Elissa Gershon, State Bar No. 169741
elissa.gershon@disabilityrightsca.org
Elizabeth Zirker, State Bar No. 233487
elizabeth.zirker@disabilityrightsca.org
Kim Swain, State Bar No. 100340
kim.swain@disabilityrightsca.org
DISABILITY RIGHTS CALIFORNIA
1330 Broadway, Suite 500
Oakland, CA 94612
Telephone: 510.267.1200
Facsimile: 510.267.1201

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE NORTHERN DISTRICT OF CALIFORNIA**

ESTHER DARLING; RONALD BELL by his guardian ad litem Rozene Dilworth; GILDA GARCIA; WENDY HELFRICH by her guardian ad litem Dennis Arnett; JESSIE JONES; RAIF NASYROV by his guardian ad litem Sofiya Nasyrova; ALLIE JO WOODARD, by her guardian ad litem Linda Gaspard-Berry; individually and on behalf of all others similarly situated,

Plaintiffs,

v.

TOBY DOUGLAS, Director of the Department of Health Care Services, State of California, DEPARTMENT OF HEALTH CARE SERVICES,

Defendants.

**Case No.: C-09-03798 SBA**

**CLASS ACTION**

**DECLARATION OF LESLIE HENDRICKSON, Ph.D., IN SUPPORT OF PLAINTIFFS' MOTION FOR ENFORCEMENT OF STIPULATED JUDGMENT AND FOR APPOINTMENT OF SPECIAL MASTER**

**Hearing Date:**
**Time:**
**Judge:** **Magistrate Judge Jacqueline Scott Corley**
**Address:** **450 Golden Gate Avenue San Francisco, CA 94102**
**Courtroom:** **F, 15th Floor**

Kenneth A. Kuwayti, State Bar No. 145384
Kkuwayti@mofo.com
Benjamin A. Petersen, State Bar No. 267120
Bpeterson@mofo.com
Morrison & Foerster LLP
755 Page Mill Road
Palo Alto, California 94304-1018
Telephone: 650.813.5600
Facsimile: 650.494.0792

Anna Rich, State Bar No. 230195
arich@nsclc.org
Kevin Prindiville, State Bar No. 235835
kprindiville@nsclc.org
NATIONAL SENIOR CITIZENS LAW CENTER
1330 Broadway, Suite 525
Oakland, California 94612
Telephone: 510.663.1055
Facsimile: 510.663.1051

Eric Carlson, State Bar No. 141538
Ecarlson@nsclc.org
NATIONAL SENIOR CITIZENS LAW CENTER
3435 Wilshire Boulevard, Suite 2860
Los Angeles, CA 90010
Telephone: 213.674.2813
Facsimile: 213.639.0934

Barbara Jones, State Bar No. 88448
bjones@aarp.org
AARP FOUNDATION LITIGATION
200 So. Los Robles, Suite 400
Pasadena, California 91101
Telephone: 626.585.2628
Facsimile: 626.583.8538

Kenneth W. Zeller, *Pro Hac Vice*
kzeller@aarp.org
Kelly Bagby, *Pro Hac Vice*
kbagby@aarp.org
AARP FOUNDATION LITIGATION
601 E Street N.W.
Washington, D.C. 20049
Telephone: 202.434.2060
Facsimile: 202.434.6424

Sarah Somers, State Bar No. 170118
somers@healthlaw.org
Martha Jane Perkins, State Bar No. 104784
perkins@healthlaw.org
NATIONAL HEALTH LAW PROGRAM
101 East Weaver Street, Suite G-7
Carrboro, North Carolina 27510
Telephone: 919.968.6308
Facsimile: 919.968.8855

**DECLARATION OF LESLIE HENDRICKSON, Ph.D.**

I, LESLIE HENDRICKSON, do hereby declare:

1. I make this declaration in support of Plaintiffs' Motion for Enforcement of Stipulated Judgment and for Appointment of Special Master. The opinions set forth herein are based on my professional expertise, my review of materials provided to me by counsel, and other data sources.

2. I have been retained by Plaintiffs' counsel to, among other things, offer my opinions about the following: (1) whether and to what extent Defendants' "Quality Assurance" reviews comport with standards in the field for quality assurance activities and. (2) whether Defendants properly overturned findings of eligibility for Community Based Adult Services (CBAS) based on such "QA reviews." I am being compensated by Plaintiffs at my customary hourly rate for similar services.

