

The Issachar Project

iss'-ah-kar

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The Issachar Project

Steven Kossor

**The children of Issachar were trusted advisors because
*"they understood the times, and knew what to do."***

The Issachar Project was created in Phoenix, Arizona on February 21, 2009 when I addressed a group of about 70 people who had gathered to learn more about the fantastic resources that exist within the Medicaid system to fund behavioral treatment for children with Autism and other disorders anywhere in the USA using the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) funding mandate *regardless of family income in 33 States.*

This book is an essential resource that explains in detail how to navigate the bureaucracy obscuring access to EPSDT treatment funding for children under the age of 21 in the USA. Practitioners can implement the treatment concepts and strategies described here that have been tested successfully for more than 20 years for the benefit of children they are treating anywhere in the world.

Introduction

Thank you for your interest in my work. Let me introduce myself. I'm a licensed psychologist and a certified school psychologist in Pennsylvania. I was licensed in 1981 after receiving a Master's degree in Clinical Psychology from Fairleigh Dickinson University in Madison, New Jersey. I completed my undergraduate education in three years, starting at Bethany College in Lindsborg, Kansas and finishing at Montclair State College in New Jersey. I had originally intended to enter the ministry, but changed my mind after taking my first psychology course in High School. I had already committed to attending Bethany, a Lutheran college, where I took every College Level Equivalency Program (CLEP) test available, and earned 20 credits in addition to the 32 credits earned by attending class four times every week. When I transferred to Montclair State those 52 credits came with me, so by taking a couple of extra courses (Fossils of New Jersey, for example) I managed to skip ahead one grade (a goal I'd had since second grade when my classmate Karen was promoted to 3rd grade early).

The Master's degree program in clinical psychology at Fairleigh was an experiential program; I learned about the Rorschach test from some of the leading proponents of that marvelous projective personality assessment technique. I learned from some of the leading proponents of Rational-Emotive Therapy, including Albert Ellis himself. I had a practicum at the Essex County Hospital Center where I had the chance to observe some of the consequences of inner-city criminality and poverty connected to substance abuse which convinced me that I didn't have enough sensitivity for the world of drug and alcohol abuse to justify acquiring professional expertise in that realm, so I've left that to others throughout my professional career as a psychologist.

I moved to Pennsylvania in 1977 to participate in an internship program that would launch my career as a specialist in the treatment, evaluation and education of children. Pennsylvania was, at that time, one of four States that granted licensure to psychologists with Master's degrees. After finishing four years of supervised experience, I took the exact same licensing examination that my associates with Doctoral degrees were permitted to take after logging just one year of experience, and passed it on the first try. I was 26 years old and a licensed psychologist. Four years later I became a certified school psychologist when the State of Pennsylvania declared an emergency over the lack of certified school psychologists. Since I was working at a private school for people with developmental and other disabilities at the time, I was granted "emergency certification" which I converted to permanent certification soon thereafter. I wrote the first Individual Habilitation Plan (IHP) for a developmentally delayed adult in Pennsylvania and expected to "leave my mark" in the field of psychology by working with children who had Autism spectrum disorders and other developmental disabilities at a place that was, at that time, a prestigious private school for children that also housed and cared for children long into their adulthood. When the administration there and their priorities changed, it was time to move on.

In 1977, the same year that Ivar Lovaas wrote the first modern description of "Discrete Trial Training," I started working with children diagnosed with Autism spectrum disorders. I have worked with hundreds of children afflicted with Autism symptoms and their families ever since. I was credited by Stanley Greenspan himself (one of the pioneers in the humane treatment of Autism) as having been responsible for creating a novel treatment program for one child whose mother called me tearfully on the occasion of his Bar Mitzvah, thanking me profusely for the help that my staff and I extended to her son, while he entertained his guests with a violin solo as his girlfriend stood at his side.

