SECOND SUPPLEMENTAL DECLARATION

OF LINDA HUFF REDMAN, Ph.D.

I, Linda Huff Redman Ph.D., hereby declare and as follows:

A. Summary of Qualifications and Opinions

1. I have over 20 years of experience in healthcare policy and public financing, in particular Medicaid. I am the former Deputy Director of Arizona's Medicaid program and the former Executive Administrator for Arizona's Medicaid program's Office of Policy and Intergovernmental Relations. In these positions, I oversaw statewide Medicaid operations, including Arizona's Medicaid State Plan Amendment process with the Centers for Medicare and Medicaid Services (CMS) and the design and implementation of Arizona's Medicaid behavioral health program.[1] For this new program, I assisted with the development of Arizona's Medicaid behavioral health policy and procedure manual, and intergovernmental agreement with the state agency to be held responsible for delivering behavioral health services. I also worked on issues related to Medicaid coverage of services for special populations, including children in foster care, children with chronic conditions, and individuals in need of long-term care.

2. Currently, I am a consultant, advising public and private agencies on a broad range of health care related issues. In this position, I have helped several states, including Nevada, Arizona, New Jersey, and New Hampshire in the redesign of their behavioral healthcare delivery systems. This work has entailed providing assistance in the development of a wide array of community-based Medicaid-covered services and in

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[1] I was directly responsible for Arizona's State Plan Amendment process as Executive Administrator of the Office of Policy and Intergovernmental Relations and later oversaw the process as Deputy Director.

the implementation of these new services through the development of Medicaid rules and policies and procedure manuals and the establishment of Medicaid rates for the services.

3. My qualifications are set forth in more detail in my earlier declarations submitted in support of Plaintiffs' Motion for Preliminary Injunction, true copies of which are attached as Exhibits 1 and 2 and are incorporated herein by reference. My most recent curriculum vitae details my education, professional experience, and organizational affiliations, a true copy of which is attached as Exhibit 3 and is incorporated herein by reference.

4. My expert opinions in this declaration are based on my professional experience, described above, as well a review of approximately a dozen states' Medicaid documents (i.e., states' State Plan Amendments, rules, Medicaid policy and procedure manuals, and Medicaid provider manuals), conversations with state Medicaid officials in several states, and a review of relevant CMS policy guidance and rules.

5. The components of wraparound services, as set forth in Appendix A, and of therapeutic foster care, as set forth in Appendix B, are coverable by Medicaid.[2] 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, all of the components of wraparound services and therapeutic foster care are covered by other states' Medicaid programs.

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[2] My reference to Appendices A and B are to the Appendices to Plaintiff Henry D.'s Further Supplemental Responses to Interrogatories, which define wraparound services and therapeutic foster care and their components.

6. I have reviewed the August 16, 2006 letter from Gale P. Arden, Director, Centers for Medicare & Medicaid Services (CMS), Center for Medicaid and State Operations Disabled and Elderly Programs to Stan Rosenstein, Deputy Director, California Department of Health Services, Medical Care Services (a true copy of which is attached as Exhibit 4 and is incorporated herein by reference) and the May 28, 2004 declaration of Mary Jean Duckett, then Acting Deputy Director, CMS, Center for Medicaid and State Operations Disabled and Elderly Programs (a true copy of which is attached as Exhibit 5 and is 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. In my expert opinion, all of the questions raised in Ms. Arden's letter and Ms. Duckett's declaration are either based on CMS needing more detailed information from California or a misinterpretation of Appendices A and B. 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. My interpretation of the letter and declaration is consistent with both long-standing and recent CMS policy.

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

7. 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 are covered by Medicaid.

8. In order to be covered by Medicaid, a service must fit within at least 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 category. An individual service need not be expressly listed in § 1396d(a) to be covered by Medicaid. Many commonly covered services are not specifically listed, such as assessments, treatment planning, therapy, crisis services, and family psychoeducation (education of a Medicaid-eligible person's family about addressing and managing the person's mental illness), all of which are covered under the service category of rehabilitative services listed in § 1396d(a)(13),[3] see U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, *A Primer on How to Use Medicaid to Assist Persons Who are Homeless to Access Medical, Behavioral Health, and Support Services*, January 2007 (a true copy of which is attached as Exhibit 6 and is incorporated herein by reference) at 58-59, and assessments to determine service needs, care plan development, referral and related activities to help an individual obtain needed services, and monitoring and follow-up activities, all of which are covered under the service category of case management services listed in § 1396d(a)(19), see Deficit Reduction Act, P.L. 109-171, § 6052(a)(2) (Feb. 8, 2006) (DRA), codified at 42 U.S.C. § 1396n(g).

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[3] 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 possible functional level." This category is commonly known as rehabilitative services.

9. Covered services often can fit within more than one service category listed in 42 U.S.C. § 1396d(a). Behavioral health therapy, for example, can be covered under a variety of service categories, including, among others, that of rehabilitative services, § 1396d(a)(13); "medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law," § 1396d(a)(6); physician services (if provided by a psychiatrist), § 1396d(a)(5)(A), or clinic services, § 1396d(a)(9).[4] States have flexibility in deciding how to cover services, and this flexibility is a hallmark of the Medicaid program.

10. 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), case management services, § 1396d(a)(19), medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law, §

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[4] 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).

1396d(a)(6); physician services, § 1396d(5)(A), and/or clinic services, § 1396d(a)(9).

11. The components of wraparound services and therapeutic foster care are covered by other states' Medicaid programs, and these states are currently being reimbursed by CMS for them. This, in my expert opinion, is strong evidence that the components of wraparound services and therapeutic foster care are covered by Medicaid.

