IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

ERIC STEWARD, by his next friend and mother, Lillian Minor, *et al.*,

Plaintiffs,

v.

CHARLES SMITH, in his official capacity as the Executive Commissioner of Texas' Health and Human Services Commission, *et al.*,

Defendants.

Case No. SA-5:10-CV-1025-OG

THE UNITED STATES OF AMERICA,

Plaintiff-Intervenor,

v.

THE STATE OF TEXAS,

Defendant.

DECLARATION AND EXPERT DISCLOSURE OF ELIN HOWE

I declare under the pains and penalties of perjury under the laws of the United States and in compliance with Fed. R. Civ. P. 26(a)(2)(B), that the foregoing is true and correct and that I am submitting this disclosure regarding my work as an expert consultant in the above case.

1. My report, which is attached, contains a complete statement of all of my opinions as well as an explanation of the basis and reasons for those opinions.

2. My report describes the facts, data and other information I considered in forming my opinions.

3. There are no exhibits prepared at this time to be used as a summary of or support for my opinions.

4. My attached curriculum vitae states my qualifications and lists all publications I have authored within the past ten years.

5. Within the last four (4) years, I have not testified as an expert either in a deposition or at trial.

6. I have been retained by the Plaintiffs and the United States as a joint expert in the Steward v. Smith litigation. My compensation in this litigation is $150.00 per hour for my review, preparation of reports and statements, and for deposition or testimony, plus expenses. My compensation is not dependent on the outcome of this litigation.

Signed and dated: April 30, 2018

Elin M. Howe

Elin M. Howe

CERTIFICATE OF SERVICE

I certify that on this 30th day of April, 2018, a true and correct copy of the foregoing Declaration and Expert Disclosure of Elin Howe was delivered via electronic mail to the attorneys for defendants at the addresses below:

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UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS
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Eric Steward, by his next friend and Mother, Lillian Minor, et al.,

Plaintiffs,

v.
Charles Smith, Executive Commissioner, Texas Health and Human Services Commission, et al.,

Defendants.

The United States of America,

Plaintiff-Intervenor,

v.

The State of Texas,

Defendant.

Civil No. 5:10-cv-1025-OLG

Expert Rebuttal Report of Elin Howe

I. Background and Related Experience

My experience in serving and supporting individuals with intellectual and developmental disabilities (I/DD) spans more than 44 years. During this time, I was employed by state agencies in New York and Massachusetts for 33 years, serving as Commissioner of the New York State Office of Mental Retardation and Developmental Disabilities for 4 years and Commissioner of the Massachusetts Department of Mental Retardation (subsequently renamed the Department of Developmental Services), for 10 years. I have worked as an independent consultant and as a consultant and Director of Consulting Services for The Columbus Organization. My experience includes serving as the Internal Compliance Monitor in the *Jackson v. Los Lunas* lawsuit in New Mexico, a federal class action on behalf of approximately seven hundred individuals with I/DD in two large state facilities; as the jointly selected Monitor in *United States v. State of New Jersey*, two lawsuits involving over 600 individuals with I/DD at the New Lisbon and Woodbridge Developmental Centers; and as the Independent Expert in the *Kentucky Protection and Advocacy v. Commonwealth of Kentucky* nursing facility lawsuit, a federal class action on behalf of individuals with I/DD in Kentucky's nursing facilities. Each of these cases required me to evaluate the adequacy of services and supports provided to individuals with I/DD under various laws including the Medicaid Act, Section 504 of the Rehabilitation Act, and/or the Americans with Disabilities Act (ADA). I have worked in 16 states on the development and improvement of services for people with

I/DD, including the provision of active treatment to individuals in Medicaid-certified facilities, and transition and supports necessary to allow individuals with I/DD to live in the community. A full description of my background and experience is set forth in my curriculum vitae, which is attached as Attachment A.

In 2007, I was jointly selected by the parties in the *Rolland v. Patrick* case, involving the institutionalization of individuals with I/DD in nursing facilities, to serve as the Court Monitor, responsible for evaluating specialized services, active treatment, and transitions to the community for approximately 800 individuals with I/DD who remained in nursing facilities in Massachusetts. At the same time, the Commonwealth was searching for a Commissioner for the Department of Mental Retardation (DMR). After careful consideration, I accepted the position as Commissioner.

As Commissioner, one of the first matters I had to deal with was the non-compliance motion filed by plaintiff Loretta Rolland and the resulting order of the federal court that found DMR was not in compliance with active treatment. By way of background, a Settlement Agreement had been approved by the Court in 2000. In the next 7 years, DMR placed approximately 1,000 people from nursing facilities into the community as required, but for those who remained in nursing facilities, the Court determined that specialized services and active treatment, required by both the federal Preadmission Screening and Resident Review (PASRR) regulations and the Settlement Agreement, were not being provided. The Court issued several remedial orders, approving standards for evaluating active treatment in nursing facilities that was required by federal law and an instrument for determining if class members were receiving active treatment, as required by federal law. The Court also appointed a Court Monitor to evaluate compliance with its active treatment orders, using an Active Treatment Protocol Instrument.

After thorough review of the court order, extensive discussion and deliberation among the three state agencies named in the case (DMR, MassHealth – Massachusetts' Medicaid agency – and the Department of Public Health) and with the Executive Office of Health and Human Services to which the three state agencies reported, the Attorney General's Office and the Governor's Office, the State decided to enter into a second Settlement Agreement.

