

# Declaration of Chris Koyanagi

September 2, 2005

I, Chris Koyanagi, declare that, if called as a witness, I could and would competently testify as follows:

## I. Summary of Qualifications and Opinions

1. I have over 30 years of experience as a policy analyst working in the mental health and disability fields in Washington, D.C.
2. I am currently the Policy Director for the Judge David L. Bazelon Center for Mental Health Law ("Bazelon Center"). The Bazelon Center is a national legal-advocacy organization representing people with mental disabilities, including mental illness. A major focus of my work is on issues related to Medicaid, children's mental health services, and systems of care. I am the author of the Bazelon Center publication, *Making Sense of Medicaid for Children with Serious Emotional Disturbance* ("*Making Sense of Medicaid*"), which was the last comprehensive survey of children's mental health services of which I am aware.
3. Based on my years of experience examining the services covered by Medicaid, I have determined that wraparound and therapeutic foster care are covered mental health services. In fact, several states cover wraparound (either as a bundled package of services or by covering all of its component parts) and nearly half of the states covered therapeutic foster care (either as a bundled package of services or by covering all of its component parts). Because wraparound and therapeutic foster care are clearly covered by Medicaid, as demonstrated by the states that cover those services under Medicaid, children in all states are entitled to those services under Medicaid's Early and Periodic Screening, Diagnosis, and Treatment ("EPSDT") mandate.

## II. Qualifications

4. Since 1993, I have been the Bazelon Center's Policy Director, with responsibility for the Center's legislative and policy advocacy agenda. I work on issues of financing, particularly Medicaid, policies to avert criminal justice involvement by adults and juveniles with mental illness, and other policy issues relating to provision of community services for adults and children with mental disorders. I regularly communicate with staff at the Center for Medicare and Medicaid Services ("CMS") and the Substance Abuse and Mental Health Services Administration ("SAMHSA"). I also work with a number of other federal agencies, including the Department of Education and the Social Security Administration, as well as with state mental health and Medicaid agencies. I do not work on any litigation matters at the Bazelon Center.
5. For seven years prior to joining the Bazelon Center staff, I was Vice-President for Government Affairs for the National Mental Health Association ("NMHA"), a mental health citizen advocacy organization with more than 340 affiliates nationwide. In that capacity, I was responsible for initiating and supervising all NMHA contacts with Congress and the executive branch of the federal government. I made recommendations on NMHA's positions on mental

health public policy issues and interpreted those positions to Members of Congress, federal agencies, other national organizations, the media and the general public. As the NMHA's chief legislative strategist, I led a three-person government affairs team which was responsible for the Association's grass roots and Washington-based lobbying activities.

6. I have served on more than a dozen advisory groups in the mental health field, including the Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Dept. of Health and Human Services; Assertive Community Treatment Program Evaluation Panel, which was convened by the Substance Abuse and Mental Health Services Administration ("SAMSHA") with the full involvement of the Center for Medicare and Medicaid Services ("CMS"); the Florida Mental Health Institute, University of South Florida, Medicaid Advisory Group; and the Advisory Committee for the National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.

7. I have also authored numerous publications on health care reform at national and state levels on various topics including Medicaid reform and children's mental health services. Among them are: *Mix and Match: Using Federal Programs to Support Interagency Systems of Care for Children with Mental Health Care Needs*, Bazelon Center Issue Brief, 2003; *The Federal Government and Interagency Systems of Care for Children with Serious Mental Health Disorders: Help or Hindrance?*, Bazelon Center Issue Brief, 2002; *Avoiding Cruel Choices: A Guide For Policymakers and Family Organizations on Medicaid's Role in Preventing Custody Relinquishment (2002)*; *Recovery in the Community: Funding Rehabilitative Approaches Under Medicaid (Vol.1)*, Bazelon Center, 2001; *Covering Intensive Community-Based Child Mental Health Services*, Bazelon Center, 2001; *Making Sense of Medicaid for Children with Serious Emotional Disturbance*, Bazelon Center, 1999; and *A Family Advocate's Guide: Managed Behavioral Health Care for Children and Youth*, Bazelon Center, 1996.

