DECLARATION OF MARTHA KNISLEY

I, Martha Knisley, hereby declare and affirm as follows:

A. Summary of Opinions

1. I have more than 25 years experience in the development and implementation of Medicaid-funded community-based services for children and adults with mental health needs. I have held leadership positions in several states' public mental health systems. I have served as the Director of the Department of Mental Health for the District of Columbia; Director of the Ohio Department of Mental Health; Deputy Secretary for Mental Health in Pennsylvania; and Deputy Executive Director of the Wake Area Mental Health Program in North Carolina. In these positions, I helped design, gain approval from the Centers for Medicare & Medicaid Services (CMS), and implement Medicaid-funded community-based services for children and adults with mental health needs.

2. I am currently a consultant with the Technical Assistance Collaborative (TAC) and was a consultant with TAC prior to my tenure as Director the Department of Mental Health for the District of Columbia. Much of my work with TAC has focused on assisting states in designing, gaining CMS approval, and implementing Medicaid-funded community-based services for adults and children with mental health needs. I have consulted with approximately a dozen states on using Medicaid to fund community-based services for children and adults with mental health needs.

3. I have reviewed the components of wraparound services and of therapeutic foster care, as set forth, respectively, in Appendices A and B to Plaintiff Henry D.'s Further Supplemental Responses to Interrogatories. It is my opinion that these components are coverable by Medicaid. All of the components

of wraparound services and therapeutic foster care fit within one or more of the Medicaid categories listed in 42 U.S.C. § 1396d(a). Moreover, I have worked with several states that cover the components of wraparound services and therapeutic foster care, and I am aware of other states that cover these services.

4. I have reviewed the August 16, 2006 letter from Gale P. Arden, Director of CMS' Center for Medicaid and State Operations Disabled and Elderly Programs to Stan Rosenstein, Deputy Director of the California Department of Health Services, Medical Care Services (a true copy of which is attached as Exhibit 1 and incorporated herein by reference) and the May 28, 2004 declaration of Mary Jean Duckett, then Acting Deputy Director of CMS' Center for Medicaid and State Operations Disabled and Elderly Programs (a true copy of which is attached as Exhibit 2 and incorporated herein by reference). Although these documents raise questions about the coverage of some of the components of wraparound services and therapeutic foster care, they also reveal that many of the components can be covered by Medicaid. Moreover, the essence of much of Ms. Arden's letter is that CMS needs more information to determine whether the proposed services are coverable by Medicaid; this is a reflection of the fact that California did not submit a formal State Plan Amendment to CMS, and instead, as I understand, submitted to CMS documents that were written for another purpose (this litigation), that did not contain the type of information that would be in a State Plan Amendment, and that were not written in a manner that CMS would expect. The other issues raised in the CMS letter and Duckett declaration are, in my opinion, based on CMS' misunderstanding of the Appendices. Neither Ms. Arden nor Ms. Duckett have raised any issues that change my expert opinion that

when properly described, the components of wraparound services and therapeutic foster care are coverable by Medicaid.

B. My Qualifications

5. I have more than 25 years experience in the development and implementation of community-based services for children and adults with mental health needs, particularly services financed by Medicaid.

6. I have held a variety of leadership positions in several states' public mental health systems.

a. I was the Director of the Department of Mental Health for the District of Columbia. In this position, I served as the Chief Mental Health Officer for the District of Columbia and the principal advisor to the Mayor on all mental health and policy programs. I was the first person appointed to this newly created position. During my tenure, I managed the development and implementation of a compressive mental health system that serves children, youth, adults and families with an emphasis on recovery and consumer/family involvement in all aspects of service delivery. As part of this process, I helped expand Medicaid-funded mental health services in the District, including intensive community-based services for children and youth with mental health needs. Among other things, I was principally responsible for designing and helping the District gain CMS approval to begin providing a variety of services under the service category of rehabilitative services, 42 U.S.C. § 1396d(a)(13), [1] to adults and children with

[1] 42 U.S.C. § 1396d(a)(13) lists as a category of services "other diagnostic, screening, preventative, and rehabilitative services . . . for the maximum reduction of physical and mental disability and restoration of an individual to the best

mental health needs. I also had management responsibility for all community mental health programs and for the District's psychiatric hospital.