There was a clear recognition on the part of state officials that providing active treatment in nursing facilities, particularly those facilities with a small number of residents, presented challenges. Nursing facilities often were not prepared to provide the specialized services or active treatment that residents with I/DD required and that were identified in their Level II PASRR Evaluations. I/DD providers contracted by DMR to provide specialized services in nursing facilities also experienced many challenges in ensuring the provision of active treatment, including issues with lack of carryover of services by nursing facility staff when the provider staff was not present. This issue was identified in multiple reports by expert reviewers over the course of the Settlement Agreement. In consideration of these challenges, coupled with the requirement to serve individuals with I/DD in the most integrated setting, the State and DMR, the agency with the major responsibility for service provision under the terms of the second Settlement Agreement, agreed to place the majority (640) of the 780 individuals who resided in nursing facilities at that time into the community, consistent with those individuals' informed choice. DMR also committed to providing active treatment to individuals for whom a move from the nursing

facility was not clinically indicated or practical, e.g., those in a vegetative state, those near death, or those who opposed placement despite intensive, ongoing efforts to engage the individual in a transition process. The Settlement Agreement also included provisions to strengthen the diversion process so that fewer individuals were approved for long-term stay in a nursing facility. This expanded diversion program was critical, since the population of individuals with I/DD in nursing facilities had not substantially decreased, despite the placement of over 1,000 individuals from nursing facilities into the community, because large numbers of individuals continued to be admitted, rather than diverted, from nursing facility placement. After a fairness hearing, the Court approved the Settlement Agreement.

Over the course of the next four years, the Department of Developmental Services, formerly, DMR, placed 670 individuals into the community and met the active treatment requirements of the individuals who remained in nursing facilities, as confirmed by reviews conducted on a regular basis throughout the case by the Monitor, Lyn Rucker. DDS significantly improved its PASRR process so that far fewer individuals were admitted into nursing facilities, and those individuals who were admitted to nursing facilities usually returned to the community within 90 days. If an individual was to remain indefinitely in a nursing facility, review and approval was required from DDS. Once all of the community placement, active treatment, diversion requirements, and other Settlement Agreement provisions were implemented, DDS agreed that it would continue to place individuals from nursing facilities back into the community within 90 days to the fullest extent possible. If individuals remained in the nursing facility beyond 90 days, for example, because development of their home was delayed, DDS tracked their progress through to placement. The Department also committed to continue its PASRR practices, which had been greatly enhanced during the term of the Settlement Agreement. The Department of Health also agreed to administer a survey review process similar to that used by the Monitor to conduct active treatment and other compliance reviews of nursing facilities serving individuals with I/DD. Based upon these achievements, and with the consent of all parties, the case was dismissed in 2013. No further litigation has ensued because the Commonwealth has kept to its commitments.

II. Purpose of this Report

Given my experience with the *Rolland* case, and with implementing compliance programs for specialized services, active treatment, and transition and diversion of individuals with I/DD from nursing facilities, I was asked by the plaintiffs and the United States to review the Outcomes and Outcome Measures contained in the PASRR Individual Review Monitoring (PIRM) agreed to by State of Texas in 2014 and implemented by an independent consultant, Kathryn du Pree, through the Quality Service Review (QSR). Specifically, I was asked to address the facts and opinions set forth in the report of Jennifer Burnett concerning PIRM Measures included in the QSR. Ms. Burnett stated that certain Outcome Measures included in the QSR are not required under PASRR. My review addressed whether the Outcomes and Outcome Measures included in the QSR are appropriate and necessary in evaluating whether a PASRR program is in compliance with federal requirements and adequately achieving the purpose of PASRR for individuals with I/DD; whether those that relate to persons in nursing facilities ensure the provision of all habilitative services consistent with active treatment standards; whether those that relate to diversion are appropriate and necessary to ensure that individuals with I/DD can avoid inappropriate nursing facility placement; and whether those that relate to transition are appropriate and necessary to ensure

that individuals with I/DD are able to make a successful transition from the nursing facility into the most integrated setting. After thorough review, it is my professional judgment that the Outcomes and Outcome Measures embody the outcomes a state program must achieve in order to comply with federal requirements for people with I/DD residing in or at risk of entering nursing facilities or transitioning from nursing facilities, as I will describe below. In addition to review of Outcomes and Outcome Measures, I also asked by the United States and plaintiffs to review data on nursing facility census.

III. Methodology

I was provided a copy of Ms. Burnett's expert report, as well as the QSR documents she considered. I also reviewed the deposition of Kathryn du Pree, the LIDDA performance contract, and the 2016 Interim QSR report and the QSR scores for 2017. I also reviewed the PASRR regulations, 42 C.F.R. Sec. 483.100, as well as the Active Treatment Protocol in Massachusetts. Finally, I reviewed data on nursing facility census contained in tables prepared by Darlene O'Connor. A full list of the materials I considered is set forth in Attachment B.