8. I also have authored or co-authored a number of peer reviewed journal articles and book chapters on Medicaid, including "The TEFRA Medicaid eligibility option for children with severe disabilities: A national study," *The Journal of Behavioral Health Services & Research* 31:3, July/Sept. 2004; "Behavioral health screening policies in Medicaid programs nationwide," *Psychiatric Services* 54:5 May 2003; "Accessing Medicaid's child mental health services: The experiences of parents in two states," *Psychiatric Service* 54:4 April, 2003; "Just what is managed care?," *National Council of Jewish Women Journal*, New York, N.Y. Spring 1997; "The Medicaid program and the Clinton plan: Implications for mental health services," *Hospital and Community Psychiatry* 45:9, September 1994; and "The missed opportunities of Medicaid," *Economic Grand Rounds, Hospital and Community Psychiatry* 41:2, February 1990.

9. A fuller description of my education and experience is set forth in my curriculum vitae, which is attached as Exhibit 1.

### **III. The Bazelon Center Study, *Making Sense of Medicaid for Children with Serious Emotional Disturbance***

10. In 1999, the Bazelon Center released the report, *Making Sense of Medicaid for Children with Serious Emotional Disturbance*. I was the primary author of this report. As far as I am aware,

this publication was the last comprehensive survey of funding for children’s mental health services under Medicaid. This report is attached as Exhibit 2 to this declaration.

11. The *Making Sense of Medicaid* publication was borne out of the Bazelon Center’s experience that some states were not defining in their Medicaid rules the full array of comprehensive mental health services that are required under Medicaid’s EPSDT mandate. As a result, the publication was produced with the goal of encouraging states to improve their Medicaid policies so that all children with mental health needs—and particularly, those children with serious mental or emotional disorders—had ready access to appropriate mental health care.

12. In order to study the nationwide use of Medicaid, the Bazelon Center conducted a survey to exhibit how states were using Medicaid to cover children’s mental health services. The intent of this survey was to identify federal funded mental health services that are specifically defined under Medicaid regulations, state or county requests for proposals and state or county contracts for managed care. Medicaid fee-for-service and managed care programs were identified in all 50 states and the District of Columbia. Our study included 39 fee-for-service Medicaid programs, 22 of the larger Medicaid managed care programs that provide benefits for children with extensive mental health needs, and seven managed care plans that provide acute mental health care benefits.

13. The *Making Sense of Medicaid* study was unique in that we based our report on the state’s actual Medicaid regulations and contract language, as well as expert opinion. Most other studies relied on expert opinion alone. Through this two-part review, we identified mental health services listed in 68 Medicaid programs.

14. For the first part of the review, which took place from March 1998 through June 1999, we examined state Medicaid regulations, provider manuals, state plans, managed care requests for proposals and contracts to identify the Medicaid-listed services. We collected these materials from the states’ own Medicaid agencies.

15. Out of our analysis of these documents, we then created standardized instruments (called “study categories”) for three discrete mental health service areas:

- i. Community-based services;
- ii. Clinic services; and
- iii. Institutional care services.

16. Programs and broad services were broken down into components to fit into these categories, particularly those in psychiatric/psychosocial rehabilitation services. For instance, if a state provides a community support program that includes family support, independent living skills and day treatment programs, then all four services were counted as listed services. Services not listed in the study categories were included in the “other” category.

17. For the second level of review, we sent a summary of the service definitions we had identified to each participating state's Medicaid agency and its Children, Youth and Family Division Representative of the National Association of State Mental Health Program Directors. For one third of the programs, we received responses from the Medicaid program and the Children, Youth and Family Representative, submitted jointly or independently. For all but four of the remaining programs, we received one response from the Medicaid program or the Children, Youth and Family Representative.

18. After this two-step review, we then made determinations with regard to whether the state covered the study categories in the aforementioned service areas (Community Based, Clinic, and Institutional Care). See Exhibit 2, Tables 1-7.

19. Services were counted for purposes of the study only if language in a Medicaid regulation, contract or RFP identified it as a defined service. Medicaid regulations often had the most complete documentation.

20. For each defined service, a "+" was placed in the column and row corresponding to that study category and state. Thus, the table represents children's mental health service required by regulation, policy, state plan or contract in each state, as confirmed by the state's own officials.

