

The Medicaid-Education Connection

Medicaid

EPSDT

BHRS

“Wraparound”

IDEA

IDEIA

School-Based Mental Health Services

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This presentation provides an in-depth understanding of the Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) benefit, especially the “Rehabilitation Option” and how schools and professional mental health practitioners can use these resources to deliver “Behavioral Health Rehabilitation Services” (BHRS) to children with disabilities who are enrolled in Medicaid in all 50 states.

When BHRS is imbued with the “wraparound” philosophy of treatment, an extremely effective, efficient treatment modality is created.

A model like this was developed by the presenter of this program and has been implemented successfully in Pennsylvania for more than 20 years, serving more than 650 children and delivering over 600,000 hours of treatment.

The following presentation describes how this “BHRS in a wraparound cup” model exists within the EPSDT framework, how EPSDT funding for it was accessed and how a simple documentation system significantly increases the probability that EPSDT funds will remain accessible for children who are receiving and benefiting from this treatment modality in their homes and schools.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



Center for Medicaid, CHIP and Survey & Certification

JUN 7 2011

The Honorable Jim Gerlach
U. S. House of Representatives
Washington, DC 20515

Dear Representative Gerlach:

Thank you for your letter recommending Steve Kossor to become a member of the National Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Improvement Workgroup. We appreciate the interest in and support for this important project.

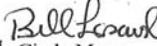
My staff has spoken with Mr. Kossor, and we learned that he has indeed developed an effective approach to serving children and adolescents with developmental disabilities, and has made the approach available to Medicaid-enrolled children through EPSDT. We are always pleased to hear about examples of when Medicaid is working well to serve children. We agree that Mr. Kossor has a great deal of expertise and is a passionate supporter of EPSDT.

The National EPSDT Improvement Workgroup was formed in late 2010, and includes a broad range of stakeholders whose knowledge and expertise have already proven to be very helpful to our thinking on these issues. Because the Workgroup is far along in its process, it would be difficult to add another member at this time.

However, we have established four "sub workgroups," one of which is focused on Behavioral Health issues. That subgroup is designing a process whereby outside experts on particular topics will be invited to share their expertise with the group. We would be delighted to have Mr. Kossor contribute to the project in this way. We will be in touch with him in the near future.

Thank you again for your letter recommending Mr. Kossor. We look forward to benefiting from his expertise as we move forward on this project.

Sincerely,


Cindy Mann
Director

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In 2009, U. S. Health and Human Services Secretary Kathleen Sebelius announced the appointment of Cindy Mann to serve as Director of the Center for Medicaid and State Operations (CMSO), part of the Centers for Medicare & Medicaid Services (CMS).

Mann most recently served as a research professor and executive director of the Center for Children and Families at Georgetown University's Health Policy Institute.

"Cindy Mann has decades of experience in health care financing at the federal and state level, and vast knowledge of health care policy," said Secretary Sebelius. *"She has devoted her career to working on behalf of children and families, the elderly and people with disabilities. She will be an outstanding leader at CMSO, particularly as the nation moves forward with health care reform."*

Although CMS does not endorse any particular model of services, her enthusiastic recognition of the IBC model for BHRS created by Mr. Kossor, and calling it *"an effective approach to serving children and adolescents with developmental disabilities,"* is noteworthy.



DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850
SMDL #01-006

Dear State Medicaid Director:

Olmstead Update No: 4
Subject: HCFA Update
Date: January 10, 2001

...

However, a child's enrollment in a [an HCBS] waiver cannot be used to deny, delay, or limit access to medically necessary services that are required to be available to all Medicaid-eligible children under federal EPSDT rules.

Under EPSDT requirements, generally children under age 21 who are served under the Medicaid program should have access to a broad array of services. State Medicaid programs must make EPSDT services promptly available [for any individual who is under age 21 and who is eligible for Medicaid] whether or not that individual is receiving services under a [an approved HCBS] waiver.

The second purpose of EPSDT services is to ensure that children receive the services they need to treat identified health problems. When a periodic or inter-periodic screening reveals the existence of a problem, EPSDT requires that Medicaid-eligible children receive coverage of all services necessary to diagnose, treat, or ameliorate defects identified by an EPSDT screen, as long as the service is within the scope of section 1905(a) of the Social Security Act. (Please note that we have long considered any encounter with a health care professional practicing within the scope of his/her practice inter-periodic screening.) That is, under EPSDT requirements, a State must cover any medically necessary services that could be part of the basic Medicaid benefit if the State elected the broadest benefits permitted under federal law (not including HCBS services, which are not a basic Medicaid benefit). Therefore, EPSDT must include access to case management, home health, and personal care services to the extent coverable under federal law.