12. I have created a table showing that, for each component of wraparound services and therapeutic foster care in Appendices A and B, other states use Medicaid funds to cover the services/activities described in the component. A true copy of this table is attached as Exhibit 7 and is incorporated herein by reference. In creating this table, I reviewed approximately a dozen states' Medicaid documents (such as states' State Medicaid Plans, state Medicaid regulations, Medicaid policy and procedure manuals, and Medicaid provider manuals).[5] I compared the description of the services/activities in the state's Medicaid documents with the description of the component in the Appendices. I considered the services/activities to be equivalent to the Appendix component when the descriptions were essentially the same, even if the names for the services/activities were different. I confirmed with state staff that all services included in my chart are funded entirely by Medicaid and available to all Medicaid eligible children in the state (i.e., they are not part of any special

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[5] I did not do a nationwide survey of states. Instead, I attempted to examine states from a variety of regions of the country and include states with different behavioral health service delivery models.

waivers, demonstration projects, etc.) when it was not clear from the Medicaid documents.

13. CMS has recently proposed new rules 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 (Proposed Rehabilitative Services Rules), 72 Fed. Reg. 45201 (Aug. 13, 2007). I address in more detail these proposed rules as they relate to the components of wraparound services and therapeutic foster care below. As a general matter, these rules are in part 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 covered individual's family regarding the individual's disorder and how to manage it, and comprehensive assessments. These proposed rules, 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, that CMS has approved as a package of services in the past, and instead would require states to bill separately for the components of the service package. The proposed rules also include language prohibiting coverage of services that are "intrinsic elements of programs other than Medicaid," including foster care and child welfare. While Medicaid does not cover services that are the clear financial responsibility of another system (such as the direct delivery of foster care services), Medicaid does cover behavioral health services for eligible adults and children, even if they are involved in another

system.[6] Because wraparound services and therapeutic foster care are behavioral 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 proposed rules are enacted.

14. CMS has also recently issued interim final rules regarding the category of services of case management services, 42 U.S.C. § 1396d(a)(19).[7] 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).[8] In substantial part, these regulations are a restatement of the definition of case management services set forth in the DRA, 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

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[6] The preamble of the rule 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 Fed. Reg. at 45205.

[7] 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.

[8] Case management services are mandatory, not optional, for children under the EPSDT mandate. See n. 4.

with the active participation of the eligible individual and others, referral and related activities, and monitoring and follow-up activities. *Id.*§ 1396n(g)(2)(A)(ii); 72 Fed. Reg. at 68092. These services are, in essence, many of the activities in Appendices A and B. Both the DRA and case management rules exclude from coverage the direct delivery of foster care or child welfare services. DRA, 42 U.S.C. § 1396n(g)(2)(A)(iii); 72 Fed. Reg. at 68093. As I discuss in more detail below, see *infra* at ¶ 22, it is the responsibility of the behavioral health system, not the foster care or child welfare system, to case manage a child's behavioral health condition and medically necessary services. Based on my experience with wraparound and therapeutic foster programs in several states, my expert opinion is that the types of case management activities in Appendices A and B relate to a child's behavioral health condition and services and are not the direct delivery of foster care services, and thus are allowable under the DRA and the interim final case management services rules.

C. Response To Issues Raised in the August 16, 2006 CMS Letter and the Declaration of Mary Jean Duckett[9]

[9] Below I address the concerns raised in the CMS letter and the Duckett declaration by area of concern, rather than component by component, as both the letter and declaration repeatedly raise the same concerns for several components. For the convenience of the court, I have created a table describing component by component my response to each of CMS' concerns and identifying the paragraph in this declaration where my response is contained. A true copy of this table is attached as Exhibit 8 and incorporated herein by reference.

15. I have reviewed the August 16, 2006 CMS Letter from Gale Arden and the declaration of Mary Jean Duckett. Although these documents raise 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 many of the activities that are the components can be covered by Medicaid.

16. With respect to wraparound services, Ms. Arden acknowledges the wraparound components of "Strength and Needs Assessment," "Wraparound Team Formation," and "Tracking and Adapting the Wraparound Service Plan" are coverable by Medicaid.[10] Exh. 4 at 3-4. The declaration of Mary Jean Duckett similarly states that "[i]t is possible that some of the component parts included in plaintiffs' conception of 'wraparound services' may be covered by Medicaid . . . ." Exh. 5 at ¶ 4. Ms. Arden also acknowledges that at least some activities that comprise other wraparound components are coverable by Medicaid, including activities in the components of "Engagement of the Child and Family," "Immediate Crisis Stabilization," "Wraparound Service Plan Implementation," and "Ongoing Crisis and Safety Planning," and "Transition." Exh. 4 at 2-5.

17. As for therapeutic foster care, Ms. Duckett acknowledges that some states have included coverage for therapeutic foster care in their state plans, which

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[10] 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 ¶ 20.

were approved by CMS based on its determination that the component parts were Medicaid-covered services. Exh. 5 at ¶ 5.

18. A careful reading of Ms. Arden's letter reveals that most of her concerns about coverage of the components of wraparound services and therapeutic foster care listed in Appendices A and B are based on CMS needing more information from California. Throughout the letter, she states that CMS would need more detailed information to determine whether a specific service could be covered by Medicaid. Exh. 4, comments regarding "Immediate Crisis Stabilization" at 2-3; "Wraparound Service Plan Implementation" at 4; "Tracking and Adapting the Wraparound Service Plan" at 4; and generally at 5 regarding therapeutic foster care (TFC). Ms. Duckett makes similar statements. Exh. 5 at ¶¶ 4-5. Such information is typically provided to CMS as part of the CMS State Plan Amendment review and approval process. State Plan Amendment documents contain, for example, a description of covered services (including excluded services and activities), provider qualifications, and reimbursement methodologies. Accord U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Using Medicaid to Support Working Age Adults with Serious Mental Illness in the Community: A Handbook*, January 2005, (a true copy of which is attached as Exhibit 9 and is incorporated herein by reference) at 50 ("When a state proposes coverage, CMS expects that a state will spell out the services it intends to offer in reasonable detail in its Medicaid plan or related policies and procedures. This detail includes the specific services that will be furnished under the coverage, provider qualifications, and the criteria that a state will use in determining the medical necessity of the service). As Ms. Arden herself describes the State Plan Amendment process, "there is

typically a flow of information about the proposed services, payment methodologies and compliance with Medicaid statutory requirements."[11] Exh. 4 at 2. Appendices A and B -- which I understand were created for this litigation and not for submission to CMS as something akin to State Plan Amendment documents -- do not contain all of the type of information one would expect to see in State Plan Amendment documents. Thus, the statements Ms. Arden makes throughout her letter about needing more information do not mean that the referenced component services of wraparound or therapeutic foster care cannot be covered by Medicaid. Instead, those comments are simply a reflection of the fact that California has not yet submitted a State Plan Amendment or similar documents to CMS.