21. Because the study covered states that had different federal waivers as well as those that did not, the results are useful in documenting which states provide community and other mental health services without regard to a special waiver. Many states use Medicaid funding to support a wide range of children's mental health services, and receive federal financial participation for community-based services. Further, states need not have waiver programs to meet their obligation to fund community-based services under Medicaid. These states are designated as fee-for-service states and include approximately 39 states.

22. This *Making Sense of Medicaid* study was revealing in that it demonstrated that wraparound and therapeutic foster care can be covered by Medicaid. Specifically, we found that many states covered wraparound (either as a bundled package of services or by covering all of its component parts) and nearly half of the states covered therapeutic foster care (either as a bundled package of services or by covering all of its component parts). Both of these points are discussed in greater detail below.

#### **IV. States Routinely Receive Federal Financial Participation to Fund Wraparound and Therapeutic Foster Care.**

23. A state's obligation to provide mental health services to Medicaid-eligible children arises if the medically necessary service covered is within one of the categories of service a state could elect to include in its Medicaid plan if it chose to do so, even if those services are not actually listed in the state plan. This is to say that in order to receive federal matching dollars (called Federal Financial Participation or "FFP"), the service must fit within one or more of the Medicaid "boxes," which are demarcated in the Medicaid statute. These categories range from hospitalization and laboratory testing, to case management and rehabilitative services. Early and Periodic Screening, Diagnosis, and Treatment ("EPSDT") is a mandate for children 21 years old

and under to receive all Medicaid-covered services that are medically necessary to treat their condition.

24. Some of the categories in the Medicaid Act—including hospital stays—are considered “mandatory” and states must provide them to both adults and children, where medically necessary. Other services—including rehabilitative services—are optional services for adults; the state may elect to provide them to adults, or may elect to not provide those services. However, as noted above, children are entitled to both mandatory and optional services because the EPSDT mandate requires that a state provide all necessary categories of service.

25. Typically, the state’s obligation to provide comprehensive community-based services arises under the EPSDT mandate, as the services typically fit within Medicaid categories. These categories include the “Rehabilitation Option,” 42 U.S.C. § 1396d(a)(13); targeted case-management services, § 1396d(a)(19); physician services, § 1396d(a)(5)(A); home health care services, § 1396d(a)(7); and clinic services, § 1396d(a)(9).

26. What is at issue in the Katie A. lawsuit—wraparound and therapeutic foster care—fit within the Medicaid services categories and are regularly funded by Medicaid.

27. Some states fund wraparound as a bundle of services. For example, at the time of the publication of *Making Sense of Medicaid*, Nebraska’s managed care contract funded wraparound per se, defining it as “intensive home-based services as well as resources and community supports tailored to the unique needs, strengths and priorities of the individual/family.” It required that wraparound “be integrated with the comprehensive community-based system of care for individuals/families that includes local health and human services system . . . .” Other states cover all of the components of wraparound under Medicaid, as I discuss more fully below. This demonstrates that wraparound is clearly a Medicaid-covered services, and as a result, children in all states are entitled to wraparound under EPSDT.

28. Based upon my experience, and the Bazelon study of children’s mental health services, some states cover all of the components of wraparound as a mental health service under the following Medicaid categories:

**a. Engagement of the Child and Family:** This component, as defined in the Katie A. suit, is “an initial meeting with the child and family. During this meeting the coordinator engages the child and family, explains wraparound care services, and encourages the participation of additional family members and other natural supports. The engagement of the child and family continues throughout the provision of wraparound care services.” This process of engagement can be billed as case management or as family education on the child’s disorder through the Rehabilitation services category. (Case management services directed at managing Medicaid covered services may be covered as a component of any Medicaid service; when case management links the individual to non-Medicaid services and supports, targeted case management must be billed.)