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The EPSDT mandate is not affected by any “waivers” that may have been introduced. Thus, the 1915(b) waiver that made Managed Care mandatory for Medicaid recipients cannot over-ride the EPSDT mandate by imposing a different definition of what constitutes “medically necessary” treatment, and the 1915(c) waiver that created Home and Community Based Services (HCBS) cannot over-ride the EPSDT mandate.

If a treatment or service is part of the EPSDT mandate, it's part of the state's Medicaid Plan, whether or not “it” is covered under the State plan. **No “waiver” can tamper with the EPSDT mandate.**

BHRS is part of the EPDST mandate in section 1905(a)(4)(b) as defined in section 1905(r)(5) when it is prescribed by a licensed practitioner of the healing arts under scope of state law **“to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.”**

1967 **E**arly and **P**eriodic **S**creening, **D**iagnosis and **T**reatment

For children under 21 years of age:

- 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**)

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The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate within the Medicaid Act was created in 1967. It has remained a part of the Social Security Act and conveys Civil Rights to treatment for any disabling condition discovered during a screening process for children (anyone up to the age of 21) who are enrolled in Medicaid anywhere in the US; it became a mandatory part of every state's Medicaid plan in 1989 under the Omnibus Budget Reconciliation Act (OBRA '89).

**42 CFR Chapter VII Subchapter XIX §1396d
[Sec. 1905(r)(5)] “The Social Security Act”**

(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.

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Here is the citation from the Code of Federal Regulations that established the mandate for EPSDT services throughout the US. Note that providers of EPSDT services are not required to deliver all such services, but can specialize in the services for which they are qualified. As “licensed practitioners of the healing arts” in Pennsylvania, licensed psychologists can be providers of EPSDT services, including the “Rehabilitation” services described in the following slide.

42 CFR Chapter IV Part 440.130 [Sec. 1905(a)(13)] “The Social Security Act”

- (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.

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Rehabilitative Services that are recommended by a licensed psychologist in Pennsylvania can be delivered by unlicensed persons who operate under the supervision and scope of practice of the licensed psychologist. This has been permissible since 1992. Since these services are intended “for the maximum reduction of physical or mental disability and the restoration of a recipient to his best possible functional level” they are available to any disabled child in Pennsylvania who is enrolled in Medicaid and is under the age of 21 years.

Pennsylvania's "Medically Necessary" definition under Medicaid Regulations

•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.

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This is the definition of what constitutes "medically necessary" services in Pennsylvania as published in the PA Bulletin. This definition was incorporated into the Managed Care contracts of all enrolled Medicaid providers of Behavioral Health Rehabilitation Services (BHRS) as a result of an explicit directive issued by the Pennsylvania Department of Public Welfare in August of 2009 – within a few weeks after testimony was given in Federal court explaining how Managed Care Organizations were using their own occult definitions of "medically necessary" services to the extent that children who were entitled to behavioral treatment under the state's Medicaid Plan were being systematically denied funding for such treatment because Managed Care Organizations were claiming that "*the provider failed to establish the medical necessity of the prescribed treatment.*"

As anyone can see, if such treatment is expected to **reduce or ameliorate** the child's condition, **or** if the treatment is expected to **reduce the severity** of the child's condition, **or** if the treatment is expected to **prevent the worsening** of the child's condition, it **is** "medically necessary" according to the laws of Pennsylvania as set forth in 55 Pa. Code Chapter 1101 section 21a.

Nevertheless, Managed Care Organizations in Pennsylvania continue to rely upon "Appendix T guidelines" to defend their denials of funding for treatment which is unequivocally "medically necessary" according to Pennsylvania law, and the PA Department of Public Welfare continues to vigorously support such behavior more than three years later.

Three Key Concepts

Each service must be sufficient in **amount, duration and scope** to reasonably achieve the purpose for which it was furnished.

42 CFR Chapter IV Part 438.210

EPSDT services must be provided to disabled children enrolled in Medicaid **whether or not** the services are provided for in any State Plan.

OBRA '89

Medicaid, not the school, must pay for covered services to a child if funding is in dispute. **Medicaid is the “payer of first resort” for services in schools.**

IDEA 1997 and IDEIA 2004

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These three concepts are vital to an understanding of the interface between Medicaid and Education. The first of these was the foundation for the “Kirk T” lawsuit that resulted in a Federal court decision in Pennsylvania that required minimum standards for the training and supervision of service providers and set standards for the prompt delivery of Behavioral Health Rehabilitation Services (BHRS).

The Medicaid-Education Connection in Federal law

Under Medicaid Law (the Social Security Act)

42 U.S.C. § 1396b(c)

- **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 IEP or IFSP.**
- Medicaid law shall not restrict payment for covered services because such services are included in an IEP or IFSP.