19. Ms. Arden's letter repeatedly states that wraparound services, therapeutic foster care, and their components are not services listed in section 1905(a) of the Medicaid Act. Exh. 4 at 1 and 5 and comments regarding "Engagement of the Child and Family" at 2; "Immediate Crisis Stabilization" at 2; "Strength and Needs Assessment" at 3; "Wraparound Team Formation" at 3; "Wraparound Plan Development" at 3; "Wraparound Service Plan Implementation" at 4; "Ongoing Crisis and Safety Planning" at 4; "Tracking and Adapting the Wraparound Service Plan" at 4; and Wraparound "Transition" at 4.

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[11] This description is consistent with my experience, where states typically work with CMS in a cooperative, back-and-forth manner to get services appropriately covered under their Medicaid State Plan. Typically, after CMS approves a State Plan Amendment, the state provides further detail on the covered services through Medicaid rules, policy and procedure manuals, and provider manuals.

Ms. Duckett's declaration makes similar statements. Exh. 5 at ¶¶ 3-5. While this is a true statement, it would be a mistake to infer from this statement that a service must be expressly listed in section 1905(a) in order to receive Medicaid coverage. The services listed in section 1905(a) are broad categories of services; there are many services and activities that fall within each of these service categories. See *supra* at ¶ 8. In my experience, CMS regularly permits states to use Medicaid funds to pay for services and activities not specifically listed in section 1905(a), so long as they fall within a category of services listed in that section; many commonly covered services are not specifically listed, such as behavioral health therapy and medication management. And this is consistent with CMS policy documents. For example, one CMS policy document describes covered services as ones that fall "under [the] broad Medicaid coverage categories" listed in section 1905(a) with "states having considerable latitude in fashioning the services that they offer under these coverage categories." Exh. 9 at 49, 51. This guidance document then provides a chart of community-based services and the "coverage category" under which they fall; none of the services listed as covered in this chart are specifically listed in section 1905(a). *Id.* at 52, Table 4-1 (listing, for example, "Community Support Services" as falling under the "coverage category" of "Diagnostic, screening, rehabilitative and preventative services ('Rehab option')"). Similarly, a recent CMS document, in which Ms. Arden wrote the introduction, provides guidance to states on the types of services and activities that fall under the category of "rehabilitative services," listed in section 1905(a)(13). Exh. 6 at 58-59. This document identifies a variety of services that are covered "rehabilitative services" including, for example: "[d]iagnosis, assessment, treatment planning and coordinating the delivery of rehabilitative services to

individuals;" "[c]risis services in order to prevent hospitalization or quickly stabilize a person so that the individual can return to the community;" [f]amily psychosocial education in order to enlist a person's family in addressing and managing the person's mental illness;" "[p]eer support and counseling whereby individuals who have experienced mental illnesses furnish support to individuals in managing and coping with their mental illnesses;" "[b]asic life skills and social skills training and support across a variety of community living dimensions;" "[m]edication education and management;" "[i]llness and disability management that is designed to increase a person's ability to recognize and respond to symptoms;" and "[s]upported employment to assist individuals in overcoming barriers to employment that stem from their mental illness," none of which are specifically listed in § 1905(a)(13).[12] *Id.*

20. Throughout Ms. Arden's letter, she states that several components of wraparound services are not independently coverable services but may be part of other Medicaid services. Exh. 4, comments regarding Wraparound "Strengths and Needs Assessment" at 3 ("not an independently covered services, but may be part of other Medicaid services"); "Wraparound Team Formation" at 3 ("activities described are not independent services . . . [but] may be recognized . . . as component parts of the covered service); and "Tracking and Adapting the Wraparound Service Plan" at 4 ("may be an integral part of the provision of another service"). This is a billing issue, however, not a coverage issue. States, in their Medicaid documents, identify services and describe the activities that comprise those services in a variety of ways. States can group together or separate

[12] Many of these services are in essence those in Appendices A and B.

covered activities for billing purposes. I agree with Ms. Arden that these wraparound services components *can* be covered as a component of another service, including a rehabilitation service or case management service. On the other hand, states sometimes cover these components (in particular "Strength and Needs Assessments") as a separately billable service. See, e.g., Exh. 7 at 14-18. What determines coverage is not the name of the service or how the covered activities are grouped together, but whether the activities themselves fit under one of the broad categories of services listed in section 1905(a).

21. Throughout Ms. Arden's letter, she expresses concern about Medicaid coverage of several components of wraparound services and therapeutic foster care because they may not be limited to activities that directly support the Medicaid-eligible child and may involve activities that benefit family members not covered by Medicaid. Exh. 4, comments regarding "Engagement of the Child and Family" at 2; Wraparound "Transition" at 5; and TFC "Plan Implementation – Family Treatment" at 6. Ms. Arden is correct that Medicaid does not cover services provided to non-Medicaid family members for their sole benefit. But Medicaid does cover services provided to non-covered family members that are for the benefit of the Medicaid-eligible child. Examples of such covered services are family counseling, family involvement in the child's treatment planning, and family psychoeducation (the education of family members regarding the child's behavioral health disorder and teaching family members how to manage it). CMS has repeatedly made clear that these services are covered by Medicaid. See, e.g., Exh. 6 at 58 (stating that covered rehabilitative services include "[f]amily psychosocial education in order to enlist a person's family in addressing and managing the person's mental illness"); U.S. Department of Health and Human