IV. The QSR Outcomes and Outcome Measures

For each of the following Outcomes and Outcome Measures, I reviewed whether the Outcome and Outcome Measures were necessary in order to achieve the PASRR requirements for identification and evaluation of individuals with I/DD and specialized services, as well as the ADA's requirement to serve individuals in the most integrated setting appropriate to their needs. In my experience, complying with these federal requirements involves implementation of policies and practices that match requirements in the federal statute and regulation, as well as implementation of professional standards and programmatic standards designed to achieve the purpose of those federal requirements. Measures for Outcome 1 include those that are necessary to administer, implement and monitor an adequate PASRR program, consistent with federal regulations, and those addressing the specific means by which Texas, based on its service delivery structure and work processes, needed to administer and oversee an adequate PASRR diversion program at the State and the Local Intellectual and Developmental Disability Authority (LIDDA) Level. Outcome 1 has 11 Measures, a number of which mirror specific requirements in the federal PASRR regulation, including requirements related to: Level 1 screenings (1-1), timely administration and completion of Level II evaluations if the Level 1 screen indicates that the individual has I/DD (1-2), confirmation in the Level II evaluation whether the individual has an Intellectual or Developmental Disability and whether the evaluation "… appropriately assesses whether the needs of the individual can be met in the community and accurately identifies, based on the information available, the specialized services the person needs …" if admitted to an NF (1-3.). Measures that evaluate adequate diversion, which is accepted in my field as necessary to ensure individuals with I/DD can avoid inappropriate nursing facility placement or a long-term stay in a nursing facility, include that: each LIDDA has a Diversion Coordinator (1-5); "The Diversion Coordinator identifies available community living options, supports and services to assist individuals in the TP (Target Population) to successfully live in the community," (1-6) and; "The Diversion Coordinator coordinates education for SCs [Service Coordinators] and other LIDDA staff to learn about community services and strategies to avoid NF placement for the TP" (1-7). Given the central goal of the PASRR rules – to prevent the unnecessary

admission of individuals with I/DD to nursing facilities where other alternatives can meet their needs – it is critical to provide information to individuals in the community who are at risk of admission to a nursing facility, as required by Outcome Measure 1-8; to "…identify, arrange and coordinate all community options, services, and supports…necessary…to avoid admission to a NF," as required by Outcome Measure 1-9; and to receive services and supports needed to remain the community, as required by Measure 1-11. These Measures go to the very core of an adequate and effective PASRR program, including that it ensures that individuals with I/DD can live in the most integrated setting appropriate to their needs.

Outcome 2 deals with PASRR requirements for individuals who are admitted to a nursing facility. It evaluates the essential elements of service delivery for individuals with I/DD and the critical elements of a professionally-adequate PASRR program, including a comprehensive assessment of their habilitation needs, a professionally-appropriate, interdisciplinary Service Planning Team (SPT), a professionally-adequate Individual Service Plan (ISP), and the provision of "specialized services with the frequency, intensity, and duration necessary to meet their [individuals'] appropriately-identified needs, consistent with their informed choice." There are 13 Measures for this Outcome. The importance of service planning (2-1) for individuals with I/DD cannot be overstated, as development and implementation of an Individual Service Plan can impact virtually every aspect of an individual's life, both positively and, in some cases, negatively, dependent on the attention given to the Individual Service Plan. Having an adequate and appropriate SPT process and ISP is particularly important if the individual has changing needs that must be addressed. Given the challenges of providing specialized services and active treatment in a nursing facility, the requirement for quarterly SPT meetings is a reasonable and necessary one, as is the requirement for the SPT to determine whether it needs to meet more frequently based on the "…individual's risk factors" (2-1). Attendance at SPT meetings by the individual or their legal representative, nursing facility staff, specialized service provider(s), and a community provider if placement is being planned (2-2) is necessary to ensure development of an ISP that is comprehensive in nature and addresses not just the individual's needs but also their preferences in how they live their life. A similar standard of practice designating who should be present at team meetings was used in the *Rolland* case. Each participant's contribution to the team and ultimately to the individual's quality of life is important and necessary. Using the planning process as the means to identify an individual's "…needs, preferences, strengths and goals, and to develop annual objectives to assist the individual to achieve these goals" (2-3) is the ultimate purpose of the Individual Service Plan. Basing the ISP on comprehensive assessments of the person's needs and recommending services based on these assessments (2-4) are accepted standards of practice that have been in place for many years.

A critical element for evaluating the adequacy of an ISP is whether the individual receives all the services required to meet the individual's habilitation needs, which should be included in the ISP. Service planning must include the ability for the individual to "…learn about community options" (2-5) in order to make an informed choice about where to receive services. The latter was particularly important in Massachusetts, as many individuals had not had the opportunity to explore or in any way participate in their communities until DDS implemented an organized outreach program that provided them concrete experiences, specialized services, and a range of opportunities to learn about and participate in

community activities. For many individuals and their families, these varied outreach strategies played an important role in their ability to make an informed decision to move into the community. Measure 2-6 sets a very minimal standard for outreach, requiring LIDDAs to "…offer individuals who are in the NFs and their LARs … information about community options" while Measure 2-7 requires that semi-annually Service Coordinators "…provide each individual and LAR information about community services and supports." Measure 2-8 requires that each individual in an NF have two plans, an ISP and a separate nursing facility plan of care (NFCPC), both of which must include all needed specialized services, must be developed and implemented in a consistent manner, and must be coordinated to ensure appropriate carry over between settings, as required by federal law. Measure 2-9 describes a process requiring documentation by the SPT of the reasons an individual must remain in a nursing facility and what "… steps the team will take to address the identified barriers to placement in the most integrated setting." Sound professional judgment on the team's part that an individual needs to stay in a nursing facility and documentation of that judgment in writing is significant to the individual and to their rights under the ADA and *Olmstead* to be served in the most integrated setting appropriate. In my opinion, each of these Measures are basic, necessary criteria for evaluating the adequacy of a PASRR program and the habilitation services required by PASRR for individuals with I/DD in nursing facilities.