The boy's mother told me that Dr. Greenspan had specifically told she and her husband, on more than one occasion, that my treatment program had been instrumental in her son's improvement. When I met the boy at age 3, he was nonverbal, avoided eye contact, and scored nearly off the scale on the Childhood Autism Rating Scale (CARS), a popular measurement instrument in the field of Autism research. His mother revealed that she'd heard him talking to the television from time to time, so it was clear that the boy *could* speak, if he wanted to.

The boy's mother and I agreed on a plan to persuade him to talk publicly. One of my staff, a very large man, would dress up in a gorilla suit and visit the boy's home. He would ring the door bell, the boy's mother would answer the door and invite the gorilla in. Then, the only person who could tell the gorilla what to do would be the boy. We agreed on a contingency plan in case the boy was too intimidated by the arrival of a gorilla, and set the intervention into motion. The gorilla rang the doorbell, the mother answered the door saying in a lilting voice: *"Oh, hello gorilla, you must have come from the zoo. Won't you please come in. [Child's name], won't you say hello to the gorilla?"*

The first words spoken publicly by the boy: *"Gorilla go home!"* We have a video of this. Priceless. After a few minutes, the gorilla goes into the living room and sits down. The boy promptly walks out of the room by another exit. The gorilla is saying the boy's name, trying to engage him in some give-and-take (reciprocal) conversation. The boy's having none of it, off-camera. His mother says *"I think the gorilla would like a banana."* The next thing you see is a banana flying through the air and landing at the gorilla's feet. Hysterical, right? A little later in the tape, you see the boy sitting next to the gorilla, who has removed his head, and the boy says *"I knew it was you"* smiling and looking into the eyes of the man in the gorilla suit, who is now engaged in a reciprocal conversation with the child.

While my staff and I definitely played a part, the boy's mother and father both deserve the vast majority of credit for bringing their son "off the Autism spectrum." They exposed him to typically developing peers in several "structured play-dates" weekly in close compliance with Dr. Greenspan's recommendations, for most of the four years that we worked together. They took him to see wonderfully creative therapists (one of whom dressed in a "Gumby suit" to facilitate interaction with autistic children by eliminating the distraction of moving arms and legs). His parents made sure that his nutrition and other health needs were addressed promptly and conscientiously. His siblings participated actively in the treatment plans; his older brother is pursuing a career in the mental health field and credits his experiences with my staff and other professionals involved in his brother's treatment with that decision.

I visited Dr. Greenspan at his home office three times, twice with the boy and his parents, over the course of his treatment. I borrowed the tape recording Dr. Greenspan made at our first meeting of his insightful analysis of the boy's condition and his treatment recommendations. I used that recording to create the novel treatment approach I called simply "Intensive Behavioral Treatment" so that the Medicaid Managed Care Organization (MMCO) overseeing the boy's access to treatment funding couldn't dismiss it as "experimental" or "educational" as MMCOs often do to evade responsibility for funding medically necessary treatment for children.

By providing treatment funding "a mile wide and an inch deep" so that everybody gets something, but nobody gets enough to get better, insurance companies and MMCOs ensure their longevity. You'll read about my experiences with MMCOs and the *Effective Treatment in a Wraparound Cup*® model I created to use EPSDT resources for mental health treatment as fully as possible in this book.

My hope is that other “licensed practitioners of the healing arts” will be inspired to pursue even greater success by using the treatment model I created. Certainly, the phenomenal level of success experienced by the little boy who made friends with a gorilla is not common in the lives of children with Autism spectrum disorders, but I’ve experienced it more than once, and to a significant extent in the lives of hundreds of children since 1997, when I founded the Institute for Behavior Change (IBC).

Over 90% of the children treated by IBC staff for the past 20 years have completed their treatment program successfully in just three years or less. More than 75% of the children have shown significant reductions in their involvement in problem behavior in as little as four months. Independent researchers at four different educational institutions have found statistically significant associations between exposure to the treatment model I created and reductions in physical aggression, environmental safety problems, noncompliance with adult prompts, communication deficits and socialization deficits in children between the ages of 2 and 19.

