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DISABLED SERVICES IN THE DISTRICT OF COLUMBIA: WHO IS PROTECTING THE RIGHTS OF D.C.'S MOST VULNERABLE RESIDENTS?

HEARING

BEFORE THE

COMMITTEE ON GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED NINTH CONGRESS

SECOND SESSION

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DISABLED SERVICES IN THE DISTRICT OF COLUMBIA: WHO IS PROTECTING THE RIGHTS OF D.C.'S MOST VULNERABLE RESIDENTS?

FRIDAY, JUNE 16, 2006

HOUSE OF REPRESENTATIVES,
COMMITTEE ON GOVERNMENT REFORM,
Washington, DC.

The committee met, pursuant to notice, at 10 a.m., in room 2154, Rayburn House Office Building, Hon. Tom Davis (chairman of the committee) presiding.

Present: Representatives Tom Davis, Kucinich, and Norton.

Staff present: Rob White, communications director; Andrea LeBlanc, deputy director of communications; Victoria Proctor, senior professional staff member; Shalley Kim, professional staff member; Teresa Austin, chief clerk; Sarah D'Orsie, deputy clerk; Tony Haywood, minority counsel; and Jean Gosa, minority assistant clerk.

Chairman TOM DAVIS. The committee will come to order.

I want to welcome everybody to today's hearing on the District of Columbia's Mental Retardation and Developmental Disabilities Administration.

We convene this morning because at a time when so many things are going right for the District, a longstanding, seemingly intractable problem has painfully reemerged and demands our attention.

The District's fundamental responsibility to be a humane and nurturing custodian of those with mental retardation and developmental disabilities is not being met. Some say the situation is irreparable, and the entire function should be taken out of the District's hands and given to a receiver. But even if that happens, the District has to find a way to reform the current system and meet the needs of these most vulnerable citizens.

How did it come to this? The story is a long and sad one. In 1976, after the deaths of two residents at Forest Haven, a facility for this population, a Federal class action lawsuit was filed against the District. Today captioned as *Evans* v. *Williams,* the case challenged the conditions of the confinement for residents of the institution which was subsequently closed. But the judgment against the District also imposes continuing obligations, under court supervision, to protect class members from harm and to provide services in the least restrictive setting for the duration of their lives. Generally, that meant the District should be able to provide community-based living situations in group homes.

In 1999, the Washington Post chronicled the tragedy of at least 24 deaths of residents in group homes operated in the city agency, the MRDDA. The articles highlighted chronic abuse and neglect of developmentally disabled individuals and described profiteering by some vendors operating group homes. Six years later a day program worker was charged with criminal negligence for burning an adult home resident. In March 2006, an employee of a day program for disabled persons pled guilty to charges of sexually abusing a patient. MRDDA made headlines again when the court monitor reported in February 2006 that a woman and three men had died since November 2004 because of inadequate health care. The report attributes the deaths to a systemic pattern of negligence in the homes and lack of oversight. The court monitor said that, "for a period of over 1 year the District repeatedly failed to notify providers of the results of mortality investigations conducted by its own reviewer. As a result, corrective actions were never discussed, let alone implemented or evaluated."

Some attribute this lack of accountability to scattered lines of authority in the city government. In effect, MRDDA has the responsibility, but not the authority over key functions required to provide quality care and protect vulnerable lives. Enforcement, personnel, facility licensing and contracting powers are scattered across disparate city agencies. In that structure MRDDA can achieve some reform, but not nearly enough to meet the court mandate or meet the needs of current and future residents. The inability of agencies with varying levels of responsibility for this population to communicate effectively has added to the failure to act timely and decisively.

The bottom line is there needs to be a single point of authority and accountability, and there must be performance and outcome measures to gauge the city's progress.

The committee has conducted oversight of several D.C. agencies and departments which have been the subject of lengthy lawsuits, many of which resulted in court appointed receiverships, including the child welfare system, mental health services and the housing authority. Five district agencies were placed in receivership in 1999 when Mayor Williams came into office. He made the commitment to regain control of the agencies and has successfully done so. It's past time to bring the same commitment and sense of urgency to fixing the MRDDA.

Thirty years of court orders, monitors and compliance plans have not worked to fix a broken approach to this special population. Today, we need to hear how the District plans to end this agonizing era of neglect, reform program management, establish visible and meaningful quality controls, and assume full responsibility for those who need and deserve the city's compassion and care.

I like to include in the record a statement by University Legal Services; and without objection, so ordered.

I would now recognize another champion of the disabled in this particular city, Ms. Norton.

[The prepared statement of Chairman Tom Davis follows:]

DRAFT OPENING STATEMENT
CHARIMAN TOM DAVIS
COMMITTEE ON GOVERNMENT REFORM
"DISABLED SERVICES IN THE DISTRICT OF COLUMBIA:WHO IS PROTECTING THE RIGHTS OF D.C.'s MOST VULNERABLE RESIDENTS?"

JUNE 16, 2006

Good morning, and welcome to today's hearing on the District of Columbia's Mental Retardation and Developmental Disabilities Administration.

We convene this morning because, at a time when so many things are going right for the District, a longstanding, seemingly intractable, problem has painfully re-emerged and demands our attention. The District's fundamental responsibility to be a humane and nurturing custodian of those with mental retardation and developmental disabilities is not being met. Some say the situation is irreparable, and the entire function should be taken out of the District's hands and given to a receiver. But even if that happens, the District has to find a way to reform the current system and meet the needs of these most vulnerable citizens.

How did it come to this? The story is a long and sad one. In 1976, after the deaths of two residents at Forest Haven, a facility for this population, a federal class action lawsuit, *Evans v. Williams,* was filed against the District. The case challenged the conditions of confinement for residents of the institution, which was subsequently closed. But the judgment against the District also imposed continuing obligations, under court supervision, to protect class members from harm and to provide services in the least restrictive setting for the duration of their lives. Generally, that meant the District should be able to provide community-based living situations in group homes.

In 1999, the *Washington Post* chronicled the tragedy of at least 24 deaths of residents in group homes operated by the city agency, the MRDDA. The articles highlighted chronic abuse and neglect of developmentally disabled individuals, and described profiteering by some vendors operating group homes. Six years later, a day program worker was charged with criminal negligence for burning an adult group home resident. In March 2006, an employee of a day program for disabled persons pled guilty to charges of sexually abusing a patient. MRDDA made headlines again when the court monitor reported in February 2006 that a woman and three men had died since November 2004 because of inadequate health care. The report attributes the deaths to a systemic pattern of neglect in the homes and lack of oversight. The court monitor said that "for a period of over one year, the District repeatedly failed to notify providers of the results of mortality investigations conducted by its own reviewer. As a result, corrective actions were never discussed, let alone implemented or evaluated."

Some attribute this lack of accountability to scattered lines of authority in the city government. In effect, MRDDA has the responsibility but the not authority over key functions required to provide quality care and protect vulnerable lives. Enforcement, personnel, facility licensing and contracting powers are scattered across disparate city agencies. In that structure,

MRDDA can achieve some reform, but not nearly enough to meet the court mandate or meet the needs of current and future residents. The inability of agencies with varying levels of responsibility for this population to communicate effectively has added to the failure to act timely and decisively.

The bottom line is there needs to be a single point of authority and accountability. And there must be performance and outcome measures to gauge the city's progress.

The Committee has conducted oversight of several D.C. agencies and departments that have been the subject of lengthy lawsuits, many of which resulted in court-appointed receiverships, including the child welfare system, mental health services, and the housing authority. Five District agencies were placed in receivership in 1999 when Mayor Williams came into office. He made a commitment to regain control of the agencies and has successfully done so. It's past time to bring the same commitment and sense of urgency to fixing the MRDDA.

Thirty years of court orders, monitors, and compliance plans have not worked to fix a broken approach to this special population. Today, we need to hear how the District plans to end this agonizing era of neglect, reform program management, establish visible and meaningful quality controls and assume full responsibility for those who most need and deserve the city's compassion and care.

[The prepared statement of University Legal Services, Inc. follows:]

UNIVERSITY LEGAL SERVICES, INC.
Protection and Advocacy Program
for the District of Columbia

Testimony of Sandy Bernstein, Legal Director of University Legal Services

Before the Committee on Government Reform
June 16, 2006

"Disabled Services in the District of Columbia: Who is Protecting the Rights of D.C.'s Most Vulnerable Citizens?"

Chairman Davis and Members of the Committee on Government Reform, thank you for holding this hearing to discuss residents of the District of Columbia with mental retardation and developmental disabilities, and their Constitutional rights to be protected from harm and provided appropriate care and treatment. I appreciate the opportunity to submit this testimony on the inability of the District, and specifically, the Mental Retardation and Developmental Disability Administration (MRDDA) to adequately provide appropriate services to its most vulnerable citizens.

I am the Legal Director at University Legal Services, the protection and advocacy program for people with disabilities in the District of Columbia. I represent the plaintiff class in the Evans v. Williams lawsuit, which was filed in federal court thirty years ago on behalf of the District residents who were institutionalized at Forest Haven, where they were subjected to horrific abuse. In 1978, the U.S. District Court for the District of Columbia found that the Evans class members' constitutional rights had been violated by the conditions of their confinement in Forest Haven, and that they had the right to adequate services and supports. The Court held that the District had a constitutional obligation to ensure that all class members are protected from abuse, neglect and

mistreatment. By 1991, Forest Haven was closed, and class members were placed in community settings – group homes, intermediate care facilities, nursing facilities.

Today, nearly three decades after the landmark decision was handed down, the situation remains grim for class members. Terrible conditions continue, and individuals with developmental disabilities are at significant risk. Many are at risk because their health care needs are neglected. Others live in rodent and vermin-infested homes. Many more are at risk because provider staff are poorly trained, and injure individuals during wheelchair transfers, or by feeding them improperly, causing them to choke. Other individuals are victimized by providers who steal their funds. And sadly, even when such incidents are reported and substantiated, no actions are taken against the providers. In fact, staff cited for neglect continue to work with class members.

Throughout the course of the thirty-year history of this case, the Court has issued orders and contempt findings, and appointed two special masters and independent court monitors to report on the District's progress in complying with its constitutional obligations to class members and other individuals with mental retardation and developmental disabilities. Despite this significant judicial intervention, the District has continually failed to comply with Court orders, protect class members from harm and provide care and treatment in the least restrictive environment.

For example, in April 2003, the District, at the urging of the plaintiffs, adopted improved health care outcomes for class members as their top priority. The Defendants committed to identify class members with high health risks, and develop, implement and monitor their health risk reduction plans. Despite this intensive focus for more than three years, the District has failed to ensure that individuals' health needs are met. This failure

has horrific consequences - pain, suffering, hospitalization and even death. One class member was moved from her residence after the District substantiated that she was subjected to neglectful nursing care. But staff at the new home were not advised that she had cancer, and failed to monitor her medical condition.

Neglect and substandard medical care were factors in the preventable deaths of four class members, according to the November 2005 report of the Evans Court Monitor. The District's own contractor, the Columbus Organization, which investigates MRDDA consumers' deaths, reviewed three of deaths cited by the Monitor, and concurred that the decedents had unaddressed medical needs. In one case, the Columbus investigator concluded that "nursing staff failed to assess and monitor the decedent when he exhibited a significant change in status," and that the cause of death "strongly suggested that this death might have been prevented." The same provider was responsible for two other individuals who died within a seven month period; all three residents had significant, unaddressed weight loss. Although the home where this decedent was living is now closed, no action has been taken to ensure that the employees who neglected him are not working with other vulnerable individuals with developmental disabilities.

In addition, contrary to policies and procedures, the District failed for more than a year to disseminate the Columbus death investigation reports to residential providers and treating professionals to enable them to make the necessary changes to avoid similar deaths and similar suffering in the future. Corrective actions were not discussed with the providers and critical recommendations offered by Columbus Organization were never implemented. The District may have policies and systems in place to investigate deaths but those policies and systems are meaningless if not implemented.

Similarly, the District fails to investigate serious reportable incidents in a timely manner and fails to implement recommendations emanating from its investigations. The investigations are often months overdue, and often, years pass before the recommendations from these investigations are addressed. As with the death investigations, these systems designed to protect individuals from harm are meaningless if the investigations are completed months after the incidents occur and recommendations are consistently ignored. Causative problems are not addressed, preventative or corrective actions are neither initiated nor pursued, and individuals with developmental disabilities remain in jeopardy.

District officials continue to break promises and commitments to the individuals they are legally obligated to support. For example, in November 2005, the District promised within ninety days to move thirty individuals out of substandard homes to quality, individualized placements. When the ninety day period ended in February, only three individuals had moved. Now, four months later, no additional placements have occurred, and the District has stated that it is examining whether it is cost-effective to fulfill their obligations. The consequences of these broken promises are suffered by individuals with disabilities. There is no accountability: No one in the District government is held responsible for broken promises.

Due to gross mismanagement and inefficiency, the District is currently facing an $18 million shortfall for fiscal year 2006. The District is 51st out of 51 jurisdictions in its use of the Medicaid home and community-based waiver for individuals with developmental disabilities. Other jurisdictions make broad use of the waiver, which allows them to provide individualized and flexible services to residents with

developmental disabilities, and receive a federal match for providing these services. The District acknowledges that it must amend its current waiver so that it could be used as a means to serve individuals with significant health needs. At the same time, the District contends it is too costly to provide these services for people with significant health needs. The District literally wastes tens of millions of dollars serving individuals in community residential facilities which are paid for with 100% local funds because they lack the competence and capacity to operate a workable home and community-based waiver. The District of Columbia City Council was so frustrated about MRDDA's failure to recoup federal funds under the waiver that council members cited it as a reason for cutting $15 million from the agency's fiscal 2007 budget request.

The District also bungled the recent transition of more than 100 MRDDA consumers from one provider to another. In December, the original provider gave the District formal notice of its intention to cease operating its seventeen group homes by the end of March 2006. Despite this extended notice, the District waited until the eleventh hour to contract with new providers. As a result, there was no transition meetings held prior to the transfer, leaving the new providers with little information about the individuals they now serve. In addition, the District paid the new providers millions of dollars out of local funds because there was no time to certify them as eligible Medicaid providers, who could receive federal reimbursement. The District then petitioned the Court –unsuccessfully – to suspend local laws because they were concerned that they could not navigate through their own system in a timely manner.

The District also has failed to provide adequate case management services to individuals with developmental disabilities. Despite having one of the lowest case ratios

in the country, the Monitor has found that a large percentage of case managers do not visit their clients the required eight times a year. As a result, class members' needs are not identified or not addressed. For years, the Monitor has reported on the absence of consistent, reliable case management, the absence of supervision and oversight of case managers and the overall failure of the case management system to provide adequate care. For example, the Monitor's nurse consultant found a class member living in a home infested with rodents and insects, and immediately reported the unsafe and inhumane conditions to the MRDDA Administrator. The class member's case manager and MRDDA nurse had not reported this situation, nor had they found the woman a new home, even though she had been asking to move for two years. The District appears to tolerate such negligence, while the individuals with developmental disabilities bear the consequences.

The District's own tracking system reveals that the MRDDA case managers, the central safeguard for MRDDA clients, are neglecting the individuals they are legally responsible for protecting. Yet, few, if any, case managers are ever terminated. When the group home provider mentioned above decided to terminate its relationship with the District, MRDDA asked its case managers to monitor the homes at the beginning of the transition to ensure that their consumers were safe and their needs were being met. The first day of the transition fell on a Saturday and the case managers refused to work. The Administrator stated that she had no authority to make them work and ensure their clients' safety.

After years of broken promises and commitments and continued harm suffered by class members, the plaintiffs in Evans filed a motion for noncompliance with the court's

orders and a motion for receivership. The Department of Justice, the plaintiff-intervenor in Evans, filed for contempt the same day. The District's response was to fire MRDDA Administrator Marsha Thompson. Ms. Thompson, appointed Administrator a year ago, was at least the eighth Administrator in seven years. Her temporary replacement, Kathy Sawyer, is a short-term, six-month consultant from Alabama, who is tasked with the same responsibilities as Ms. Thompson with the same limited authority.

MRDDA has no authority over licensing and enforcement actions. In addition, MRDDA does not have the authority to administer the Medicaid home and community-based waiver, as recommended by the Special Master, the Court Monitor and the plaintiffs. The District repeatedly has rejected all recommendations and proposals for reorganization of MRDDA.

The service delivery system for individuals with developmental disabilities is fragmented, with different agencies with different responsibilities and no coordination between the agencies. The court recognized the need for greater coordination among the District agencies and in January 2004 issued an order requiring the Mayor to designate, within the executive branch, an individual with the responsibility to ensure both interagency coordination and compliance with the court's orders. The Deputy Mayor for Children, Families, Youth and Elders was assigned this role but has failed to provide the critical oversight to coordinate the interagency efforts and responsibilities necessary to comply with the court's orders.

The District has proven time and time again that it cannot comply with the Evans court orders. The District cannot provide minimally adequate services and protect individuals from harm. Clearly, the mayoral administration has not made the protection

of individuals with developmental disabilities a priority. Holding agencies and employees accountable for broken commitments and promises is not a priority. Restructuring the system is not a priority. Until systemic and structural obstacles are addressed, the services cannot improve, and compliance with the court's orders cannot be achieved.

The District of Columbia has ample resources and experts to serve and support its citizens with developmental disabilities. Many other states, including Virginia and Maryland, provide adequate services to individuals with developmental disabilities and protect them from harm. The Evans case is among the oldest open cases on the national's federal court docket involving the legal rights of individuals with developmental disabilities. There is no excuse for the lack of attention and priority given to this vulnerable population. There is no excuse for allowing the abuse, neglect and suffering to continue.

Thank you for this opportunity to provide this testimony. I am available for questions and can provide additional information if requested.

Ms. NORTON. Thank you very much, Mr. Chairman.

Mr. Chairman, I really regret that the committee has found it necessary to hold this hearing on services provided by a local D.C. agency. And we all know that this Chair does not do so often, and he doesn't do it lightly, because he is a strong supporter of home rule. And this is, frankly, a classic home rule matter that doesn't belong in the U.S. Congress. As a matter of fact, Mr. Chairman, I have a letter coming to you concerning hearings I wanted the U.S. Attorney, who is unfortunately a Federal official—and on structural deficit, where you promised me a hearing. But I can understand why this caught the attention of the chairman. Congress has learned that when—the city has learned that when matters that are quite inflammatory come to the attention of the Congress through the newspapers it gets congressional attention.