**Background and Employment History**

3. I have 25 years of Medicaid experience including management positions in two state Medicaid programs. In Oregon, I was the Senior Budget Analyst in the Medicaid Budget Office for six years and performed hundreds of fiscal impacts on the Medicaid program. I then became a manager in the Division now known as the Division of Seniors and Persons with Disabilities. In that capacity, I supervised long-term care eligibility, General Assistance, Aid to the Blind and Disabled, the Medicaid Personal Care option, the criminal background check unit and participated in budget analysis and in-home policy work. From 1997-2002, I served as an Assistant Commissioner in the New Jersey Medicaid program and was responsible for Medicaid and non-Medicaid home and community-based services, nursing facility reimbursement, eight field offices with support staff and nurses and social workers that conducted preadmission screening for nursing home admissions, a nursing home transition program that helped 3,000 persons leave nursing homes, and a large pharmaceutical program for persons over Medicaid income levels. As an Assistant Commissioner, I supervised quality assurance activities for Medicaid and non-Medicaid home and community based services.

4. Upon retiring from New Jersey Medicaid, I accepted the position of Revenue Services Director for Maximus, Inc., a large, national consulting company, that had revenue maximization contracts with states. During the next two years I worked in ten states on financial analyses to improve the amount of Medicaid and Medicare reimbursement received by those states.

5. Since leaving Maximus, Inc. in 2004, except for one year when I was a visiting Professor at Rutgers University, I have been an independent consultant and have worked on studies of state long-term care and behavioral health programs. For example, this work includes statewide reviews of long-term care in California, Alaska, and West Virginia, statewide reviews of mental health and substance abuse in Oregon, Texas, and West Virginia, studies of specific Medicaid programs, such as Ohio's home and community-based waiver programs, the Texas Medicaid non-emergency medical transportation program, the Texas early intervention program, Colorado pay-for-performance nursing home programs, and Florida programs for the visually impaired. In the last nine months I have worked in six states.

6. I co-authored a 300-page report on California long-term care programs entitled, Home and Community-Based Long-Term Care: Recommendations to Improve Access for Californians, prepared for the California Health and Human Services Agency and published in November, 2009. My California-related presentations include appearances before the Little Hoover Commission and State's *Olmstead* Committee, and I was asked by California Assembly and Senate subcommittees responsible for aging and long-term care to make presentations to them as well.

7. During the period 2007-2008, when I was a Visiting Professor at Rutgers University, Center for the Study of State Health Policy, I supervised a technical assistance center for state programs that had received Real Choice System Change grants from the Center for Medicare and Medicaid Services (CMS). I have conducted research, visited at, interviewed staff, and prepared reports on adult foster homes, Area Agencies on Aging, assisted living programs, community mental health centers, hospitals, independent living centers, neighborhood health centers, nursing homes, private intermediate care facilities for the mentally retarded (ICFs/MR), programs for the visually impaired, state developmental centers, state mental health hospitals, and substance abuse treatment

programs. My work assessing state programs typically includes a review of quality assurance activities and my last such review was done in January 2012 when I examined quality assurance activities done in mental health and substance services provided by the State of Texas, and in the spring of 2012 in a three-state study of long-term services and supports programs..

8. My educational background includes a Bachelor of Arts degree in Sociology from San Francisco State College, and Master's and Doctorate degrees in Sociology from the University of Oregon.

9. True and accurate copies of my resume and list of publications and presentations are attached to my previous declaration in this case as Exhibits A and B. (ECF Nos. 287-1, 287-2).

10. I have read the settlement agreement in *Darling v. Douglas* (ECF No. 438-1). In addition to the documents identified in my previous declarations (ECF Nos. 287 and 326), I have read the Motion for Enforcement of Stipulated Judgment and Civil Contempt Sanctions that was filed by Plaintiffs on March 22, 2012 (ECF No. 448), and the following Declarations and Exhibits filed in support of and in opposition to that Motion: the Declaration and Exhibits of Diane Puckett (ECF Nos. 457, 457-1 and 457-2), the exhibits of Corinne Jan (ECF Nos. 454-1 and 454-2), the Declaration of David Temme (ECF No. 466), the Declaration of Christine King Broomfield (ECF No. 470), and the Declaration of Jane Ogle, (ECF No.468). I have also read the presentation titled, "Response to *Darling v. Douglas* Plaintiff's Counsel Request for Documents and Data Deliverables," September 7, 2012 and "Plan for Oversight and Monitoring for CBAS Providers" dated July 1, 2012.