Under the Individuals with Disabilities Education Act (IDEA)

§ 612(a)(12) of the 1997 amendments to IDEA, 20 U.S.C. § 1400 et seq.

- if **any public agency other than the educational agency** is responsible for providing services under federal and state law, such public agency should fulfill that responsibility.

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This summary of Medicaid-Education Connection in Federal Law appears in Policy Analysis Paper #5 from The Bazelon Center for mental Health Law, published in April 1998 called **Defining Medically Necessary Services to Protect Children**. The text above appears as footnote #33 in that document. It is available on-line here:

<http://www.bazelon.org/issues/managedcare/moreresources/PAPER5.PDF>

The Education-Medicaid Partnership

1989
OBRA '89
EPSDT
funding is
mandatory
In all 50
states

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF EDUCATION
July 26, 1989

SUBJECT: Medical Assistance Funds

TO: Intermediate Unit Executive Directors

FROM: James Tucker, Director
Bureau of Special Education

Public Law 100-360 (1988) clearly establishes that Medical Assistance reimbursement may be claimed for health services identified in a medical assistance eligible, special education students' IEP as a related service. While it is hard to predict the total value of Medicaid reimbursement which Pennsylvania may be eligible to claim, current estimates range from \$4 million to \$20 million annually.

Soon, the Departments of Education and Public Welfare will sign an interagency agreement which will enable each intermediate unit and school district to enroll as a Medicaid provider and thereafter to submit claims for Medicaid reimbursement. Medicaid reimbursement is based on the Commonwealth having paid the full cost of the related health services prior to submitting claims. Participation in the Medicaid Reimbursement System will provide a new source of funds for services to unserved and under-served students.

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This is the earliest notice to school districts from the PA Department of Education regarding the availability of Medicaid funding for school districts. Note that the letter was issued in the same year as the OBRA '89 mandate for the inclusion of Medicaid's EPSDT mandate into all state Medicaid plans.

The Education-Medicaid Partnership

1989

MOU

Memorandum of Understanding

MEMORANDUM OF UNDERSTANDING BETWEEN
THE PENNSYLVANIA DEPARTMENT OF EDUCATION
AND
THE PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE

WHEREAS, the Medicare Catastrophic Coverage Act of 1988 (P.L.100-360) clarified that Medicaid matching funds are available for the cost of health services covered under a State's Medicaid plan, and provided to a handicapped child pursuant to the child's individualized educational program or individualized family service plan; and

WHEREAS, the Commonwealth's Medicaid plan, administered by the Department of Public Welfare, covers health services which may be included in a child's individualized educational program as related services; and

WHEREAS, the Education of All Handicapped Children Act of 1975 (P.L.94-142) entitles handicapped children to a free appropriate public education provided in conformity with an individualized educational program which describes the special education and related services necessary to meet the child's unique educational needs; and

WHEREAS, school districts and intermediate units use state funds to provide health services that are also related services required by a child's individualized education program; and

WHEREAS, these state funds may be designated as state matching funds for the purpose of claiming federal Medicaid reimbursement;

IT IS HEREBY AGREED that the Pennsylvania Department of Education (PDE) and the Pennsylvania Department of Public Welfare (DPW) shall jointly develop and implement a system or systems for claiming both private third-party reimbursement and Medicaid reimbursements for health services that are also

This Memorandum of Understanding (MOU) was created in 1989 between the PA Department of Public Welfare (the State Medicaid Agency) and the PA Department of Education to facilitate access by PA school districts to Medicaid funding.



Covered Services

The following services are covered under the SBAP Program:

- | | |
|---------------------------------|-------------------------|
| Assistive Devices | Audiology |
| IEP Meetings | Nursing |
| Occupational Therapy | Vision |
| Orientation and Mobility | Personal Care Assistant |
| Physical Therapy | Physician |
| Psychiatric | Psychology |
| Social Work | Special Transportation |
| Speech, Language & Hearing | |
| Teacher of the Hearing Impaired | |

http://www.leaderservices.com/services/pa/sbapmanual/SBAP_Fullmanual.pdf

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Note that the SBAP can bill Medicaid for a wide variety of services. The school district collects time data from employees. After adding costs associated with “administrative claiming,” it submits the data for work done with children who have been enrolled in Medicaid because they have Individual Education Plans (IEPs) to Leader Services.

Leader Services bills Medicaid and deposits the recovered funds (equal to the Federal portion of Medicaid funding which is about 55% in Pennsylvania), into the school district’s account.