The recent request for a receivership, provided by the Mental Retardation and Development Agency brings this matter too close to the congressional orbit for comfort because the Federal courts would be involved or if the D.C. courts were involved, those come under the jurisdiction of the Congress at this point.

So the death in group homes, the abuse of helpless people making the papers—anybody in this city knows that Congress reads the papers, too. And of course one doesn't have to be personally affected to understand why mentally—retarded, and developmentally disabled residents would catch the attention of this body. These are our citizens that are often at the mercy of whoever is in charge, and has the responsibility for their well-being. Well, who has the responsibility is not the Congress of the United States, it is the society defined as the citizens of the District of Columbia, and of course the MRDDA. So the concern could not be more well placed.

I raise the issue of whether a Congressional hearing is necessary or appropriate, not because of the seriousness of the issue—nothing could be more serious than the issues involving people who can't take care of themselves when no one else seems to be taking care of them. I do note that the hearing is being held at a time when in the papers there is evidence both of some council leadership indicating that there is oversight in the city which knows the issue best, and of course where there have been some changes made; tardy though they were—for example, an experienced and new director on board. The council certainly takes the matter seriously. They take it so seriously that they have invoked the harshest punishment; denying the agency increases pending improvement. You couldn't get people's attention better than that. And of course it has a terrible downside that I hope all involved will understand so that we can quickly get the matter back to some sense of normalcy.

It is an extremely complicated matter. Many agencies providing the necessary services, or even finding group homes in a city like this where people are being chased out every day by the cost of housing, as the market has escalated those costs. Nobody wants a group home, even for these residents who are helpless. The problem the city has found in getting contractors, people who supervise these citizens is itself a—who are competent to do so—is a story all its own. And of course the difficulty is magnified by the fact that these citizens are not located in one place. They are spread

across the city, as well they should be because we're trying to provide a normal environment for them in the least restrictive setting.

So I stress that the only way to get systematic oversight is for the city to increase oversight, and the alternative to that is not congressional oversight. The alternative to that is something that the city wants least, and that is third party oversight, like a receiver. And what a shame that would be, to head back to 5 or 6 years ago when so many agencies were in receivership. This happens all across the country in other cities as well. But here was the District, after the control board period—which literally brought troubled agencies out of receivership, every last one of them. And as a result, there hasn't been much said here in Congress because the fact that they were in receivership brought them right under our nose and jurisdiction.

It was a great achievement, but in a real sense—it was a great achievement because it shows that the government was working, because the courts would not have released these agencies' receivership if the courts didn't think that the city could do it. But if the agencies that have responsibility for these citizens aren't working, the conclusion will be the government isn't working. This is a real test of whether the government works. I know we don't want to head back to 30 years ago, and I really don't believe that's where we're headed. Those of us who group up in this city remember *Evans* v. *Williams,* the class action that started it all, went on for so many years, the closing of the old Forest Haven, the move to group homes for the least restrictive environment.

Given recent responses, what we're trying to find out is whether the city gets the point and is on a systemic road, the kind of systemic road it will take to straighten this out before we go all the way back to control board times when in essence we had a control board for these agencies.

This hearing is yet another outside intervenor that should get the city's attention. The city finds congressional intervenors particularly undesirable, but worse, much worse would be a receivership. I can't believe, I don't believe that this administration intends to come full circle and head back to the bad old days, but I can't know for sure. That's why I will be listening very attentively to the witnesses today. I welcome them and appreciate their testimony.

Chairman TOM DAVIS. Thank you, Ms. Norton.

I can just say that we didn't rush into this hearing willy-nilly . I mean, we've been waiting a long, long time for some action. It just gets worse. And I think I would be not fulfilling my responsibility as chairman to move forward and shed some light on this, as we have always worked together to try to give the city the resources it needs and understand the particulars of home rule. But I think this situation has dragged on and on and on, and that's the reason for the hearing today.

Members will have 7 days to submit opening statements for the record.

[The prepared statement of Hon. Elijah E. Cummings follows:]

U.S. House of Representatives
109th Congress

Opening Statement

Representative Elijah E. Cummings, D-Maryland

Full Committee Hearing: "Disabled Services in the District of Columbia: Who Is Protecting the Rights of D.C.'s Most Vulnerable Residents?"
Committee on Government Reform

June 16, 2006

Mr. Chairman,

Thank you for holding this important hearing to examine recent—and longstanding—problems at the District of Columbia's Mental Retardation and Developmental Disabilities Administration (MRDDA).

I have been watching in the newspapers, as I am sure you and Ms. Norton have, the unraveling of the disturbing situation before us today.

Bureaucratic squabbling and mismanagement have created a situation that no one in this room can or should accept. Group home residents in the District of Columbia are dying of starvation, the victims of negligence so extreme it is difficult to fathom.

The following is a passage from a May 31 *Washington Post* article that details the tragedy:

"Emily, 60, who liked movies, shopping and piling mountains of stuffed animals on her bed, weighed only 50 pounds when she died in 2004 …

"Matthew died at age 43. He loved eating out, going on trips and watching sports. … He was chronically underweight and … was not given proper attention. He died a month and a half after his housemate, Emily, dropped to her fatal 50 pounds."

The horror does not end there. In addition to Emily and Matthew, a 41-year-old man named Mike also died of starvation, and countless others suffered from neglect.

As we sit here today, I do not doubt that people receiving services from the District of Columbia's MRDDA continue to suffer. We can only hope that their fate will not be the same as that of Emily, Matthew and Mike.

The Justice Department threatened to usurp control of MRDDA and place it under the watch of a court-ordered receiver.

Mayor Williams had a different approach—firing MRDDA Administrator Marsha H. Thompson and bringing on community advocate Kathy Elmore Sawyer to take her place.

I appreciate the Mayor's attempt to address this issue, but I question whether his approach is the best one for the people who MRDDA serve.

When she takes the helm of MRDDA on Monday, Ms. Sawyer will be the agency's *tenth* administrator in seven years. Something tells me, Mr. Chairman, that the problems run deeper than leadership.

We are here today to examine how we can save this failing agency and those who are in their care, and make it run as effectively and efficiently as possible.

We have no choice but to find a solution. We cannot afford more death and suffering at the hands of incompetence.

I look forward to the testimonies of today's witnesses and yield back the balance of my time.

Chairman TOM DAVIS. We're going to recognize our distinguished panel. Mr. Robert C. Bobb, the Deputy Mayor/city administrator; Ms. Brenda Donald Walker, the Deputy Mayor for Children, Youth, Families and Elders, Government of the District of Columbia; Ms. Marsha Thompson, former administrator for the District of Columbia Mental Retardation and Developmental Disabilities Administration; Mr. Robert Gettings, executive director of the National Association of State Directors of Developmental Disabilities; and Ms. Holly Morrison, vice president and chief administrative officer of the Council on Quality and Leadership; and Tina Campanella, the executive director of the Quality Trust for Individuals with Disabilities.

We may have a vote on the floor between 11 and 11:30. If we're not through, it would be my intent at that point to just hand the gavel over to Ms. Norton, if she has questions, to allow that to happen while I go vote. I regret that she can't come over and vote on this resolution and cancel my vote out, but we're working on that. But just to kind of keep things going and try to—if we have questions.

It's our policy that all our witnesses be sworn before they testify, so if we can have the witnesses come forward. And let me thank you all for coming today. If you could raise your right hands. Thank you.

[Witnesses sworn.]

Chairman TOM DAVIS. Thank you very much.

Mr. Bobb, you're no stranger to the committee, and I'll start with you. We have a light in front of you—your entire statements are in the record. The light will turn green when you start, orange after 4 minutes, red after 5. Since your entire statement is in the record and we have some questions we're prepared to ask off that, you don't need to go forward unless you feel you have to. And we, of course, don't—if you feel you have to say, we won't cut you short, but it makes it go crisper if we can stay within it.

Mr. Bobb, thanks for being with us. And as I said before, this city is doing a lot of things right. And this is just one area that we've not been able to get our hands around and solve, and that's the purpose for the hearing today. But I don't want to be overly critical on so many other things that are going right in this city, and we appreciate you and the mayor's leadership.

STATEMENTS OF ROBERT C. BOBB, DEPUTY MAYOR/CITY ADMINISTRATOR, GOVERNMENT OF THE DISTRICT OF COLUMBIA; BRENDA DONALD WALKER, DEPUTY MAYOR FOR CHILDREN, YOUTH, FAMILIES, AND ELDERS, GOVERNMENT OF THE DISTRICT OF COLUMBIA; MARSHA THOMPSON, FORMER ADMINISTRATOR, DISTRICT OF COLUMBIA, MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES ADMINISTRATION; ROBERT M. GETTINGS, EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF STATE DIRECTORS OF DEVELOPMENTAL DISABILITIES SERVICES; HOLLY MORRISON, VICE PRESIDENT AND CHIEF ADMINISTRATIVE OFFICER, THE COUNCIL ON QUALITY AND LEADERSHIP; AND TINA M. CAMPANELLA, EXECUTIVE DIRECTOR, THE QUALITY TRUST FOR INDIVIDUALS WITH DISABILITIES

STATEMENT OF ROBERT C. BOBB

Mr. BOBB. Thank you very much. And good morning, Chairman Davis and Ms. Norton, members of the Committee on Government Reform.

I'm Robert C. Bobb, city administrator/Deputy Mayor for the District of Columbia, and I'm here today on behalf of Mayor Anthony Williams.

It is my pleasure to address the committee concerning the work that has been and is being done in the District to improve the Mental Retardation and Developmental Disabilities Administration. Mayor Williams and I remain committed to making the necessary changes to improve this agency.

MRDDA is facing tremendous and diverse challenges. As you are well aware, MRDDA has struggled for years to improve its service delivery and to attract and maintain competent providers.

In addition to addressing service delivery concerns, the Williams administration is working to ensure that the day-to-day management of the agency is strengthened. For the past several months I have been a regular participant at the weekly meetings with Deputy Mayor Brenda Donald Walker and MRDDA senior management. During our budget review process, we have been working with the District Council to make certain that the agency is appropriately funded.

In selecting the new MRDDA Administrator Cathy Sawyer, the Mayor and I sought a strong director with a proven track record of turning a troubled agency around. A lot can be accomplished in the next 6½ months, and we are convinced that Ms. Sawyer is the right person to be at the helm. During her tenure, we will also conduct a search to identify candidates for the permanent director.

In summary, we truly believe that we are laying the right foundation for MRDDA so that it will provide the necessary services and care that we all want for District residents facing mental and developmental challenges.

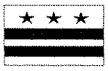
Let me also state unequivocally that we are opposed to the appointment of a receivership. The Williams administration continues to seek the necessary changes to make MRDDA a better functioning operation. Yes, the task has taken longer than we anticipated; however, with the concerted attention the agency is under, internally and externally, and with the addition of a nationally recog-

nized expert in these matters, we are convinced that improvements will be made before the end of the year.

Thank you.

[The prepared statement of Mr. Bobb follows:]

Government of the District of Columbia



Executive Office of the Mayor

Committee on Government Reform
United States House of Representatives

The Honorable Tom Davis, Chairman

Status of the District of Columbia's Mental Retardation and Development Disabilities Administration

Testimony of
Robert Bobb
City Administrator/Deputy Mayor
District of Columbia

Friday, June 16, 2006
2154 Rayburn House Office Building
10:30 a.m.

Good morning, Chairman Davis, and members of the Committee on Government Reform.

I am Robert Bobb, City Administrator and Deputy Mayor for Washington, DC. I am here today on behalf of Mayor Anthony Williams.

It is my pleasure to address the Committee concerning the work that has been and is being done in the District to improve the Mental Retardation and Developmental Disabilities Administration (MRDDA). Mayor Williams and I remain committed to making the necessary changes.

MRDDA is facing tremendous and diverse challenges. As you are well aware, MRDDA has struggled for years to improve its service delivery and to attract and maintain competent providers.

In addition to addressing service delivery concerns, the Williams Administration is working to ensure that the day-to-day management of the agency is strengthened. For the past several months, I have been a regular participant at the weekly meeting with Deputy Mayor Brenda Donald Walker and the MRDDA senior management. During our budget review process, we have been working with the District Council to make certain that the agency is appropriately funded.

In selecting the new MRDDA administrator, Kathy Sawyer, the Mayor and I sought a strong director with a proven track record of turning a troubled agency around. A lot can be accomplished in the next 6 ½ months, and we are convinced that Ms. Sawyer is the right person to be at the helm. During her tenure, we will also conduct a search to identify candidates for the permanent director.

In summary, we truly believe that we are laying the right foundation for MRDDA so that it will provide the necessary services and care that we all want for District residents facing mental and developmental challenges.

Let me also state unequivocally that we are opposed to the appointment of a receivership. The Williams Administration continues to seek the necessary changes to make MRDDA a better functioning operation. Yes, the task has taken longer than we anticipated; however, with the concerted attention the agency is under – internally and externally – and with the addition of a nationally recognized expert in these matters, we are convinced that improvements will be made before the end of the year.

Deputy Mayor Donald Walker will provide more information regarding our next steps. I will be happy to address your questions.

Thank you.

Chairman TOM DAVIS. Thank you very much.

Ms. Walker.

STATEMENT OF BRENDA DONALD WALKER

Ms. WALKER. Good morning, Chairman Davis and Congresswoman Norton. My name is Brenda Donald Walker, and I am Deputy Mayor for Children, Youth, Families and Elders for the District of Columbia.

Prior to being appointed Deputy Mayor in November 2005, I was the director of the Child and Family Services Agency for the District. I was recruited to CFSA as a chief of staff to help guide that agency through major reforms and transition out of court imposed receivership. By virtue of a tremendous amount of work, fiscal responsibility, innovative practices and a solid management team, we were able to create what is now a well regarded child welfare agency.

I offer this history because the challenges facing MRDDA today resemble very much the issues facing CFSA when I started there 5 years ago.

As you know, MRDDA faces formidable challenges, including budget, management and service delivery. We have had literally decades of decay at MRDDA, yet I come before you today to testify that I believe we are on the right track.

As with our accomplishments at CFSA, MRDDA cannot be transformed in months, but rather over several years. However, the critical foundation—that upon which substantial reform will be built, can be laid in the next 6 months.

As the city administrator just mentioned, the Mayor recently appointed Cathy Sawyer as the new administrator for MRDDA. Ms. Sawyer has consulted for the agency since last October, thus developing a working knowledge of the agency, so she will hit the ground sprinting when she starts on Monday.

In accepting the position, Ms. Sawyer has identified three primary goals for the next 6 months; one, positioning MRDDA to effectively operate within its budget; two, successfully amending the existing home and community based waiver; and three, establishing a solid organizational foundation to enable MRDDA to function more efficiently and effectively in its delivery of services.

The coming months will be intense and critical. Everyone who has met Cathy Sawyer comes away impressed with her confidence, experience and commitment to improving the lives of persons with disabilities. I would like to have her brief you and your staff in the next few months after she has had a little bit of time to begin work on executing her goals.

Ms. Sawyer represents only one component of our recent efforts. As I mentioned, a strong management team is essential. We have also added a Chief Operating Officer, Dr. Heather Stow, who is here with me today. Dr. Stow has over 20 years of senior management experience in the human services field. We've also recently hired a highly regarded quality assurances manager, a new director of programs, and several other senior staff.

Over the last several months we conducted an organizational and staffing analysis of MRDDA. And the city administrator and I will support Ms. Sawyer's rapid implementation of the critical manage-

ment and organizational changes needed to move the agency forward.

Much of our work at MRDDA since I became Deputy Mayor, and more intensely in the last 4 months, has been driven by the systems improvement plan that I outlined to address the agency's basic structural deficiencies. This plan has seven major components: one, expansion of provider capacity; two, provider monitoring and accountability; three, contracts management; four, feasibility of waiver operations; five, improvement in day programs; six, case management; and seven, training. Through intensive weekly meetings which I chair, we are closely tracking our progress, modifying things when necessary and, most importantly, remaining focused.

As you are aware, we also face a significant legal challenge to our stewardship of MRDDA. Counsel for the plaintiffs' class in the U.S. Department of Justice filed motions for receivership and contempt in the longstanding class action lawsuit, *Evans* v. *Williams.* I am making available for the committee's records copies of the District's oppositions to those motions, as well as my declaration submitted to the court on Monday.

[The information referred to follows:]

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

JOY EVANS, et al., Plaintiffs,	)	
and	)	
UNITED STATES OF AMERICA, Plaintiff-Intervenor,	)	Civ. No. 76-293 (ESH)
v.	)	
ANTHONY WILLIAMS, et al., Defendants.	)	

DEFENDANT DISTRICT OF COLUMBIA'S OPPOSITION TO PLAINTIFFS' MOTION TO FIND DEFENDANTS IN NONCOMPLIANCE AND TO APPOINT A RECEIVER

INTRODUCTION

No one doubts that services to our mentally retarded citizens need to improve. And no one doubts that these improvements need to take place promptly and efficiently. But this certainly does not justify the court's taking over this part of our government. Rather, as is set out in the settled case law that no party can dispute is controlling here, only the most extreme circumstances can justify a court-imposed receivership – where the responsible local officials are plainly unable or unwilling to bring about compliance, and no other remedy but the court-imposed receivership has any reasonable prospect of achieving that compliance.

Plaintiffs, in their motion, do not begin to meet these stringent standards. To the contrary, while there have been unfortunate outcomes and incidents and this case has

been pending for too long a time, the record herein does not begin to reflect a history of recalcitrant, obstructive hostility toward and a static pattern of non-compliance with the courts orders. Indeed, the District of Columbia successfully transitioned its system of care for mentally retarded citizens from an institutional system of care at Forest Haven to a system of community care, a major goal of this long pending lawsuit. While much remains to be done, the record here does not demonstrate a continuing pattern of non-compliance with and contempt of this court's orders. In fact, plaintiffs (and plaintiff-intervenor) point to no prior court finding of non-compliance, let alone a prior finding of contempt that is relevant to the violations of this court's orders that they assert exist today. Moreover, the violations they do assert are of orders that impose broad general obligations that are insufficiently clear and precise to hold defendants in contempt. (See, Defendants' Opposition to Plaintiff-Intervenor's Motion for an Order to Show Cause Why Defendants Should Not be Held in Contempt, which is incorporated herein by reference).[1] Without a finding of contempt, which is unwarranted here, the extraordinary remedy that plaintiffs seek to leap immediately to is not even relevant.