b. I also served in several leadership positions with the Ohio Department of Mental Health, including Deputy Commissioner, Deputy Director, and culminating with my appointment as Director. As Director, I was responsible for the administration and direction of a Cabinet level state department with an annual budget of over $600 million. I was appointed by and reported directly to the Governor. In this position, I helped expand the array of Medicaid-funded community-based services available to adults and children with mental health needs. Among other things, I designed and helped gain approval from CMS for Ohio to begin providing a variety of services under the service category of case management services, 42 U.S.C. § 1396d(a)(19), to adults and children with mental health needs.

c. I served as Pennsylvania's Deputy Secretary for Mental Health. I was primarily responsible for the direction and supervision of the Office of Mental Health in the Department of Public Welfare, with a budget exceeding $660 million. In this position, I also helped expand community-based services for children and adults with mental health needs, including by designing and helping gain CMS approval for Pennsylvania to add a variety of services under the service category of case management services, 42 U.S.C. § 1396d(a)(19), for children and adults with mental health needs.

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possible functional level." This category is commonly known as rehabilitation services.

d. I also was the Deputy Executive Director of the Wake Area Mental Health Program. During my tenure, among other things, I began a Medicaid managed-care operation for children with mental health and/or substance disorders, implemented a system-wide Children's Initiative, and substantially increased Medicaid funding for children's mental health services.

7. I am currently a consultant with the Technical Assistance Collaborative (TAC) and was a consultant with TAC prior to my tenure as Director the Department of Mental Health for the District of Columbia. TAC assists public and non-profit agencies in planning and implementing the design, financing, and management of public sector human services, mental health, substance abuse, and health care strategies. Much of my work with TAC has focused on assisting states in expanding Medicaid-funded community-based services for adults and children with mental health needs. Among other things, I have helped states develop Medicaid plans that meet Medicaid rules and best practices, assisted states with gaining CMS approval for services, and engaged in auditing/compliance activities to ensure that states are following Medicaid rules in providing services. I have consulted with approximately a dozen states on using Medicaid to fund community-based services for children and adults with mental health needs, including North Carolina, Maine, Florida, New Mexico, Pennsylvania, New Jersey, and Louisiana.

8. I was the principal investigator for a five-year Systems of Care Grant in the District of Columbia awarded by the Substance Abuse and Mental Health Services Administration (SAMHSA) in the Department of Health and Human Services. I have been the principal investigator on approximately half a dozen

other major grants dealing with services for children and adults with mental health needs, including several grants from the National Institute for Mental Health.

9. I have served as an expert to the court in several cases related to services for people with mental health needs, as well as an expert for the U.S. Department of Justice and for several non-profit organizations. I am an expert for plaintiffs in *Rosie D. v. Romney*, a lawsuit about children's entitlement to community-based services under Medicaid in Massachusetts.

10. I have been involved in many professional organizations related to mental health issues, including the National Association of State Mental Health Program Directors. I regularly present on issues related to mental health system reform, financing, and services. I have published several articles or book chapters on community-based services for people with mental illness, and I have received a number of honors and awards for my work.

11. My curriculum vitae details my educational, professional experience, and organizational affiliations, a true copy of which is attached as Exhibit 3 and incorporated herein by reference.

C. Medicaid Covers the Components of Wraparound Services and Therapeutic Foster Care

12. I have reviewed the components of wraparound services, as described in Appendix A, and of therapeutic foster care, as described in Appendix B. It is my expert opinion that all of the components of wraparound services and therapeutic foster care can be covered by Medicaid.

