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**IN THE UNITED STATES DISTRICT COURT**

**FOR THE NORTHERN DISTRICT OF CALIFORNIA**

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| 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 CIVIL CONTEMPT SANCTIONS****Hearing Date: March 29, 2012** **Time: 9:00 a.m.** **Judge: Magistrate Judge** **Jacqueline Scott Corley****Address: 450 Golden Gate Avenue** **San Francisco, CA 94102****Courtroom: F, 15th Floor** |

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**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 Civil Contempt Sanctions. 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**

1. 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.
2. 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.
3. 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 three months I have worked in six states.
4. 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.
5. 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 on mental health and substance services provided by the State of Texas.
6. 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.
7. 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).
8. 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, the Declaration and Exhibits of Diane Puckett (ECF No. 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)
9. 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:

### 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. 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).

1. 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. 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]](#footnote-1)
2. 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 the 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.”
3. 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:
* The number of assessments done;
* What percent of the ADHC participants have had assessments;
* What are the results of the assessments;
* 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.
1. 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
2. For example, the Defendants present no information showing there is a process for continuous improvement and the declaration 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. Indeed, Mr. Temme’s Declaration (ECF No. 466, ¶¶ 17, 20) shows that entire Centers could have their assessments done in ways that were discrepant from assessments done at other Centers, without any action other than to overturn eligibility findings at that center based on a review of the assessors’ completed paperwork.
3. 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.
4. 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]](#footnote-2) With changes, the Federal framework from 2000 has been carried down to today and strengthened. CMS identified a three-part quality structure.[[3]](#footnote-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;
* 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.

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]](#footnote-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”.

1. 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.
2. 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 contribute to the utilization management appearance of the Defendants’ procedures.
3. 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.
4. 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.
5. 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.
6. 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]](#footnote-5) Given the Defendant’s lack of 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.” The fact that a Branch Chief in the Defendants’ Utilization Management Division is in charge of the process contributes to the appearance that these denials of eligibility use procedures that are more similar to those used in utilization management than those used in quality program designs. *See* Temme Dec. ¶ 1.
7. 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 Declaration of Christine King-Broomfield (ECF 470, ¶6) conveys the impression that numerous QA reviews would be done off site, but no data is presented by the Defendants to show how many were done off site. 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.
8. 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. 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.
9. Moreover, it is impossible to conduct a valid quality assurance process without data upon which to identify trends, patterns, and problems. The Defendants have not released or identified the existence of data that can be used to determine whether trends, patterns, and problems exist. Defendants state that they have had over 200 nurses conducting assessments around the State and inputting data into a database. It is probable that an examination of the results from these assessments and their associated database would yield important information about whether the assessment process is consistent and rational.

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

 Executed on March 27, 2012, in East Windsor, N.J.

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| 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.

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| By: |  /s/ |

 Elissa Gershon

 Attorneys for Plaintiffs

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> [↑](#footnote-ref-1)
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. [↑](#footnote-ref-2)
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> [↑](#footnote-ref-3)
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> [↑](#footnote-ref-4)
5. For example see the URAC definition of “utilization management” retrieved on 3-27-2012 from <https://www.urac.org/resources/caremanagement.aspx> [↑](#footnote-ref-5)