ARGUMENT

I. A Review of the Applicable Legal Standards Does Not Support the Imposition of a Receivership In This Case;

A receivership removes the responsibility of duly elected officials, answerable to their citizens to administer the functions of an agency established and funded under local

[1] On June 5, 2006, defendants moved for an enlargement of time to respond to plaintiffs' and plaintiff-intervenor's motion, seeking at least the almost three months that plaintiffs had to prepare their motion and the voluminous exhibits they attached thereto. Defendants were given an additional week to respond to both motions. Defendants' responses, therefore, address, primarily, the legal issues raised by both of these motions. While defendants submit that the legal grounds raised in opposition are sufficient to deny both motions, to the extent they are not denied, defendants request an appropriate scheduling order, a reasonable period within which to conduct discovery, and an opportunity to file a supplemental opposition prior to a hearing on these motions.

law and vests that responsibility and authority in a judicial appointee without accountability to or the consent of the citizens or community it serves, or the oversight of its duly elected legislative branch. Because it alters the fundamental doctrine of separation of powers embodied in the Constitution of the United States, it must be considered gravely for what it is, a divestiture and disenfranchisement of the governed.

A receivership is an "extraordinary remedy that should be employed with the utmost caution." 12 C. Wright & A. Miller, Federal Practice and Procedure, Section 2983, at 21 (1973). The United States Supreme Court has warned that "one of the most important considerations governing the exercise of equitable power is a proper respect for the integrity and function of local government institutions." *Missouri v. Jenkins*, 495 U.S. 33, 51 (1990). Interference with local government functions is improper when there are less drastic alternatives. As the 1st Circuit concluded in the case of *Morgan v. McDonough*, 540 F.2d 527, 535 (1st Cir. 1976), cert. denied, 429 U.S. 1042 (1977), "the substitution of a court's authority for that of elected and appointed officials is an extraordinary step *warranted only by the most compelling circumstances*." (emphasis supplied).

Moreover, as a practical matter, and understandably so, receiverships are rarely successful. Courts are poorly equipped to manage executive agencies and lack specified government management and subject matter expertise. Budget decisions are often made without regard to their impact on other agencies or the government as a whole. Moreover, when a receivership ends, often years after the judicial takeover, the affected agency is rarely returned in compliance with the orders whose violation was the basis for the appointment in the first place. An agency under receivership rarely functions

appropriately within the government structure, becoming fractured and isolated, doomed to a difficult re-entry into that structure when control is inevitably returned to the executive branch, often resulting in a whole new set of problems. A receivership is not a panacea for the frustrations inherent in reforming a government agency and transforming a system of institutionalized care for a very challenging and fragile population to the system of community care that is in place and evolving in the District. It is for all of the above-referenced reasons that the standards for imposing a receivership are so stringent. When weighed against those standards, it is clear that plaintiffs have not met their burden to justify the imposition of a receiver.

Though plaintiffs cavalierly treat the relevant law as an afterthought, discussing it only on the final three pages of their 45 page memorandum of law,[2] it is unquestioned that a receivership is appropriate only as a remedy of last resort. *Morgan v. McDonough, supra.*; *Dixon v. Barry*, 967 F.Supp. 535 (D.D.C. 1997); *Perez v. Boston Housing Authority*, 400 N.E. 2d 1231 (Mass. 1980); *District of Columbia v. Jerry M.*, 738 A.2d 1206, 1213 (D.C. 1999). All of these cases apply essentially the same criteria, standards which plaintiffs have not and cannot satisfy.

As the Court in *Dixon* found, "[t]he most significant factor in the propriety of appointing a receiver is whether any other remedy is likely to be successful." *Dixon,* 967 F. Supp. at 550. The *Perez* Court similarly concluded "a receivership must be thoroughly justified on the facts, is always to be considered a remedy of 'last resort' and therefore is

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[2] Additionally, plaintiffs frequently rely on hearsay and anecdotal anomalies to support the extraordinary relief they seek and a majority of the alleged failures they describe do not constitute violations of any of the Court's orders (for example, the 90-day Plan, the closure of the CADC homes, and the realignment of MRDDA's reporting structure). Furthermore, plaintiffs improperly rely on statements by the Court from the bench during non-evidentiary status conferences as "evidence" as if they are rulings, and improperly rely on and refer to Court Monitor's reports as "findings." This reliance on hearsay statements and opinion cannot serve as evidence to support a receivership.

not often applied in practice." *Perez*, 400 N.E. 2d at 1249. The *Dixon* court identified the factors to be evaluated when considering this remedy of last resort as follows:

> In evaluating whether a receivership is really the only remedy left for the court, the court should consider whether there were repeated failures to comply with the Court's orders, whether continued insistence that compliance with the Court's orders would lead only to 'confrontation and delay', if there is a lack of sufficient leadership to turn the tide within a reasonable time period, whether there was bad faith, and whether resources are being wasted.

967 F. Supp. at 550 (citations omitted). The final key factor cited by Judge Robinson in *Dixon* is that "the Court must consider whether a receiver can provide a quick and efficient remedy."

The standards cited by the Court in *Perez* are similar:

> repeated or continuous failure of the official to comply with a previously issued decree; a reasonable forecast that the mere continued insistence by the court that these officials perform the decree would lead only to 'confrontation and delay'; a lack of any leadership that could be expected to turn the situation around within a reasonable time. Other less drastic expedients had been exhausted ...

400 N.E. 2d at 1250, 1251.

In this case, plaintiffs make no effort to demonstrate that these well established standards have been met. Rather, the first 40 pages of plaintiffs' memorandum are devoted to describing many of defendants' alleged failings, without regard to whether these failures violated a clear and unambiguous order of this court, and without any analysis of how these shortcomings addressed, let alone satisfied the relevant receivership criteria. Even if these alleged shortcomings were all tied to a specific court order and were accurate, such non-compliance would be insufficient to justify the relief plaintiffs seek. It is not enough merely to observe that prior commitments were not met.

Receiverships are not imposed as a punishment for past non-compliance. Past non-compliance is only relevant as an indication of whether defendants are currently willing and able to meet the requirements of the Court's orders. Plaintiffs cannot rest on their contention that defendants have failed to comply with all of the court's orders during the lengthy history of this case. As the D.C. Court of Appeals recently stated in reversing a Superior Court order appointing receivers:

> the trial court relied principally upon only one of the factors essential for a reasonable exercise of its discretion to impose this extraordinary remedy. It focused upon the history of the District's failure to comply fully with the court's requirements. The District's abysmal response to its mandates for such a protracted period of time, as the trial court found, is a compelling consideration; *however, it is not the only one.*

Jerry M., 738 A.2d at 1213 (emphasis added). Likewise, as to the plaintiffs' instant motion, "[a] proper consideration of all of the relevant factors, given the extraordinary nature of the remedy, can lead only to the conclusion that an insufficient basis was shown for the appointment of a receiver." *Id.* at 1214.

Even if all of the factors warranting a receivership had been shown – which they have not – the Court would still be required to reject that remedy unless all other less drastic remedies have been tried and found wanting. That is not the case here.

Plainly, less extreme and more tailored remedies are available. As set forth below, plaintiffs have not demonstrated that the stringent factors for imposing the extraordinary remedy they seek weigh in favor of its use here. Indeed, as argued more fully in opposition to the plaintiff-intervenor's motion for an order to show cause, there is an insufficient predicate for finding defendants in contempt of any of the Court's orders.

However, even if there were, plaintiffs fail to demonstrate that a receivership is the only remedy available that presents any reasonable possibility of curing such contempt.

A. Additional Efforts to Secure Compliance Will Neither Be Futile Nor Lead Only to Delay

In determining whether continued insistence on compliance will lead only to confrontation and delay, it is not enough merely to observe that prior commitments were not met. The *Dixon*, *Morgan* and *Perez* analysis requires the Court to consider whether continued insistence on defendants' performance would lead *only* to delay and confrontation. There is no evidence, nor do plaintiffs proffer any basis, to satisfy this required element. The record in this case demonstrates that defendants have chosen collaboration over confrontation and delay and except for these recent filings, which defendants vigorously oppose, are committed to continuing, to the extent possible.

The District has worked cooperatively and collegially with the parties and court officers for years. With the exception of the last year, the parties, the Monitor and the Masters conceded that there were improvements both systemically and anecdotally in the quality of life for many class members. As problems arose, the parties were able to collegially work to resolve them without confrontation or delay. While there are numerous examples, a quick list would include: 1) responding to plaintiffs' concerns with the prompt development of a rule to fund one-on-one care for medically fragile consumers; 2) the recruitment and retention of a nationally recognized health care contractor to serve class members; 3) the shutdown of homes and providers that were problematic; 4) regular access and meetings with the parties and agency officials to work through issues and problems.

The District collaborated with the parties to develop the 2001 Plan for Compliance and Conclusion. The District agreed and did lower case management ratios from the court ordered requirement of 60:1 to 30 clients or less (the lowest in the country). In conjunction with the parties, the District developed operational policies and procedures on virtually every aspect of service delivery. Defendants have established an incident management and investigation unit, a quality assurance unit, a training unit, a death investigation mechanism, a fatality review committee and process independent of the Mental Retardation and Developmental Disabilities Administration (MRDDA), an Alert reporting process, an automated MCIC computer operated record keeping and information tracking system, a process and shortened timelines for the provision of adaptive equipment, a process for prompt referral to the oversight and enforcement body (the Health Regulatory Administration – "HRA") for the enforcement of regulatory requirements against providers, proposed legislation for surrogate decision making sponsored by the Mayor, a 10 year audit of class member funds and reimbursement of converted or inappropriate funds in excess of one million dollars, periodic audits of class member funds, the near doubling of the annual budget for MRDDA since 1999, and the establishment and generous endowment and funding of the Quality Trust for Individuals for Disabilities (which provides advocates for class members, and legal guidance and monitoring for non-class members). While there are imperfections in the implementation of any system, and at times disappointing delays and results, there has been significant progress in building a foundation at the MRDDA sufficient to facilitate routinely meeting client needs. A review of the entire history of defendants' performance reflects a record

of collaboration and cooperation in seeking to meet the concerns presented by the parties and the Court, not one of resistance, obstruction and confrontation.

B. There is Leadership Sufficient To Make Reasonable Progress Possible

The Court must consider the availability of new leadership and the brief time in which they had to act before imposing a remedy of last resort. *Jerry M., supra.* The MRDDA has had turnover in leadership during this Court's tenure as defendants have sought to identify an administrator who has both significant management experience and the requisite subject matter expertise. This combination has, until recently, proved elusive. However, as announced by Mayor Anthony A. Williams at a press conference on June 7, 2006, Kathy Elmore Sawyer has agreed to enter into a contract with the District to serve as the acting administrator of MRDDA, effective June 19, 2006. Ms. Sawyer will serve as the acting administrator for the remainder of Mayor Williams' term. During the next six months, the District government will recruit, through a nation-wide search, qualified candidates for the position of administrator of MRDDA. Ms. Sawyer is a nationally recognized expert in the field of mental retardation and developmental disabilities and brings unquestionable experience, skill and credentials to this position. She has worked in the field for more than 30 years. Ms. Sawyer's résumé is attached as defendants' exhibit 1.

Ms. Sawyer served as the Commissioner for the Alabama Department of Mental Health and Mental Retardation from 1999 through 2005. As Commissioner, Ms. Sawyer reached a court-approved settlement of a lawsuit that spanned 33 years and 14 commissioners. Ms. Sawyer reformed practice and implemented measures to establish operating efficiencies. She oversaw a budget in excess of $600 million. She was

responsible for the overall administration and management of all state in-patient facilities as well as community contracted and certified programs for mental retardation, mental health and substance abuse services.

Ms. Sawyer retired as Commissioner in Alabama in 2005 and has been working as a consultant in other jurisdictions, including the District of Columbia, to whom she was referred by Special Master Sundram. Ms. Sawyer became a part-time consultant to the MRDDA in October 2005. Over this time she has become familiar with many of the issues and challenges facing the MRDDA and has started to develop a plan to improve agency performance.

Ms. Sawyer will have direct access to the Deputy Mayor for Children, Youth, Families and Elders (Deputy Mayor), as well as the City Administrator and the Mayor as she performs her duties and responsibilities. The goal is to vest Ms. Sawyer with as much authority as possible, consistent with local law, to facilitate her ability to make rapid progress in meeting her duties, which are more fully set forth in the Deputy Mayor's declaration, attached hereto as exhibit 2. Ms. Sawyer will be meeting at least weekly with the Deputy Mayor and/or City Administrator to identify, coordinate, and resolve any inter-District agency issues as necessary to facilitate the timely delivery of appropriate services to class members and other matters as more fully set forth in exhibit 2.

The new Administrator has the confidence and high regard of the parties and the full commitment of the Mayor to support and facilitate her work as necessary. It is reasonable to expect that Ms. Sawyer's efforts will be substantially enhanced by the personal attention and priority placed on this work by the Mayor, the City Administrator

and the Deputy Mayor and that reasonable progress can be achieved in relatively short order.

Unlike the leadership described in the *Morgan* and *Perez* cases, there is no reason to believe that the new leadership recently identified for MRDDA is unwilling or unable to meet the requirements of the Court's orders and that there is no reasonable prospect of progress in a reasonable time. For example, the Court in *Morgan, supra*, found that South Boston High School administrators and faculty had steadfastly refused to desegregate and had engaged in actions that precipitated and condoned physical and verbal violence against black students. The Court concluded that the services provided were primarily custodial, not educational, and that the staff's response to the changes that it was seeking to effectuate was hostile and intransigent.[3]

In *Perez v. Boston Housing Authority, supra*, the Court found that the evidence "revealed that the [housing] Board is incapable of effective leadership and is unable and unwilling to carry out [its] ... responsibilities" under the remedial decree and that its performance had been characterized by "incompetence and indifference to those obligations ...." *Id.* at 1244. The Court further found that the housing board's members had "no clear idea of the requirements of the decree or the state of compliance with its provisions, and that they had not made any serious attempt to supervise such compliance." *Id.* at 1243.

In stark contrast to the situation in *Perez*, and *Morgan*, defendants here have not been proven to be unwilling, obstructive, and recalcitrant, let alone hostile and intransigent administrators, and there is no basis to conclude that the recently identified

leadership team lacks the ability, commitment or support necessary to "turn the tide within a reasonable time period."

C. There is No Evidence of Bad Faith and Claims of Wasted Resources Are Overstated.

So, too, another element to be considered in the imposition of a receiver cannot be met by plaintiffs. The plaintiffs have not and cannot demonstrate bad faith in this case. Indeed, this Court has stated at a recent hearing that she does not question the well meaning, good faith attempts to reform the system by the District of Columbia, despite its areas of disappointment.[4] In fact, while plaintiffs accuse defendants of questionable veracity, pointing to mistakes in recent documents, which defendants disclosed and corrected, they make much use of defendants' candor, made in good faith in both meetings and status hearings. Over and again, plaintiffs cite statements made by the District conceding problems in the system. While it may be expected that such honesty and forthrightness will be used to defendants' detriment in Court, such arguments cannot be reconciled with plaintiffs' assertions of bad faith. While the District has not always heeded this Court's wise admonishment not to be overly ambitious, such efforts are, at the very least, evidence of an earnest, good faith desire to improve its compliance, not indicia of bad faith.

Moreover, there is no indication that resources are being wasted. The District expends the majority of its budget directly on services and supports for class members, not on luxuries and benefits for its administration. The District has recently retained a

[3] Even under these circumstances, the Court appointed the Superintendent of Schools as the receiver so that there would be "little danger that the receivership will introduce educational policies contrary to those prevailing in the system as a whole." *Morgan*, 540 F.2d at 535.
[4] Defendants do not have a transcript and are relying on their memory of statements made by the Court.

Medicaid Waiver consultant to assist it in optimizing its waiver services and to maximize its use of federal dollars (see Section II.B.).

D. Receivership Will Provide Neither A Quick Nor Efficient Remedy.

Plaintiffs provide no evidence that a receiver can provide a quick and efficient remedy. Nor is there any reason to believe that a court appointed receiver would in fact be able to proceed more quickly or efficiently than the new Administrator, Kathy Sawyer. Ms. Sawyer has served as a part time consultant to the District for several months, is already knowledgeable of the issues and challenges facing MRDDA, and has experience facing similar challenges in Alabama.

Receiverships have not been successful in ameliorating the conditions which justified their appointment in the first place. In neither *Dixon* nor *LaShawn A., et al., v. Williams,* Civil Action No. 89-1754, was the receiver able to come into compliance, prior to his/her termination, with the Court's orders whose violation resulted in their initial appointments. For example, the September 1998 progress report on the receivership instituted in *LaShawn A.* concludes that the receiver's "performance in most areas is still far below minimal expectations...." That receivership was created by the federal district court in August 1995.

Putting aside any dispute over the success or failure of any prior receivership, receiverships create serious systemic problems of resource allocation, budgeting, management and administration, which judges and their appointees are not well suited to address. Receiverships tend to lead to further governmental fragmentation (not less) and make reform more difficult by superimposing external forces upon agencies that must work together to achieve reform, efforts that are now underway here under the

supervision of the Deputy Mayor and the City Administrator. Such orders lead to less not more accountability in government. Elected officials and their appointees cannot be held responsible for the activities of agencies and the performance of functions they no longer control. Further, such orders lead to a misallocation of scarce financial and other resources, or at least to an expenditure of resources on particular objectives without regard to the functions of other government agencies and the overall public need. In short, a receivership is neither a quick nor efficient remedy.