13. For a service to be covered by Medicaid, it must be able to fit within one of the categories of services listed in 42 U.S.C. § 1396d(a). These categories of services are very broad, and many individual services fall within each service

1 category. An individual service need not be expressly listed in § 1396d(a) to be
2 covered by Medicaid. For example, when I was the Director of the Department of
3 Mental Health for the District of Columbia, I designed and assisted the District
4 with gaining CMS approval for a number of community-based services, all of
5 which were covered under the service category of rehabilitative services listed in §
6 1396d(a)(13). The specific individual services that were approved by CMS as
7 rehabilitative services are: Diagnostic/Assessment, Medication/Somatic
8 Treatment; Counseling; Community Support; Crisis/Emergency;
9 Rehabilitation/Day Services; Intensive Day Treatment; Community-Based
10 Intervention (CBI); and Assertive Community Treatment (ACT). See D.C.
11 Municipal Regs., tit. 22A, § 3402 (a true copy of which is attached as Exhibit 4
12 and incorporated herein by reference), at § 3402.4. None of these specific services
13 are listed in § 1396d(a). Similarly, I recently advised New Mexico on developing
14 a service entitled Comprehensive Community Support Services (a true copy of
15 which is attached as Exhibit 5 and incorporated herein by reference). New
16 Mexico gained approval from CMS for providing a service Again, this service is
17 not listed in § 1396d(a) but instead fall under the broad service category of
18 rehabilitative services, § 1396d(a)(13).
19 14. Covered services often can fit within more than one service category
20 listed in 42 U.S.C. § 1396d(a). Counseling, for example, can be covered under a
21 variety of service categories, including, among others, that of rehabilitative
22 services, § 1396d(a)(13); "medical care, or any other type of remedial care
23 recognized under State law, furnished by licensed practitioners within the scope of
24 their practice as defined by State law," § 1396d(a)(6); physician services (if
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provided by a psychiatrist), § 1396d(5)(A), or clinic services, § 1396d(a)(9).[2] States have flexibility in deciding how to cover services, and this flexibility is a hallmark of the Medicaid program.

15. All of the components of wraparound services and therapeutic foster care fit within one or more of the categories of services listed in 42 U.S.C. § 1396d(a). Appendices A and B list the service categories within which each component fits. I agree with the list of service categories for each component. While states have flexibility and could cover the components under the variety of service categories listed in Appendices A and B, in my experience, most states generally cover the activities that are the components of wraparound services and therapeutic foster care under the categories of rehabilitative services, § 1396d(a)(13), and case management services, § 1396d(a)(19).

16. I have worked with several states that cover the components of wraparound services and therapeutic foster care. For example, the District of Columbia covers most of the components listed in Appendices A and B through its service entitled "Community-Based Intervention" (CBI). Exh. 4 at § 3422. CBI includes a wide variety of community-based interventions and activities intended to keep children in their own communities and homes (or when that is not possible, a home-like environment) and prevent institutionalization of children. There are three levels of CBI, depending on the level of need of the child. All levels of CBI include the following services: immediate crisis

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[2] In the case of services for children, services under all categories of services listed in § 1396d(a) are mandatory under the "[e]arly and periodic screening, diagnostic and treatment services" (EPSDT) mandate, 42 U.S.C. § 1396d(r).

response; crisis stabilization; assessment (including identification of risk factors that may endanger the child or his/her family and assessment of strengths of the child and his/her family); individual and family support interventions that develop and improve the ability of the family and significant others to care for the child's behavioral, emotional or mental health disorder; skills training (including training related to behavioral management, medication management and monitoring, and helping the child's family develop skills for managing the child's disorder); and coordination and linkage with other services and supports to prevent utilization of more restrictive residential treatment (including referral of child and family to other providers, assisting with transition, and supporting and consulting with the consumer's family or support system). *Id.* at § 3422.6. This, in my expert opinion, is strong evidence that the components of wraparound services and therapeutic foster care are covered by Medicaid.

17. CMS has proposed new regulations regarding the category of services known as "rehabilitative services," 42 U.S.C. § 1396d(a)(13). Proposed rules, Department of Health and Human Services, Centers for Medicare & Medicaid Services, Medicaid Program: Coverage for Rehabilitative Services, 72 FR 45201 (Aug. 13, 2007). In part, these regulations are a continuation of prior CMS policy and make clear that this category of services can be used for such activities as: team-based treatment planning that includes the covered individual's family and other people important to the individual, education of the Medicaid-eligible individual's family regarding the individual's disorder and how to manage it, and comprehensive assessments. The proposed regulations, however, depart significantly from prior CMS policy in that they propose to prohibit a state from covering certain packages of services, including therapeutic foster care, and