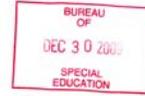
The school district accesses these funds as needed to supplement its Special Education budget. Note that these accesses are not necessarily “budget line” items; the Coatesville Area School District accessed over \$600,000.00 in 2008-2009 alone.

DEC 28 2009

SUBJECT: Impact of School Based-ACCESS Program Services on Medical Assistance Services

TO: John J. Tommasini, Director
Bureau of Special Education
Department of Education

FROM: *Leesa M. Allen*
Leesa M. Allen, Director
Bureau of Policy, Budget and Planning
Department of Public Welfare



“The health related services a student receives through the SBAP are separate and apart from the MA services a child receives outside of the school setting.”

“Additionally, there is no “cap” or limit on the total amount of money that may be paid by the MA program for SBAP services or MA services that the MA-eligible child may receive.”

This memorandum is to address the concerns some parents have regarding the impact of School Based-ACCESS Program (SBAP) services on the Medical Assistance (MA) Program services their child receives outside the school setting. We understand parents are being advised by parties in the community that their child's MA services will discontinue if they sign the parental notification form and allow the school entity to bill the MA Program for SBAP services. It is also our understanding that parents are being told that the SBAP services their child receives will count toward a “cap” or limit on the services they may receive under the MA Program. Staff from the Pennsylvania Department of Education and school district personnel indicated that this misinformation has led to many parents refusing to sign the parental notification form to allow the schools to bill the MA Program for their child's SBAP services.

The health related services a student receives through the SBAP are separate and apart from the MA services a child receives outside of the school setting. SBAP services are health care services that are rendered by professional staff employed or contracted by the school entity to perform health care services as identified on the Individual Education Plan (IEP) to children who are MA eligible recipients. The scope and duration of the SBAP services are clearly identified on the IEP and authorized as determined to be medically necessary by a practitioner. The medically necessary MA services that are provided to the MA-eligible child outside of the school setting have a separate scope and duration than those SBAP services performed by the school personnel or contractor. Both types of services are billed through the MA Program for payment of service.

Additionally, there is no “cap” or limit on the total amount of money that may be paid by the MA Program for SBAP services or MA services that the MA-eligible child may receive. The MA Program does not impose MA benefit “caps” or limits on covered services provided to MA eligible children. Based on federal Medicaid law, MA eligible children are eligible for all medically necessary services.

Please keep in mind that a parent still has the right to refuse to sign the parental notification and to not allow the school entity to bill the MA Program for SBAP services.

We hope this information provided to you assists the Department of Education in carrying out the SBAP program.

This memorandum was generated by the PA Department of Public Welfare to quell rumors that participation in the School Based Access Program would have a negative effect on the funding of other services for Medicaid-enrolled students. The SBAP clearly have no effect whatsoever on any other funding that a child may be receiving “outside of school” and there can be no “cap” on EPSDT funding – whether the services are delivered inside or outside of school (there is also no Managed Care interference with EPSDT funding of services delivered **via the SBAP inside the school**).

Note that this memorandum was written more than three years after “mandatory Managed Care” was supposedly established for **all** Medicaid recipients in Pennsylvania via a Waiver of section 1915(b) of the Social Security Act. Schools were, and are, exempt from any Managed Care oversight or influence.



Personal Care Assistant Services \$40.00 hourly

A personal care assistant must be a **high school graduate or have a general equivalency diploma (GED)**.

She/he must also have a current certification in first aid and cardiopulmonary resuscitation (CPR). These certifications must be maintained during employment. Verification of the educational and certification requirements are the responsibility of the LEA. The LEA is responsible for assuring appropriate training and supervision of all personal care assistants.

http://www.leaderservices.com/services/pa/sbapmanual/SBAP_Fullmanual.pdf

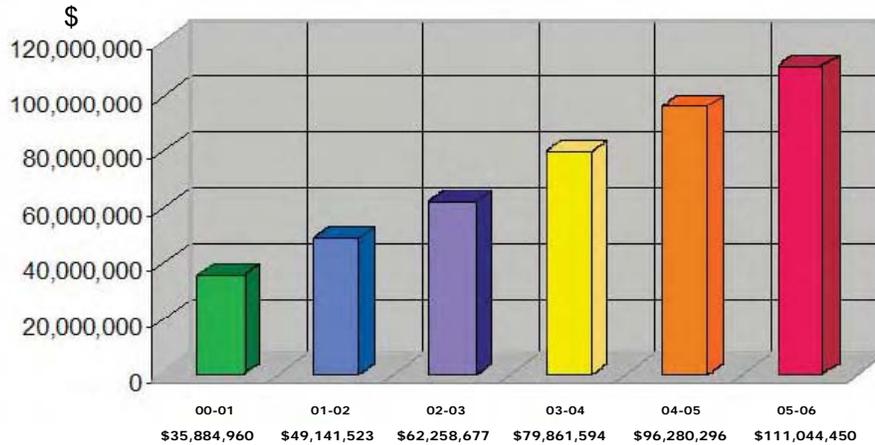
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A Personal Care Assistant (PCA) requires a GED, not even a High School Diploma. This is one of the more egregiously inflated billing rates in the SBAP.

