent once weekly
- Collecting behavioral (outcome) data weekly

The Mobile Therapist can start working:

- Meeting with the child once or more each week
- Meeting with school people and other adults
- Meeting with the parent once weekly

The Behavior Specialist Consultant (BSC) and Mobile Therapist (MT) provider can begin working **as soon** as the Treatment Plan is signed by the Interdisciplinary Team. There is no need, or reason, to wait because these are “fee schedule” services that do not require prior authorization by an insurance company or other entity.

And then?

The typewritten psychological evaluation report is signed by the licensed psychologist and delivered to the County branch of the State Medical Assistance (Medicaid) office (up to 60 days later).

The child's application for MA (Medicaid) benefits has now been filed. This filing can be done up to 90 days AFTER the EPSDT services (including the data collection for the psychological evaluation) *started!*

This 90-day "look-back" period is part of the **federal EPSDT regulations**; it's another example of how *badly* the US Congress has wanted these services to be available to children who need them, since 1967.

In order to be found eligible for Medical Assistance benefits in Pennsylvania, an application for benefits must be delivered to the State Office of the Department of Public Welfare. There is an office in every County. The necessary materials can be mailed to that office (return receipt requested, since there is a 45 day statutory limit on the amount of time that the bureaucracy can take to act on an application).

Notice that the data collection for the psychological evaluation, the evaluation face-to-face meeting with the psychologist, the writing of the Treatment Plan, the Interagency Team Meeting to present the plan to the Team and obtain their consent to implement it, **and** the Behavior Specialist and the Mobile Therapy services that were provided within 90 days BEFORE the **application** for Medical Assistance benefits was delivered are **all covered**, as soon as the child's Medical Assistance eligibility is established, and can be billed to the State Medical Assistance (MA) Office (which allows bills to be submitted more than 90 days in arrears).

It's been said that a licensed psychologist who performs or supervises these services is *"taking a risk"* that the child's eligibility for Medical Assistance will not be approved. Nonsense. If the child has a mental disability that is identified in the Social Security Administration's "Blue Book" of recognized disabilities, and the psychologist's evaluation report is written **competently**, and the necessary documents are delivered to the MA office on-time, the child's eligibility for Medical Assistance is a **certainty**.

And then?

Depending on their backlog, the State reviews the psychological evaluation report. If it is written properly, the child's MA eligibility is established and it then becomes possible to bill the State for the EPSDT services that the child has been receiving. This can take a couple of weeks, or longer. No matter; the EPSDT services can be delivered without interruption.

Shortly after the child's MA eligibility is established, the child becomes a client of the local Managed Care Organization – *with EPSDT services already in place.*

The child has presented with symptoms of a mental illness or other significant disabling condition that has been diagnosed by a licensed practitioner who is enrolled as a provider in the State Medicaid system. The practitioner has evaluated the child face-to-face and has prescribed treatment. The treatment has been approved by the treatment team and documented in a formal written treatment plan. The treatment has begun. During the course of treatment, data is being collected regarding the effectiveness of the plan. The team sees that the treatment is working. The application for Medical Assistance benefits has been filed. Eventually, it is approved. The treatment provider bills the State Medicaid agency for the services that have been provided under the EPSDT mandate. The provider is paid for these services by the State Medicaid agency as soon as the child's eligibility for Medical Assistance is determined. As soon as the child's eligibility for Medical Assistance is determined, the funding of the child's treatment becomes the responsibility of a Managed Care Organization. The psychological evaluation report, treatment plan, and other necessary documents are delivered to the Managed Care Organization. The treatment provider continues to provide services, as a "network provider" or as an "out-of-network" provider. It doesn't matter. The child is getting better and the provider is getting paid. Now, a Managed Care Organization is being paid, too, by the State and the County where the child lives.

And then?

Since the child is now a client of a Managed Care Organization (MCO), the child's EPSDT documentation is delivered to the MCO and the MCO becomes responsible for paying the EPSDT service bills, for the remainder of the initial authorization period.