Unfortunately, none of these remarkable research findings are adequate in the insular minds of the authorities who oversee the publication of “peer reviewed” research in the field of psychology. There is no “control” group – there is no group of children from whom treatment was withheld and with whom the responses of the children who did get treatment could be compared. The fact that withholding treatment from some children to see if it really worked for others could not be done ethically or legally doesn’t matter – without a “control” group, these authorities say, the research findings aren’t worthy of publication. But we have data for more than 1,000 cases. Four different independent researchers have examined it and reported that the probability that the outcomes we are documenting are due to “chance” is *less than one in ten thousand*. More than *seven hundred fifty* cases showed improvement. Doesn’t matter. *No control group, no publication*.

As a result of this sad state of the art, “Behavioral Health Rehabilitation Services” (BHRS, often mistakenly called “wraparound services” in Pennsylvania) are a scarce and shrinking commodity. These treatment services, which are unquestionably “evidence based,” are unknown to most people who need them just because their existence is being actively suppressed. I have traveled throughout the US since 2007 explaining how the Medicaid EPSDT mandate can be used by psychologists, pediatricians, psychiatrists and other “licensed practitioners of the healing arts” to fund the delivery of BHRS and other treatments. EPSDT funding is so unknown to millions of children with Autism spectrum disorders, ADHD and other seriously challenging behavioral disorders that I call it “the greatest treatment funding secret ever concealed.” Although this funding has been a requirement of the Medicaid program in every US State -- set by the US Congress in 1989 -- and is available to children with disabilities *regardless of family income* in 33 States, it remains conscientiously concealed.

State government officials are responsible for the widespread ignorance about EPSDT funding for mental health treatment; they have been directed *three times* by the Federal government since 1972 to actively outreach to eligible recipients. Instead, they fail to recognize effective treatment practices like the BHRS model I’ve developed, they support the reduction or elimination of BHRS treatment funding by Medicaid Managed Care Organizations, and keep non-school EPSDT funding “a mile wide and an inch deep.” Schools tap EPSDT funding without any such constraints. This book is an attempt to change that power imbalance. Medicaid is actually “a keg with two taps.” One runs full-tilt into public schools. The other is a little spigot that parents can use to obtain EPSDT funding for their child’s treatment both inside and outside of school. That little spigot is *really* well hidden.

Strategies for expanding and promoting EPSDT funding and BHRS treatment awareness appear throughout this book. You won't find any better source for this information. I have striven to raise awareness of the availability of EPSDT funding for the behavioral treatment of Autism, ADHD and other mental illnesses in children after proving over and over that it is a viable resource for the past 20 years. When State Medicaid authorities in Pennsylvania were allowing MMCOs to set and enforce State Medicaid policy, and refused to answer questions about this, I filed a Civil Rights complaint against the State of Pennsylvania and all of its Medicaid Managed Care Organizations. That was in December of 2012 (in the same week that Adam Lanza in Newtown, Connecticut killed his mother and dozens of others in a school there). That young man was eligible for EPSDT funding for his desperately needed behavioral treatment, but there is no record that his mother ever knew about it. She certainly was looking for help for her son; apparently, nobody told her how available it actually was. Connecticut is one of the 33 States where her son could have received the same treatment plan for Autism symptoms that children in Pennsylvania have been receiving under my scope of practice since 1992, including the little boy who befriended a gorilla. Access to such treatment could, literally, have saved dozens of lives in Newtown, Connecticut in 2012.