**b. Immediate Crisis Stabilization:** This component is defined as “actions taken to address immediate concerns about safety and security. Before the first full team meeting, the wraparound coordinator and other team members might need to address safety issues related to medical

needs, severe psychiatric symptoms, behaviors of a child that might place others in jeopardy, or issues related to a child living in an unsafe environment. In addition to the immediate relief of existing safety concerns, the wraparound coordinator attempts to predict potential areas of crisis and to clearly identify ways to resolve the crisis, should one occur.” Crisis intervention is a crucial mental health intervention and can be covered under the outpatient rehabilitative services option. (As of January 2004, 31 states covered crisis management/intervention for adults as part of the outpatient rehabilitative services option, but all are required to cover this service for children under the EPSDT mandate.)

c. **Strengths and Needs Assessment:** This component is defined as: “gathering information that identifies the unique skills, talents, interests, and resources of the child and family. This information is used to build a strength-based and individualized service plan.” Mental health assessments are an entitlement to children as a part of the EPSDT “screening” and often as part of a state’s Rehabilitation Option. The Rehabilitation Option includes diagnostic, screening, preventive, and rehabilitative services. Strength and need-based assessments are commonly provided to children with significant mental health needs.

d. **Wraparound Team Formation:** Within this component, the “wraparound coordinator contacts potential team members” who include “the child, the parent or guardian, and the wraparound coordinator” and often “friends, extended family, neighbors, members of the family’s faith community, teachers, social workers, therapists and co-workers” and “explain[s] the specific reasons they are needed on the team and coordinates the schedules of team members.” Again, as with “Engagement of the Child and Family,” engagement of other team members and any initial service planning that may occur as a team is forming, can be billed as either case management or as targeted case management. Further, there may be an assessment aspect to the team formation, which could be billed as part of the EPSDT “screening” and often as part of a state’s Rehabilitation Option.

e. **Wraparound Plan Development:** Within this component, the “wraparound team works together to develop and adopt a wraparound plan. The service plan describes the needs, long-range vision and short-term objectives for the child and family, and the services that will best fit their needs.” Further, “[d]uring the wraparound team meetings, the wraparound facilitator will coordinate the assignment of tasks to team members. Deadlines for task completion are recorded.” This component will “secure services and supports, sometimes from formal networks of mental health supports, other times from other child-serving systems, and often from community and other informal sources” As discussed above, this is both a rehabilitative task and a case management task. The inclusion of family-voice and family-choice serves rehabilitative goals for the child. This encompasses two forms of case management. Case management services directed at managing Medicaid covered services may be covered as a component of rehabilitation services. Case managed services which are directed toward gaining access to and monitoring non-Medicaid services can be billed under the targeted case management. See, Memorandum from Christine Nye, HCFA Medicaid Bureau Director, to All Regional Administrators, Rehabilitation Services for the Mentally Ill (1992), attached as Exhibit 3 to this declaration. We found that 43 states specifically included targeted case management as an included service in its state plan, in our research for *Making Sense of Medicaid*.

**f. Wraparound Service Plan Implementation:** Wraparound services are, by definition, highly individualized, so the specific services, and the Medicaid categories in which they covered will also vary. However, as the plaintiffs' definition notes, services "will consist of both natural and formal supports." The "formal services that are provided may include (but are not limited to): diagnostic intellectual evaluations, comprehensive neurological evaluations, therapeutic behavioral support services, individual and family crisis planning and intervention services, parent coaching and education, medication monitoring, intensive in-home, individual, group, and family therapy services, interactive psychotherapy using play equipment, physical device, or other mechanisms of non-verbal communication, individual rehabilitation services, and day rehabilitation." Each of these services is reimbursable under a variety of different Medicaid categories. For example, counseling and therapy can be covered under either the Clinic or the Rehabilitation services categories. Services directed toward the elimination of psychosocial barriers that impeded the development or modification of skills necessary for independent functioning in the community are Rehabilitation services. Further, contact with "collaterals" (i.e., family members, teachers) would also be included, so long as it were directly and exclusively to the effective treatment of the recipient. See, Memorandum from Christine Nye, HCFA Medicaid Bureau Director, to All Regional Administrators, Rehabilitation Services for the Mentally Ill (1992). The Rehabilitation Option also specifically provides that rehabilitation services may be furnished in a variety of community locations, including the child's home, school, daycare program, or other natural setting.