E. Less Drastic Alternatives

Even if the other factors warranting receivership had been shown -- which they were not -- the Court still is required to reject that remedy unless all other less drastic remedies have been tried and found wanting. Here, that is not the case. With the possible exception of the January 21, 2004 Order requiring the Mayor to appoint a senior level official to oversee interagency coordination, there have been no attempts to employ less drastic, more narrowly tailored alternative remedies. In fact, the plaintiffs primarily rely on broad, general mandates contained in orders and decrees from 1978 and 1983, orders that primarily address conditions in Forest Haven and which predate the District's successful efforts at de-institutionalization.[5] Further, as referenced earlier, defendants submit that the orders relied upon by both plaintiffs and plaintiff-intervenor are insufficiently clear and precise to hold defendants in contempt. Here there is no record of implementing orders refining the broad general relief originally imposed and a record that these implementing orders have been consistently violated. The implementing orders that

[5] Plaintiffs reference an order from 1996, but their reliance is misplaced. That order was tailored largely to vendor payments. Moreover, defendants are in compliance with that well tailored order, by the parties' own concessions and the Monitor's reports. In fact, if anything, the history of the defendants' performance

do exist primarily relate to vendor payments which is not an issue plaintiffs (or plaintiff-intervenor) complain about.[6]

Plaintiffs argue, weakly, that the Court utilized less drastic measures through the appointment of a court monitor and two special masters, which they characterize as unprecedented in the country. Whether or not this is unprecedented, it does not demonstrate that all other less drastic remedies have been tried and found wanting. The Court never appointed two successive special masters as a remedy to increase Court oversight of the system. The Court originally appointed one special master, largely to oversee the payment of vendors during the District's "financial crisis." Years later, the Special Master then brought in a co-Special Master, on her own initiative, largely to facilitate her gradual disengagement from the case. A change in her plans resulted in both staying on, but dividing responsibilities, not doubling them as plaintiffs imply, as well as dividing the same special master fund, and resulting in no increase in Court intervention.

As for the Court Monitor, if anything, the scope of her focus has been narrowed, from a more comprehensive review of all systemic reform under the Plan, as performed by her predecessor, to a report focusing solely on identified problem areas, including health and safety problems involving a small sampling of class members. Indeed, the parties' agenda items, both at meetings and status hearings before the Court, have

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under that order supports the benefit of a specific and narrowly tailored remedy and undercuts the argument in support of a receivership.

[6] Plaintiffs' reliance on the 2001 Plan is misplaced. The Plan explicitly provides that it is not an independently enforceable document and that non-compliance with the tasks identified in the Plan is evidence only of noncompliance with the underlying related order, i.e., in this case of the general orders imposed in 1978 and 1983. So too is their reference and reliance on the 90-day plan, which was not ordered by the Court.

focused on these identified problem areas and a Monitor's report that is tailored to those areas, not to a broader analysis of defendants' performance.

At any rate, the record in this case belies any finding that all other less drastic remedies have been tried and found wanting.

F. Plaintiffs' Proposed Receivership Order is Overly Broad.

Plaintiffs' proposed receivership order is overbroad and vague. As the D.C. Court of Appeals held in *District of Columbia v. Jerry M.*, 571 A.2d. 178 (1990), the Superior Court's "authority to assure compliance by the District government with the Consent Decree turns on the scope of the Decree" and therefore could not lawfully include an order "redesigning and reordering the administration of YSA." Id. at 186, 188. The Court Order proposed by plaintiffs here does not abide by these limitations.

Plaintiffs boldly propose an order that places all of MRDDA into receivership. They make no attempt to tailor the oversight to the specific functions they contend are not in compliance. Instead, they urge that the entire agency be placed in receivership, to include all of its operations, regardless of the efficacy of their functions or relevance to the alleged violations of court orders. They also propose that the receiver be established "with the authority necessary to implement the previous orders" (Proposed Order at 1) but leave the "full extent" of the receiver's authority as an unknown commodity, evidently to be determined at another time. Moreover, despite the fact that less than half of the clients that MRDDA serves are class members, the scope of the receiver's authority would extend to approximately one thousand non-class members, who, apparently, would become subject to this Court's authority without any proof, process or consent. Plaintiffs make no effort to tailor a remedy to proven non-compliance.

However, even "a receivership must not go beyond the constitutional purposes which the device is designed to promote." *Morgan*, 540 F.2d at 535.

Plaintiffs seek a drastic and extraordinary remedy but fail to address, let alone satisfy the exacting standards necessary before imposing this remedy of last resort. Moreover, plaintiffs ignore the questionable record of performance demonstrated in other receiverships imposed in this jurisdiction, receiverships that did not, after a lengthy tenure, bring the defendants into compliance with the orders whose violation was used to justify the appointment of those receivers.

Receiverships alter the fundamental doctrine of separation of powers by shifting control from duly elected government officials who are accountable to the electorate. Once imposed, receiverships tend to take on a life of their own. The participants in them acquire a vested interest in their maintenance and the incentive to remove them diminishes. Receiverships compound the problems inherent in many consent decrees where:

> effective control of the state or local governmental institution is shifted from elected officials, to an ad hoc group of lawyers that writes and administers the judicial regime – we call them the "controlling group." Consent decrees are plagued by unintended consequences, yet are difficult to modify in light of experience and changing circumstances. It is not unusual for consent decrees to control a state or local agency for 20 or 30 years, and even then, there may be no end in sight.

Ross Sandler & David Schoenbrod, *The Supreme Court, Democracy and Institutional Reform*, 49 N.Y.L. SCH. L. REV. 915 (2004/2005).

II. The Defendants Have a Record of Progress in Achieving the Goals of the Court Orders and The 2001 Plan;

Plaintiffs rely heavily on the necessary steps, timeframes and standards, which they characterize as the "legal requirements" of the 2001 Plan for Compliance and Conclusion (Order p. 3). However, the Court's Order of March 31, 2001 approving the Plan (as well as the Plan itself, see Section 9 of the Introduction) clearly states (at p. 6) that "the Plan is not intended to be an independently enforceable document." Indeed, that Order merely approves the Plan "as, in effect, a statement of the conditions for the expected vacating of the Court's relevant prior Orders." (Order at 10).

Although the current Court Monitor's reports have not addressed the implementation of the Plan for the past two years, there has been progress towards its implementation. Indeed, this Court stated, in its Order dated January 21, 2004 that "[t]he Court recognizes that progress has been made in the implementation of the 2001 Plan and Settlement Agreement over the last two years." The Special Masters and the previous Court Monitor had also reported improved conditions and progress regarding the implementation of the Plan.

In fact, defendants were ready to begin petitioning the Court for findings of compliance and to vacate the related portions of the court orders under the Plan in several areas. Those areas include the development of a data driven budget, the timeliness of vendor payments, the case management ratios and the establishment, endowment and funding of the Quality Trust, all of which represent significant accomplishments.[7] Yet all of these accomplishments, even the District's unquestionable establishment of and

[7] These functions would, nonetheless, fall within the overbroad control of the receiver as proposed by plaintiffs, despite compliance with the Plan.

contributions to the Quality Trust, are omitted from the plaintiffs' recitation of the history of compliance in this case.

Moreover, in arguing "non compliance" in this case, plaintiffs largely rely on actions that are not required under the Court's orders, primarily the 90-day plan, the CADC home closures, and the Deputy Mayor's initiative to have MRDDA removed from the Department of Human Services (DHS) chain of command and report directly to her. Moreover, with the exception of the 90-day plan, these were accomplished. The CADC transition was completed timely without any need for emergency Court relief and MRDDA continues to report directly to the Deputy Mayor (as more fully set forth in Section II.K).

No one doubts that certain services need to be improved for MRDDA clients in the District of Columbia. And no one doubts that some improvements are overdue. But this certainly does not justify a federal judicial takeover of a component of the local government. And the Court cannot consider the plaintiffs' allegations of failures to abide by the Court's orders without considering and balancing progress made by the District.

A. Individual Habilitation Plans

Individualized Habilitation Plans are closely tracked through the Individual Service Plan (ISP) tracking committee. The committee is responsible for ensuring that the ISP's for all consumers are timely completed. A database was established that identifies all adaptive equipment needs. Forms were developed that identify for prioritization by Medical Assistance Administration the requests for purchasing adaptive equipment for MRDD consumers. The database is tracked and delays are followed up on and expedited by MRDDA staff.

B. Medicaid Waiver

Improvements in the provision of residential, vocational and day services include the implementation of the Medicaid Home and Community Based Waiver (Waiver). On September 1, 1998, the Centers for Medicare and Medicaid Services (CMS) approved the Waiver. Consistent with federal requirements, the day-to-day administration of the Waiver is performed by the MRDDA, with oversight by the Department of Health (DOH), Medical Assistance Administration (MAA). On November 20, 2002, the Waiver was renewed by CMS for a five year period ending on November 19, 2007. The 2002 renewal increased the enrollment cap to allow an enrollment of 1445 individuals by the end of the fifth year. Although the 2001 Plan has a goal to transfer a minimum of 75 persons to the Waiver, the defendants have exceeded that goal. As of April 2006, the Department of Health, Medical Assistance Administration enrollment reports reflects 744 persons enrolled into the Waiver.

An extensive rulemaking process was undertaken, beginning in 2002, to develop rules for each of the services provided under the Waiver. The rules set forth provider standards for each service, standards regarding billing documentation, eligibility requirements, requirements regarding the application process, appeal rights for enrollees and other general provisions of the program. The following 24 services are currently available under the Waiver:

1. Adaptive equipment;
2. Adult companion;
3. Attendant care;
4. Case management;
5. Chore services;
6. Day habilitation;
7. Dental services;
8. Environmental accessibility adaptation services;

9. Family training;
10. Homemaker services;
11. Independent Habilitation;
12. Nutritional Counseling;
13. Occupational therapy;
14. Personal care services;
15. Personal emergency response services;
16. Physical Therapy services;
17. Preventative, consultative and crisis support;
18. Prevocational services;
19. Residential Habilitation Services;
20. Respite Care;
21. Skilled Nursing;
22. Speech, hearing and language services;
23. Supportive Employment services; and
24. Transportation services.

After all the rules were in place, the District recognized that there was a shortage of physical and occupational therapists enrolled as Medicaid providers. In response to the shortage, the District amended the Waiver to broaden the provider qualification standards to authorize therapists in private practice to provide occupational and physical therapy services. As of April 2006, there were in excess of 100 providers enrolled in the Medicaid program as Waiver providers. Many providers are enrolled to provide several Waiver services.

Other notable achievements include:

- The provision of 3 types of habilitation services, in addition to medical day treatment provided under the state plan - day habilitation, independent habilitation and residential habilitation.
- Two services that are designed to assist enrollees in gaining meaningful employment- supportive employment services and prevocational services.
- Several in-home support services - chore aide; homemaker services; personal care services; adult companion, attendant care and respite care.
- Development of the Blueprint for administration of the Waiver in October 2005

MRDDA has completed amendments/rules for the Waiver application. The amendments and revised rules were submitted to MAA for review and comment. MAA

and MRDDA have agreed that an outside consultant will be needed to assist in the completion of the full package prior to submission to the Centers for Medicare and Medicaid and the Council of the District of Columbia (Council). A "scope of work" was developed (which plaintiffs reviewed and agreed with) and submitted for bids on two (2) components of the application process. (Appendices G and H - Cost Neutrality and Quality Framework). That solicitation has concluded and the District has hired a Waiver consultant. Defendants, with the consultant's assistance, are working to complete all applicable documents before submission to the Council for approval. Thereafter, the District's submission will be forwarded to the Center for Medicaid/Medicare Services (CMS) for final review and approval. The last step of this process includes publishing the amended rules and allowing a 30-day comment period.

C. Training

Consistent with the Plan, MRDDA established a Training Unit for MRDDA. The Unit is staffed with five trainers who provide regularly scheduled, intermittent training to MRDDA staff and providers, to include direct care workers, provider nurses, MRDDA case managers and investigators with training on all agency policies and procedures, training recommendations emanating from the FRC, investigative techniques, specialized care and many other areas.

D. Incident Management, Investigation and Review

Consistent with the Plan, the District established an MRDD Incident Management System in 2001. MRDDA implemented, in consultation with the parties, an incident management policy clearly prohibiting abuse, neglect and a myriad of other inappropriate occurrences and establishing a reporting and investigation protocol. Incidents are

reported regarding class members in accordance with the policy. All staff, including provider staff, must be trained according to the policy. Findings are shared with the providers for action, and appropriately referred to MPD when a crime has taken place. The District established a 24 hour Hotline called Answers Please for reporting incidents when they occur.[8]

All MRDD deaths are autopsied by the Office of the Chief Medical Examiner. All deaths are referred to an independent contractor, Columbus, for an independent investigation, and while the investigation may sometimes take longer than the few weeks prescribed by the policy, all deaths investigations are initiated and completed.[9] All deaths are reported to and reviewed by the Fatality Review Committee, a multidisciplinary team established by Mayor's order and chaired by the Chief Medical Examiner. The FRC examines past events and circumstances surrounding the deaths of MRDD clients in an effort to reduce the number of preventable deaths and promote improvement and integration of both the public and private systems responsible for serving this population.

The FRC meets monthly in accordance with the Mayor's Order 2005-143, September 30, 2005, titled "Re-establishment – District of Columbia Mental Retardation and Developmental Disabilities Fatality Review Committee." The FRC maintains

[8] Defendants acknowledge that there is an inconsistency in the investigation files, e.g., timeframes are not always followed (Court Monitor and/or Quality Trust not contacted in a timely manner), some investigation reports are not on file etc. However, it does not rise to the level of a "failure" to protect class members from harm. Any system will have anomalies and areas that need improvement, and any system will be vulnerable to anecdotal problems. Plaintiffs, in their motion, point to some incident investigations, findings and recommendations, where the report states that provider and agency failed to appropriately serve class members or there were incidents of negligence. They argue that the sheer existence and nature of the reports, which they refer to erroneously as admissions, prove the system is in disrepair. However, the opposite is true. The number of reports in a system involving 2000 clients, the nature of the incidents and the candor of the investigations and the findings, are symptomatic of a system that is working as it should. A low count of incidents would probably reflect under-reporting, and findings that rarely found wrongdoing might point to inadequate investigations or slanted conclusions. Ironically, the very evidence that plaintiffs tout as indicative of the failure to protect clients, is indicative that the system is operating appropriately.

confidential integrity by closing the proceedings to the public when the meeting relates to the review of cases of MRDD fatalities or where the identity of any person, other than a person who has consented to be identified, may be revealed. The Office of the Chief Medical Examiner (OCME) Fatality Review Unit secures all information and records generated from the FRC in a confidential manner. Recommendations are issued by the FRC to various agencies for response and follow up on the recommendations the panel makes. An annual report is published by the FRC on their operations and findings.

Consistent with the Plan, an annual plan for monitoring is prepared, monitoring the safety, quality and effectiveness of services and supports to consumers. This is an on-going process that involves Quality Assurance and Case Management to ensure that the recommendations are consistently a part of the Administration's best practices policy. The members of these units monitor and update the progress of the implementation, and input the information initiated through the Alert Resolution System (ARS) in the MRDDA Consumer Information System (MCIS). An "Alert Issue" is a formal notification that a service, support or protection that is needed to ensure the health, safety, and welfare of the customer is not being addressed appropriately and may place the customer at risk. This also includes provider site issues that are affecting or have the potential to affect one or more customers. The Immediate Response Committee (IRC), discusses and reviews all alerts. The IRC convenes weekly to discuss and assess the identified alert issues by customer and/or provider within a given Case Management Branch.

[9] Violation of an internal policy is not equivalent to the violation of a standard of care.

E. Quality Assurance

Consistent with the Plan, MRDDA implemented a Quality Assurance Program that addresses recommendations for prevention, correction and improvements. Quality Assurance, based on its review of incident patterns and trends, refers these issues to MRDDA's Quality Improvement Committee (QIC) and Human Rights Advisory Committee (HRAC). In September 2005, the QIC was established to review the quality of the District's service delivery system and to identify broad areas in need of improvement. These areas include, among others, safety, security, health, rights and dignity, and service planning. The HRAC reviews cases related to consumers' human rights issues. Both committees provide recommendations to the MRDDA Administrator relating to goals, objectives and strategies according to the relevant issue. MRDDA through its QIC, is responsible for developing strategies, and other necessary actions to ensure consumers' protection.

F. Enforcement

With regard to enforcement, the appropriate licensing agency (Department of Health, Health Regulatory Agency) is informed of serious incidents and of the outcomes and recommendations for preventive and corrective action from investigations, and takes appropriate action for prevention and correction. When HRA detects problems on its inspections, it sends a Statement of Deficiency to MRDDA's Quality Assurance department and to the contracted provider involved in the incident. Quality Assurance then sends a letter to that provider offering technical assistance.[10]

[10] Plaintiffs argue that MRDDA has no in-house licensure enforcement capability. This is irrelevant. Enforcement is accomplished by another agency in the government, HRA, with whom MRDDA works closely. While plaintiffs have been pushing to transfer the responsibility and functions of enforcement to

G. External Monitoring

Consistent with the Plan, MRDDA conducted a 10 year audit of all class member funds and reimbursed clients approximately one million dollars for all funds improperly converted or improperly documented for use in the client records. A client funds manual was developed with the input of the parties, and the agency conducts periodic audits of client funds, the most recent of which was completed on May 1, 2006 for the period of October 1, 2001 to September 30, 2003.[11]

The District of Columbia, in collaboration with the parties, established an External Monitoring and Advocacy body for Consumers called the Quality Trust for Individuals with Disabilities. The Trust was endowed with 11 million dollars, and receives an annual operational budget in excess of 2 million dollars a year from the District of Columbia.

H. Data Driven Budget/Timely Vendor Payments

Consistent with the Plan, MRDDA has developed a Data Driven Budget, wherein the agency budget is developed by reviewing the ISP's for every consumer, and tabulating the costs of the prescribed programs and services on a per diem basis. In addition, in compliance with the orders in this case, vendor payments have been consistently made timely, resolving an issue that was a driving force in this case for many years.

MRDDA, the District is not agreeable to such a transfer until the agency is in a better position to take on new responsibilities. This disagreement is not a violation of any order or decree.

[11] Plaintiffs attempt to argue that the District has violated the Court's orders on the basis of two class members whose money had been allegedly stolen by direct care staff. However, these incidents are referred to MPD for investigation and any money determined to have been stolen will be reimbursed. Plaintiffs asked that the money be returned before an investigation is completed on a provisional basis, however, the District cannot "float" funds in that manner.

I. Surrogate Decision Making

Consistent with the Plan, the parties collaboratively developed legislation for a surrogate decision making process. The Mayor sponsored the legislation and submitted it to the Council in 2005, however; the Council declined to pass it. Instead, a temporary version of the Health-Care Decisions for Persons with Mental Retardation and Developmental Disabilities Amendment Act was passed by the Council on November 15th and enacted on November 17th. In pertinent part, the temporary Act requires the identification of health care decision-makers to be an expanded, routine part of the ISP process and requires MRDDA to provide a written plan to encourage the availability of decision-makers by December 1, 2005. The Act also requires MRDDA to provide monthly reports on health-care decision-makers for consumers and a final comprehensive report on April 15, 2006. Council staff has indicated that the results of the final report will shape the permanent legislation on this issue.