Services, Centers for Medicare & Medicaid Services, *Medicaid Support of Evidence-Based Practices in Mental Health Programs*, available at http://www.cms.hhs.gov/PromisingPractices/Downloads/EBP_Basics.pdf (a true copy of which is attached as Exhibit 10 and is incorporated herein by reference) at 8-9 (describing Medicaid-covered activities of family psychoeducation to include "*individual family counseling* – time to review illness history, warning signs, coping strategies, and concerns and developing goals; *family treatment planning* – active involvement of family members in the planning and input of setting goals and treatment; *family supports* – helping families support their loved ones who have mental illness in their recovery) (italics in original); accord Proposed Rehabilitative Services Rules, 72 Fed. Reg. at 45207 (stating that including a child's parents in the treatment planning process and including parents in counseling sessions for the treatment of the child are covered rehabilitative services); Interim Final Case Management Services Rules, 72 Fed. Reg. at 68092 ("Case management may include contacts with non-eligible individuals that are directly related to the identification of the eligible individual's needs and care, for the purposes of helping the eligible individual access services, identifying needs and supports to assist the eligible individual in obtaining services, providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs."). All references to family participation and/or treatment in Appendices A and B are to these types of covered services that include families for the sole purpose of treating and for the direct benefit of the Medicaid-eligible child.

22. Ms. Arden's letter cites the case management provisions of the Deficit Reduction Act of 2005 (DRA) as the basis for raising questions about coverage of

one component of wraparound services and many of the components of therapeutic foster care, stating that these components contain activities that are the responsibility of the child welfare or foster care systems, and not the behavioral health system. Exh. 4, comments regarding "Wraparound Plan development" at 4; TFC "Development of a Treatment Plan" at 5; TFC "Tracking and Adapting the Treatment Plan" at 5; and TFC "Transition" at 6. She similarly questions coverage of several components of wraparound services and therapeutic foster care, stating that they contain services that go beyond the scope of the Medicaid program and are a function of the foster care system (without specifically citing the DRA). Exh. 4, comments regarding "Immediate Crisis Stabilization" at 2-3; "Ongoing Crisis and Safety Planning" at 4; "Recruitment and Matching" at 5; and "Therapeutic Foster Parent Training" at 5. Ms. Duckett states that case management services that are "an integral part of the administration of the foster care and child welfare programs" are not Medicaid-covered services. Exh. 5 at ¶ 6. I believe both Ms. Arden and Ms. Duckett have misinterpreted Appendices A and B to the extent they believe any component contains activities that go beyond behavioral health activities and are the responsibility of the child welfare or foster care systems.

a. The section of the DRA regarding case management that Ms. Arden references codifies prior policy regarding case management and does not represent a change in policy. Compare DRA, 42 U.S.C. § 1396n(g) and Interim Final Case Management Services Rules, 72 Fed. Reg. at 8091-92 with State Medicaid Director Letter # 01-013, from Olivia Golden, Assistant Secretary for Children and Families, and Timothy M. Westmoreland, Director, Center for Medicaid and State Operations, Health Care Financing Administration, January 19, 2001 (a true copy of which is attached as

Exhibit 11 and is incorporated herein by reference) (Westmoreland Letter); accord Exh. 4 at 5 (Ms. Arden states that "[t]he Deficit Reduction Act of 2005 supports the discussion of the longstanding CMS interpretation of Medicaid payment for foster care services, set forth by Ms. Duckett in her 2004 declaration . . . ."). The DRA, Westmoreland letter, and interim final case management services rules specifically list as examples of allowable case management activities: assessments, development of a specific care plan/care planning, referral and related activities/linkage, and monitoring and follow up activities to ensure plan implementation. DRA, 42 U.S.C. § 1396n(g)(2)(A)(ii); Exh. 11 at 2; 72 Fed. Reg. at 68092. They all state that direct delivery of foster care services are not reimbursable and contain a list of unallowable activities. DRA, 42 § 1396n(g)(2)(A)(iii); Exh. 11 at 2-3; 72 Fed. Reg. at 68093. The child welfare and foster care systems are responsible for the case management of social services and for placement activities related to providing a child a home and family for him/her until he/she is either returned to his/her birth parents or adopted. However, the child welfare and foster care systems do not have an obligation, or even the expertise, to develop a behavioral health care plan and manage the services a child needs to treat his or her behavioral health condition. Those systems' only case management responsibility with respect to the behavioral health needs of a child is to refer that child to the behavioral health system for treatment. It is the behavioral health system that is responsible for case management related to the child's behavioral health condition and behavioral health services. Neither the DRA, Westmoreland letter, or interim final case management services rules prohibit Medicaid from paying for this type of behavioral health case management just because a Medicaid-eligible child is involved in the child welfare or foster care systems. Accord Interim Final Case Management Services Rules, 72 Fed. Reg. at 68086 ("[A] Medicaid eligible child with a mental disorder receiving child protective services may also qualify to

receive case management services targeted to children with mental disorders."). Based on my experience with wraparound and therapeutic foster care programs in several states, my expert opinion is that the Appendices describe the types of case management activities that are allowable under the DRA, Westmoreland letter, and interim final case management services rules, and they do not constitute the direct delivery of foster care or child welfare services.

i. The components "Wraparound Service Plan Development" and TFC "Development of Treatment Plan," identified in Appendices A and B, are case management activities reimbursable under the DRA, Westmoreland letter, and interim final case management services rules. They are, in essence, the development of a specific behavioral health care plan/care planning, a covered case management activity listed in the DRA, Westmoreland letter, and interim final case management services rules. DRA, 42 U.S.C. § 1396n(g)(2)(A)(ii)(II) ("'[C]ase management services' . . . includes . . . [d]evelopment of a specific care plan based on the information collected through the assessment, that specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual, including activities such as ensuring the active participation of the eligible individual and working with the individual . . . and others to develop such goals and identify a course of action to respond to the assessed needs of the eligible individual."); Interim Final Case Management Rules, 72 Fed. Reg. at 68092 (same); Exh. 11 at 2 ("[Care planning] builds on information collected through an assessment phase and builds on activities such as ensuring the active participation of the Medicaid-eligible individual and working with the individual and others to develop the goals and identify a course of action to respond to the assessed needs of the Medicaid eligible individual. The goals and actions in the care plan should address medical, social, educational and other services needed by the Medicaid