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instead require states to bill separately for the components of the service package. If these proposed regulations were enacted, they would require many states to alter the payment methodology for many services that had previously been approved by CMS for payment as single package, including therapeutic foster care, multi-systemic therapy, and assertive community treatment. States could still, however, cover the individual components of these services. Further, the proposed regulations include language prohibiting coverage of services that are "intrinsic elements of programs other than Medicaid," including foster care and child welfare. Medicaid does not cover services that are the clear financial responsibility of another system, such as the direct delivery of foster care services. But Medicaid has always covered mental health services for eligible adults and children, even if they are involved in another system.[3] Because wraparound services and therapeutic foster care are mental health interventions available to all children (regardless of whether or not they are involved in the foster care system), the activities that comprise the components of these services should continue to be coverable, even if the new regulations are enacted.

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[3] The preamble of the regulation is consistent with this and specifically states that "Medicaid rehabilitation services must be available for all participants based on an identified medical need and [that] otherwise would have been provided to the individual outside of the foster care . . . and other non-Medicaid systems." 72 FR 45201, 45205.

18. CMS has also recently issued interim final rules regarding the category of services of case management services, 42 U.S.C. § 1396d(a)(19).[4] Interim Final Rule with Comment Period, Department of Health and Human Services, Centers for Medicare & Medicaid Services, Medicaid Program: Optional State Plan Case Management Services (Interim Final Case Management Services Rules), 72 Fed. Reg. 68077 (Dec. 4, 2007).[5] In substantial part, these regulations are a restatement of the definition of case management services set forth in the Deficit Reduction Act of 2005 (DRA), P.L. 109-171, § 6052(a)(2) (Feb. 8, 2006), codified at 42 U.S.C. § 1396n(g). The DRA and the interim final case management services rules list case management services to include comprehensive assessments, development (and periodic revision) of a care plan with the active participation of the eligible individual and others, referral and related activities, and monitoring and follow-up activities and to exclude the direct delivery of foster care and child welfare services. *Id.*§ 1396n(g)(2)(A)(ii) and (iii); 72 Fed. Reg. at 68092-93. These allowable case management services are, in essence, many of the activities in Appendices A and B. In my expert opinion, the types of case management activities in Appendices A and B relate to a child's behavioral health condition and services (case management of which is the responsibility of the mental health system) and are not the direct delivery of foster

[4] These rules become final on March 3, 2008 unless they are revised by CMS after the comment period for these interim rules ends on February 4, 2008.

[5] Case management services are mandatory, not optional, for children. 42 U.S.C. § 1396d(r) (the "[e]arly and periodic screening, diagnostic and treatment services" (EPSDT) mandate).

care services, and thus are allowable under the DRA and the interim final case management services rules.

D. The August 16, 2006 CMS Letter and the Declaration of Mary Jean Duckett

19. I have reviewed the August 16, 2006 CMS Letter from Gale Arden and the declaration of Mary Jean Duckett. These documents do not change my opinion that when properly described, the components of wraparound services and therapeutic foster care can be covered by Medicaid.

20. As I discussed above, I have significant experience in dealing with the process for gaining approval for states to cover services using Medicaid funding. When a state wants to use Medicaid to cover a new service, the state submits a formal request to CMS through a State Plan Amendment. A State Plan Amendment contains, for example, a description of the proposed service (including excluded services and activities), provider qualifications, and reimbursement methodologies. It is written using the type of language that CMS would expect. After a state submits a State Plan Amendment to CMS, CMS and the state typically engage in a back-and-forth process to ensure that services are appropriately covered. CMS then works with the state to address any concerns that CMS has about the State Plan Amendment, and the state and CMS eventually reach agreement on the details of the services to be covered.[6]

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[6] States sometimes initiate contact with CMS about services they want to propose to cover prior to submitting a formal State Plan Amendment. They do this by submitting to CMS a "concept paper," which is, in essence, a less formal version of a State Plan Amendment that does not require the same level of approval within a

21. The CMS letter from Gale Arden makes clear that California did not submit a formal State Plan Amendment to CMS. Instead, as I understand, California submitted documents that were written for another purpose (this litigation), which did not contain the type of information that would be in a State Plan Amendment, and that were not written using the language that CMS would expect. The CMS letter is not a reply to a formal proposal for services and should not be treated as such.