MRDDA has also worked with the Quality Trust to address guardianship issues. MRDDA, in conjunction with the Quality Trust, conduct regular training sessions regarding surrogate decision-makers, guardians and court-appointment definition, roles and responsibilities.

J. Health Care

The District has secured a contract with Georgetown University to serve as a Health Resources Partner with the District for building health care capacity, education and training for clients of MRDDA.[12] The District's health care contractor is providing technical assistance and intervention for the 48 consumers determined to be exhibiting

the most complex medical needs, notifying MRDDA immediately of significant concerns with regard to particular plans and their implementation;[13] and providing prompt technical assistance where modification of the plan or additional training is needed to implement the Health Care Plans. For example, the health care contractor is offering additional technical assistance through seminars for registered nurses and expert panels based on issues that emerged from these visits related to nursing practice. They include:

- Adequacy of implementation of the nursing process by RNs
- The development and implementation of a health passport to improve communication with hospitals and specialists
- Management of individuals with dual diagnoses
- Management of individuals with long-term immobility and low weight
- Seizure management
- Physical assessment
- Supports to clients admitted to hospitals and nursing homes
- Understanding implications of genetic disorders for long-term health

The health care contractor is strengthening the skills of registered nurses serving individuals with mental retardation in community based settings through nursing seminars, expert panels, and refresher sessions on physical assessment.

K. Inter-Agency Coordination

Pursuant to the Court's 2004 Order requiring the Mayor to appoint a senior level official within the government to address interagency issues, the Mayor appointed the Deputy Mayor for Children, Youth, Families and Elders. Although not required by any Order, the District of Columbia has amended the MRDDA chain of command to have the MRDDA Administrator report directly to the Deputy Mayor, rather than through the

[12] This contract will expire on June 30, 2006 but will be extended through September 30, 2006 to allow the parties to that contract to consider revisions or amendments that may be needed for a future contract extension.

[13] As of Feb. 6, 2006, all 48 HCMPs were incorporated into the ISPs in the client homes.

Director of DHS, for those functions of personnel, procurement and budget that were within the DHS Director's control. The Director of DHS has relinquished authority over these issues in a letter of delegation from the DHS director to the MRDDA administrator, who now reports directly to the Deputy Mayor, effective October 1, 2005. However, those personnel, contracting and budget functions that were outside the DHS Director's control remain under the control of the D.C. Office of Personnel (DCOP), the Office of Contracting and Procurement (OCP) and the Office of the Chief Financial Officer (OCFO), as was originally intended. For fiscal year 2007, MRDDA developed its own budget and had a separate budget hearing. Although the budget is still a part of the overall DHS budget, MRDDA spending will not be subject to approval by the DHS Director. On January 23, 2006, the Deputy Mayor coordinated the transfer of 3 million dollars from other agencies in her cluster for critical MRDDA hires. She also filled key mid-level management positions such as Cynthia Kauffman, the Chief of Program Integrity (which includes QA, training and policies). Ms. Kauffman was the former Vice President of the Council for Quality and Leadership, an international accreditation and quality of life consultation organization. The District assigned a personnel specialist to MRDDA to expedite approvals for filling critical positions. The Deputy Mayor worked with the OCP to expedite the award of Human Care Agreements to new providers seeking to offer Waiver services to MRDDA clients, including the issuance of required tax certificates. The Deputy Mayor oversaw the retention of the waiver expert consultant to complete the requirements for an amendment to the current MRDD Waiver. The Deputy Mayor appointed a Chief Operating Officer for MRDDA and retained Kathy

Sawyer, a nationally recognized expert in the field, to serve as the Acting Administrator of MRDDA while initiating a national search to permanently fill the position.

The establishment and implementation of the foundation and infrastructure for a better functioning agency, including improved case management ratios, a training unit, a quality assurance unit, an incident investigation and management unit, a information technology system, an *Evans* compliance unit, a waiver unit, a fatality investigation and review process, the expedition and tracking of adaptive equipment, oversight on restrictive control procedures, lay advocacy, legal assistance and monitoring by the Quality Trust for Individuals, substantial and continued modifications to the waiver, shutdown of poor providers, recruitment of new providers and many more improvements, have all been accomplished by defendants' efforts to come into compliance with the Court's orders and implement the 2001 Plan. And while no one is claiming that the system is not in need of continued substantial improvements, these efforts demonstrate further that continued insistence on compliance will not lead only to confrontation and delay and undermine (further) plaintiffs' arguments that a receivership is the only viable remedy left to the Court. Moreover, the retention of a new administrator, nationally recognized for her expertise, demonstrates that defendants continue to be committed to reforming and improving the services provided to this vulnerable population.

Conclusion

For all the above-stated reasons, plaintiffs' motion to find the defendants in non-compliance and to appoint a receiver should be denied.

Respectfully submitted,

ROBERT J. SPAGNOLETTI
Attorney General for the District of Columbia

GEORGE C. VALENTINE
Deputy Attorney General
Civil Litigation Division

____/s/_____
RICHARD S. LOVE [340455]
Chief, Equity 1

___/s/_____
MARIA C. AMATO 414935
Senior Assistant Attorney General
Equity 1
441 Fourth Street, N.W., 6th Floor South
Washington, D.C. 20001
Telephone: (202) 724-6642
Facsimile: (202) 727-0431

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

JOY EVANS, et al., Plaintiffs,	)	
and	)	
UNITED STATES OF AMERICA, Plaintiff-Intervenor,	)	Civ. No. 76-293 (ESH)
v.	)	
ANTHONY WILLIAMS, et al., Defendants.	)	

DEFENDANTS' OPPOSITION TO PLAINTIFF-INTERVENOR'S MOTION FOR AN ORDER TO SHOW CAUSE WHY DEFENDANTS SHOULD NOT BE HELD IN CONTEMPT

Introduction

The plaintiff-intervenor's motion for an order to show cause why defendants should not be held in contempt (hereinafter "plaintiff-intervenor's motion") should be denied for the following reasons, which are discussed more fully below: (1) the Court Orders that plaintiff-intervenor allege defendants have violated are not clear and unambiguous, which is a required predicate for any contempt finding; and (2) the plaintiff-intervenor fails to show by clear and convincing evidence that the defendants violated a clear and unambiguous order of this Court.[1]

[1] Given the one additional week defendants were permitted to file this response (and their response to plaintiffs' motion for appointment of a receiver) and for all the reasons set forth in Defendants' motion for an enlargement of time to file its responses and for a scheduling order filed on June 5, 2006, the defendants do not attempt here to address all of the extensive factual issues raised by plaintiff-intervenor. Rather, the foregoing discussion focuses the Court's attention on the pertinent legal issues raised by the plaintiff-intervenor's motion, which should be dispositive of the issue. In the event and to the extent it is not, defendants respectfully request that the Court establish a schedule for discovery, grant defendants leave to

Standard of Review

Civil contempt is "a remedial sanction used to obtain compliance with a court order or to compensate for damage sustained as a result of noncompliance." *Food Lion v. United Food Commercial Workers Int'l Union*, 103 F.3d 1007, 1016 (D.C. Cir. 1997) (*quoting NLRB v. Blevins Popcorn Co.*, 659 F.2d 1173, 1184 (D.C. Cir.1981). "'[C]ivil contempt will lie only if the putative contemnor has violated an order that is clear and unambiguous,' and the violation must be proved by 'clear and convincing' evidence." *Armstrong v. Executive Office of the President, Office of the Administration*, 12 F.3d 1274, 1289 (D.C. Cir. 1993) (citations omitted).

The finding of civil contempt is a significant step; "the Court will proceed with caution, as a finding of civil contempt is a 'potent weapon.'" *Joshi v. Professional Health Services, Inc.*, 817 F.2d 877, 879 n. 2 (D.C. Cir.1987). "The party seeking contempt must prove the elements by clear and convincing evidence, rather than the preponderance of the evidence standard typical to civil cases." *NLRB v. Blevins Popcorn Co.*, 659 F.2d 1173, 1183-1184 (D.C. Cir.1981); *see Food Lion, Inc.* at 1016; *see also Washington-Baltimore Newspaper Guild, Local 35 v. Washington Post Co.*, 626 F.2d 1029, 1031 (D.C. Cir. 1980) (describing the burden on the moving party as a "heavy burden of proof"). "Furthermore, if the order contains any ambiguities, the Court must resolve those issues in favor of the party against whom contempt is sought." *Broderick v. Donaldson*, 338 F.Supp.2d 30, 47 (D.D.C. 2004). As discussed below, the plaintiff-intervenor has failed to meet its heavy burden of proof.

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file a supplemental opposition, and conduct an evidentiary hearing prior to any ruling. A party charged with an alleged contempt that occurs outside the Court's presence that relies on substantial facts is entitled to a hearing where witnesses may be called and evidence is taken. *See International Union, United Mine Workers of America v. Bagwell*, 512 U.S. 821, 834 (1994).

Argument

I. Clear and Unambiguous Court Orders

The plaintiff-intervenor fails to identify clear and unambiguous Court orders that the defendants allegedly violated, the required first prong for a finding of civil contempt. This prong is sometime referred to as the "four corner" test, in which the allegations of contempt must be directly tied to a clear and specific directive found within the four corners of a court order. *See U.S. v. Saccoccia*, 433 F.3d 19, 23 (1st Cir. 2005) (stating that the test is "whether the putative contemnor is able to ascertain from the four corners of the order precisely what acts are forbidden." (citation omitted).

> The purpose of this four corners rule is to assist the potential contemnor by narrowly cabining the circumstances in which contempt may be found. It is because the consequences that attend the violation of a court order are potentially dire that courts must read court decrees to mean rather precisely what they say.

Id. at 28 (citations and quotation marks omitted).

The test for a clear and unambiguous order "cannot be read in the abstract. The question is not whether the order is clearly worded as a general matter; instead, the 'clear and unambiguous' prong requires that the words of the court's orders have clearly and unambiguously forbidden the precise conduct on which the contempt allegation is based." Id. at 24-5 (*citing Perez v. Danbury Hosp.*, 347 F.3d 419, 424 (2d Cir. 2003)).

In the instant case, the plaintiff-intervenor's motion cites primarily provisions from an almost 30 year-old Order that lacks detail and clarity on what is precisely required of the defendants or prohibited to them, and that relates primarily to the then-existing institutionalized system at Forest Haven. The plaintiff-intervenor quotes the

following provisions from the 1978 Final Judgment and Order, *Evans v. Washington*, 459 F. Supp. 483 (D.D.C. 1978):

> Provide all class members with community living arrangements suitable to each, together with such community-based day programs and services as are necessary to provide them with minimally adequate habilitation until such individuals are no longer in need of such living arrangements, programs and/or community services. Such community living arrangements, programs and other services shall be provided in the least separate, most integrated and least restrictive community settings.

Id. at 485. The terms in the above-quoted provision do not contain precise definitions, and the provision lacks clear guidance on the required or prohibited conduct. For example, the provision does not provide the detail needed to determine "suitable" living arrangements or "minimally adequate" habilitation, with the precision required for a finding of contempt.

> Provide all necessary and proper monitoring mechanisms to assure that community living arrangements, programs and supportive community services of the necessary quantity and quality are provided and maintained. [2]

Id. at 485. This provision is equally unclear and ambiguous; it does not define or clarify the type of monitoring mechanisms defendants are required to have in place in order to be in compliance with the order.

> A plan to safeguard each class member's personal possessions, including money, but not limited to, provision for depositing each class member's funds in interest-bearing accounts and for withdrawal of such funds.[3]

Id. at 487. Like the provisions cited above, the provision concerning class members' money and personal possessions is unclear and ambiguous. The provisions requires a

[2] Plaintiff-intervenor also cited in a footnote the Consent Order dated 1981 and the 1983 Consent Order.
[3] Plaintiff-intervenor also cited in a footnote the Consent Order dated 1983.

"plan" with no specifics as to what must be contained in the plan other then a requirement that the plan contain a provision for interest-bearing accounts. Otherwise the order is silent on the provisions that defendants must include in its plan.

> Defendants, . . . are enjoined to exert maximum efforts to comply with the following requirements: Acts of physical or psychological abuse, neglect or mistreatment of any [class member], including, but not limited to assaults, fractures, cuts, bruises, abrasions, burns, bites, lacerations, drug overdoses and verbal abuse, are prohibited.

Id. at 488. The preceding provision requires defendants to "exert maximum efforts" to prevent "[a]cts of physical or psychological abuse, neglect or mistreatment" and gives some examples of what constitutes abuse, neglect or mistreatment. However, the provision does not clearly and unambiguously define what "maximum efforts" are or whether it prohibits discrete, individual or more wide-ranging, systemic violations. In a system that serves close to two thousand consumers, there will be discrete incidents of abuse, but those incidents do not prove systemic violations of the order. Moreover, this provision appears within Section III of the 1978 Final Judgment and Order, which pertains to the "Interim Operation of Forest Haven," not the system of community care that defendants now operate. Under these circumstances, the aforementioned provision is neither clear nor unambiguous.

> A program of medical, dental and health related services for class members which provides accessibility, quality and continuity of care for physical illness or injury is required.

Id. at 489. Again, this provision concerning medical, dental and health related services is unclear and ambiguous. The provision requires a "program" of services that provides for "quality and continuity of care". Moreover, this provision also appears in section III of

the 1978 Final Judgment and Order which pertains to the Interim Operation of Forest Haven. The above-quoted provision goes on to state: "the plan for Interim Operations of Forest Haven shall develop and establish medical, dental and health related services to class members." The provision does not precisely define these terms, which, combined with the other ambiguities of this almost 30 year-old provision, prevents defendants from knowing what is required by the order, with the precision required for a finding of contempt.

As noted, each of the above provisions fail to provide the clarity necessary for a finding of contempt. For example, the terms "community living arrangements *suitable* to each [class member]" and "*necessary* and *proper* monitoring mechanisms" are undefined in any specific manner, as required to provide defendants the guidance they need to determine what conduct is required or prohibited by the order.

In *Broderick v. Donaldson*, 338 F.Supp.2d 30, 47 (D.D.C. 2004) the Court commented that the terms "appropriate work assignments, on-the-job training, evaluation standards and increased responsibilities" as used in a court order are "extremely subjective and imprecise." "The Court does not presume to possess the institutional competence to police the [defendant] in providing [plaintiff] with 'appropriate work assignments, on-the-job-training, evaluation standards, and increased responsibilities.'" *Id.* (*quoting Broderick v. Ruder*, 685 F. Supp. 1269 (D.D.C. 1988).

Similarly, the terms used in those provisions of the Court's orders upon which plaintiff-intervenor relies are extremely subjective, insufficiently precise, relate to an entirely different time and system, and under these circumstances, fails to provide the potential contemnor the requisite definition of the acts forbidden.

The plaintiff-intervenor fails to identify clear and unambiguous provisions of the Court's orders that the defendants have allegedly violated. This failure alone is fatal to their motion.

II. Clear and Convincing Evidence

Given the plaintiff-intervenor's failure to identify clear, precise, unambiguous orders that defendants have violated, consideration of the second prong of the contempt analysis is irrelevant and unnecessary, nonetheless defendants address it below as well.

The plaintiff-intervenor fails to show by *clear and convincing evidence* that the defendants have violated the Court's prior orders (even assuming that they were clear, precise, and unambiguous). There is insufficient evidence to show that defendants have systemically failed to comply with the provisions of the above-quoted orders. There are clear factual disputes as to the pervasiveness of class member care issues. There are bad outcomes in any program, particularly in a system that cares for fragile individuals with complex medical and social needs. But defendants have taken numerous steps and have a variety of policies, practices, and systems in place that seek to prevent and mitigate such outcomes.[4] The plaintiff-intervenor's shotgun approach, detailing a few specific incidents without (i) referring to a specific provision of the Court's orders that was allegedly violated and (ii) showing that the incidents are part of a systemic failure by the defendants, is insufficient to provide the type of clear and convincing evidence required for a finding of contempt. Indeed, many of the incidents detailed by the plaintiff-intervenor are taken out of context and mischaracterized.

[4] Defendants' relevant policies, practices, systems, plans and efforts are described in more detail in Defendant District of Columbia's Opposition to Plaintiffs' Motion to Find Defendants in Noncompliance and to Appoint a Receiver, which is incorporated herein by reference.

The plaintiff-intervenor cites five provisions of the Court's orders on page 2 of its memorandum of points and authorities. One would assume that the remaining pages of the memorandum would detail - through clear and convincing evidence - how the defendants violated each of those provisions. However, the next 36 pages of the memorandum fail to refer to any provision of the Court's orders. Instead, the plaintiff-intervenor provides 36 pages of details about the defendant's "failings" without any connection or even reference to which provision of the Court's order the defendants supposedly have failed to meet or how the "failings" relate to any of the Court's orders.

The following are examples of evidence presented by the plaintiff-intervenor in support of its argument that the defendants are in contempt of the Court's orders. However, none of these examples provides "clear and convincing" evidence sufficient to support a finding of contempt.

Defendants' statements: The plaintiff-intervenor details the defendants' "admissions" as quoted by media outlets or as made before the Court. The statements reflect recognition by the defendants that MRDDA faces problems and issues that must be addressed to better serve the class members. The statements are not, however, admissions that they defendants are in contempt of any provision of the Court's orders, nor does the plaintiff-intervenor assert as such. Rather than reflecting defendants' "contempt" for the Court's orders, such statements are demonstrative of defendants' concern about the issues and challenges facing MRDDA and their commitment to improving services.

90-day plan: The plaintiff-intervenor details problems the defendants experienced in implementing the 90-day plan. However, the 90-day plan was not a Court order; for a

contempt finding, the plaintiff-intervenor must show that the defendants violated a Court order, not a plan developed by the parties. Again, there is no reference to a Court order being violated in plaintiff-intervenor's discussion of the 90-day plan.