Public schools in every State certainly know about, and have been vigorously accessing EPSDT funds without any Managed Care oversight whatsoever – to the tune of over \$100,000,000.00 annually. For the past decade alone, schools have taken over \$50 Billion dollars from the Medicaid EPSDT program. The Civil Rights complaint I filed in 2012 was finally shut down in 2016 when the Office for Civil Rights (OCR) concluded that, because no children were being institutionalized, there were no violations of Civil Rights in Pennsylvania. For reasons that remain obscure, a State official opined to Federal investigators that *the one and only reason for the delivery of Behavioral Health Rehabilitation Services (BHRS, funded by EPSDT under the Medicaid Act) in Pennsylvania was to deter institutionalization*. That declaration apparently resulted in the OCR finding that no violations of Civil Rights had occurred. I filed an appeal of the OCR conclusion that documented this inexplicable and incontrovertibly wrong declaration. In fact, Pennsylvania law States that treatment that will 1) prevent the worsening of the child's condition, or 2) will treat the child's condition, or 3) will help the child to maintain his/her level of functioning at a level comparable to that of other children of the same age **is** "medically necessary" (and thereby *entitles* the child to EPSDT funding for BHRS treatment as a Civil Right).

There is a great deal of money and power at stake on the EPSDT battlefield. Imagine the good that could be done if government bureaucrats and insurance companies were prevented from defying the US Congress by denying funding for medically necessary treatment to children. The National Academy of Sciences notified Congress in 2001 that children with Autism symptoms (this includes many children with ADHD as well) need a *minimum* of 25 hours of intensive, individualized treatment every week, throughout the year, in order to have a reasonable chance for symptom reduction. The American Academy of Pediatrics echoed that same finding *twice*, in 2007 and 2012.

These unimpeachable national authorities' opinions are denigrated, dismissed or ignored by governmental bureaucrats, some of whom have risen to the highest echelons within the "Autism Community," and by licensed practitioners who do the bidding of their MMCO paymasters by recommending just five (5) hours of intensive weekly treatment for children with compelling Autism symptoms. They're prescribing treatment that is the equivalent of *"driving a tack with a toothpick."* They'll make sure that lots of toothpicks get broken and that nobody ever really gets much better. It's maddening but that's "the state of the art" in the fratricidal field of psychology where it has long been said that *"for every expert, there is an equal and opposite expert."*

Some licensed professionals do their utmost to insure that EPSDT -- the most reliable way to fund "Applied Behavior Analysis" (the only treatment modality proven to be effective for children with Autism symptoms and other serious behavioral challenges, which can easily be implemented within a BHRS framework, as I have been doing for 20 years) -- remains unknown and unavailable to almost every family that could benefit from it. But the schools will keep cashing their EPSDT checks....

Inexplicably, the Office for Civil Rights (OCR) *continued* to disconnect BHRS from EPSDT funding when it reviewed my appeal of the original OCR conclusion, yet that connection was the *foundation* of my complaint. All of the national advocacy groups to which I had appealed for help in this dreadful miscarriage of justice have encouraged for me to pursue the arguments I had advanced. Unfortunately, it now appears that only Federal court or legislative action may fix the dilapidated State of EPSDT funding for children's mental health treatment in the US. It is clear that parents have the only viable "standing" with which to pursue justice regarding access to EPSDT benefits. I hope to be a contributor to that battle for many years to come, as it will surely rage on. In 2015, the Supreme Court ruled that providers of Medicaid-funded treatment have no standing in arguments with State authorities about grossly inadequate EPSDT funding. Pennsylvania's EPSDT funding rates for BHRS were set in 1992 -- 24 years ago -- and have never been raised. That is a formula for killing the BHRS program eventually, of course. Death by attrition. It has been perpetrated conscientiously in Pennsylvania by successive governmental regimes for more than 25 years, and the providers of BHRS treatment have no voice to call for reasonable pay for the "medically necessary" and effective treatment services we deliver. The Supreme Court spoke and State Medicaid Agencies throughout America breathed a huge sigh of relief in August of 2015.