Implementing a review and approval process for long-term stays in nursing facilities caused DDS officials, PASRR staff, service coordinators and others within the agency to think more comprehensively about what services might be needed to meet individuals' needs in more integrated settings. For example, at the beginning of the second *Rolland* Settlement Agreement, we believed that we did not have capacity to serve individuals who are ventilator-dependent, or who had other intensive medical needs, in the community. As we progressed through the Settlement Agreement, we recognized that in order to provide services to this group of people, we needed to ensure that staff acquired the necessary skills to support them and provide funding needed by private sector providers to support them in the Commonwealth's communities, which we did. In order to adequately serve individuals who were part of the *Rolland* class, DDS determined that the workload involved for Service Coordinators was greater and fundamentally different than that of Service Coordinators serving non-class members. DDS addressed this by reducing the caseload size for Service Coordinators similar to what is suggested in Measure 2-10. Meeting with individuals each month (2-11) is standard practice for Service Coordinators and monthly contact is required to claim federal funds for Service Coordination services. Measure 2-13 requires that individuals be admitted only to nursing facilities that can meet their needs for specialized services or to a facility where their needs can be addressed by the LIDDA or the LIDDA and the NF. This practice directly addresses requirements for specialized services included in PASRR regulations. 42 C.F.R. Sec. 483.120. Measure 2-15 requires the State to identify "… the frequent reasons for admission to NFs of individuals in the Target Population and take steps to reduce admissions and to remove barriers to diversion and transition for such individuals." Tracking data enabled Massachusetts to identify, for example, the problem noted above in relation to lack of services for vent-dependent individuals. As noted above, these additional Measures are essential to preventing the unnecessary admission of individuals to nursing facility, to facilitating their timely transition to the community, and to providing them the PASRR required services while in nursing facilities. Relatedly, these measures are also fundamental to ensuring that individuals can receive services in integrated settings.

Outcome 3 requires that "Individuals in the Target Population in nursing facilities who are appropriate for and do not oppose transition to the community will receive transition planning, transition services, and placements in the most integrated setting necessary to meet their appropriately-identified needs, consistent with their informed choice." There are 11 Measures for this Outcome, which constitute the basic elements and requirements for a professionally-acceptable transition process, including 3-1, which requires that "…services and supports be made available for individuals to move to the community and remain in the community." While some Measures for this Outcome, including 3-5, 3-6, 3-7, and 3-8 - all of which relate to the Service Planning Team and the Individual Service Plan development and implementation for individuals residing in NFs - appear in earlier Outcomes, this Outcome concentrates on the basic elements of transition planning, transition services, and actions necessary to effectuate a safe and appropriate transition to the community, including: contacting an individual within 30 days if he or she indicates interest in moving into the community through their answer to Section Q of the MDS (3-4); placing an individual into the community with 180 days after they accept the waiver slot or another program type, with time extensions granted by DADS (3-9); coordinating the Community Living Discharge Plan (CLDP) with the ISP and the NFCPC (3-10); developing and implementing a CLDP for the individual (3-11); monitoring individuals discharged with "… the frequency specified in the CLDP…" with "at least 3 monitoring visits during the first 90 days following the individual's move to the community," including one within the first seven days "to determine whether all supports and services specified in the CLDP are adequately provided to the individual and address any gaps in services to prevent crises, re-admissions, or other negative outcomes." (3-13). Lastly, for an individual whose team recommends that they remain in the NF, Measure 3-12 requires that the SPT document the reasons for this decision in a plan that identifies barriers to placement in the most integrated setting. The SPT must develop and implement steps to address the identified barriers in timeframes specified by the team. Each and all of the above Measures are the very foundation of ensuring effective and appropriate transitions of individuals with I/DD from segregated settings, like nursing facilities, to integrated settings in the community.

Outcome 5 specifies that "Individuals in the Target Population who do not refuse service coordination will receive coordination from trained service coordinators with the frequency necessary to meet the individual's appropriately- identified needs, consistent with their informed choice." It applies to individuals who are diverted or transitioned from nursing facilities, as well as those in nursing facilities. The Measures in this Outcome clearly describe all service coordinator responsibilities to the individual, their LA and the individual's team, including service providers. Since service coordination is the foundation for planning, coordinating, delivering, and monitoring services to individuals with I/DD (and other disabilities), the 9 Measures for this Outcome are central, indeed foundational, to the provision of adequate habilitation required by PASRR and services to ensure individuals can transition to and remain in the community, as required by the ADA. Requirements for monitoring of the individual's plan are specified in Measure 5-4, which states, "Each individual in the TP meets with his/her SC at least monthly to review his/her plan and its implementation while in the NF and/ or for the first 180 days are moving to a community program."