11. The settlement agreement requires that the Defendants undertake quality assurance activities. That section states: "It is the responsibility of Defendants to provide quality assurance monitoring and oversight to all Class Members. In carrying out this obligation, the following general standards shall apply:

> A. Quality assurance activities performed by Defendants shall include: monitoring the quality and accuracy of the screening and assessment of Class Members for CBAS services and the actual provision of services to Class Members by providers, managed care plans and APS, and shall include reviews of data, random sampling of files and in person reviews with individuals whose files are examined.

B. Quality assurance activities shall be focused on measuring whether services are provided to Class Members' in accordance with this Agreement." (Settlement Agreement Section XVI, ECF No. 438-1).

12. I have been asked to express my opinion as to whether or not the "quality assurance" procedures explained by Defendants in their declarations conform to standards in the field of quality assurance as it applies to home and community based services for aged persons and persons with disabilities.

13. I conclude that the quality assurance activities described by the Defendants appear to be disconnected from Federal procedures for reviewing program quality. The Defendants' quality assurance activities appear to be limited to ad hoc procedures that review the eligibility determinations made by nurses who did an assessment. The "Second Level Reviews" described appear to be nothing more than "desk review" procedures to ensure that paperwork is correctly filled out and the documentation supports the eligibility determination.[1]

14. Such procedures are disconnected from Federal program quality concepts because there is no quality program design, other essential assurances such as quality of care received by the beneficiary and their quality of life are missing, the procedures do not appear to collect new or different data, and there is no continuous improvement process. For example, state Medicaid agencies are required to provide quality assurances to the Centers for Medicare and Medicaid Services (CMS) regarding the health and safety of beneficiaries and appropriateness of their care. CMS is extending these required assurances to quality of life as well and California is participating in quality of life surveys collected on Medi-Cal beneficiaries participating in the state's Money Follows the Person program. Judged against this broader set of assurances, the CBAS procedures described do not encompass all of the meanings usually referred to as "quality assurance."

[1] When routinely done on a sample of beneficiaries each month, such practices are typically referred to as a Medicaid Eligibility Quality Control (MECQ) Review. See the Medicaid Manual at Section 7206 for a fuller description of this monthly sampling process. See Chapter 7, retrieved on 3-26-2012 from http://www.cms.gov/Manuals/PBM/itemdetail.asp?itemID=CMS021927

15. The Defendants' descriptions also lack essential information which would be important in the development and implementation of a valid quality assurance process. They have not provided information on:

- How many assessments receive a "QA Review";
- How many QA reviews involve talking to the ADHC participant, reviews of data, and random sampling of files as required by the Settlement (Section XVI.B.1 at 38);
- How many and what kind of outcomes result from the "QA Review";
- What are the reasons cited for changes to the assessment at the QA review level;
- How many "Second Level Reviews" are done;
- How many Second Level Reviews involve talking to participants;
- How many Second Level Reviews involve review of medical records, notes, or supporting documentation, as required by the Settlement (Section XI.A.4.c at 16)
- How many and what kind of outcomes result from the Second Level Reviews;
- What are the reasons cited for changes to the assessment at the Second Level Review;
- How many Centers have had a Second Level Review of all assessments done at the Center, and
- How many and what kind of outcomes are resulting from reviews of individual plans of care or persons found ineligible in the face-to- face assessment.

16. As noted above, sufficient information about what the Defendants are doing has not been provided by the Defendants. From a reading of the Declarations cited above, it appears that the outcome of the procedures appears to result in denials of eligibility, rather than recommendations for additional training, evaluation, or further review. To the extent that this is correct, it would be reasonable to conclude that Defendants "quality assurance" reviews of assessments for CBAS appear more related to utilization management than Federal procedures for reviewing quality

17. For example, the Defendants present no information showing there is a process for continuous improvement and the declarations of the state staff do not describe any standardized process whereby consistent standards are applied to these denials of eligibility or what program improvements are being made in the assessments based on the results of a quality examination of the procedures. There is no description of what guidelines or instructions were issued to nurses to ensure that uniform and consistent judgments were made leaving open the real possibility that different reviewers may come to different judgments in examining the four- page assessment.

18. To understand what the Defendants are not doing, it is useful to briefly discuss Federal quality efforts in relation to home and community based services (HCBS). CMS has a long established quality of care framework that it applies to Home and Community Based Waiver programs ("HCBS Waiver") paid for through the Medicaid program. Such a framework is applicable to the Medi-Cal program as well as all other state programs.