Despite all of the obstacles created by government bureaucrats, MMCOs and their friends, I have devised strategies to make the BHRS program thrive on "1992 dollars" so it's clear that the model can be implemented cost-effectively everywhere. By investing in intensive behavioral treatment for a short period of time in a young child's life, it is literally possible to place a child with developmental delays and mental illness symptoms on a productive track, and get them off the dreadful path they're heading down. My staff and I have done this more than 1,000 times over the past 20 years. Our successes, including my untangling of "the thread of Medicaid Eligibility" are described in this book. I have created training programs to show practitioners how the EPSDT BHRS treatment model I created can be applied in their practice. It is possible, for example, for pediatricians or family practitioners to implement "Medical Home" programs with expertise in children's behavioral health that will be **self-sustaining** through EPSDT funding -- they will actually *make* money for the practice -- by incorporating highly skilled children's mental health professionals into their medical practices.

I've learned a *tremendous* amount from the parents and children I've worked with. Their courage, tenacity, dedication and capacity for "doing new things that make sense" (even if they had secretly thrown in the towel many times in the past) has truly been inspirational. With very few exceptions in 20 years, I have been privileged to work with people like this. At the Institute for Behavior Change, we have been fortunate to recruit, train, deploy and monitor the performance of many, many excellent providers of professional mental health treatment to children. I've always operated in a "continuous quality improvement" mode. At the time of this writing, I own the largest private practice of psychology in Pennsylvania that is dedicated exclusively to the treatment of children in their homes, schools and communities (The *Network* for Behavior Change). We are currently treating over 130 children in six Southeastern PA Counties. More than 100 staff now work for the Institute for Behavior Change supplying staff to the *Network*, with an income over \$2 Million annually.

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The **Summary of Appendices** is an “internal table of contents” for the Appendices.

The appendices contain scanned documents and other media with embedded internet links. They are separated from each other by a single page that precedes each Appendix, describes the contents of that Appendix, and the pages included in it.

Summary of Appendices

Appendix A Pages 88 – 105

Presents the text of the criteria for Disability Evaluation Under Social Security for Children. This is the “Blue Book” published by the Social Security Administration which lists the diagnostic “disabling conditions” that justify access to EPSDT funding for treatment. The presentation here focuses on child mental illness symptoms that respond really well to Behavioral Health Rehabilitation Services (BHRS), especially when the *Effective Treatment in a Wraparound Cup*® model is used.

Appendix B Pages 107 -127

Presents the **Medical Necessity Criteria** (MNC) in each of the 50 US States that determine whether or not a given treatment or service can be funded by EPSDT in that State. If a treatment, like BHRS for example, is prescribed in accordance with the MNC in the State, then funding for that treatment must not be withheld from a child who is enrolled in Medicaid in that State. That’s Federal law. That’s what makes EPSDT funding for “medically necessary treatment” a Civil Right for disabled children enrolled in Medicaid.

Appendix C Pages 129 - 130

Presents a two-page paper called *Steps to secure EPSDT funding for Effective Treatment in a Wraparound Cup for children*. It is an outline of the process for securing EPSDT funding that was recognized by Dennis Embry at the PAXIS Institute and by Mental Health America as a useful tool for parents to embark on the odyssey of seeking EPSDT funding for their child’s mental health treatment. The Issachar Project could help to facilitate success tremendously in that undoubtedly daunting task.

Appendix D Pages 132 - 133

Shows in a two-page presentation how EPSDT creates enforceable rights for disabled children. Several noteworthy Disability Rights organizations reviewed this summary favorably, although the Office for Civil Rights (OCR) discovered a path that nobody seems to have contemplated before I brought my complaint to them. They successfully separated EPSDT from BHRS. That was a surprise. But if they *hadn’t* done that, then Pennsylvania (one of the more liberal implementers of the EPSDT mandate) would have been found lacking and required to improve access to EPSDT funding for mental health treatment.

The obvious implication here is that, if *Pennsylvania* was not doing EPSDT properly, the rest of the country, which falls far below Pennsylvania’s standards in many, many places, would have to improve their implementation of EPSDT and assure much greater awareness of, and more access to, this wonderful resource! Awareness of *that* possibility may account for the three-year delay before the OCR struck gold with the “separation of EPSDT from BHRS solution” that was handed to them by a Pennsylvania State Medicaid Agency employee who left his State position less than six months later.