Outcome 6 requires that "Individuals in the Target Population will have a service plan, developed by an interdisciplinary service planning team through a person-centered process that identifies the services and supports necessary to meet the individual's appropriately-identified needs, achieve the desired outcomes, and maximize the person's ability to live successfully in the most integrated settings consistent with their informed choice." Like service coordination, adequate service planning is the foundation for adequate service delivery, either in a nursing facility or in the community.

V. Core v. Enhanced Outcome Measures

Ms. Burnett also comments about whether those Outcome Measures that Ms. du Pree identified as "core," as opposed to as "enhanced," are required by federal law. It appears that she interpreted this distinction as meaning "required by federal law." But as Ms. du Pree explained in her deposition, this distinction was based on her judgment of which Outcomes Measures were more foundational and should be the focus and priority of the State's improvement efforts. While I am not in a position to judge which Measures should be the initial focus of improvement efforts, I have, as a compliance monitor and internal monitor in other related cases for individuals with I/DD, suggested that state defendants prioritize those obligations that are the ones that are the building blocks for other, more complex obligations as Ms. du Pree articulated or that are the easiest to achieve.

Finally, while the PASRR regulations may not explicitly mention service coordination, I disagree with Ms. Burnett's suggestion that an effective service coordination program is not necessary to achieve the PASRR requirements of specialized services and active treatment. Moreover, Texas' own PASRR requirements mandate that every person with I/DD who is admitted to a nursing facility must be assigned a service coordinator by the LIDDA, unless the individual refuses.

VI. QSR Findings

I reviewed the 2016 PASRR Compliance Status Interim Report, which contained the 2015 and 2016 findings for each Outcome Measure from the Quality Service Review that was conducted by the State's independent consultant, Ms. du Pree. In addition, I reviewed the 2017 QSR Review Results by Outcome Measure that provided the most recent QSR findings. Overall, most of these compliance scores showed little improvement, and at times regression, over the three year period. In fact, the scores for many of the key indicators of PASRR and ADA compliance are, in my judgment and experience, low and reflect that Texas is not meeting its obligations to people with I/DD in nursing facilities under both PASRR and the ADA.

Outcomes 2 (PASRR services for individuals in nursing facilities), 5 (service coordination) and 6 (Individual Service Planning) show year to year declining compliance levels or levels remaining the same from year to year with: Outcome 2 at 35% in 2015, 31% in 2016, and 32% in 2017; Outcome 5 at 53% in 2015, 50% in 2016 and 49% in 2017 and; Outcome 6 at 38% in 2015, 32% in 2016 and 32% in 2017. This trend is further confirmed in Table 3 Comparison of Outcome Achievements (page 9) of the 2016 report of compliance across target groups with the possible exception of Outcome 1 on Diversion. Outcome 3 (community services and transition) is also low, with scores of 43% in 2015, 44% in 2016, and 46% in 2017.

Particularly concerning are Outcome scores reported in the 30 and 40 percent range – with a number of Outcome Measure scores even lower – because it would appear, based on my experience in Massachusetts, that there is a systemic problem or multiple systemic problems in the administration, operation, and effectiveness of Texas' PASRR and transition programs that demonstrate noncompliance with federal requirements and acceptable system implementation.

Of special concern are the consistently low scores for the Outcome 2 Measures over the three year period 2015 through 2017, which are reported as:

2-1. 35% in 2015, 36% in 2016, 36% in 2017;

2-2. 33% in 2015; 35% in 2016, 37% in 2017;

2-3. 39% in 2015, 44% in 2016, 55% in 2017;

2-4. 30% in 2015, 40% in 2016, 38% in 2017;

2-5. 19% in 2015, 14% in 2016, 16% in 2017;

2-6. 15% in 2015, 21% in 2016, 16% in 2017;

2-7. 48% in 2015, 51% in 2016, 58% in 2017;

2-8. 27% in 2015, 25% in 2016, 19% in 2017;

2-9. 11% in 2015, 0% in 2016, 17% in 2017;

2-11. 46% in 2015, 39% in 2016 and 31% in 2017; and

2-13. 75% in 2015, 39% in 2016, 33% in 2017.

By 2017, only 2 Outcome Measures -- **2-3**. at 55% and **2-7.** at 58% -- had attained scores over 50%, while all other 2017 Measures scores ranged from 16% to 37%. Of particular concern are the ratings shown in the report for Outcome 2 Measures that relate directly to the development and implementation of the Individual Service Plan and delivery of specialized services for individuals in nursing facilities, including 2-1., 2-2., 2-3., 2-4. 2-5., 2-8., 2-11.