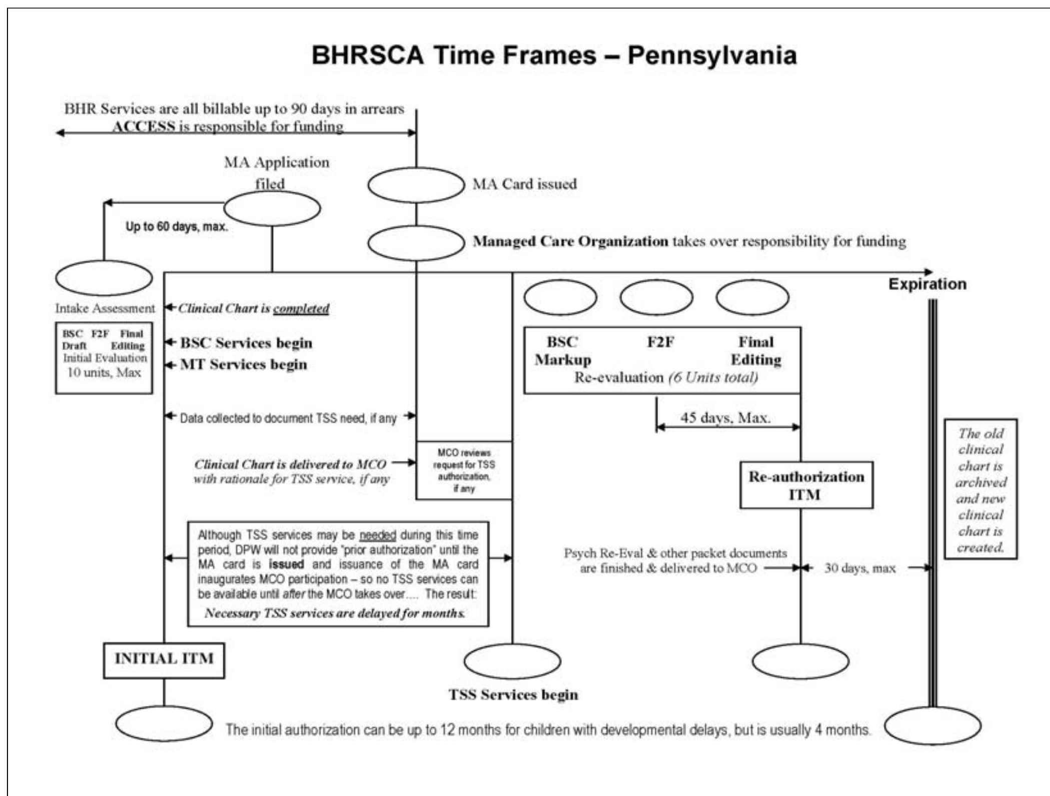
It is also *finally* possible to request **Therapeutic Staff Support** (TSS) service for the child (TSS service has to be "prior authorized" by the MCO -- unlike Behavior Specialist or Mobile Therapy services).

However, the **data collection process** that has been going on for the past several weeks virtually *assures* the authorization of TSS service if the data shows that TSS service is needed. Remember the Medical Necessity criteria for **EPSDT** services – if it corrects **or ameliorates** a child's disabling condition, it's "medically necessary."

The request for Therapeutic Staff Support is a critical element in the EPSDT BHR service delivery system. No other component of EPSDT BHR treatment in Pennsylvania has been more important, more influential **or more maligned** in Pennsylvania, than "TSS" service. **Hordes** of untrained, unmotivated and inconceivably negligent "TSS" providers emerged in the early years of EPSDT BHR services in Pennsylvania (1992), to the point that a lawsuit (under Part 440.230) was brought in the late 1990's that mandated at least 15 hours of pre-service training, 20 hours of annual in-service training, regular supervision of TSS providers and other necessary improvements.

The Institute has **always** had these high expectations for its TSS providers, so it wasn't difficult at all for us to accommodate these new expectations. Other providers of TSS service left the field entirely, or continue to struggle with "bad apples" who continue to poison the value of TSS services in many peoples' minds…

When it is done properly, TSS service is the most **important** part of the EPSDT BHR service delivery system because the TSS provider is WITH the child for several hours each day – **preventing** the child from making foolish mistakes and using ineffective solutions to problems, and **teaching** alternative, more successful ways of behaving. It works when the TSS provider is closely supervised, well trained and highly motivated. **Precisely** the type of TSS providers that the Institute for Behavior Change has been recruiting and training!



This is a diagram from the **www.ibc-pa.org** website showing how EPSDT BHR services can be delivered in Pennsylvania, with virtually no delay, for a child who needs this help **but who is NOT enrolled in Medical Assistance**. Most people do not know that, under federal EPSDT regulations, EPSDT BHR services can be delivered to a child for up to 90 days **before** the child is officially enrolled in Medical Assistance (Medicaid), during what is called a period of "presumptive eligibility." This is **also** before the child is enrolled in any Behavioral Health Managed Care Organization. For reasons that remain obscure, authorities (schools, government agencies, etc) persist in telling parents that they have to ***wait*** until their child is enrolled in a County's Managed Care Organization before ***any*** Behavioral Health Rehabilitation (BHR) services can be started, rather than simply referring the child to the Institute for Behavior Change if he/she lives in Pennsylvania, is under 21, has a disability, and is not yet enrolled in Medicaid….