individual.).[13] Case management and its components (e.g., service plan development) also can be covered as rehabilitative services as it relates to the management and coordination of activities and benefits covered as rehabilitation services. Exh. 6 at 58 (describing as a covered rehabilitative service "treatment planning and coordinating the delivery of rehabilitative services"); Exh. 9 at 64 (describing case management activities coverable as rehabilitative services to include "service/treatment planning, periodic review of treatment plan, coordination and referral, monitoring, and/or advocacy" related to activities and benefits covered as rehabilitative services); accord Proposed Rehabilitative Services Rules, 72 Fed. Reg. at 45211 (requiring as a component of rehabilitative services, the development of rehabilitation plans with participation by the individual, his/her family, and other persons of the individual's choosing). Ms. Arden is incorrect that "Wraparound Service Plan Development" and TFC "Development of a Treatment Plan" are duplicative of tasks handled by the child welfare or foster care systems. Exh. 4 at 4-5. The wraparound service or treatment plan developed by the behavioral health system focuses on and is driven by the child's behavioral health needs and has as its overall goal to improve the child's behavioral health condition, while any case plan developed by the child welfare or foster care system focuses on issues of abuse and neglect by a child's parents or family and has as its overall goal to return the child

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[13] Compare Appendix A at 5 ("[T]he wraparound team works together to develop and adopt a wraparound service plan . . . [that] describes the needs, long-range vision and short-term objectives for the child and family, and the services that will best fit their needs."); Appendix B at 3-4 ("Each child has a treatment plan that is both standardized and individualized. . . . The plans are focused on the individualized strengths and needs of the child.").

home, or when that is not possible, to a substitute permanent home (i.e., adoption). TFC "Development of a Treatment Plan" also focuses on treatment of the child's behavioral health issues. The treatment of children with behavioral health needs who are in the child welfare and foster care systems is provided by the behavioral health system, not the child welfare or foster care system. Moreover, wraparound services and therapeutic foster care are behavioral health services provided to Medicaid-eligible children both in and outside of the child welfare and foster care systems. The covered behavioral health services available to the Medicaid-eligible child are the same regardless of whether or not the child is involved in the child welfare or foster care systems. When a child receiving wraparound services or therapeutic foster care is in the foster care or child welfare systems, those systems remain responsible for payment for any tasks that are the responsibilities of the foster care or child welfare systems. Therefore, it is my expert opinion that after the DRA, the components of "Wraparound Service Plan Development" and TFC "Development of Treatment Plan" continue to be covered by Medicaid.

ii. The TFC component "Tracking and Adapting the Treatment Plan" is another case management activity reimbursable under the DRA, Westmoreland letter, and interim final case management services rules. It is the activity of monitoring and follow-up to ensure plan implementation, which is a listed covered case management service in the DRA and Westmoreland letter. DRA, 42 U.S.C. § 1396n(g)(2)(A)(ii)(IV) (("'[C]ase management services' . . . includes . . . "[m]onitoring and followup activities, including activities and contacts that are necessary to ensure the care plan is effectively implemented and adequately addresses the needs of the eligible individual, and which may be with the individual, family members, providers, or other entities and conducted as frequently as necessary . . . ."); Exh. 11 at 2 ("[Monitoring/Follow-up] includes activities and contacts that are necessary to ensure the care plan is effectively implemented and

adequately addressing the needs of the Medicaid-eligible individual. The activities and contacts may be with the Medicaid eligible individual, family members, providers, or other entities."); Interim Final Case Management Services Rules, 72 Fed. Reg. at 68092 (Case management activities include "[d]evelopment (and periodic revision) of a specific care plan" and "[m]onitoring and follow-up activities," which "include[s] making necessary adjustments in the care plan and service arrangements with providers.").[14] This case management activity also can be covered as a rehabilitative service. Exh. 6 at 58 (describing as a covered rehabilitative service treatment planning and coordinating the delivery of rehabilitative services); Exh. 9 at 64 (describing case management activities coverable as rehabilitative services to include "service/treatment planning, periodic review of treatment plan, coordination and referral, monitoring, and/or advocacy" related to activities and benefits covered as rehabilitative services); accord Proposed Rehabilitative Services Rules, 72 Fed. Reg. at 45211 (describing as covered rehabilitative service evaluating progress towards goals set in the rehabilitation plan and of revising the plan when progress is not being made). Moreover, therapeutic foster care is a behavioral health service provided to Medicaid-eligible children both in and outside of the child welfare and foster care systems,[15] and the TFC treatment plan focuses on

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[14] Compare Appendix B at 4 ("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, psychiatrist, caseworkers, parole/probation officers, employers and other important members of the child's community.").

[15] When I helped design Arizona's TFC program, we specifically designed it as a behavioral health intervention available to Medicaid-eligible children in and

behavioral health issues. The activities done to track and adapt the TFC treatment plan are the same regardless of whether or not the Medicaid-eligible child is involved in the child welfare or foster care systems. When a TFC Medicaid-eligible child is in the foster care or child welfare systems, those systems remain responsible for payment for any tasks that are the responsibilities of the foster care or child welfare systems. Therefore, it is my expert opinion that after the DRA, the TFC component "Tracking and Adapting the Treatment Plan" continues to be covered by Medicaid.

iii. Ms. Arden states that the TFC component "Transition" is a foster care function and, therefore, DRA forbids Medicaid payment. I believe Ms. Arden's comment is based on a misreading of this component. TFC transition in Appendix B addresses a child's transition out of TFC and the behavioral health services a child needs to transition successfully. It is based on an assessment of the child's behavioral health needs. Transition is a behavioral health service involving activities to ensure continuity of care. When a TFC client is not in foster care, there is no responsibility for that system with respect to transition. When a child transitioning out of TFC is in the child welfare or foster care systems, transition involves the behavioral health system coordinating with all relevant systems to ensure continuity of care, specifically related to meeting the child's behavioral health needs. Such coordination is a covered case management service.