19. The Federal framework for the analysis of quality in HCBS was laid out over a decade ago and concretized in instructions to CMS regional field offices, and state Medicaid agencies.[2] With changes, the Federal framework from 2000 has been carried down to today and strengthened. CMS identified a three-part quality structure.[3] The first component is the design of the quality system. The design serves as the blueprint for provider requirements, specifies how monitoring activities will be carried out, as well as goals, plans and methods for quality improvement activities The second part of the framework emphasized that state Medicaid programs had to provide assurances in six areas;

- For the health and welfare of waiver participants;
- For plans of care responsive to waiver participant needs;
- That only qualified providers serve waiver participants;

[2] For example in December 2000 CMS promulgated its *CMS Regional Office Protocol for Conducting Full Reviews of State Medicaid Home and Community-Based Services Waiver Programs* and its use was made mandatory in January 2001.

[3] For a brief description of changes since 2000, see the CMS quality of care website, at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-HCBS.html

- That the State conducts level of care need determinations consistent with the need for institutionalization;
- That the State Medicaid Agency retains administrative authority over the waiver Program; and
- That the State provides financial accountability for the waiver.

20. The third part of the quality structure emphasized quality improvement work; identifying what needs to be remediated and improving the program. As shown in the application that states are required to fill out if they want a 1915 waiver, CMS's quality improvement concepts place a heavy emphasis on a three-part process of discovery, remediation and continuous improvement and have evolved into an emphasis on continuous quality improvement (CQI).[4] Each part of the process has become more specified as well, for example, quality work now goes beyond simple discovery and focuses on what is called "root cause analysis".

21. A comparison of the Federal framework for quality assurance for HCBS with the settlement's quality assurance requirements shows both are primarily concerned with the health and safety of the beneficiary and the provision of responsive, timely and appropriate services. Yet the Defendants do not address these essential quality assurances.

22. While there is no one procedure that is always used in Medicaid programs to assure quality, what is missing in the Defendants' approach is the application of current quality measures used by CMS. For example, one important component of quality assurance that is more frequently being conducted is a "root cause analysis" which is a means of reviewing the circumstances of an activity, and its magnitude, location, and timing with the goal of identifying its beneficial and harmful outcomes. The result of the root cause analysis will help determine actions to be taken to improve quality and/or address quality deficiencies. The absence of methods like a root cause analysis contributes to the utilization management appearance of the Defendants' procedures.

[4] For example, see Sara Galantowicz, (2010, January), *Implementing Continuous Quality Improvement (CQI) In Medicaid HCBS Programs*, Retrieved on 3-26-2012 from http://www.nationalqualityenterprise.net/nqe

23. Based on my review of the Defendants' actions, in the current situation, in which the Defendants are claiming to conduct quality assurance activities by reviewing individual assessments for CBAS eligibility, it is not apparent that the Defendants have any organized plan, let alone the capacity to analyze data, to be able to effectively identify quality deficiencies or address them appropriately. In my Supplemental Declaration in support of Plaintiffs' Motion for Preliminary Injunction, I opined on the lack of outcome based planning contained in Defendants' plan to move ADHC recipients into managed care when ADHC is eliminated. (ECF No. 326). In that Declaration, I noted that "The Defendants are silent as to outcome expectations, including the quality of outcomes; Defendants should, up front, prepare an analysis of the outcomes they expect to achieve as a result of their efforts." ¶ 16. I recommended that "Defendants need to develop a standard set of performance measures, and a uniform data collection mechanism so that the managed care plans, and other responsible entities, will be able to understand what constitutes effective transition performance and how to achieve it." ¶ 10. I further stated that "A responsible transition plan would monitor each step, evaluate the pace and effectiveness of each step, and modify the transition planning as necessary to achieve the desired results, prior to elimination of the ADHC benefit." ¶ 17.

24. Apparently this planning did not occur and I am not surprised to see the result. These statements continue to be true for Defendants to measure their performance under the settlement. It is not apparent from the information I have received that they have done so. Without these elements, any quality assurance activities they undertake are conducted in a vacuum, without any context to determine what quality they are measuring.