Notice that "TSS" service cannot be delivered during this "presumptive eligibility" period – the child has to wait, sometimes for **months**, before this vital service can be delivered, because it has to be "prior authorized" by the Managed Care Organization. The good news is that, during the period of "presumptive eligibility," data can be collected by the Behavior Specialist and the Mobile Therapist that clearly and unequivocally **documents** the child's behavior and **need** for TSS service *if it exists*. Presented with these data, the Managed Care Organization will have little reason or opportunity to refuse to grant the authorization of the prescribed TSS service, if it is prepared properly.

Therapeutic Staff Support (TSS) is provided in Pennsylvania by a person with a Bachelors degree (usually in psychology) who works 1:1 with the child for several hours each day, at home, in school, and in the community.

Prescriptions for 20 *or more* TSS hours weekly are often appropriate, necessary and authorized by the MCO if the child's behavioral **data** supports the need for TSS service.

Therapeutic Staff Support (TSS) providers can accompany the child to school, to church, to youth group meetings, on shopping outings with a parent, to a summer camp, or to **any** location in the child's **home**, **school** or **community** where the Treatment Plan is implemented. In the early days of TSS service in Pennsylvania, some children received prescriptions of more than 40 hours of TSS service per week. While it may be necessary for some children to receive such a high level of treatment, it is not common.

The State of Pennsylvania created its own set of Medical Necessity Criteria when it created its Proposal to bring Mandatory Managed Care into the Pennsylvania Medicaid system in the mid 1990's This document is called "Appendix T" of the Request for Proposals (RFP) that the State had to submit to the Centers for Medicare and Medicaid Services (CMS) to get permission (a "waiver") to implement its Mandatory Managed Care program under the Social Security Act. The CMS granted the waiver, continues to monitor it, and re-authorizes it periodically. The CMS is the final authority, because they "permit" the State of Pennsylvania to implement its version of the EPSDT mandate.

How long is the initial authorization period?

Four months.

That's *plenty* of time to accumulate all of the data necessary to prove that a child needs "TSS" service, or the continuation of Behavior Specialist services, or the continuation of Mobile Therapy services.

The "Medical Necessity Criteria" set by the State of Pennsylvania in its Proposal to waive the parent's right to choose of a provider of EPSDT services (the Mandatory Managed Care or "**Section 1915b waiver**" of the Social Security Act) cannot interfere with the child's access to treatment under 42 USC Chapter IV Part 440.230, so it is intentionally vague.

For every expert, there is an equal and opposite expert. What is necessary for **one** child may be **inadequate** for another child **with the same diagnosis**.

That's what 42 USC Chapter IV Part 440.230 is all about – it is **illegal** to limit access to, or the scope or intensity of treatment to the point that treatment is likely to **fail**.

The determination as to whether or not a given level of treatment, or a given treatment service, is "Medically Necessary" is made by the licensed psychologist who **prescribes** it.

If the prescription is written competently, no insurance company on earth can challenge it successfully. They may **make up** their own definition of what is "Medically Necessary" but they **cannot** change the **EPSDT definition**, and no State or other governmental body can **allow** them to do that.

What happens after the initial authorization?

If the data shows that the child **needs** continued, more or new EPSDT services, the licensed psychologist sees the child again face-to-face and **prescribes** them (just like in the initial evaluation, about a month before the authorization period ends). The Team meets to review the revised Treatment Plan, signs the papers, and the EPSDT services continue without interruption and the MCO continues to pay for them.

If you know what you're doing,
it really **is** *that easy.*

Data. Data. Data.

Without it, there is no defense. It's one professional's word against another's. **Nobody** can defend their work without data **from the recipient** that it's working.

On the other hand, if you **have** data, and *especially if it's from the recipient of the service* (or their **parent**, if they're a child),

and the data **shows** that the service is helping (or even that it has a reasonable **probability** of helping), then

according to the EPSDT regulations, the service **IS** "medically necessary" and **MUST** continue to be funded. **Period.**

For every expert, there is an equal and opposite expert. **Data** makes them **exactly** equal, and their "professional opinions" equally **irrelevant** if they depart from discussion of the **data**.

This sounds too good to be true….

EPSDT services are available in every state. Although the name for the EPSDT services varies state-by-state, and the obstacles imposed by people who don't want too many children to use these services are fairly creative, these are federally mandated services in all 50 states that **can't** be denied…

…if they are prescribed correctly

and documented properly.

This probably includes the BSC, MT and TSS services that Pennsylvania children benefit so much from.

It's **not** too good to be true. It's what we've been doing at the Institute for Behavior Change for ten (10) years.

Services "come to" the child...

Behavior Specialists, Mobile Therapists and TSS providers **all** deliver their services in the child's home, school and/or community.

Parents do not need to "bring" their child to a treatment office to receive EPSDT services.

The treatment providers can't be fooled by clever, deceitful behavior – they can *see* what the child is doing **with their own eyes!**

Important! Important! Important!