Transition: The plaintiff-intervenor fails to refer to any Court Order that was violated during the CADC transition. In addition, as discussed below, the plaintiff-intervenor cynically mischaracterizes the transition and the request by the defendants to suspend local laws as a sign of systemic failure. However, the request was made provisionally to be used only if absolutely necessary, in an abundance of caution for the protection of class members. Ultimately, the transition was timely completed in compliance with all applicable laws and without the need for any assistance from the Court. Contrary to plaintiff-intervenor's characterization, defendants effectively coordinated the efforts of several agencies outside MRDDA, including the Health Regulatory Administration of the Department of Health, the Department of Consumer and Regulatory Affairs, and the Office of the Fire Marshal in order to timely comply with the applicable regulatory and procedural requirements and timely transition the CADC homes upon expiration of its contract. Moreover, plaintiff-intervenor fails to refer to any provision of the Court's orders that was violated during the CADC transition.[5]

Class Member Funds: The plaintiff-intervenor alleges that the defendants have failed to safeguard class member funds and personal assets. However, again, the

[5] Another example of plaintiff-intervenor referring to an issue that does not implicate an Order of the Court is the discussion of the Medicaid Home and Community Based Waiver (Waiver). Again, like the other issues that plaintiff-intervenor discusses in its memorandum, there is no reference to a Court order pertaining to the issues of the waiver. Further, the plaintiff-intervenor mischaracterizes the work performed by the defendants on the waiver issues. The defendants' admit that the wavier needs to be amended to optimize waiver services and to maximize use of federal dollars. The defendants have been working toward that goal, the amendments and revised rules are in the process of being drafted by MRDDA, in conjunction with the Medical Assistance Administration. In addition, the defendants have entered into a contract with Pennhurst Government Solutions to assist in the completion of the amendments and rules for submission to the Council of the District of Columbia and the Centers for Medicare and Medicaid Services.

plaintiff-intervenor mischaracterizes the issue. The plaintiff-intervenor references that an audit was performed by an independent contractor that covered 1992 to 2001. The MRDDA reimbursed class members approximately 1 million dollars in funds that were found to have been improperly converted or improperly documented. In addition, the MRDDA developed a client funds manual and conducts periodic audits. These audits are performed by an independent contractor, the most recent of which was completed on May 30, 2006 and covered fiscal years 2002 and 2003. (*See, e.g.*, Defendant District of Columbia's Opposition to Plaintiffs' Motion to Find Defendants in Noncompliance and to Appoint a Receiver, Section II.G., as well as sections II.D. and F.).

The well-being of class members: The plaintiff-intervenor alleges that the class members are subject to abuse, neglect, and that there have been preventable deaths. As "evidence" for these allegations, plaintiff-intervenor relies on the unfortunate outcome experienced by a number of ill and fragile class members. Yet these anecdotal examples fail to show that the defendants have a systemically deficient system of medical and dental care and are not making efforts to monitor class members' well being and taking efforts to prevent harm. For example, the defendants established an incident management system in 2001. The incident management policy prohibits abuse, neglect, and mistreatment of all consumers. There is a reporting and investigation protocol on which all staff are trained. Reported incidents are investigated and findings are shared with providers for appropriate action. All deaths of class members are autopsied and referred to an independent contractor for investigation. The District has secured a contract with Georgetown University to serve as a Health Resources Partner with the District for building health care capacity, education and training for clients of MRDDA. In addition,

annual plans for monitoring are prepared and two units within MRDDA, Quality Assurance and Case Management, monitor and update progress of implementation of the annual plans. These policies and practices are designed to ensure that all MRDDA consumers are protected. (See, Defendant District of Columbia's Opposition to Plaintiffs' Motion to Find Defendants in Noncompliance and to Appoint a Receiver, Sections II.D. and II.J., as well as sections II.B., E., F., G., and K.).

Conclusion

The plaintiff-intervenor, in its motion, fails to meet what it acknowledges as its burden of proving by "clear and convincing evidence" that the defendants have violated an existing Court Order. Those limited provisions that are cited reference broad, general provisions of orders that are almost 30 years old, many of which pertain to interim operations at Forest Haven, all of which lack the precision and clarity required to hold a defendant in contempt of court. Moreover, plaintiff-intervenor fails to present clear and convincing evidence to support such violations, relying on hearsay statements, events unconnected to any court order, and the unfortunate outcomes of a relatively small number of consumers in a system that provides a complex menu of services and care to close to two thousand consumers with complicated medical and social needs.

For the foregoing reasons, the defendants respectfully request that the Court deny plaintiff-intervenor's motion for an order to show cause why defendants should not be held in contempt.

Respectfully submitted,

ROBERT J. SPAGNOLETTI
Attorney General for the District of Columbia

GEORGE C. VALENTINE
Deputy Attorney General
Civil Litigation Division

_____
RICHARD S. LOVE [340455]
Chief, Equity 1

_____
MARIA C. AMATO 414935
Senior Assistant Attorney General
Equity 1
441 Fourth Street, N.W., 6th Floor South
Washington, D.C. 20001
Telephone: (202) 724-6642
Facsimile: (202) 727-0431

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

JOY EVANS, et al., Plaintiffs,	)	
and	)	
UNITED STATES OF AMERICA, Plaintiff-Intervenor,	)	Civ. No. 76-293 (ESH)
v.	)	
ANTHONY WILLIAMS, et al., Defendants.	)	

District of Columbia

DECLARATION OF BRENDA DONALD WALKER, DEPUTY MAYOR FOR CHILDREN, YOUTH, FAMILIES AND ELDERS

I, Brenda Donald Walker, pursuant to 28 U.S.C. § 1746, declare under penalty of perjury that the following is true and correct:

1. I serve as the Deputy Mayor for Children, Youth, Families and Elders. I have served as the Deputy Mayor since October 31, 2005. In the role of Deputy Mayor I oversee the operations of the District of Columbia's human services agencies, including the Mental Retardation and Developmental Disabilities Administration ("MRDDA") and I have been designated by the Mayor, consistent with this Court's Order of January 21, 2004, to coordinate the efforts of all District agencies as necessary to secure the timely delivery of services to members of the class in this civil action in compliance with the Court's orders.

2. As announced by Mayor Anthony A. Williams at a press conference on June 7, 2006, Kathy Elmore Sawyer has agreed to enter into a contract with the District to serve as the acting administrator of MRDDA, effective June 19, 2006. Ms. Sawyer will serve as the acting administrator for the remainder of Mayor Williams' term. During the next six months, the District government will recruit, through a nation-wide search, qualified candidates for the position of administrator of MRDDA.

3. Ms. Sawyer is a nationally recognized expert in the field of mental retardation and developmental disabilities and brings unquestionable experience, skill and credentials to this position. She has worked in the field for more than 30 years. Attachment 1 is Ms. Sawyer's résumé.

4. Ms. Sawyer served as the Commissioner for the Alabama Department of Mental Health and Mental Retardation from 1999 through 2005. As Commissioner, Ms. Sawyer reached a court-approved settlement of a lawsuit that spanned 33 years and 14 commissioners. Ms. Sawyer reformed practice and implemented measures to establish operating efficiencies. She oversaw a budget in excess of $600 million and was responsible for the overall administration and management of all state in-patient facilities, as well as community-contracted and -certified programs for mental retardation, mental health and substance abuse services.

5. Ms. Sawyer retired as Commissioner in Alabama in 2005 and has been working as a consultant in other jurisdictions, including the District of Columbia. Ms. Sawyer became a consultant to the MRDDA in October 2005. She is familiar with the issues and challenges facing the MRDDA and has started to develop a plan to improve agency performance.

6. Ms. Sawyer will have direct access to me, the City Administrator and the Mayor as she performs her duties and responsibilities.

7. Ms. Sawyer will have the following duties as the acting administrator of MRDDA:

    a. To report to the Deputy Mayor and/or City Administrator every week or more often as necessary and the Mayor as necessary, on: (i) the identification, coordination and resolution of any inter-District agency issues as necessary to secure the timely delivery of appropriate services as required by the orders entered in this case, (NOTE: This is pulled, essentially from the one Order J. Huvelle entered, the 1/21/04 Order, and is given prominence here because she believes that cutting through these inter-agency "bureaucratic" issues is essential to compliance) (ii) actions taken and progress toward achieving agency objectives and improving compliance with court orders, (iii) changes, modifications, obstacles encountered, (iv) any other issues deemed appropriate by Ms. Sawyer.
    b. To oversee, supervise, coordinate and direct the District's efforts to implement the court orders, and to effectively require private provider agencies to provide safe, appropriate and quality services and supports to class members and other eligible persons with mental retardation;
    c. To oversee, supervise and direct all financial, administrative, and personnel functions of the MRDDA as necessary to implement the court orders, including employee and provider recruitment, training, contracts, procurement, licensing and enforcement;

d. To develop and improve management systems, performance standards, coordinated enforcement processes, recruitment of high-quality staff and provider agencies, training and employee-management relations for MRDDA;
e. To cooperate and develop working relationships within the District of Columbia government, including the Chief Financial Officer, the Council of the District of Columbia, and other officials and staff within the District of Columbia agencies, and with the United States Congress and federal agencies as necessary;
f. To identify and eliminate inefficiencies and waste within MRDDA and shall specifically strive to maximize the use of Medicaid-funded services under the home and community-based waiver as appropriate;
g. To establish as soon as possible a plan for submission to the Mayor, which shall contain the following: (i) establishment of specific objectives, tasks, schedules and performance standards for the MRDDA; (ii) recommendations for a structural reorganization of governmental roles and responsibilities for the provision of services and supports to persons with mental retardation and developmental disabilities, as needed; and (iii) addressing the means by which the District may improve compliance with the requirements of the court orders; and
h. To meet and consult regularly, as needed, with the Special Masters, Court Monitor, plaintiffs and plaintiff-intervenor personally, regarding progress in the implementation of the court orders.

8. Ms. Sawyer will have the following powers and authorities as the acting administrator of MRDDA, consistent with applicable law, to carry out her duties and responsibilities:
   a. The authority to develop and make budget recommendations for mental retardation services, including appropriations needed for Medicaid-covered services, and to work with the Mayor, the City Administrator, and the Chief Financial Officer in negotiating and securing approval for the budget, including revisions in the Fiscal Year 2006 and 2007 budgets, as necessary;
   b. Subject to the requirements of federal law pertaining to the role of a single state agency for the Medicaid program, to have the responsibility and authority to work in conjunction with the District of Columbia Medicaid Assistance Administration, to develop and implement the home- and community-based waiver and any other Medicaid-funded services necessary to provide class members services and supports in the least restrictive, most integrated settings appropriate to meet their needs;
   c. To the extent permitted by law, the authority to establish personnel policies; to create, modify, abolish, or transfer positions; to hire, terminate, promote, transfer, evaluate, and set compensation for staff;
   d. To the extent permitted by law, the authority to negotiate new, and renegotiate existing contracts, agreements, and memoranda of understanding;

e. Authority to apply for and receive funds from public and private sources to the extent permitted by law, including grant funding, and to expend funds in fulfillment of her duties and authorities;
f. Act in a manner consistent with the laws and regulations of the District of Columbia. However, where those laws and regulations clearly prevent Ms. Sawyer from carrying out her duties and responsibilities, Ms. Sawyer shall report the impediment to me, the City Administrator or the Mayor.

Brenda Donald Walker, Deputy Mayor

Date 6-12-06

Ms. WALKER. Our work over the next few months—over the last few months and in the 6 months ahead is designed to lay the foundation for long-term systemic reform. With the commitment of the Mayor, the support of the city administrator and MRDDA's new leadership, we are confident that we can finally get this agency on track.

Thank you for the opportunity to update you on our plans for MRDDA, and I'm available for your questions.

[The prepared statement of Ms. Walker follows:]

Government of the District of Columbia

Office of the Deputy Mayor for
Children, Youth, Families and Elders

Committee on Government Reform
United States House of Representatives

The Honorable Tom Davis, Chairman

Status of the District Columbia's Mental Retardation and Developmental Disabilities Administration

Testimony of
Brenda Donald Walker
Deputy Mayor for
Children, Youth, Families and Elders
District of Columbia

Friday, June 16, 2006
2154 Rayburn House Office Building
10:00 a.m.

Good morning Chairman Davis and members of the Committee on Government Reform. I am Brenda Donald Walker, Deputy Mayor for Children, Youth, Families and Elders for the District of Columbia. I am here today, on behalf of Mayor Williams, to give you an update on the status of the District's Mental Retardation and Developmental Disabilities Administration (MRDDA).

Prior to being appointed Deputy Mayor in November 2005, I was the Director of the District's Child and Family Services Agency (CFSA). I was recruited to CFSA as the Chief of Staff to help guide that agency through major reforms and transition out of court-imposed receivership. By virtue of a tremendous amount of work, fiscal responsibility, innovative practices and a solid management team, we were able to create what is now a highly regarded child welfare agency. I offer this history because the challenges facing MRDDA today resemble very much the issues facing CFSA when I started there five years ago.

As you know, MRDDA faces formidable challenges – including budget, management, and service delivery. We have had, literally, decades of decay at MRDDA. Yet, I come before you today, to testify that I believe we are finally on the right track. As with our accomplishments at CFSA, MRDDA cannot be transformed in months – but rather over several years. However, the critical foundation – that upon which substantial reform will be built, can be laid in the next six months.

As you know, the Mayor recently appointed Kathy Sawyer as the new Administrator for MRDDA. Since her retirement as Commissioner for the Alabama Department of Mental Health and Mental Retardation, Ms. Sawyer has acted as a consultant for a number of jurisdictions across the country. She has consulted for MRDDA since last October, thus developing a working knowledge of the agency -- so she will hit the ground sprinting when she starts on Monday. In accepting the position, Ms. Sawyer has identified three primary goals for the next six months:

1) Positioning MRDDA to effectively operate within its budget;
2) Successfully amending the existing Home and Community Based Waiver; and
3) Establishing a solid organizational foundation to enable MRDDA to function more efficiently and effectively in its delivery of services.

The coming months will be intense and critical. Everyone who has met Kathy Sawyer comes away impressed with her confidence, experience and commitment to improving the lives of persons with disabilities. I would like to have her brief your staff later this fall after she has had a few months to begin work on executing her goals.

Ms. Sawyer represents only one component of our recent efforts. As I mentioned, a strong management team is essential. We have also added a Chief Operating Officer, Dr. Heather Stowe, who is here with me today. Dr. Stowe has over 20 years of senior management experience in the human services field. We have also recently hired a highly regarded Quality Assurance Manager, a new Director of Programs, and several

other senior staff. Over the last several months we conducted an organizational and staffing analysis of MRDDA. The City Administrator and I will support Ms. Sawyer's rapid implementation of the critical management and organizational changes needed to move the agency forward.

Much of our work at MRDDA since I became Deputy Mayor – and more intensely in the last four months – has been driven by the Systems Improvements Plan that I outlined to address the agency's basic structural deficiencies. This plan has seven major components: 1) expansion of provider capacity; 2) provider monitoring and accountability; 3) contracts management; 4) feasibility of waiver operations; 5) improvement in day programs; 6) case management; and 7) training. Through intensive weekly meetings, which I chair, we are closely tracking our progress, modifying things when necessary, and most importantly, remaining focused.

As you are aware, we also face a significant legal challenge to our stewardship of MRDDA. Counsel for the plaintiffs' class and the United States Department of Justice filed motions for receivership and contempt in the longstanding class action lawsuit *Evans v. Williams*. I am making available, for the Committee's records, copies of the District's oppositions to those motions, as well as my declaration submitted to the court last Monday.

Our work over the last few months, and in the six months ahead is designed to lay the foundation for long term systemic reform. With the commitment of the Mayor, the

support of the City Administrator, and MRDDA's new leadership, we are confident that we can finally get this agency on track. Thank you for the opportunity to update you on our plans for MRDDA. I look forward to your questions.

Chairman TOM DAVIS. Thank you very much.

Ms. Thompson.

STATEMENT OF MARSHA THOMPSON

Ms. THOMPSON. Hello, Chairman Davis and Congresswoman Norton. I'm Marsha H. Thompson, former administrator of the District of Columbia's Mental Retardation and Developmental Disabilities Administration.

I believe that while Mayor Williams may have already made changes in structure and policy to support the incoming administrator, my sincerest hope is that my comments can contribute to improving the outcomes for this population, which I tried my very best to serve as administrator.

I began as interim administrator in May 2005, just in time for the mid-year budget review with D.C. Department of Human Services. DCDHS is the cabinet level agency above MRDDA.

Former Deputy Mayor Neil Albert and I determined that amending our MRDDA Medicaid waiver to reduce the burden on the local budget was a critically needed step. I hired a waiver specialist, formed a waiver work group, communicated budget pressures and possible solutions to the provider, advocacy and client community, and began work on the needed waiver revisions.

The parties associated with the Evans court decree insisted that MRDDA quickly move people from homes fully funded by the D.C. Medicaid budget, implement a restructure, and provide improved specialized health care services through private health care practitioners and hospitals. I communicated the increasing spending pressures to Mr. Albert. He called an all-hands meeting to develop a plan for funding to continue services during that year, and after which he determined what should be done to meet the needs in fiscal year 2006. He advised that I complete the amendment for the current MRDDA waiver, prepare a supplemental budget request to the Mayor for fiscal year 2006, and collaborate with an expert to better leverage local funds for the capture of the Federal match in other ways.

Even though former Deputy Mayor Neil Albert and I had previously mapped out a structure for MRDDA, I was unable to implement it due to funding challenges and the hybrid legal status under which we were operating. As of June 6, 2006, MRDDA was in need of internal legal counsel to handle the daily court appearances around client services and many other legal obligations, internal budget staff with adequate fiscal acumen who could directly access fiscal reports and forecasts, internal contract staff with the authority to negotiate contracts and monitor performance, an internal human resources office to manage personnel functions. MRDDA did have an assigned personnel specialist, but the office was not adequately functioning as of June 6, 2006. Internal information technology staff with the requisite skills to manage complex information management needs and design improvements for responsive and comprehensive information.

MRDDA is one of many city agencies that must work closely together to achieve the outcomes required by the Evans plan. These agencies include D.C. Medicaid, D.C. Office of Contracting, etc. The coordination and responsiveness of these agencies in support of

people with disabilities has always been recognized as critical to meeting the compliance measures in Evans. The Mayor has delegated responsibility for coordination to the Deputy Mayor for Children, Youth, Families and Elders.

The District MRDDA is in need of radical realignment. The replacement of the administrator is, quite frankly, a woefully inadequate step in alleviating the systemic problems of this administration. I submit a few items to be considered and given support to be implemented: MRDDA needs the undivided attention of executive leadership and should therefore report directly to the city administrator. Mr. Bobb is a well known and well respected administrator.