25. It is troubling that Defendants actually appear to be practicing "utilization management", the control of future medical services, even though they call it "quality assurance." Utilization management is essentially a budget control process whereby insurance companies and medical payors manage or limit the use of future medical services.[5] Given the Defendant's lack of

[5] For example see the URAC definition of "utilization management" retrieved on 3-27-2012 from https://www.urac.org/resources/caremanagement.aspx

transparency, there exists the possibility that the Defendants continue to pursue their original intent of reducing program expenditures, but now use techniques they call "quality assurance."

26. I understand from reading the Plaintiffs' Motion and Plaintiffs' and Defendants' declarations that the following pattern occurred: ADHC participants were assessed by DHCS nurses at face-to-face assessments, which included interviews with participants and reviews of the ADHC medical chart; then, DHCS conducted a "QA review" of these assessments which appear to have occurred in many cases after the date of the face-to-face assessment and on a day that the assessment teams were not at the ADHC center. The "files" received by the participants consist only of the completed CBAS Eligibility Determination Tool (CEDT), which means that the off-site QA reviewer would only have the CEDT to review. In some cases, the QA reviewer appeared to check the box "Agree" with the assessor, but the "Agree" box was whited out and the box "Disagree" was checked. In some cases, the signature of the QA reviewer appears to be the same as the signature for the next review, called the "Second Level review." In all the cases, the reason for the QA review disagreeing with the finding of eligibility is for lack of nursing intervention, even in categories in which nursing intervention is not a required element of CBAS eligibility.

27. Based on my experience, this process cannot possibly comport with standards for quality assurance reviews. First, it is not apparent if the QA reviewers were basing their determinations on a review of any first-hand information, or any objective criteria or additional data. At the federal level, options counseling standards promulgated by the Administration on Community Living are very clear in what they require. For example, these standards are being used in California's Aging and Disability Resource Center (ADRC) program. There is no indication that the CBAS assessments performed and contact with program participants meet these nationally promulgated options counseling standards. Second, to review for accuracy or reliability, the QA review would need to be able to measure the CEDTs against another set of information—specifically, medical records and/or in-person interview. It appears that this was not done. It is important that the settlement contemplates using such comparison data for quality assurance in that it requires data review, random sampling, and in-person reviews. Third, if a valid QA review revealed quality

deficiencies, such as a need for assessors to better document nursing interventions, then an appropriate response would be better training for assessors, not a denial of eligibility for the participants.

28. Moreover, it is impossible to conduct a valid quality assurance process without data upon which to identify trends, patterns, and problems. For example, in my review of the "Response to *Darling v. Douglas* Plaintiff's Counsel Request for Documents and Data Deliverables," September 7, 2012, I observed in the reported data that over 4,000 more persons are enrolled than received assessments. Without a good data foundation it is hard to understand if this indicative of incorrect data reporting or is actually a lapse in quality management.

29. I still believe that the comments made above are valid notwithstanding the document entitled Plan for Oversight and Monitoring for CBAS Providers" (the Plan) dated July 1, 2012. The document is correctly described as it is a compliance plan for enforcing state policy on providers. It is a straightforward document that describes the organizational structure of the program, how the state will regulate the CBAS provider, and the range of penalties the state has for ensuring compliance.

30. The July 12, 2012 document can be thought of as one part of a quality assurance process, but should not be mistaken for a quality assurance plan. It can best be described as a licensing and contract compliance plan for CBAS providers.

31. Even as a compliance plan it is weakly written since it focuses on the CBAS providers when it should also be articulating quality of care standards for the managed care organizations. Under CBAS, quality management will be the responsibility of the managed care organization.

32. I reviewed the "Response to *Darling v. Douglas* Plaintiff's Counsel Request for Documents and Data Deliverables," September 7, 2012 to see to what degree the Defendants have provided answers or a data process in response to the Plaintiff's requests. I examined the response to each request. It appears that much valuable and necessary information has not been made available to Plaintiffs.

33. What is needed is a consistent data reporting policy that provides historical months plus the current month in each monthly report issued wherever such reports are requested in the

agreement. Consistent reporting needs to be applied to all data elements that are routinely collected on a monthly basis. The Defendants have the ability to positively build routine reports which can be used by all persons to monitor and improve the program.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on September 11, 2012, in East Windsor, N.J.

By: /s/
LESLIE HENDRICKSON, Ph.D.

I hereby attest that I have on file all holograph signatures for any signatures indicated by a "conformed" signature (/S/) within this e-filed document.

By: /s/
Elissa Gershon

Attorneys for Plaintiffs