For comparison, a provider of comparable services under the Behavioral Health Rehabilitation Services (BHRS) program is billed at about \$30 hourly, but that person is required to have a Bachelors degree, 15 hours of pre-service training, 24 additional hours of training in the first six months, and at least 3 hours of observation by a Masters level mental health professional before they can begin working alone with a child. They also require weekly supervision by a MA level mental health professional and 20 additional hours of training each year.



*"Since the inception of SBAP in 1992, LEAs have recovered more than **\$576 million** in federal Medicaid reimbursement."*
In PA alone



<http://www.leaderservices.com> accessed in 2006, no longer on website

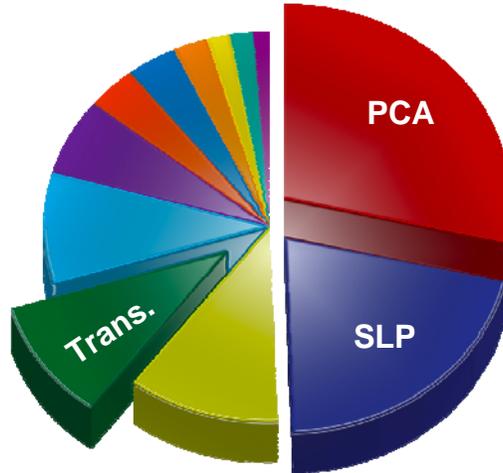
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The SBAP had taken nearly \$600,000,000 from Medicaid and distributed it to PA school districts by 2004. Note that Medicaid funds taken under the SBAP do not influence any other use of Medicaid funds. The Medicaid funds taken by the SBAP are drawn through a separate and distinct channel that is not affected by any other Medicaid funding programs or policies.



2008-2009 Projected Reimbursement

PCA – \$32,412,671
SLP – \$23,300,260
OT – \$12,181,431
Trans. – \$11,260,875
IEP – \$10,230,088
PT – \$7,214,976
Psychological – \$4,117,697
...continued



<http://www.leaderservices.com/services/news.aspx?ts=0&nk=98>

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The SBAP has grown terrifically in Pennsylvania over the years. Leader Services also facilitates Medicaid billing by school districts in at least four other states.

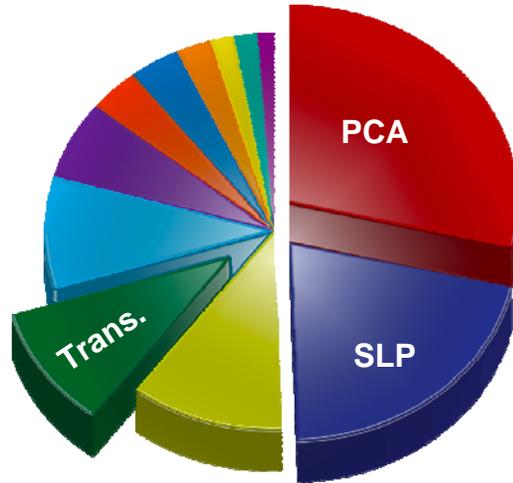


2008-2009 Projected Reimbursement

RN — \$4,096,931
THI — \$2,843,282
Social Work — \$1,870,888
Other services — \$1,584,407
LPN — \$1,227,582

Total =
\$112,341,088

Other services include:
O&M, Physician, Assistive
Devices, Psychiatry, Audiology



<http://www.leaderservices.com/services/news.aspx?ts=0&nk=98>

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In 2008-2009 alone, the SBAP took over \$112 Million from Medicaid and passed it to PA school districts. This equates to \$1 **Billion** in Medicaid funds that have been accessed through the SBAP in the past 10 years for the purpose of reimbursing PA school districts for the cost of budgeted services and supplies. This begs the question: *What are local school taxes funding?*

Under various names, this same system is operating throughout the US, and has tapped Medicaid for **over \$50 Billion so far**.



Medical Necessity

... think of medical necessity as being **medical/educational** necessity. Under IDEA, a child is entitled to a Free Appropriate Public Education [FAPE].

In order for a child to receive this education, he/she must receive medical/mental health-related services.