Another example of a Medicaid-covered service that may be part of a wraparound implementation plan is therapeutic behavioral aide services. Therapeutic behavioral aides typically are experienced staff persons available on a one-on-one basis to work with a child with severe emotional or mental disabilities in his or her home and community. The services offered by these aides are aimed at assisting a beneficiary in improving, maintaining or restoring skills, and are offered through a mental health treatment plan with specific treatment goals. They are generally categorized as Rehabilitation services, and examples of these services include teaching the child appropriate problem-solving skills, anger management, and other social skills or engaging the child in constructive activities in the community.

**g. Ongoing Crisis and Safety Planning:** The long-term crisis planning that is envisioned under this component of wraparound is also a Medicaid reimbursable service, as is the initial crisis stabilization. This can be either a Clinic or a Rehabilitation service under Medicaid.

**h. Tracking and Adapting the Wraparound Service Plan:** In this component the "wraparound facilitator tracks assignment completion." This is a case management task. Further, this component also includes the "modif[ication] of the wraparound plan when appropriate." This component is Medicaid reimbursable in the same way as the "Wraparound Service Plan Development," discussed above.

**i. Transition:** The last component of wraparound involves the "wraparound team ensur[ing] that children and families are appropriately transitioned from wraparound, either when the child leaves the children's mental health system for the adult mental health system, or when the child and family no longer need formal supports." Services to assist a child in transition are not generally different from other services furnished to a child, but are age-appropriate and focus on

skills training that lead to independent living or success in work or higher education. These are rehabilitation services.

29. Therapeutic foster care (“TFC”) is a mental health service that is commonly billed under the Medicaid Rehabilitation category. Indeed, as discussed above, nearly half of the states covered therapeutic foster care as a Medicaid service. States, including Nevada, generally bill therapeutic foster care as a bundled package of services, where all of the components are billed in one case rate. I understand, however, that at least one state, Arizona, covers all of the component parts of the therapeutic foster care, but bill separately for those parts. I believe that it is highly preferable to bill therapeutic foster care as a bundled service. In either case, all of the components of therapeutic foster care are covered, and all of the human activities associated with therapeutic foster care are Medicaid reimbursable.[1] This demonstrates that therapeutic foster care is clearly a Medicaid-covered service, and as a result, children in all states are entitled to it under EPSDT.

30. Based upon my experience, and the Bazelon study of children’s mental health services, a state like Arizona that bills separately the components of therapeutic foster care could bill under the components following Medicaid categories:

a. **Recruitment and Matching:** This component, as defined in the Katie A. suit, is “the recruitment of families to serve as therapeutic foster parents, and then matching those families with children in need of a therapeutic foster home.” This process of recruitment can be billed as case management through the Rehabilitation services category. (Case management services directed at managing Medicaid covered services may be covered as a component of any Medicaid service; when case management links the individual to non-Medicaid services and supports, targeted case management must be billed.) In order to match a child with a family, it is likely that the child will need to be assessed, to determine both his strengths and needs, so that an appropriate placement can be made. Mental health assessments are an entitlement to children as a part of the EPSDT “diagnosis” and often as part of a state’s Rehabilitation Option. The Rehabilitation Option includes diagnostic, screening, preventive, and rehabilitative services. Strength and need-based assessments are commonly provided to children with significant mental health needs.

b. **Therapeutic Foster Parent Training:** This component involves the training of the foster parent before a child with mental health needs enters their home, during which “the foster parent is taught how to use behavior management strategies.” It also involves the “ongoing supervision and support, similar to that given to therapist trainees” provided to therapeutic foster parents. This process of training foster parents and providing ongoing support can be billed as case management or as family education on the child’s disorder through the Rehabilitation services category.

c. **Development of Treatment Plan:** The treatment planning process in therapeutic foster care, is described as developing a “treatment plan that is both standardized and individualized” and “focused on the individualized strengths and needs of the child” in order to “guide[] the foster parents to be specific in the way they reinforce progress and to be consistent in setting limits and consequences.” The treatment plans are created in team meetings, “during which the overall integrity of the child’s treatment plan is monitored and re-evaluated, and the sequencing and



timing of interventions is planned.” The entire treatment planning process is billed in the same manner as “Wraparound Service Plan Development,” (i.e., as both a rehabilitative task and a case management task).