Other Outcome Measures important to the provision of services to individuals also show little progress. For example, scores for Outcome Measures that are foundational to meeting the needs of individuals who are moving into the community or those who have moved into the community for services include Outcome Measure 3.3 requiring that the Level II PASRR "…appropriately assesses whether the needs of the individual can be met in the community and identifies the specialized services the individual needs." Scores of 34% in 2015, 20% in 2016 and 16% in 2017 are evidence of a failure to provide and support appropriate transitions, since this Measure goes to the very foundation of providing individuals with appropriate and needed services that would facilitate their move from a nursing facility to a more integrated setting in the community. Also significant and concerning are scores that have remained low or have declined for:

Outcome Measure **3-5.** (30% in 2015, 35% in 2016 and 33% in 2017) addressing development, review and revision of an individual's ISP by their SPT;

Outcome Measure **3-6.** (35% in 2015, 44% in 2016 and 54% in 2017) requiring identification of the individual's needs, preferences, strengths and goals… and annual objectives to assist the individual to achieve these goals.";

Outcome Measure **3-7.** (28% in 2015, 38% in 2016 and 35% in 2017) requiring that "The ISP is based on assessments of the person's needs…" and;

Outcome Measure **3-8.** (19% in 2015, 12% in 2016 and 12% in 2017) requiring that "The individual has an ISP that includes all of the services and supports…he/she needs to achieve his/her goals…"

Finally, several of the core measurements of service coordination adequacy demonstrate a similar pattern. For instance, of particular concern is Outcome Measure 5.2 (38% in 2015, 31% in 2016 and 29% in 2017) that addresses development, review and revision of an individual's ISP by their SPT. This same issue is also identified in scores for Outcome Measures 2-1., 3-5., and 6-2., further pointing out deficiencies in the service coordination and the service planning team process.

Having served as a Monitor, a consultant, Commissioner of the Massachusetts DDS and Commissioner and in various staff capacities in the New York state agency, I have been continuously involved in class action suits and monitoring work in various states regarding their compliance with Section 504 of the Rehabilitation Act since 1976 and with PASRR and ADA standards since they became effective. In my experience, the overall compliance scores reported in Ms. du Pree's reports would not result in findings of substantial compliance with the federal standards required by PASRR and the ADA. Outcome 1 is the only Outcome that appears to be approaching compliance, but it is notable that this Outcome, regarding diversion, is only reviewed for individuals who have actually been diverted; it does not provide information about the effectiveness of diversion efforts for those individuals who could be diverted, but are not.

VII. Nursing Facility Census

Texas' Nursing Facility census has not been decreasing and has remained consistent, according to data produced by Darlene O'Connor. As reported in the table titled "Monthly Census of Medicaid Nursing Facility (NF) Residents, Age 21+, with ID/DD Qualifications on their Last PASRR Level 2 (L2) Evaluation; April 2011 to May 2017", over the last several years and including during the period when the QSR has been conducted, the census consistently is reported in the range of over 3,600 to over 3,700 individuals.

Data included in the table in a section titled "ID/DD Qualifications on Last L2 Evaluation – Long Stay Residents by Length of Stay Episode" also demonstrates that the census is not declining. It shows that the census for "All Long Stay Residents (> 90 days)" reached a high of 3,358 in January, 2015, but has not declined significantly; remaining above 3,300 through May, 2017 with a census of 3,308.

Similarly, the data for individuals in residence for 1 year or more, 3 years or more, and 5 years or more shows that census is not decreasing. Data for "NF Residency 1+ Year" shows the census has not declined below 2,600 since January 2014 and continuing through May, 2017, with a census of 2,684. The census is consistently reported in the over 2,600 to over 2,700 range.

Data for "NF Residency 3+ Years" reached 1,600 in February, 2014 and never declined below 1,600 through May 2017, with a census of 1,622. The census is consistently reported in the 1600 plus range.

Data for "NF Residency 5+Years" is first recorded in December 2015 with a census of 1,076. This census never declined below 1,000 through May 2017, with a census of 1,079.

Data shown in the table titled "Monthly Census and Admission Discharge Profile of Medicaid Nursing Facility (NF) Residents Age 21, with ID/DD Qualifications on their Last PASRR L2 Evaluation; April 2011 to May 2017" - "All Residents in Target Group" provides information on the number of admissions and discharges by month. For the 74 months recorded, there are 54 months where admissions equaled or exceeded discharges and only 20 in which the discharges exceeded the admissions. Focusing just on the last two years of data, discharges (3,565) have exceeded admissions (3,537) by only 28 people.

In my experience, the movement in a nursing facility census of individuals with I/DD, and particularly the change in census among individuals experiencing longer stays, is an important indicator in the effectiveness of diversion and transition programs. When working effectively, these efforts combined should result in a reduction to the nursing facility census. As I explained above, we found in Massachusetts that although we transitioned over 1,000 individuals with I/DD from nursing facilities to the community over six years, we were unable to substantially impact the census until we added a robust diversion program, because individuals with I/DD were continuing to be admitted to the nursing facility, taking the place of those who left. Similarly, although there will be natural discharges, often due to death, from the groups of individuals experiencing longer stays, if individuals are not transitioned after short stays then they often continue to remain in the nursing facility and become part of the longer stay groups. Finally, it was important to our eventual success in dramatically reducing the census by over 75% (from more than 1600 to approximately 200), to make special efforts to focus on those who had been in the nursing facilities for many years – often referred to as the long term stay population – to address their needs and concerns, so that most eventually, and successfully, transitioned to the community.

Based upon my experience in Massachusetts and elsewhere, if Texas had been effectively identifying individuals with I/DD and diverting them from nursing facility entry, as well as educating and assisting individuals to transition to the community, I would expect to see a decrease in both the total nursing facility census, and the longer-stay census groups. But based upon the data I reviewed, this clearly is not happening.