Consequently, staff wear two hats – one medical and one educational. Recognizing the medical nature of the services provided is critical to proper service documentation and payment to the SBAP provider.

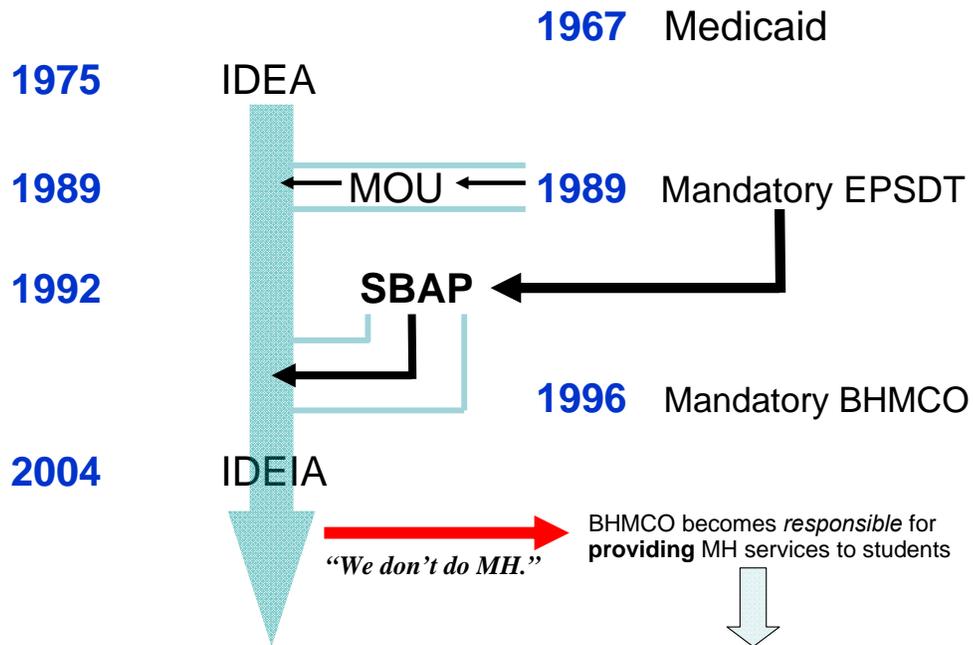
http://www.leaderservices.com/services/pa/sbapmanual/SBAP_Fullmanual.pdf

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Leader Services explicitly instructs its members that “*staff wear two hats – one medical and one educational.*” This is commonly referred to as a “conflict of interest” or a “dual relationship” in professional literature and in which *professionals are explicitly prohibited from engaging.*

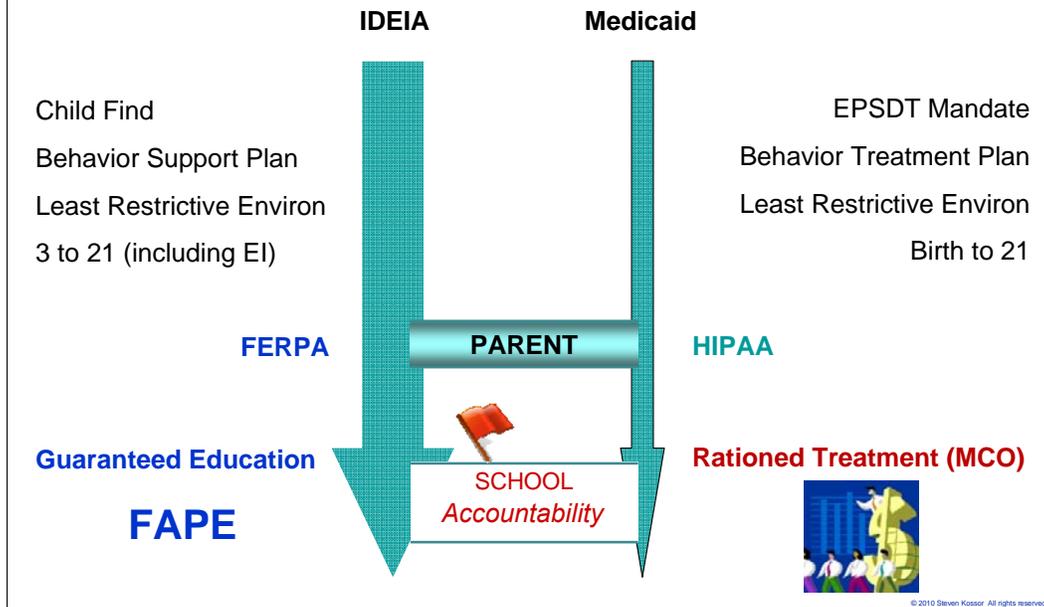
The necessary dual relationship required by participants in the SBAP and other programs that allow school districts to “tap Medicaid” may expose school districts to potentially disastrous consequences, including instances when medical information is wantonly shared with schools (in violation of HIPAA) or educational information is wantonly shared with Medicaid providers (in violation of FERPA), or when the standards of **Medicaid** documentation are not fully and exactly implemented by school employees for various reasons.