22. Given the fact that California did not submit a formal State Plan Amendment to CMS, I am not surprised by the content of CMS' response.[7] The essence of much of the letter is that CMS needs more information (namely, the type of information that would be in a State Plan Amendment) to determine whether the proposed services are coverable by Medicaid. Throughout the letter, Ms. Arden states that CMS would need more detailed information to determine whether a particular component could be covered by Medicaid. California could remedy this problem by submitting a formal State Plan Amendment and then engaging in a back-and-forth with CMS to address any additional concerns.

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state (e.g., approval from the state legislature and all affected state agencies) that a State Plan Amendment typically does. A concept paper includes much of the same information as a State Plan Amendment, including a description of the proposed service, provider requirements, and payment methodologies.

[7] I am surprised, however, that CMS responded in writing at all, instead of requiring California to submit a formal State Plan Amendment, or at least a concept paper.

23. While the CMS letter and Duckett declarations do raise some additional questions about the coverage of some of the components of wraparound services and therapeutic foster care, which I address below, these documents also reveal that CMS agrees that many of the activities that are the components can be covered by Medicaid. See, e.g., Exh. 1 at 3-4 (acknowledging that the wraparound components of "Strength and Needs Assessment," "Wraparound Team Formation," and "Tracking and Adapting the Wraparound Service Plan"[8] and at least some activities of "Engagement of the Child and Family," "Immediate Crisis Stabilization," "Wraparound Service Plan Implementation," and "Ongoing Crisis and Safety Planning," and "Transition" are coverable by Medicaid); Ex. 2 at ¶ 4 ("[i]t is possible that some of the component parts included in plaintiffs' conception of 'wraparound services' may be covered by Medicaid"); Ex. 2 at 5 (acknowledging that CMS has approved states including therapeutic foster care in their state plans based on a determination that the component parts were Medicaid-covered services).

24. Throughout the letter, Ms. Arden repeatedly raises the same several concerns regarding coverage of the components of wraparound services and therapeutic foster care. The declaration of Ms. Duckett raises these same issues. I

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[8] Ms. Arden raises issues related to billing for these components, not their coverage. Specifically, she questions whether these components are part of another service (and, therefore, must be billed as part of that service) or are services themselves (and, therefore, can be billed separately). These billing issues do not affect whether the components can be covered by Medicaid. See *infra* at ¶ 25.

have reviewed the declaration of Linda Huff Redman, Ph.D. (a true copy of which is attached as Exhibit 6 and incorporated herein by reference), which addresses all of the issues raised by Ms. Arden and Ms. Duckett, and I agree with her detailed responses. Below I briefly address the major issues raised by Ms. Arden and Ms. Duckett.

25. First, both Ms. Arden and Ms. Duckett repeatedly state that wraparound services, therapeutic foster care, and their components are not services listed in section 1905(a) of the Medicaid Act. I agree with Dr. Redman that it would be incorrect to infer from this statement that a service must be expressly listed in section 1905(a) in order to receive Medicaid coverage. Exh. 6 at ¶ 19. As I discussed above, the services listed in section 1905(a) are general categories of services; there are many services and activities that fall within each of these service categories. I have worked with states in designing CMS-approved services, the vast majority of which are not specifically listed in the statute. For example, as I discussed above, see *supra* at ¶ 13, none of the specific services that I assisted the District of Columbia gain CMS approval for covering under the category of rehabilitative services, 42 U.S.C. § 1396d(a)(13), are expressly listed in § 1396d(a).