Appendix E Pages 135 - 188

Presents The Thread of MA Eligibility which I created over a two-year period and have shared with lawyers, advocates, parents and practitioners to help them understand how Medical Assistance (MA) benefits become accessible to children with disabilities under the Social Security Act's "Medicaid" provision. The EPSDT benefit is actually "a plan within a plan," tucked inside the Medicaid Act which it itself embedded within the Social Security Act. I navigated through this confusing "bowl of legal spaghetti" and tied the ends together in a 60-page paper that makes the whole mess intelligible.

Appendix F Pages 190 - 192

Describes how the Institute for Behavior Change has infused "Applied Behavior Analysis" (ABA) principles throughout its treatment planning and delivery processes so that every Treatment Plan is an implementation of ABA. Since the term "ABA" has been hijacked by educational institutions and other entities for a variety of nefarious reasons, it is important to understand what the term *actually* means, as defined and described in the pages of this Appendix by the people who created the term and applied it to the treatment of behavioral disorders in humans in the 1950s and earlier.

Appendix G Pages 194 - 213

Gives an example of the kind of "life domain bio-psycho-social" evaluation that results in authorizations for 30 or more weekly hours of BHRS treatment. You will find that it is extensive, but the Institute for Behavior Change has mastered the process of creating these documents cost-efficiently. We would be happy to share our ideas with others who want to work with us.

Appendix H Pages 215 - 240

Contains the document submitted to the National Registry of Evidence-based Programs and Practices in 2016 as a Program Assessment. Although it was rejected for review because no "control group" was used, the document contains a wealth of useful information nonetheless.

Appendix I Pages 242 - 274

Contains documents from my 37 month-long odyssey with the Office for Civil Rights that began with my filing of a complaint in December of 2012 through the final slamming of the door (finding that no Civil Rights violations occurred in the lives of children with mental illness symptoms *simply* because none of them had been institutionalized) by the Department of Health and Human Services in January of 2016. For reasons unknown, the name of the Pennsylvania State Medicaid Agency official whose statements provided the basis for the OCR conclusion appears near the top of their 2015 conclusion statement; he is no longer employed in that position.

Appendix J Page 276

Presents a selection of some interventions our staff use to teach key concepts. One of the most difficult concepts to teach children who have developmental delays is how to "ignore" someone who is behaving cruelly toward them. I created the "filthy ball experience" as a teaching tool about ignoring and the staff have used it for decades with great success.

Appendix K Pages 278 - 284

Presents **The Behavior Barometer**. It is a paper form that is meant to be cut out and posted on the refrigerator in a home where a child's behavior is in need of correction. By sliding a pointer (mounted onto a magnet) up and down on the Behavior Barometer, the parent or other caretaker can give ongoing "visual feedback" to the child about his or her behavior. The Behavior Barometer has been used in more than 137 countries around the world since 2007 and has a US Patent.

Appendix L Page 286

Presents a paper titled "*How to tell if you're getting the best quality treatment services for your child.*" It presents the five core values that the staff of the Institute for Behavior Change strive to achieve: Tell the Truth, Share Fairly, Help Others, Be Thankful and Move Forward. If your treatment provider embraces and follows those values, chances are your child will be getting quality treatment.

Appendix M Page 288

Presents a one-page snapshot of The Institute for Behavior Change, showing our client base, staffing patterns and track record since 1997 to January of 2016. It is noteworthy that the Institute for Behavior Change is the only provider of children's mental health treatment in the State of Pennsylvania that will begin treating children upon their diagnosis, for up to 3 **months** before their application for Medical Assistance (Medicaid) has been *filed*. This is a little-known provision of the Medicaid Act which allows treatment to be started without delay; it's called "the period of presumptive eligibility" and all BHRS providers in the State could do what the Institute is doing....