Consistent budget overruns from a social services program of this magnitude and with these persistent issues cries out for adequate funding and appropriate performance measures.

A new Medicaid waiver and the resources to carry out the program's mandate must be implemented now.

Executive leadership coupled with a legislative committee chair who will commit the time to understanding the community.

And without the above minimal commitments, the agency should be immediately placed into receivership.

While the District is moving in a positive direction and I'm sure will continue to buildupon its accomplishments to date, much is left to be done at all levels of government. My primary regret is that I was unable to garner the appropriate level of support to bring systems change to MRDDA.

Thank you.

[The prepared statement of Ms. Thompson follows:]

Testimony of
Marsha H. Thompson
Former Administrator
District of Columbia
Mental Retardation and Developmental Disabilities
Administration

Status of the District of Columbia's Mental Retardation and Developmental Disabilities Administration (MRDDA)

One Hundred Ninth Congress
CONGRESS OF THE UNITED STATES
House of Representatives
Committee on Government Reform

June 16, 2006

Room 2154
Rayburn House Office Building
Washington, DC 20515-6143
10:00 A.M.

HELLO, CHAIRMAN DAVIS AND MEMBERS OF THE COMMITTEE ON GOVERNMENT REFORM. I AM MARSHA H. THOMPSON, FORMER ADMINISTRATOR OF THE DISTRICT OF COLUMBIA'S MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES ADMINISTRATION (MRDDA). I BELIEVE THAT WHILE MAYOR WILLIAMS MAY HAVE ALREADY MADE CHANGES IN STRUCTURE AND POLICY TO SUPPORT THE INCOMING ADMINISTRATOR, MY SINCEREST HOPE IS THAT MY COMMENTS CAN CONTRIBUTE TO IMPROVING THE OUTCOMES FOR THIS POPULATION WHICH I TRIED MY VERY BEST TO SERVE AS ADMINISTRATOR.

I BEGAN AS INTERIM ADMINISTRATOR IN MAY 2005, JUST IN TIME FOR THE MID-YEAR BUDGET REVIEW FOR THE DC DEPARTMENT OF HUMAN SERVICES (DHS). DHS IS THE CABINET LEVEL AGENCY ABOVE MRDDA. LET ME BE CLEAR FROM THE START: AS INTERIM ADMINISTRATOR I DID NOT INHERIT A SLICE OF HEAVEN AND TURN IN INTO A HELL. RATHER, I INHERITED A SLICE OF HELL AND DID MY BEST TO BRING IT AT LEAST TO EARTH, ONLY TO BE STOPPED SOMEWHERE IN PURGATORY. FOR EXAMPLE, DISCUSSION WITH MY NEW SUPERVISOR WHO WAS THEN THE DHS DEPUTY FOR PROGRAMS, AND WITH FORMER DEPUTY MAYOR NEIL ALBERT, WE DETERMINED THAT AMENDING OUR MRDD MEDICAID WAIVER TO REDUCE THE BURDEN ON THE LOCAL BUDGET WAS A CRITICALLY NEEDED STEP. I HIRED A WAIVER SPECIALIST; FORMED A WAIVER WORK GROUP; COMMUNICATED BUDGET PRESSURES AND POSSIBLE SOLUTIONS TO THE PROVIDER, ADVOCACY AND CLIENT COMMUNITY, AND BEGAN WORK ON THE NEEDED WAIVER REVISIONS. THE PARTIES ASSOCIATED WITH THE *EVANS* COURT DECREE INSISTED THAT MRDDA QUICKLY MOVE PEOPLE FROM HOMES FULLY FUNDED BY THE DC MEDICAID BUDGET,

IMPLEMENT A RESTRUCTURE, AND PROVIDE IMPROVED SPECIALIZED HEALTH CARE SERVICES THROUGH PRIVATE HEALTH CARE PRACTITIONERS AND HOSPITALS. I COMMUNICATED THE INCREASING SPENDING PRESSURE TO MR. ALBERT. HE CALLED AN "ALL HANDS" MEETING TO DEVELOP A PLAN FOR FUNDING TO CONTINUE SERVICE DURING THAT YEAR. AFTER HE CONSIDERED WHAT SHOULD BE DONE TO MEET NEEDS IN FY 2006, HE ADVISED THAT I COMPLETE THE AMENDMENT FOR THE CURRENT MRDD MEDICAID WAIVER, PREPARE A SUPPLEMENTAL BUDGET REQUEST TO THE MAYOR FOR FY 2006, AND COLLABORATE WITH AN EXPERT TO BETTER LEVERAGE LOCAL FUNDS FOR THE CAPTURE OF THE FEDERAL MATCH IN OTHER WAYS. WHEN NEW DEPUTY MAYOR BRENDA DONALD WALKER CAME ON BOARD FOR ORIENTATION IN OCTOBER 2005, MRDDA WAS REALIGNED TO REPORT DIRECTLY TO HER OFFICE. WE DISCUSSED BUDGET ISSUES; I PRESENTED A SCOPE OF WORK TO HER; AND I ASKED TO OBTAIN CONTRACTOR SUPPORT TO ORGANIZE A PROCESS TO USE MEDICAID FUNDS TO SUPPORT MRDDA'S FUNCTIONS WHILE CONCURRENTLY STREAMLINING THE AGENCY, PROVIDING SERVICES TO THOSE LEGALLY ENTITLED, AND DEVELOPING AN ADEQUATE QUALITY ASSURANCE SYSTEM. THIS WAS REBUFFED BY DEPUTY MAYOR WALKER AS BEING UNNECESSARY.

INTERNAL AGENCY STRUCTURAL CHALLENGES

EVEN THOUGH FORMER DEPUTY MAYOR NEIL ALBERT AND I HAD PREVIOUSLY MAPPED OUT A STRUCTURE FOR MRDDA, I WAS UNABLE TO IMPLEMENT IT DUE TO FUNDING CHALLENGES AND THE HYBRID LEGAL STATUS UNDER WHICH WE WERE OPERATING. AS OF JUNE 6, 2006, MRDDA WAS IN NEED OF:

- *INTERNAL LEGAL COUNSEL* TO HANDLE THE DAILY COURT APPEARANCES AROUND CLIENT SERVICES AND MANY OTHER LEGAL CONCERNS.

- *INTERNAL BUDGET STAFF* WITH ADEQUATE FISCAL ACUMEN WHO CAN DIRECTLY ACCESS FISCAL REPORTS AND FORECASTS.
- *INTERNAL CONTRACTS STAFF* WITH THE AUTHORITY TO NEGOTIATE CONTRACTS AND MONITOR PERFORMANCE.
- *AN INTERNAL HUMAN RESOURCES OFFICE* TO MANAGE PERSONNEL FUNCTIONS. MRDDA DID HAVE AN ASSIGNED PERSONNEL SPECIALIST, BUT THE OFFICE WAS NOT ADEQUATELY FUNCTIONING AS OF JUNE 6, 2006.
- *INTERNAL INFORMATION TECHNOLOGY STAFF* WITH THE REQUISITE SKILLS TO MANAGE COMPLEX INFORMATION MANAGEMENT NEEDS AND DESIGN IMPROVEMENTS FOR RESPONSIVE AND COMPREHENSIVE INFORMATION MANAGEMENT NEEDS.

AS MRDDA ADMINISTRATOR I WAS IN THE POSITION OF RELYING UPON DC DHS FOR THESE FUNCTIONS, EVEN THOUGH THE MRDDA WAS NO LONGER ACTUALLY REPORTING TO THE DC DHS. UNFORTUNATELY THE IMPLEMENTATION OF SUPPORT SERVICES REQUIRED TO ADMINISTRATIVELY SUPPORT MRDDA DID NOT KEEP PACE WITH THE INCREASING PERFORMANCE DEMANDS PUT UPON THE AGENCY.

MRDDA IS ONE OF MANY CITY AGENCIES THAT MUST WORK CLOSELY TOGETHER TO ACHIEVE THE OUTCOMES REQUIRED BY THE *EVANS* PLAN. THESE AGENCIES INCLUDE DC MEDICAID; DC OFFICE OF CONTRACTING AND PROCUREMENT; REHABILITATION SERVICES; HEALTH REGULATION; MENTAL HEALTH AND OTHERS. THE COORDINATION AND RESPONSIVENESS OF THESE AGENCIES IN SUPPORT OF PEOPLE WITH DISABILITIES HAS ALWAYS BEEN

RECOGNIZED AS CRITICAL TO MEETING THE COMPLIANCE MEASURES IN *EVANS*. THE MAYOR HAS DELEGATED RESPONSIBILITY FOR COORDINATION TO THE DEPUTY MAYOR FOR CHILDREN YOUTH FAMILIES AND ELDERS.

FINALLY, AS PERFORMANCE PRESSURE MOUNTED FROM THE COMMUNITY OF FAMILIES, CLIENTS, AND ADVOCATES, THESE ISSUES WERE CHARACTERIZED AS MY FAILINGS. I WISH TO MAKE VERY CLEAR TO YOU THAT MRDDA DOES NOT HAVE THE SKILLED EXECUTIVE LEADERSHIP OR KNOWLEDGEABLE LEGISLATIVE OVERSIGHT THAT UNDERSTANDS THE NEEDS OF THE PEOPLE SERVED.

CONCLUSION

THE DISTRICT MRDDA IS IN NEED OF RADICAL REALIGNMENT. THE REPLACEMENT OF THE ADMINISTRATOR IS, QUITE FRANKLY, A WOEFULLY INADEQUATE STEP IN ALLEVIATING THE SYSTEMIC PROBLEMS OF THIS ADMINISTRATION. I SUBMIT A FEW ITEMS TO BE CONSIDERED AND GIVEN SUPPORT TO BE IMPLEMENTED:

- MRDDA NEEDS THE UNDIVIDED ATTENTION OF THE EXECUTIVE LEADERSHIP, AND SHOULD THEREFORE REPORT DIRECTLY TO THE CITY ADMINISTRATOR;
- CONSISTENT BUDGET OVERRUNS FROM A SOCIAL SERVICES PROGRAM OF THIS MAGNITUDE AND WITH THESE PERSISTENT ISSUES CRIES OUT FOR ADEQUATE FUNDING WITH APPROPRIATE PERFORMANCE MEASURES;
- A NEW MEDICAID WAIVER AND THE RESOURCES TO CARRY OUT THE PROGRAM'S MANDATE MUST BE IMPLEMENTED NOW;

- EXECUTIVE LEADERSHIP COUPLED WITH A LEGISLATIVE COMMITTEE CHAIR WHO WILL COMMIT THE TIME TO UNDERSTANDING THE COMMUNITY, AND
- WITHOUT THE ABOVE MINIMAL COMMITMENTS, THE AGENCY SHOULD BE IMMEDIATELY PLACED INTO RECEIVERSHIP.

WHILE THE DISTRICT IS MOVING IN A POSITIVE DIRECTION, AND I AM SURE WILL CONTINUE TO BUILD UPON ITS ACCOMPLISHMENTS TO DATE, MUCH IS LEFT TO BE DONE AT ALL LEVELS OF GOVERNMENT. MY PRIMARY REGRET IS THAT I WAS UNABLE TO GARNER THE APPROPRIATE LEVEL OF SUPPORT TO BRING SYSTEM CHANGE TO THE MRDDA.

THANK YOU CHAIRMAN DAVIS AND COMMITTEE MEMBERS. I AM PLEASED TO ANSWER QUESTIONS TO THE BEST OF MY ABILITY AND KNOWLEDGE AT THIS TIME.

Chairman TOM DAVIS. Thank you very much.

Mr. Gettings.

STATEMENT OF ROBERT M. GETTINGS

Mr. GETTINGS. Thank you, Mr. Chairman.

Mr. Chairman, my name is Bob Gettings, and I am the executive director of the National Association of State Directors of Developmental Disabilities Services, an organization that represents public developmental disabilities agencies in the 50 States and the District of Columbia.

I come before you today to discuss my observations concerning the prerequisites of an effectively managed service delivery system for persons with developmental disabilities. In drawing together these observations, I draw upon 40 years of experience in working with State and local disability officials to improve services to this population.

You have already heard from the previous witnesses some of the issues that are faced. I just want to bring it back to this level. Two of the foundational rules of public administration are that authority must be commensurate with responsibility and public servants must be held accountable for their performance. I'm pleased to hear from Mr. Bobb and Ms. Walker that the District is committed to changing some of the issues, but the truth is that is not the way in which—and these rules have not been followed in the past.

The Mental Retardation and Developmental Disabilities Administration is responsible under the city code for delivering high quality services to eligible individuals, but because the city is highly reliant, as all 50 States are reliant, on Medicaid as a funding source, the funding of services are divided between MRDDA and the Medical Assistance Administration, which is the single State Medicaid agency in the District. As a consequence, funding an administrative authority for the city's services are not carried out in a unified manner.

I think that—and I want to stress that Federal Medicaid regulations allow States, to administer programs in a unified way. In the District of Columbia prompt steps need to be taken to develop an effective interagency agreement between the Medical Assistance Administration and MRDDA, governing the management of Medicaid dollars that support specialized long-term services for persons with developmental disabilities.

A central aim of this agreement should be to assign clear, unambiguous authority to MRDDA to manage services in a unified manner. That means pulling together all specialized services, whether they're derived from Medicaid or non-Medicaid sources. I think you said it well in your opening statement, Mr. Chairman, there needs to be a single point of responsibility and accountability within city government for assuring that services in this population work.

Unlike most jurisdictions, the District continues to rely heavily on the ICFMR service model as its primary method of drawing down Medicaid assistance. Over 60 percent of the budget for services in fiscal year 1994 went to payments for ICFMR services, and only 3 percent went to the home and community-based waiver program.

You've heard from the previous witnesses a commitment to make the home and community-based service system work. The home and community-based waiver program has been in existence since 1998, and I think we're still waiting for those kinds of changes.

At the moment, the District operates one of the smallest MRDDA waiver programs in the Nation. Expanding and improving the District's waiver program would not only open a variety of new financing options, but also allow city officials to claim Federal financial participation in the cost of existing services to Title XIX eligible persons that are currently being funded fully through city revenues. This potentially could add $30 to $35 million in additional Federal payments that could be deployed to improve some of the weaknesses in the existing city infrastructure.

The District really needs to move aggressively to improve the home and community-based waiver program, but I just would stress with you that unless existing lines of responsibility and accountability are clarified and a single District official is charged with assuring that this task is successfully and expeditiously completed, recent history strongly suggests that the waiver renewal process will remain mired in a sea of bureaucratic infighting.

I want to stress as well that in the 2001 compliance plan MRDDA is responsible for developing a comprehensive quality management program, yet at the current time the responsibility for monitoring and complying with city rules currently rests with the Health Regulation Administration within the Department of Health. Because of this division of responsibility and because of the lack of effective interagency coordination, provider agencies often receive mixed signals about where their emphasis should lie. There is an urgent need for the District government to develop a global plan for monitoring and improving the quality of services.

Within the next 10 months, the city will be responsible for submitting waiver renewal requests to the Centers for Medicare and Medicaid Services. That request will have to include a comprehensive quality management plan, which is now a new requirement of CMS. That's going to take a lot of work. That's an area that needs to be given attention.

Faced with the catastrophic consequences of the city's past failure to protect its most vulnerable citizens from harm, there is, I think, an understandable tendency on everybody's part to grasp for quick solutions. Certainly anyone familiar with the current problems facing the District's DD service system has to acknowledge the need for prompt, corrective actions, and a sense of urgency in implementing them. Immediate steps to stabilize the situation, however, need to be linked to a broader set of systemic change strategies aimed at improving the District government's capacity to effectively manage services for individuals with disabilities over the long haul.

One of the central lessons that can be drawn from the sad history of the Evans litigation, and indeed from similar class action lawsuits across the country, is that deep-seated systemic failures won't be resolved by a series of quick overnight fixes. The service

system needs to be rebuilt from the bottom up, and that requires commitment and sustained leadership from government officials at all levels, especially top elected and appointed officials.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Gettings follows:]

Statement of Testimony

Disabled Services in the District of Columbia:
Who is Protecting the Rights of D.C.'s Most Vulnerable Residents?

Robert M. Gettings
Executive Director
National Association of State Directors
of Developmental Disabilities Services, Inc.

Presented before the

The Committee on Government Reform
U.S. House of Representatives

June 16, 2006

Thank you, Mr. Chairman. My name is Bob Gettings. I am the Executive Director of the National Association of State Directors of Developmental Disabilities Services. In that capacity, I am responsible for assisting developmental disabilities agencies in the fifty states and the District of Columbia to expand and improve publicly funded long-term supports for individuals with mental retardation and other lifelong disabilities. The mission of NASDDDS is to assist member state agencies to develop effective and efficient service delivery systems that furnish high-quality services to persons with developmental disabilities.

I also serve in a voluntary capacity as a member of the Board of Directors of the Quality Trust for Individuals with Disabilities, an independent, nonprofit organization created as part of the 2001 Compliance Plan in the ***Evans*** class action lawsuit. The mission of the Quality Trust is to advance the individual and collective interests of residents of the District of Columbia with developmental disabilities as well as their family members and friends.

I do not appear before you today as an official representative of NASDDDS, or as a spokesperson for the Quality Trust. Instead, I've been asked to share with you my personal observations concerning the principal characteristics of an effectively managed service delivery system for persons with developmental disabilities. These observations are drawn from over 40 years of experience in working with state and local officials to improve services to this population.

The Changing Management Environment.

When I began my career in the early 1960s, the limited public services then available to children and adults with mental retardation were furnished almost exclusively in large, severely over-crowded state institutions, many of which were located in isolated rural communities. Services – such as they were – were furnished by state employees, under the direct supervision on-site managers. With the exception of a few, scattered day care centers operated mainly by local parent organizations, there were virtually no community services provided outside of public school special education classes, which in many communities refused to serve youngsters with severe disabilities.

The situation has changed dramatically over the intervening decades. The number of individuals residing in state-run institutions plummeted from over 200,000 in the early 1970s to 42,514 in 2004.[1] Meanwhile, the number of persons receiving specialized community DD services has climbed to over 750,000. Eighty percent of the $38.55 billion the states expended, collectively, on specialized DD services in 2004 financed community services,[2] most of which were managed by private sector agencies.[3]

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[1] Bruninks, Robert, et. al., ***Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2004***, Research and Training Center on Community Living, Institute on Community Integration, University of Minnesota/Minneapolis, July 2005, page 8.