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outside of Arizona's foster care system. While the name of the service was recently changed (i.e., to "therapeutic residential support (in-home, excluding room and board") in Arizona's CMS-approved waiver document and to "home care training to home care client services for children" in Arizona's covered behavioral services manual), the services under the newly re-named program are identical to those under their prior TFC program.

DRA, 42 U.S.C. § 1396n(g)(2)(A)(ii)(IV) (describing the covered case management activity of "[m]onitoring and followup activities" to include "activities and contacts that are necessary to ensure the care plan is effectively implemented and adequately addressing the needs of the eligible individual" when "there are changes in the needs or status of the eligible individual"); Exh. 11 at 2 (describing the covered case management activity of monitoring/follow-up to include "activities and contacts that are necessary to ensure the care plan is effectively implemented" when there are "changes in the needs or status of the Medicaid eligible individual); Interim Final Case Management Services Rules, 72 Fed. Reg. at 68092 (same); accord *id.* at 68091-92 (discussing case management services to transition individuals from institutional settings to community settings).[16] Both children in and outside of the foster care system receive TFC, and transition activities are the same whether or not the child is involved in the foster care system. States commonly use Medicaid case management services to coordinate care and ensure the continuity of care whenever a child receiving behavioral health services makes a transition, be it from one setting to another (as is the case with TFC transition), from the children's to the adult behavioral health system, or even from one provider to another.

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[16] Coordination of services can also be covered as rehabilitative services. Exh. 6 at 58 (describing coordinating the delivery of rehabilitative services to individuals as a covered service); Exh. 9 at 64 (describing case management activities coverable as rehabilitative services to include coordination of activities and benefits covered as rehabilitative services); accord Proposed Rehabilitative Services Rules, 72 Fed. Reg. at 45205 (stating that "Medicaid rehabilitative services must be coordinated with, but do not include, services furnished by other programs").

Thus, after the DRA, the TFC component "Transition" continues to be covered by Medicaid.

b. While not directly citing the DRA, Ms. Arden questions whether several components in the Appendices are reimbursable under Medicaid on the grounds that they are responsibilities of the child welfare or foster care systems, and not the behavioral health system. In my expert opinion, Ms. Arden is incorrect and her opinion is based on a misunderstanding of the Appendices.

i. With respect to the wraparound services components of "Immediate Crisis Stabilization" and "Ongoing Crisis and Safety Planning," Ms. Arden acknowledges that the activities described in those components are mental health rehabilitative services to the extent they address mental health treatment issues. Exh. 4 at 3-4. Her acknowledgement is consistent with CMS guidance, Exh. 6 at 58 (listing "[c]risis services" as a Medicaid-coverable rehabilitative service); accord Proposed Rehabilitative Services Rules, 72 Fed. Reg. at 45205 (stating that rehabilitative services can be covered in any setting, including in mobile crisis vehicles). She, however, questions coverage of these components to the extent they deal with "unsafe living environments and safety issues, as well as matters related to medical (including mental health) needs." Exh. 4 at 3, 4. In my expert opinion, the reference to "safety" and "unsafe living environments" in the descriptions of these components references safety issues that might arise due to or be caused by the child's behavioral health condition – a clear responsibility of the behavioral health system – and not the type of safety and unsafe living issues that are the responsibility of the child welfare or foster care systems, such as abuse or neglect by the child's parents. An example of the type of "safety" issue these components address would be a child's behavioral health condition leading to a risk of harm to himself or others; likewise, an example of the type of "unsafe living

environment" these components address would be a situation that triggers difficult behavior due to the child's behavioral health condition and causes a need for behavioral health crisis intervention. Further, to the extent Ms. Arden's letter can be read as claiming that crisis issues related to medical needs go beyond the Medicaid program, she cannot be correct; stabilizing individuals in crisis situations caused by their behavioral health and/or medical needs and planning how to avoid them in the future are exactly the types of crisis activities that are regularly covered by other states with CMS' approval. See, e.g., Exh. 7 at 7-14. Thus, it is my expert opinion that wraparound services components of "Immediate Crisis Stabilization" and "Ongoing Crisis and Safety Planning," are covered by Medicaid.

ii. Plaintiffs' component of TFC "Recruitment and Matching" discusses the activities of recruiting therapeutic foster parents and of matching a child with appropriate therapeutic foster parents. Below I separately address the activities of recruitment and of matching.

a. There are two types of recruiting relevant to therapeutic foster care: recruiting a family to serve as therapeutic foster parents for a specific child for whom therapeutic foster care has been determined to be medically necessary; and recruiting individuals to become therapeutic foster parents who are later matched with a specific child for whom therapeutic foster care has been determined to be medically necessary.

i. With respect to the first type of recruiting (i.e., recruiting a family to serve a therapeutic foster parents for a specific child for whom TFC has been determined to be medically necessary), the suitability of the therapeutic foster parents is based in large part on their capacity to provide the medically necessary behavioral health interventions that the specific child needs. Helping the child obtain these needed

behavioral health services (in this case, identifying and recruiting the therapeutic foster parents) can be directly billed to Medicaid as case management for the Medicaid-eligible child.[17] If a TFC client is not in the foster care or child welfare systems, there is no responsibility for those systems with respect to the recruiting of therapeutic foster parents for this child. If a child being placed in TFC is in the child welfare or foster care systems, the behavioral health system must coordinate with those systems when recruiting individuals to serve as therapeutic foster parents for the child; such coordination is a covered case management service. DRA, 42 § 1396n(g)(2)(A)(ii)(III) (describing the covered case management activity of "[r]eferral and related activities" to help an individual obtain needed services); DRA, § 1396n(g)(2)(A)(ii)(IV) (describing the covered case management activity of "[m]onitoring and followup activities" to include "activities and contacts that are necessary to ensure the care plan is effectively implemented and adequately addressing the needs of the eligible individual" when "there are changes in the needs or status of the eligible individual"); Exh. 11 at 2 (describing the covered case management activity of referral and linkages to include activities that help