Appendix N Pages 290 - 291

Describes **The Issachar Project** in brief, and shows the questions we pose to State Medicaid Agency personnel regarding the availability of EPSDT funding for behavioral treatment programs in any given State. With the answers to these questions, it is possible for a parent to strategically navigate the dark waters of the EPSDT system in any State in a search for honest and compassionate government employees. They do exist, but it's really disheartening to wade through the system until you find one, especially without a map.

The mission of **The Issachar Project** is to provide that map, individualized for every state. It will be updated no less than once yearly and maintained in an on-line database, supported by philanthropy.

Appendix O Pages 293 - 361

Describes the foundational documents in the State of Pennsylvania that finally brought BHRS to life here following a lawsuit filed in Federal Court in 1991. Like all States, Pennsylvania fought vigorously to delay, suppress and avoid the implementation of the Federal EPSDT mandate created by the Congressional *Omnibus Budget Reconciliation Act* of 1989. These documents showcase:

- the initial BHRS definitions and plans (1994) followed by
- the gradual tightening of the screws without any cost-of-living increases (2005) and
- the stumbling, repetitive efforts following the filing of my Civil Rights complaint in 2012 to create the *appearance* of reforming the BHRS system so as to have fewer collisions with the Civil Rights of disabled children. Three successive "BHRS draft Bulletins" were produced:

- April of 2013
- November of 2013
- June of 2014

All of these “BHRS Draft Bulletins” contain essentially identical information (coincidentally addressing 17 of the 18 points I made in my December of 2012 Civil Rights complaint), without ever achieving “finished” status (so *nothing* has ever officially changed in the administration of BHRS in Pennsylvania in all that time, up to the present date).

When asked in a Quarterly meeting of the Mental Health Planning Council in March of 2016 when the Department of Human Services (DHS, the State Medicaid Agency) would identify someone as their “answer person” for providers to obtain answers to questions regarding Medicaid Managed Care Organization behavior (one of the desperate needs identified in my 2012 OCR complaint), the Deputy Secretary of DHS responded: “*We’ll talk about that at our next meeting.*” That’s in **June**, 3½ years after my OCR complaint was filed & still no answers....

Appendix P Page 363

Contains the summary of BHRS that I created in 1994 and which continues to be used as each new BHRS reauthorization begins to introduce our staff and services to clients and their parents so that they understand the necessarily collaborative nature of our working relationship.

Appendix Q Pages 365 - 370

Shows the “strategy” I recommend using to defend the appropriateness of using EPSDT funds to deliver Behavioral Health Rehabilitation Services (BHRS) with EPSDT funding via the *Effective Treatment in a Wraparound Cup*® model I created. The strategy concludes with an appeal to *Accountability and Standards* and offers counter-arguments to the predictable claims that insurance company, State and local government authorities will make to prevent parental access to EPSDT funds for the treatment of their children.

Appendix R Pages 372 – 374

Shows the April 1, 2016 Bulletin released by the Pennsylvania Department of Human Services citing the authority of the Affordable Care Act that restricts the prescription of EPSDT funded treatment to those practitioners who are enrolled in Medicaid. In other words, for 50 years, any “licensed practitioner of the healing arts under scope of state law” could prescribe a treatment within their scope of practice, and if that treatment was a “covered service” under Medicaid, the child for whom it was prescribed could obtain EPSDT funding for that treatment if he or she was enrolled in Medicaid. Not anymore. Now, the **prescriber**, not just the service **provider** has to be enrolled in Medicaid in order for their prescription to be considered valid by the State Medicaid Agency.

With this change, the State Medicaid Agency effectively controls the practice of psychology and psychiatry in Pennsylvania when it comes to Medicaid-funded treatment. We’ll see how long this lasts; since it explicitly contradicts both the words and the intent of the Medicaid Act and wasn’t necessarily intended by the Affordable Care Act either.