26. Second, Ms. Arden states that several components of wraparound services are not independently coverable services but may be part of other Medicaid services. I agree with Dr. Redman that a service/activity need not be an independently coverable service to be reimbursable. See Exh. 6 at ¶ 20. States, in their State Plan Amendments, define services, including the activities that comprise those services, in a variety of ways. States can group together or separate covered services for billing purposes. For example, Ms. Arden states that

the wraparound services component "Strength and Needs Assessment" "is not an independently coverable service, but may be part of other Medicaid services furnished to an eligible child." Exh. 1 at 3. I agree with Ms. Arden that a strength and needs assessment *can* be covered as a component of another service, as it can be in the District of Columbia as part of CBI, see Exh. 4 at § 3422.7. But states can also choose to bill these assessments as a separate service, as they can be in the District of Columbia under the service of Diagnostic/Assessment, see Exh. 4 at § 3415.5. The point is that this is not a coverage issue. What determines coverage of a service is whether the activities that comprise the service fall within one of the general categories of services listed in section 1905(a).

27. Third, Ms. Arden expresses concern about Medicaid coverage of several components of wraparound services and therapeutic foster care, stating that they may involve activities that benefit family members not covered by Medicaid. I agree with Dr. Redman that while Medicaid does not cover services for the sole benefit of non-covered family members, Medicaid does cover services provided to non-covered family members that are for the benefit of the covered child. Exh. 6 at ¶ 21. When I was the Director of Mental Health for the District of Columbia, we proposed and gained CMS approval for providing these types of activities involving the Medicaid-eligible individual's family as part of several rehabilitative services. For example, the following services under CBI involve and/or are provided to family members for the benefit of the covered child: immediate crisis response to reduce family conflict, stabilize the family unit, and increase family support; assessments to identify family strengths; family support interventions that develop and improve the ability of parents and other family members to care for the child's disorder; skills training in parenting techniques to

help the child's family develop skills for managing the child's disorder; and supporting and consulting with the child's family and support system. Exh. 4 at § 3422.7. Similarly, Counseling includes family therapy, as well as teaching skills necessary to enhance the family unit and/or support the family. *Id.* at §§ 3417.1, 3417.2. Likewise, Community Support includes mental health education, support and consultation with consumer's families and their support system. *Id.* at § 3418.2. And I have assisted many states in designing and getting CMS approval for these types of services. All references to family participation and/or treatment in Appendices A and B are to these types of covered services that include families but are for the purpose of treating and are for the benefit of the covered child.

28. Finally, Ms. Arden and Ms. Duckett question whether several of the components involve either the direct delivery of foster care services, as prohibited by the Deficit Reduction Act of 2005 (DRA), P.L. 109-171, § 6052(a)(2) (Feb. 8, 2006), codified at 42 U.S.C. § 1396n, and prior CMS policy, or involve activities that are the responsibility of the foster care system. I agree with Dr. Redman that both Ms. Arden and Ms. Duckett have misinterpreted Appendices A and B to the extent they believe any component contains activities that go beyond mental health activities and are the responsibility of the child welfare or foster care systems. Exh. 6 at ¶ 22.

29. Wraparound services and therapeutic foster care are mental health interventions. These services are available to children both in and outside of the foster care system. The provision of these services is the same, regardless of whether or not the child is in the foster care system. It is the mental health system, not the foster care system, that has the expertise and the obligation to provide these mental health services to all children for whom the services are

medically necessary. And Medicaid requires states to provide all medically necessary services that can be covered by Medicaid to children, including to children in the foster care system.

30. The DRA and interim final case management services rules sets forth a list of allowable and prohibited case management activities, which codifies prior policy regarding case management. Examples of allowable case management activities under the DRA and these rules include assessments, development of a specific care plan/care planning, referral and related activities/linkage, and monitoring and follow up activities to ensure plan implementation. See DRA, 42 U.S.C. § 1396n(g)(2)(A)(ii); Interim Final Case Management Services Rules, 72 Fed. Reg. at 68092. These allowable activities are, in essence, the precise activities that comprise the components of wraparound services and therapeutic foster care in Appendices A and B. They do not involve the direct delivery of foster care services.[9]

31. In sum, it is my expert opinion that the components of wraparound services in Appendix A and of wraparound services in Appendix B can be covered by Medicaid.

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[9] As Dr. Redman discussed in her declaration, many of these same activities can also be reimbursed under the category of services of rehabilitative services. Exh. 6 at ¶ 21.

1 Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the laws of
2 the United States of America and the State of California that the foregoing is true
3 and correct. Executed this __day of _______, 2007 in ______________________.
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7 Martha Knisley
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