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[17] To recruit therapeutic foster parents for a specific child, the child must be assessed, which includes identifying the child's behavioral health needs and gathering information from the child and other sources about individuals whom may help meet those needs, all of which are covered case management activities. DRA, 42 U.S.C. § 1396n(g)(2)(A)(ii)(I) (describing assessment to include taking client history, identifying needs, and gathering information from other sources). One strategy for this type of recruiting is attempting to recruit families with an existing relationship with the child who can meet that child's behavioral health needs to serve as therapeutic foster parents.

link individuals with needed services and describing monitoring/follow-up to include "activities and contacts that are necessary to ensure the care plan is effectively implemented" when there are "changes in the needs or status of the Medicaid eligible individual); Interim Final Case Management Services Rules, 72 Fed. Reg. at 68092 (describing the covered case management activity of referral and related activities to include "activities that help link the individual with medical, social, and educational providers that are capable of providing needed services to address identified needs and achieve goals specified in the care plan).

ii. The second type of recruiting relevant to TFC is recruiting individuals to become therapeutic foster parents who will then later be matched with a specific child for whom TFC has been determined to be medically necessary. This type of recruiting (that is, the type of recruiting done for programs, not for individual children) is not in my experience typically billed directly to Medicaid, but is instead built into the reimbursement rate as an administrative expense for the Medicaid provider agency contracted to deliver TFC services. Many types of administrative expenses are typically built into the reimbursement rate paid to providers for the delivery of covered services, including training and supervision of employees, writing of notes and record-keeping, and travel time. The reimbursement rates for other out-of-home services for which TFC is an alternative, such as Residential Treatment Centers or group homes, include similar administrative activities. As I previously discussed, issues related to reimbursement rates are typically addressed during the State Plan Amendment process. See *supra* at ¶ 18. [18]

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[18] Both the DRA and the interim final case management services rules exclude from case management the direct delivery of foster care and child welfare services,

including "[r]ecruiting or interviewing potential foster parents." DRA, 42 § 1396n(g)(2)(A)(iii); 72 Fed. Reg. at 68093. With respect to the first type of recruiting (i.e., seeking appropriate therapeutic foster parents for a specific Medicaid eligible child for whom it has been determined that TFC is medically necessary), the recruitment activities focus on the ability of the therapeutic foster parents to meet that child's behavioral health needs; it is no different than the case management activity of selecting any other behavioral health provider. To the extent these case management exclusions apply to therapeutic foster parent recruitment (which only the preamble, not the rules themselves, state), compare 72 Fed. Reg. at 68087 with *id.* at 68093, it should only be the second type of recruitment (i.e., general recruitment of therapeutic foster parents into the provider pool) that may not be able to be billed as a case management activity. And as I discussed above, my experience is that states do not typically bill this activity as case management but instead include this as an administrative expense built into the reimbursement rate. Similarly, CMS has recently proposed rules regarding rehabilitative services that would prohibit coverage of services that are "intrinsic elements of other programs," including foster care and child welfare, and provides as an example of an excluded service TFC "except for medically necessary rehabilitation services for an eligible child." 72 Fed. Reg. at 45213. Though not included in the proposed rule, the preamble indicates that TFC "provider recruitment, foster parent training and *other such services that are the responsibility of the foster care system*" are not covered by Medicaid. 72 Fed. Reg. at 45205 (emphasis added). Again, TFC is a behavioral health intervention available to children both in and outside of foster care. There is no responsibility

b. With respect to the activity of "matching" a child for whom TFC is medically necessary to appropriate therapeutic foster parents, this is a case management activity, regardless of how the therapeutic foster parents are recruited. The activity of matching a child to a particular provider of TFC and to therapeutic foster parents is the same activity performed when "matching" a child to a provider of any behavioral health service, be it TFC or counseling. The activity includes identifying the child's needs and identifying potential providers to meet those needs, which are covered case management activities. DRA, 42 U.S.C. § 1396n(g)(2)(A)(ii)(I) (describing the covered case management activity of assessment); § 1396n(g)(2)(A)(ii)(III) (describing the covered case management activity of "[r]eferral and related activities" to help an individual obtain needed services); § 1396n(g)(2)(A)(ii)(IV) (describing the covered case

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of the foster care system for therapeutic foster parent recruitment activities for children who are not in the foster care system. Even for children in the foster care system, the recruitment activities related to TFC are not the responsibility of foster care but are the responsibility of the behavioral health system, as they relate to the ability of therapeutic foster care parents to meet children's behavioral health needs. These rules by CMS are only proposed; if CMS were to enact this particular rule, it would be a departure from prior policy. These rules should have no affect on the activity of seeking appropriate therapeutic foster parents for a specific child, which as I discussed above, can be billed as a case management activity. It is only coverage of general recruiting of therapeutic foster parents that may not be able to be billed as a rehabilitation service. But, as I discussed, in my experience, states do not bill this type of recruitment as a rehabilitation service but instead include it as an administrative expense built into the provider reimbursement rate.

management activity of "[m]onitoring and followup activities" to include "activities and contacts that are necessary to ensure the care plan is effectively implemented and adequately addressing the needs of the eligible individual" when "there are changes in the needs or status of the eligible individual"); Exh. 11 at 2 (describing covered case management activities of assessment, referral and linkages, and monitoring/follow-up activities); 72 Fed. Reg. at 68092 (same).[19] Therefore, in my expert opinion, the component of TFC "Recruiting and Matching" is coverable by Medicaid.

iii. Plaintiffs' description of the component "Therapeutic Foster Parent Training" includes two types of training: training given to therapeutic foster parents regarding the behavioral health disorder of the specific child for whom they will be the therapeutic foster parents (e.g., educating them about the child's behavioral health condition and teaching them to manage the child's behavior); and general pre-service and ongoing training given to therapeutic foster parents on caring for children with complex behavioral health.

a. The first type of training – training regarding the specific child's behavioral health disorder and how to manage it – is a family psychoeducation service, which CMS policy has repeatedly stated is a Medicaid covered service. See