Medicaid-Education History



This is a schematic of the major historical developments in the Medicaid-Education Partnership between 1967 and 2012.

Education-Medicaid “Outsourcing”

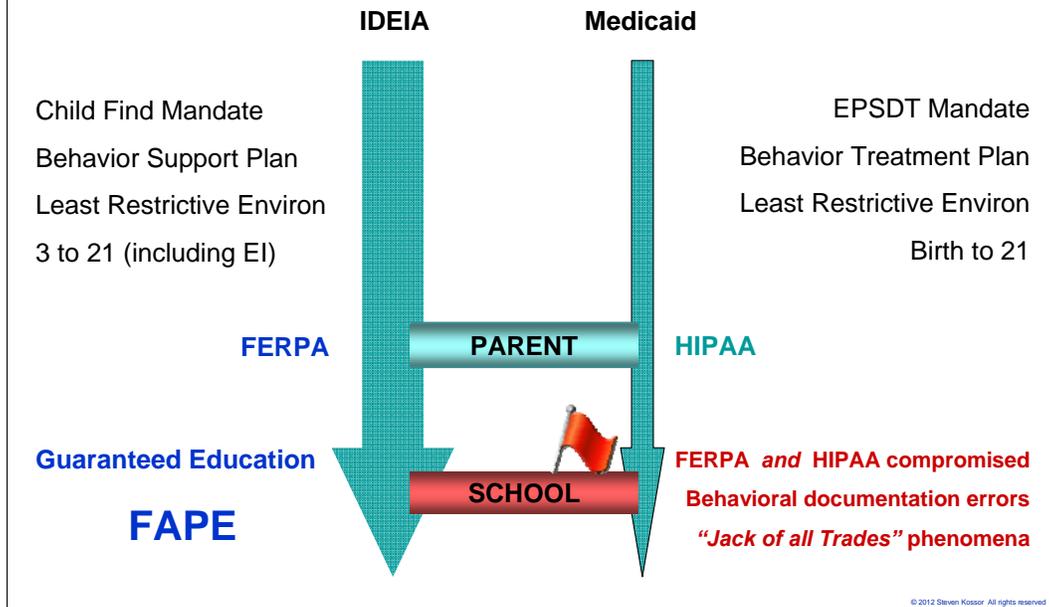


One solution is to “outsource” the responsibility for providing mental health treatment and behavioral support to an INSURANCE COMPANY. Bad idea. They exist to **reduce** or **eliminate** services to the greatest extent possible.

IDEIA is fundamentally incompatible with the philosophy of Managed Care. The school remains accountable for providing FAPE, including all related services and necessary supports to the child, *no matter who the family is referred to for services.*

Insurance companies usually don't know (or care about) FERPA and can expose schools to significant risks related to violations of state and Federal laws governing education.