VIII. Conclusion

Based upon my years of experience as a state official responsible for implementing a PASRR program that complies with federal law and achieves the fundamental purposes of PASRR and the ADA – to avoid

unnecessary admission to and ongoing stays in nursing facilities, whenever possible – the Outcomes and Outcome Measures in the QSR are required to achieve these objectives. In my judgment, the Outcomes and Outcome Measures in the QSR reflect what is necessary to comply with federal requirements for people with I/DD residing in or at risk of entering nursing facilities and generally describe the minimally necessary requirements, standards, and elements of adequate specialized services, diversion and transition services consistent with PASRR and the ADA. In fact, the Outcome Measures appear far less rigorous than the Active Treatment Standards adopted by the federal court in *Rolland*, and less demanding than the Active Treatment Protocol used by the Court Monitor to evaluate active treatment in nursing facilities in Massachusetts. Moreover, the actual scores for most of these Outcome Measures for individuals in nursing facilities are not improving, and sometimes declining, over the past three years. Finally, there has been almost no impact on the nursing facility census, which has remained relatively constant over the past four years, when one would expect it to decrease.

Attachment A

Elin M. Howe

Experience

THE COLUMBUS ORGANIZATION, Wayne, PA
Senior Consultant, September 2017 to present

Serves as a consultant and subject matter expert for the Consulting and Community Services divisions within The Columbus Organization

MASSACHUSETTS DEPARTMENT OF DEVELOPMENTAL SERVICES, Boston,MA
Commissioner, July 2007 to July 2017

Responsible for policy development, planning, financing, regulating, managing, and providing services to 38,000 individuals with intellectual and developmental disabilities. Services are provided by more than 6,000 state employees and over 300 provider agencies. Agency funding is approximately $1.9 billion.

THE COLUMBUS ORGANIZATION, King of Prussia, Pennsylvania
Vice President of Consulting Services, 2003 to 2007
Project Director, July 1999 to January 2003
Sub-Contractor, November 1996 to June 1999, 2007 to 2009

As Director of Consulting Services, provided corporate leadership for all Columbus consulting projects including those in the states of California, New Mexico, New Jersey, Kentucky, Tennessee, Washington, Missouri, Texas, Iowa, and the District of Columbia.

Served as the Independent Monitor, jointly selected by defendants and plaintiffs, in the United States Department of Justice CRIPA Settlement Agreement with the State of New Jersey in the New Lisbon Developmental Center and the Woodbridge Developmental Center cases. Along with her team of experts was charged with monitoring the Centers' compliance with the terms of the CRIPA settlement agreement.

Served as the Internal Compliance Monitor in the Jackson class action lawsuit in New Mexico. Responsible for monitoring the progress of the Department of Health, Department of Human Services and the Division of Vocational Rehabilitation in complying with the terms of the Joint Stipulation on Disengagement.

Served as the agreed upon expert between the Commonwealth of Kentucky and Kentucky Protection and Advocacy in the legal action regarding individuals with

developmental disabilities residing in nursing facilities.

Provided consultation to state defendants in California, Missouri, Texas, Kentucky, New Jersey, New Mexico, Washington, and Indiana on legal action between these States and the United States Department of Justice.

Provided a variety of consultation services in the state of California both as a sub-contractor and a Columbus employee from 1997 to 2006 including serving as: the Project Manager for the CA Department of Developmental Disabilities Risk, Mitigation and Assessment contract; the Interim Executive Director of the Regional Center of the East Bay which served over 11,000 individuals in a variety of community based services; Project Director of the Specialized Services Alliance at the Regional Center of the East Bay, a project designed to improve community services capacity via provision of technical assistance, training and consultative services; an advisor to the DDS Developmental Centers Division and to the Developmental Centers on a wide array of service delivery, facility downsizing and quality management issues.

Assignments as a Columbus sub-contractor included consultation to the State of Indiana Family and Social Services Administration and the New Castle Developmental Center on the development and implementation of the plan to close the center and the corresponding development of community based services for individuals leaving New Castle. Assisted the State in preparation for a United States Department of Justice CRIPA review of the New Castle Developmental Center.

Independent Contractor – December 1994 to June 1999

Among assignments as an independent contractor are the projects shown below.

STATE OF NEW MEXICO, DIVISION OF DEVELOPMENTAL DISABILITIES
Independent Contractor, December 1994 to July 1999

In addition to serving from 1997 to 1999 as the Internal Compliance Monitor (duties described previously), served as the Administrator of the Fort Stanton Hospital and Training School. As the joint selection of plaintiffs and defendants in the Jackson lawsuit, managed the phase down and closure of the facility.

Served as a consultant to the Los Lunas Center for Persons with Developmental Disabilities on improvement of institutional conditions. She also consulted on the development and subsequent operation of the Los Lunas Community Program that includes state-operated residential, day and therapeutic services.

Facilitated the development of a plan to improve community services infrastructure in the state that became the foundation of the Joint Stipulation on Disengagement of the Jackson class action lawsuit.

STATE OF GEORGIA, DIVISION OF DEVELOPMENTAL DISABILITIES
Independent Contractor, November 1995
Provided management and programmatic consultation to the Administrator of the Brook Run Center and Divisional representatives on planning, development and financing of community services for individuals.