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[19] These activities also can be covered as rehabilitative services. See Exh. 6 at 58-59 (describing rehabilitative services to include diagnosis, assessment, treatment planning, and coordinating the delivery of rehabilitative services); Exh. 9 at 64 (describing case management activities coverable as rehabilitative services to include "service/treatment planning, periodic review of treatment plan, coordination and referral, monitoring, and/or advocacy" related to activities and benefits covered as rehabilitative services).

supra ¶ 21; Exh. 6 at 58 (stating that covered rehabilitative services include "[f]amily psychosocial education in order to enlist a person's family in addressing and managing the person's mental illness"); Exh. 10 at 8-9 (describing the Medicaid-covered activities of family psychoeducation). Regardless of whether it is the biological parent(s) or individuals serving as temporary parents, this service is focused on the child's behavioral health needs and hence reimbursable. It is not duplicative of any responsibility of the child welfare or foster care system, if the child is even involved in those systems. TFC is a behavioral health intervention available to children regardless of whether they are involved in those systems.

b. The second type of training – general pre-service and ongoing training to therapeutic foster parents on caring for a child with complex behavioral health needs (e.g., behavior management strategies) – is not in my experience typically billed directly to Medicaid but instead is built into the reimbursement rate for the therapeutic foster care agency as an administrative expense. When I helped set the Medicaid reimbursement rate for therapeutic foster care in Arizona, for example, we included in the TFC reimbursement rate the costs for pre-service training by a licensed professional. Arizona continues to include this general pre-service training on behavioral health treatment strategies as a covered administrative expense built into the TFC reimbursement rate. Exh. 7 at 43. Children both in and outside of the child welfare and foster care systems receive TFC. The TFC component training is a behavioral health intervention and not the responsibility of the child welfare or foster care systems.

Therefore, in my expert opinion, the TFC component of "Training" is coverable by Medicaid.[20]

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[20] The preamble to CMS' proposed rules regarding rehabilitative services indicates that TFC "provider recruitment, foster parent training and *other such services that are the responsibility of the foster care system*" are "intrinsic element[s]" of the foster care program, and therefore not covered, 72 Fed. Reg. at 45206 (emphasis added). As I discussed above, even for children in the foster care and child welfare systems, the therapeutic foster parent training activities described in the component are not the responsibility of the child welfare system but are the responsibility of the behavioral health system, as they relate to the child's behavioral health needs. These rules by CMS are only proposed; if CMS were to enact this rule, it would be a departure from prior policy. Under the proposed rules, training the TFC family about the behavioral health needs of the specific child with whom they have been matched and how to address those needs would remain covered. 72 Fed. Reg. at 45207 (describing psychoeducation of family members as a covered rehabilitative service). It is only coverage of the second type of training (i.e., general pre-service and ongoing training) that may not be able to be billed as a rehabilitative service under the proposed rules. Similarly, the preamble to the interim final case management services rules, not the rules themselves, state that "all activities integral to the administration of the foster care program" are excluded, including training of foster care parents. Even for children in the foster care system, the training of therapeutic foster parents about a specific child's behavioral health condition and strategies to manage it cannot be considered integral to the administration of the foster care program, as it is the behavioral health system that

23. Ms. Arden's letter raises several other concerns regarding components in the Appendices.

a. With respect to the TFC component "Plan Implementation – Individual Child Treatment," Ms. Arden notes that TFC providers must have the same qualifications as individuals who furnish services to children not in foster care. Exh. 4 at 6. I agree with this statement, and there is nothing in Appendix B to suggest otherwise. As I mentioned earlier, states typically address details such as provider qualifications through the State Plan Amendment process with CMS, which has not yet occurred as I understand. In my experience, therapeutic foster parents typically become qualified Medicaid providers by associating (e.g., via contract) with a Medicaid provider agency and receiving appropriate training and supervision from that agency.

b. Ms. Arden claims that plaintiffs' description of the wraparound component "Transition" goes beyond Medicaid rehabilitative services to include non-covered educational and habilitative services. I disagree with Ms. Arden and do not believe there is anything in the description of this component that goes beyond rehabilitative services. Recent CMS guidance, to which Ms. Arden wrote the introduction, describes the very broad range of services/activities that can be covered as

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is responsible for managing the child's behavioral health disorder. It is only the general pre-service and on-going training that is given to therapeutic foster parents on caring for a child with complex behavioral health needs that may not be able to be billed as a case management activity. However, as I discussed, in my experience, states do not typically bill this type of general pre-service and ongoing training as a rehabilitative or case management service but instead include it as an administrative expense built into the reimbursement rate for the provider agency.

rehabilitative services, including "[b]asic life and social skills training and support across a variety of community living dimensions to promote self-sufficiency and independence by overcoming functional limitations associated with mental illness,"[21] and "[s]upported employment to assist individuals in overcoming barriers to employment that stem from their mental illness."[22] Exh. 6 at 58-59; accord Proposed Rehabilitative Services Rules, 72 Fed. Reg. at 45206-07 (providing examples of covered recreational and social rehabilitative service activities). It is these types of rehabilitative services to which I understand the wraparound component of "Transition" to refer. In my expert opinion, there is nothing in plaintiffs' description of this component that goes beyond this CMS guidance.

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[21] The CMS guidance states that covered "basic life skills training may include 'restoration of those basic skills necessary to independently function in the community, including food planning and preparation, maintenance of living environment, community awareness and mobility skills' and social skills training may include 'redevelopment of those skills necessary to enable and maintain independent living in the community, including communication and socialization skills and techniques." Exh. 6 at 58-59.

[22] CMS guidance states that "[r]ehabilitative supported employment services can be provided to assist individuals to function in the workplace, provided that the services are not associated directly with specific job performance." Exh. 6 at 59. There is nothing in plaintiffs' description of this component that would indicate they are seeking coverage of services directly related to specific job performance.

24. In sum, it is my expert opinion that the components of wraparound services in Appendix A and of therapeutic foster care in Appendix B fall under the categories of services listed in § 1396d(a) and therefore are covered by Medicaid.

Pursuant to 28 U.S.C. § 1746, 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 this 10 day of Dec, 2007 in Tempe, Arizona.

Linda Huff Redman

Linda Huff Redman