This is what **makes** EPSDT "Behavioral Health Rehabilitation" services **so** effective: The services **COME TO** the child.

We aren't listening to the child **lie** to us about what's happening in his life once a week in an office! ***We see it with our own eyes!***

Our staff **go** where the child goes – into school, camp, *wherever!* The staff are, for the most part, **young professionals-to-be**. They're **energetic**, **motivated**, **excited** to be working "in the field." They work **with** the parents! The Parents **want** us in their child's life. The **child** wants the staff in their lives! They all **see** us helping.

If, for any reason, the parent doesn't want us around anymore, they just **say so**, and we **can't stay**. **THEY'RE IN CHARGE.**

O.K. Let's talk about *"wraparound."*

Wraparound is a treatment philosophy.

It is not part of the EPSDT mandate.

It has **nothing** to do with EPSDT.

It **can** be that easy, but only if you know the rules, the regulations, the statutes and the laws.

If you get tied up in knots with "philosophy" that obscures your view of the facts, or impedes your ability to take and maintain an objective, clinical perspective, you're finished.

The Institute for Behavior Change wants to help psychologists thrive in the world of EPSDT services, to avoid the fog of confusion that bureaucracies require for their survival.

We know how to do that, based on 10 years of experience.

Providing treatment that works, supervising *"the best new professionals in the business,"* using cutting-edge research (and doing some yourself), and earning reliable income at the same time is the dream of many psychologists – it was my dream, and I'm living it. I started small, part-time, and built the Institute for Behavior Change into an organization that is part of a system that has generated gross income of over $1 million dollars annually since 2003.

- Services **must** be "time limited" (a year or less).
- Services **must** be "titrated" (reduced over time).
- Services **must** be replaced by "naturally occurring" [i.e., low-cost or no-cost] supports as quickly as possible.
- Treatment skills **must** be "transferred" to parents and other caretakers.
- Caretakers must be present at **all** times while treatment services are being rendered.
- Services can **not** be delivered in a doctor's office.

NONE of this is part of the EPSDT system!

The "wraparound" philosophy is a nice ideal to shoot toward, **as long as it doesn't interfere with the child's access to necessary EPSDT services.**

… is a worthwhile ideal to aspire to.

It makes sense to reduce service intensity as quickly as possible, to transfer skills to caretakers, and to utilize "community supports" to the greatest extent possible…

… as long as it doesn't interfere with the child's access to EPSDT treatment.

As an Advisor to the National Wraparound Initiative since 2006, I have had the opportunity to dialogue with some of the country's leading authorities in the field. All of them recognize that the wraparound philosophy has tremendous merit, can be applied in a variety of settings, and is extremely powerful as a means of stimulating people and communities to help themselves. I am an ardent supporter of the philosophy of "wraparound" services and strive to help the staff of the Institute for Behavior Change to implement it whenever possible … as long as it doesn't interfere with the child's access to necessary EPSDT treatment.

The CASSP Principles

In Pennsylvania, there are six "CASSP principles" that are part of the EPSDT system. Notice that none of these creates a barrier to the delivery of EPSDT services, so they're permitted by Medicaid:

Services must be child centered, family-focused, multi-system, community-based, culturally competent, least restrictive and least intrusive.

The CASSP Principles **do not** hamstring EPSDT BHR services like overzealous "fidelity" to the wraparound philosophy can, and the Centers for Medicare and Medicaid Services (CMS) accordingly **allowed** Pennsylvania to include these CASSP Principles in the regulations for EPSDT services.

The **CASSP principles** are not like the "wraparound' philosophy in two important respects:

1. Fidelity to them is **required** under Pennsylvania's implementation of EPSDT services. They are, like the wraparound philosophy, worthy ideals to aspire to. A seventh "proposed CASSP Principle" that services should be "data driven" has been around for about a decade, but hasn't been honored very widely, unfortunately. We support that one, too.

2. The CASSP principles **do not** interfere with the delivery of EPSDT services like an overzealous "fidelity" to the wraparound philosophy does.

Parents and others interested in quality mental health care for children should look into EPSDT Behavioral Health Rehabilitation (BHR) services. EPSDT **is** in your state, **EPDST BHR Services work,** and they may be totally ***free*** *regardless of family income.*

There isn't a private health insurance plan *anywhere* in America that offers treatment options like EPSDT BHR services.

The Institute for Behavior Change is available to help any State government or psychologist implement a more successful, cost-efficient, professional and outcome-based implementation of EPSDT BHR services.

More information is available at www.ibc-pa.org

… **as long as it doesn't interfere with the child's access to necessary EPSDT services.**

Contact the Institute for Behavior Change to learn more: www.ibc-pa.org

I'm interested in providing presentations of this material at locations where groups of interested psychologists, parents and advocates are meeting.

Steve Kossor