**d. Tracking and Adapting the Treatment Plan:** In this component, therapeutic foster care coordinators “provide intensive case monitoring, coordinate the efforts of the foster parents and the individual therapists.” They also “maintain contact with the child’s biological parents, teachers, employers, and other important members of the child’s community.” As discussed above, contact with the members of the child’s community would also be included, so long as it were directly and exclusively to the effective treatment of the recipient. See, Memorandum from Christine Nye, HCFA Medicaid Bureau Director, to All Regional Administrators, Rehabilitation Services for the Mentally Ill (1992). This process is billed as both rehabilitative and case management tasks.

**e. Plan Implementation—Individual Child Treatment:** Within this component, both the services provided by the therapeutic foster parent (and as the service description notes, “On a day-to-day basis, the therapeutic foster parent is the primary agent who implements the child’s treatment plan”) and the formal services, which may include “diagnostic intellectual evaluations, comprehensive neurological evaluations, therapeutic behavioral support services, individual and family crisis planning and intervention services, parent coaching and education, medication monitoring, intensive in-home, individual, group, and family therapy services, interactive psychotherapy using play equipment, physical device, or other mechanisms of non-verbal communication, individual rehabilitation services, and day rehabilitation.” As with the “Wraparound Service Plan Implementation” these services are covered under a variety of categories. By way of example, the evaluations are an entitlement to children as a part of the EPSDT “diagnosis” and often as part of a state’s Rehabilitation Option. The Rehabilitation Option includes diagnostic, screening, preventive, and rehabilitative services. The counseling and therapy can be covered under either the Clinic or the Rehabilitation services categories. Services directed toward the elimination of psychosocial barriers that impeded the development or modification of skills necessary for independent functioning in the community are Rehabilitation services. Each of the formal services listed are considered Medicaid covered services. All of the human activities associated with the natural supports—for example, coordinating the provision of natural supports—are Medicaid covered services. As previously noted, case managed services which are directed toward gaining access to and monitoring non-Medicaid services can be billed under the targeted case management. See, Memorandum from Christine Nye, HCFA Medicaid Bureau Director, to All Regional Administrators, Rehabilitation Services for the Mentally Ill (1992).

**f. Plan Implementation—Family Treatment:** Within this component, and where appropriate, “family therapy is provided, and parents are taught how to use the behavioral management techniques used by the child’s therapeutic foster family.” The counseling and therapy services, where aimed directly and exclusively to the effective treatment of the child, are Medicaid covered services. This form of counseling and therapy can be covered under either the Clinic or the Rehabilitation services categories, depending on where it is provided.

**g. Transition:** The final component of therapeutic foster care is “ensur[ing] that children and families are appropriately transitioned from therapeutic foster care, either when the child and family no longer need therapeutic foster care, or when the child leaves the children’s mental health system for the adult mental health system.” Often this involves transitioning the child from therapeutic foster care, to wraparound care. Because wraparound is a Medicaid covered service, case management services may be covered as a component of any Medicaid service, and in this case, billed as Rehabilitative services. Further, the “family therapy continues after the child leaves care” and again, as long as this therapy is aimed directly and exclusively to the effective treatment of the child, it is covered under the Rehabilitative or Clinic service categories.

31. Sometimes there are instances when either wraparound teams or

therapeutic foster program go beyond providing mental health services. These costs are not necessarily covered under Medicaid. For example, occasionally a wraparound team or a therapeutic foster program will recommend buying one-time or occasional goods and/or services needed to support the child and their family through a crisis, such as purchasing clothes or a refrigerator or paying utility or rent bills. Or, a wraparound team or therapeutic foster care program may recommend school-related services, like a tutor, which are funded by the school system and not Medicaid. These costs are not Medicaid-covered services, nor are they central or core components of either wraparound or therapeutic foster care as mental health services.

## **VI. Conclusion**

31. Wraparound and therapeutic foster care are covered Medicaid services, eligible for Federal Financial Participation.

33. *The Making Sense of Medicaid* publication demonstrated that wraparound and therapeutic foster care can be covered by Medicaid. Because wraparound and therapeutic foster care are clearly covered by Medicaid, as demonstrated by the states that cover those services under Medicaid, children in all states are entitled to those services under Medicaid’s EPSDT mandate.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the foregoing is true and correct. Executed on September 2, 2005, in Washington, D.C.



Chris Koyanagi