A perilous Education-Medicaid Partnership

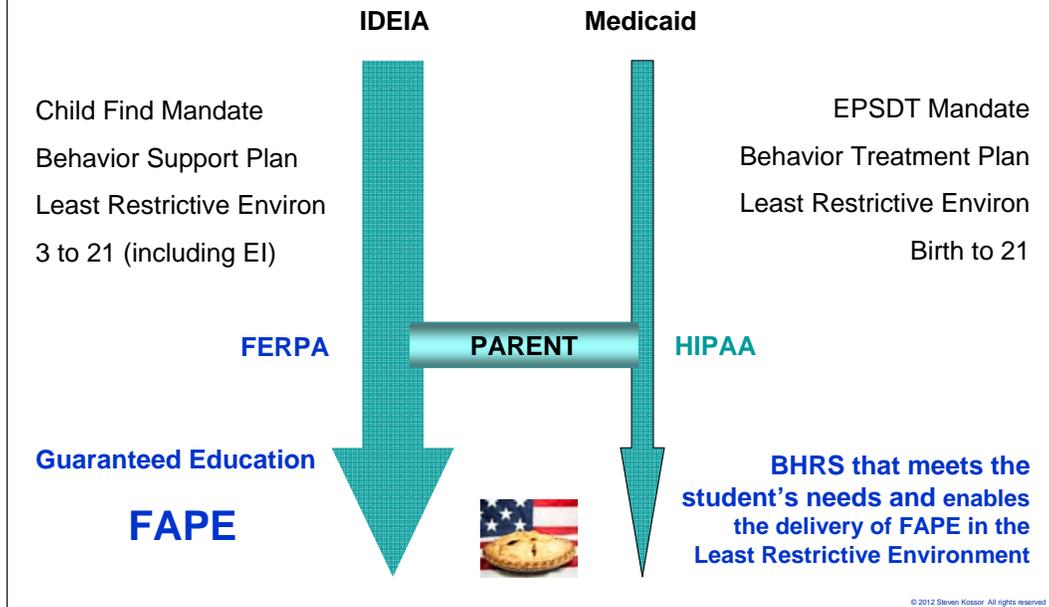


The union of Medicaid and Education is fraught with potentially disastrous pitfalls. Documentation must meet Medicaid standards which are significantly different from Education standards, for example.

Parents must be the conduit through which Educational and Medicaid information flows; the secondary pipeline between schools and Medicaid invites violations of both FERPA and HIPAA.

Schools should concentrate on providing "Free, Appropriate Public Education" to students rather than trying to "do everything themselves," especially in regard to providing **psychological** and **behavioral treatment**.

The best Education-Medicaid Partnership



This is an ideal partnership between Education and Medicaid.

By contracting with reputable, effective and cost-efficient **independent expert** providers of Medicaid funded behavioral support services who are “school aware,” instead of trying to “do everything themselves,” schools provide necessary support to students in need of psychological and behavioral treatment with minimal disruption to the students, classroom, administration or faculty.

Parents are the conduit through which Educational and Medicaid information flows, which provides a channel through which their support and involvement is managed optimally.

Recommendations

Consider the benefits of contracting with Behavioral Health Rehabilitation Services (BHRS) treatment providers for in-school MH services:

- who are taking outcome data from the **recipients** of services (or their teachers, or their parents), **not just their own staff**, and
- who are closely supervised by **licensed mental health professionals**, with their own liability to manage and supervision standards to uphold, and
- who are implementing treatment plans identifying specific, **measurable** outcomes that are “school aware” and incorporate **evidence-based practices including the “wraparound” model** and
- are showing **improvement** in their clients’ behavior because they are *using the outcome data to update treatment program conscientiously* to achieve this goal.

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Independent expert providers of Medicaid EPSDT Behavioral Health Rehabilitation Services should comply with all of these standards. They were proposed in the Deficit Reduction Act of 2005 and can be implemented successfully as the Institute for Behavior Change has done since 1996.

Ongoing Outcome Research

N= 23 children 53 Treatment Plans

TSS Treatment Delivery ranged from 28 to 1798 days (1 month to 59 months)

No TSS	TSS Treatment Delivered	No TSS
--------	--------------------------------	--------

Average treatment term: 1.4 years

90% completed in less than 3 years

No difference between ASD, ADHD, other diagnoses, ages, genders or ethnicity

No difference when treatment was interrupted (no “halo” effect)

Significant reduction ($p < .01$) in all Outcome measures

- **Physical Aggression**
- **Lack of Environmental Safety**
- **Noncompliance with adults**
- **Communication Deficits**
- **Socialization Deficits**

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Children who received Therapeutic Staff Support (TSS) services for at least 28 days were randomly selected from among 175 candidates who had behavioral outcome data collected weekly for at least 10 weeks.

The average of the first four weeks' data was compared with the average of the last four weeks' data from the TSS Treatment Delivery period.

In cases where TSS Treatment Delivery was less than 10 weeks, data from the four weeks *preceding* TSS service delivery was compared with the average of the last four weeks' data of the Treatment Delivery period.

90% of all children completed the BHRS treatment program in 3 years or less. The average term in treatment was 1.4 years. Treatment effects were comparable across age, ethnicity, gender and diagnosis:

Parent reports of progress indicated significant reductions in Target Behavior associated with TSS treatment. No change in parental ratings of child behavior occurred when brief interruptions in TSS service occurred during the Treatment Delivery period.



BHRS stands for “Behavioral Health Rehabilitation Services” which can exist under the Medicaid EPSDT mandate in all 50 states.

“Wrap-around” is a philosophy of care in which services “wrap-around” the child to provide optimal support from adults in the child’s home, school and community.

The delivery of BHRS within the context of a “wraparound” philosophy is the ultimate means of delivering cost-efficient, highly effective treatment for children with mental illnesses and behavioral challenges in their homes, schools and communities.

This is the model created by the founder of The Institute for Behavior Change, Steven Kossor sakossor@ibc-pa.org www.ibc-pa.org

Funding for the delivery of “BHRS in a Wraparound Cup” is available through the Medicaid EPSDT mandate throughout the USA and its Territories.