OFFICE OF THE MONITOR, ARNOLD VS. SARN, ARIZONA SUPERIOR COURT
Independent Contractor, June through September 1995
Along with other consultants and staff of the Office of the Monitor, participated in the development of an audit tool to monitor conditions of severely mentally ill individuals living in supervisory care homes. Served as a member of an audit team that reviewed and reported on the condition of individuals residing at the Arizona State Hospital as well as on those individuals who had been discharged into the community.

State Government Experience

NEW YORK STATE OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES
Commissioner, December 1989 through September 1993
As Chief Executive Officer of one of the largest agencies in New York government, had overall responsibility for policy development, planning, financing, regulating, managing, and providing services to all New York State citizens with mental retardation and developmental disabilities. She was responsible for services to more than 75,000 individuals and 25,000 state employees as well as more than 30,000 private-sector workers with whom the agency contracted for services. Responsibilities included the administration of the agency's budget of approximately $2 billion.

NEW YORK STATE OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES
Executive Deputy Commissioner, November 1984 through December 1989
As Chief Operating Officer, managed all day-to-day and internal operations of the agency. She assisted the Chief Executive in the performance of all the responsibilities enumerated above in the description.

NEW YORK CITY COUNTY SERVICES GROUP, NYS OMR/DD
Associate Commissioner, January 1984 through November 1984 As Regional Director, oversaw and coordinated all services to the mentally retarded and developmentally disabled in the five boroughs of New York City. Responsibilities included planning and coordination of de-institutionalization and community placement of individuals living in five state institutions housing more than 7,500 individuals; financial management of all services; provision of technical assistance and monitoring of all services provided by private agencies to the mentally retarded and developmentally disabled citizens of New York City.

SOUTHEASTERN COUNTY SERVICES GROUP, NYS OMR/DD
Associate Commissioner, November 1980 through December 1983
As Regional Director of the nine-county area surrounding New York City, performed similar duties to those enumerated for my New York City position. She supervised New York's three largest institutions for the mentally retarded and developmentally disabled. In both this position and the position in New York City, she participated in planning and executive management of state operated services on a statewide level.

STATEN ISLAND BOROUGH DEVELOPMENTAL SERVICES, NYS OMR/DD
Director, October 1977 through November 1980
As primary administrator of developmental disability services within the Borough of Staten Island, was responsible for the care of more than 2,000 individuals living in the Willowbrook institution and for development of all state and private agency community-based services within the borough.

STATEN ISLAND DEVELOPMENTAL CENTER, NEW YORK STATE DEPARTMENT OF MENTAL HYGIENE
Deputy Director for Institution, March 1977 through October 1977

BROOKLYN DEVELOPMENTAL CENTER, NEW YORK STATE DEPARTMENT OF MENTAL HYGIENE
Business Officer, October 1976 through March 1977

NEW YORK STATE DEPARTMENT OF MENTAL HYGIENE
Consent Decree Coordinator, August 1976 through October 1976

NEW YORK STATE DEPARTMENT OF MENTAL HYGIENE
Institution Administration Consultant, June 1976 through October 1976

NEW YORK STATE DEPARTMENT OF MENTAL HYGIENE
Assistant Institution Administration Consultant, August 1974 through June 1975

NEW YORK STATE DEPARTMENT OF MENTAL HYGIENE
Personnel Administrator, August 1972 through August 1974

NEW YORK STATE DEPARTMENT OF CIVIL SERVICE
Personnel Services Representative, August 1971 through August 1972

NEW YORK STATE PUBLIC EMPLOYMENT RELATIONS BOARD
Public Administrate Intern, July 1970 through August 1971

Education

STATE UNIVERSITY OF NEW YORK AT ALBANY
Master of Public Administration, 1970

MASSACHUSETTS STATE COLLEGE AT SALEM
Bachelor of Arts (History), 1969

Attachment B

Steward v. Smith
5:10-CV-1025-OLG
In the United States District Court
for the Western District of Texas
San Antonio Division

REBUTTAL REPORT OF ELIN HOWE
CONSIDERED MATERIALS
Attachment B

	DOCUMENT	**BATES NUMBER**
1.	Expert Report, *Steward, et al., v. Smith, et al.*, Prepared by Jennifer Burnett, Principal, Health Management Associates, March 30, 2018.	
2.	PASRR Individual Review Monitoring (PIRM), Measure Overall Compliance, Report Date: 4/4/2017	DefE-00096530-DefE-00096538
3.	PASRR Individual Review Monitoring (PIRM), Matrix Review, Review Year: 2016, Report Date: 3/28/2016	DefE-00406157-DefE-00406241
4.	Active Treatment Protocol, *Rolland v. Patrick* (Dec. 7, 2007)	PL0094466-PL0094544
5.	Transcript of the Deposition of Kathryn duPree, February 6, 2018, Austin, Texas	
6.	Tex. Health & Human Svcs. Comm'n, LIDDA Performance Contract, Attachment A-4, PASRR and Enhanced Community Coordination, FY 2018-2019, *available at* https://hhs.texas.gov/sites/default/files//documents/doing-business-with-hhs/providers/long-term-care/lidda/performance-contract/performance-contract-attach-a4.pdf	
7.	2016 PASRR QSR Compliance Status Interim Report	DefE-00096540-DefE-00096568
8.	2017 QSR Results	US00257639
9.	Exhibit B of the Expert Report of Darlene O'Connor, *Steward, et al. v. Smith, et al.*, (April 30, 2018).	