[2] Braddock, David, ***State of the States in Developmental Disabilities: 2005***, American Association on Mental Retardation: Washington, D.C., 2005, page 8.

[3] Bruninks, et al. report that, as of June 30, 2004, of the 420,202 persons receiving residential services, 87.1 percent were been served in non-state operated settings; and, if you focus on persons living in settings for one to six

I point these changes out simply to underscore the fact that the task of managing public developmental disabilities service systems is much different today than it was 20 or 30 years ago. The skills it takes to directly administer a public facility, staffed by state workers, are not the same as the skills required to negotiate and oversee the performance of a widely dispersed network of contractual services furnished through private vendor agencies. In the present environment, government must assume responsible for steering, rather than rowing, the ship of state, to draw upon the image popularized by Osborne and Gaebler in the early 1990s.[4] States that have successfully navigated the transition to a privately managed DD service system have hired public managers with the necessary skills to ensure that vendor agencies are qualified to perform their assigned functions and then systematically monitored and held accountable for their performance. Drawing upon the experiences of these states, let me share with the Committee my observations concerning the critical issues that need to be addressed in order to improve the management of developmental disabilities services in the District of Columbia.

Fixing Accountability and Responsibility for District DD Services.

Two of the foundational rules of public administration are that: (a) authority must be commensurate with responsibility; and (b) public servants must be held accountable for their performance. At present, neither of these rules is consistently followed in the management of the city's services to individuals with developmental disabilities. Under the District code, the Department of Human Services, acting through the Mental Retardation and Developmental Disabilities Administration (MRDDA), is responsibility for assuring that services are provided to eligible individuals and that such services are furnished in an effective and efficient manner. But, because the city, like all 50 states, relies heavily on federal-state Medicaid dollars to finance specialized DD services, the bulk of service funding is channeled through the budget of the Medical Assistance Administration (MAA) in the D.C. Department of Health, which functions as the District's single state Medicaid agency (SSMA). As a consequence, funding and managerial authority for the city's DD services are divided between the budgets of two departments, making it difficult to develop and carry out a unified approach to serving individuals with developmental disabilities.

Federal regulations (42 CFR 431.10) assign to the single state Medicaid agency (SSMA) responsibility for ensuring that all Title XIX-funded services comply with applicable federal regulations. But, federal rules also permit the SSMA to enter into interagency agreements with other agencies of state government, as long as it retains authority to: "...(i) [e]xercise administrative discretion in the administration or supervision of the [state Medicaid] plan;" and to "... (ii) [i]ssue policies, rules and regulations on program matters."[5] Over the years, most states have consolidated day-to-day responsibility for managing Medicaid-funded and non-

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individuals (the most rapidly growing out-of-home living settings), 98.1 percent live in non state settings. Ibid, page 63.

[4] Osborne, David and Ted Gaebler, ***Reinventing Government: How the Entrepreneurial Spirit is Transforming the Public Sector***, Penguin Books, USA: New York, NY, 1993.

[5] 42 CFR 431.10(e)(1).

Medicaid-funded services to individuals with developmental disabilities within the state MR/DD agency. Consistent with federal Medicaid policies, these arrangements are carried out in accordance with an interagency agreement between the SSMA and the state MR/DD authority that spell out the methods to be used to ensure that the single state Medicaid agency retains effective oversight of all applicable Title XIX-funded services. The Centers for Medicare and Medicaid Services (CMS), the agency responsible for administering the Medicaid program at the federal level, has repeatedly approved such interagency agreements, recognizing "... that it may be more efficient and effective for a state" to manage services in this manner.[6] A 2002 survey commissioned by CMS, in fact, found that day-to-day management of Medicaid-funded home and community-based waiver services to persons with developmental disabilities was assigned to the state MR/DD agency in two-thirds of the states.[7]

In the District of Columbia, prompt steps need to be taken to develop an effective interagency agreement between MAA/DoH and MRDDA/DHS governing the management of Medicaid dollars that support services for persons with developmental disabilities. This agreement should **mandate the development and management of a unified budget for specialized DD services** within the District government. This unified budget should encompasses all sources of Medicaid and non-Medicaid funding, including both city matching dollars and anticipated federal payments for ICF/DD, targeted case management, and home and community-based waiver services. Consistent with the dictates of federal Medicaid policy regarding the rule-making and state plan oversight responsibilities of MAA/DoH, **the central aim of this interagency agreement should be to assign clear, unambiguous authority to MRDDA to manage all specialized developmental disabilities services offered by the city in a unified manner, regardless of the source of revenue**. As the experiences of many other states have demonstrated, the consolidation of program and fiscal authority is an essential prerequisite to effectively managing services to this population.

At the present time, MRDDA has nominal authority to manage the city's DD waiver program under an interagency agreement between MRDDA and MAA. But, in practice, control of the waiver budget as well as the development and issuance of waiver management policies still rests with MAA, and past efforts to modify those policies have resulted in excruciatingly long and often fruitless interagency negotiations. For example, staff from MRDDA and MAA's Office of Aging and Disability began meeting over a year ago, with the stated aim of modifying several key features of the city's DD waiver program that prevent the financing of more flexible and responsive services for eligible individuals. Yet, despite the development of detailed recommendations by a specially constituted task force, the two agencies appear to be no closer today to resolving their differences and modifying the existing waiver rules than they were when the negotiations began.

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[6] See Appendix A, ***Instructions, Technical Guide and Review Criteria, Application for a Section 1915(c) Home and Community-Based Waiver*** (Version 3.3), November 2005, pages 63-66.

Modernizing the City's Approach to Financing and Delivering Services.

As Forest Haven, the city's only institution for persons with mental retardation was downsized and eventually closed in 1990, District officials decided to open a network of privately run group homes to accommodate former facility residents. The city's aim at the time was to provide former Forest Haven residents with a more home-like living environment, while at the same time off-setting federal Medicaid revenues that otherwise would have been lost by certifying these group homes as intermediate care facilities for persons with mental retardation (ICFs/MR). Unlike most jurisdictions, however, the District continues to rely on the ICF/MR service model as its primary method of drawing down federal revenue to support DD services. In FY 2004, the District Government spent $187.5 million on specialized services for persons with developmental disabilities. HCB waiver expenditures totaled $11.9 million, or about 3 percent of the city's total DD spending. The balance was spent on reimbursements to ICF/DD facilities (59.5% of the total, or $111.5 million), day habilitation services (13.2%, or $24.8 million) targeted case management services ($20.3 million, or 10.8%) and unmatched city general revenue expenditure ($26.3 million, or 14%).[8]

Over the past fifteen years, most states have adopted the Section 1915(c) waiver authority as their primary vehicle to claim federal Medicaid reimbursement for DD community services. As of June 30, 2004, more than four times as many individuals were receiving HCB waiver services (424,855) as were residing in public and privately operated ICF/MR facilities. Only ten years, earlier more individuals were being served in ICF/MR facilities (142,118) than were enrolled in HCB waiver services (122,075). As of June 30, 2004, only about one out of ten individuals (11.6%) who were living in small community residences (serving 1 to 15 individuals) were residing in an ICF/MR-certified facility.[9] In sharp contrast to this pattern, the overwhelming majority of individuals who were receiving Medicaid-funded out-of-home residential services at the time were living in community-based ICF/MR facilities.

Among the primary reasons most states have elected to finance services through the Medicaid HCBS waiver authority is that it:

- ✓ Affords them far greater latitude in tailoring support strategies to the individual needs and preferences of each participant and his or her family, thus allowing consumers to choose from a wider range of support options;
- ✓ Represents a generally more economical approach to organizing and delivering services since states are not obligated to provide 24-hour, wrap-around supports to all recipients, as they are under the ICF/MR model.[10]

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[8] Braddock, Ibid, pages 102-3.

[9] Lakin, Ibid, pp. viii-ix.

[10] The average per capita cost of ICF/MR services in the U.S. in 2004 was $114,132; whereas, the average per capita costs of HCB waiver service ran $36,497. The contrast was even sharper in the District of Columbia, with the average per capita cost of ICF/MR services running $108,105 in 2004, compared to an average per participant cost for HCB waivers services of $14,796 per annum [Lakin, Ibid, pp. 96 and 103].

- ✓ Allows states to qualify a much wider range of services and supports for federal reimbursement since residence in a particular type of living environment (an ICF/MR-certified facility serving four or more unrelated individuals) is not a prerequisite for the receipt of federal Medicaid payments;

- ✓ It makes benefits far more portable so that a recipient's place of residence and support plan can be more easily altered as his/her needs and preference change; and

- ✓ Permits states to offer self- and family-directed support options, an approach strongly favored by a growing number of waiver participants and their families.

In order to develop a programmatically and fiscally sustainable program for serving city residents with mental retardation and other developmental disabilities, **District officials must move aggressively to create a Medicaid home and community-based MR/DD waiver program that functions effectively**. In 1998, D.C. became the last jurisdiction in the nation to receive CMS approval to operate a home and community-based waiver program for this general target population; and, it still operates one of the smallest MR/DD waiver programs, relative to the overall size of a state's DD budget, in the country. The plaintiffs in the ***Evans*** lawsuit, with the strong backing of the federal court, have been pressing city officials to restructure and expand HCB waiver services for the past several years, with limited success.

There are no secrets to fashioning an effective HCBS waiver program; indeed, there are abundant examples of effective operational designs available simply by drawing upon the experiences of other states. Advice from outside experts may expedite the process of re-designing the District's existing waiver program. But, as I emphasized earlier, **unless existing lines of responsibility and accountability are clarified and a single District official is assigned the authority necessary to ensure that the task is successfully and expeditiously completed, recent history strongly suggests that the waiver renewal process will remain mired in a sea of bureaucratic infighting**. In the past, the District Government has commissioned several analyses of the city's MR/DD waiver program and received thoughtful recommendations on how it might be restructuring to improve participation level and expand access to needed benefits. Yet, none of those recommendations have been implemented thus far and the reports continue to gather dust on government bookshelves.

A well-designed waiver program alone, however, will not necessarily trigger substantial reforms in service delivery practice. Lacking a clear strategy for reallocating expenditures between major spending categories as they presently exist, the growth in waiver services will be dependent on the availability of new city matching dollars (which are in short support at the moment) to draw down additional federal payments for services covered under a revamped waiver program. **What's needed is a global plan or blueprint for restructuring the financing and delivery of ALL specialized DD services along more flexible, consumer-centered lines, of which the steps necessary to redesign the waiver program becomes an integral but subordinate part of the overall strategy**. Planning changes in the waiver program in isolation from a strategy for offering ICF/DD residents, CRF residents and center-based day habilitation participants expanded opportunities to live independent, productive lives in the community will only perpetuate the fragmented planning and policy development that has long plagued the city's DD

service system. Other states, for example, have developed bridge funding strategies to assist community provider agencies to transition persons from ICF/MR facilities to move personalized and integrated community living arrangement of their choice. The District of Columbia should consider employing a similar strategy. Similar steps can and should be taken to shift participants from segregated day habilitation centers and sheltered workshops to integrated support employment programs financed through the HCBS waiver program.

Creating an Effective Quality Oversight and Improvement System.

The 2001 Compliance Plan in the ***Evans*** lawsuit calls for MRDDA to develop a comprehensive quality management program to ensure that all members of the class are safe, healthy and receive the habilitation and support services specified in their individual service plans. Yet, primary responsibility for monitoring compliance with city rules currently rests with the Health Regulation Administration (HRA), located in the D.C. Department of Health. HRA is responsible for licensing all residential and daytime settings where DD services are furnished as well as for certifying all providers of Medicaid-funded services, including services furnished in ICF/DD-certified group homes, Community Residential Facilities and day service programs that participate in the city's DD waiver programs. Because of this division of responsibility and the absence of effective interagency cooperation between MRDDA and HRA, private provider agencies often receive mixed signal from the two agencies on where the emphasis should be placed in developing and delivering services to persons with developmental disabilities. Provider agencies have long complained that HRA's licensing requirements and reviews focus primarily on the maintenance of the physical plant, largely ignoring in the process the quality and appropriateness of the habilitation services being furnished to facility residents and day program participants. Meanwhile, as dramatically documented in evidence presented to the federal district court over recent years, the limited quality oversight programs initiated by MRDDA (especially its incident reporting and mortality review programs) often have proven to be ineffective in shielding recipients of city services from harm. Nor, have District officials been able to articulate a clear strategy for assuring that existing monitoring and oversight activities are carry out in a coordinated manner that adheres to a common set of goals, objectives and operating practices.

As with service financing arrangements, **there is an urgent need for the District Government to develop a global plan for monitoring and improving the quality of services and supports to city residents with developmental disabilities**. Within the next seven months, the city will have to submit to CMS a request to renew its DD waiver program, which is scheduled to expire in the fall of 2007. Within the past two weeks, the city has retained an outside consulting firm to assist MAA and MRDDA officials in preparing a waiver renewal request; but, as I suggested earlier, there are numerous, long-standing issues that will need to be resolved before the District Government can prepare and submit a request that is likely to be approved by CMS. One of the issues that must be confronted is the design and implementation of a comprehensive quality management program.

Over the past two years, CMS has substantially revamped the process it expects states to use in preparing and submitting Section 1915(c) waiver applications. These changes are incorporated in a new waiver application template that was released in the fall of 2005. The centerpiece of CMS' new waiver application is a requirement that states describe and be prepared to carry out a

comprehensive quality management program.[11] A state's quality management program must address a minimum array of design elements that are set forth in CMS' Quality Framework and, of at least equal importance, a state must be able to demonstrate that it has the capacity to not only identify sub-standard conditions and sub-par services but also to institute targeted improvement strategies at both an individual and systems level to rectify such problems once they are uncovered. Given the District Government's dismal record of addressing even the most egregious, life-threatening deficiencies in the quality of care, the preparation and implementation of a credible quality management plan represents a major challenge. This task, therefore, should be assigned very high priority if the District Government expects to receive approval of its DD waiver renewal request.

Fixing the Existing Case Management System.

Case managers or service coordinators, as they often called, act as an essential linchpin in any well-designed, effectively managed community service system for people with developmental disabilities. Positioned on the frontlines of the service delivery system, case managers serve as the eyes and ears of the system: safeguarding the interests of persons on their caseload and advocating on their behalf for more and better services; coordinating the development of individual, person-centered service plans; helping individuals and families to access needed specialized and generic services; negotiating needed modifications in services and supports with responsible providers; and identifying emerging problems before they blossom into major concerns.

Largely as a result of court intervention, MRDDA has one of the most favorable case manager-to-client caseload ratios in the nation, especially for members of the ***Evans*** class. Yet, the performance of the city's case management system has been poor for many years, according to all available reports. The Court Monitor in the ***Evans*** case, for example, has repeatedly documented the system's failure to meet even the most fundamental expectations spelled out in the 2001 Evans Compliance Plan. It seems clear that, if city services for people with developmental disabilities are to improve, **assertive steps will need to be taken to substantially upgrade the performance of MRDDA's case management staff**. To achieve such improvements, it will be necessary to: (a) appoint a strong, knowledgeable leader to head up MRDDA's case management operations; (b) establish more and better training opportunities for case managers; (c) strengthen the supervision of District case managers; (d) institute a performance monitoring system for case managers that is modeled after the approaches that some states have had in place for years; and (d) hold individual case managers directly accountable for their performance.

If after careful analysis city officials conclude that it is not possible to institute the recommended changes in policy and practice within the structure of the District's personnel system, consideration should be given to out-sourcing the provision of case manager services to a private contract agency. Should the District decide to privatize case management services, however, it will be essential to retained within MRDDA the capacity to monitor the performance of the case

[11] See Appendix H (Quality Management Strategy) in ***Application for a Section 1915(c) Home and Community Waiver***, Centers for Medicare and Medicaid Services, October 2005 and Appendix G of ***Instructions, Technical Guide and Review Criteria***, Centers for Medicare and Medicaid Services, November 2005.

management agency and enforce the provisions of the vendor contract. In addition, providers of other direct DD services should be ineligible to bid on the case management contract in order to avoid potential conflicts of interest.

Concluding Thoughts.

Faced with the catastrophic consequences of the city's past failure to protect its most vulnerable citizens from harm, there is an understandable tendency to grasp for quick solutions. Certainly, anyone familiar with the current problems facing the District's DD service system must acknowledge the need for prompt corrective actions. Immediate steps to stabilize the situation, however, need to be linked to a broader set of systemic change strategies aimed at improving the city's capacity to effectively manage services for individuals with developmental disabilities over the long haul.

One central lesson that can be drawn from the sad history of the ***Evans*** litigation – and, indeed, from other, similar class action lawsuits across the country – is that deep-seated systemic failures won't be resolved by a series of quick, overnight fixes. The service system needs to be re-built from the bottom up, and that requires committed and sustained leadership from government officials at all levels – especially top level elected and appointed officials.

I have attempted to offer the Committee some insights into a few of the fundamental flaws in the District's existing MR/DD service system that lie behind the city's continued inability to protect the welfare of vulnerable citizens with lifelong disabilities. I've also tried to pinpoint several critical issues that need to be addressed as part of any attempt to improve District services to citizens with developmental disabilities.

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I want to thank you Mr. Chairman for this opportunity to share with the Committee my views on this vitally important topic. I will be happy to respond to any questions the Committee may wish to raise or amplify any of the points covered in my testimony.

Chairman TOM DAVIS. Thank you very much.

Ms. Morrison, thanks for being with us.

STATEMENT OF HOLLY MORRISON

Ms. MORRISON. Good morning, Chairman Davis and Congresswoman Norton. My name is Holly Morrison, and I'm with the Council on Quality and Leadership. I'm currently the vice president and chief administrative officer. It's a pleasure to be here this morning.

I think CQL's experience and history make us uniquely qualified to discuss performance, measurement and quality improvement for services for people with disabilities. National organizations founded CQL as a standard setting body in the field of intellectual disabilities in 1969. CQL has revised and published successive editions of its standards on a continuous basis in 1971, 1973, 1978, 1984, 1989, 1991, 1993, 1997, 2000, and again in 2005.

CQL remains a private, nonprofit organization incorporated in the District of Columbia and sponsored by the leading national organizations in the field of intellectual disabilities, including the American Association on Mental Retardation, ANCOR, which is the American Network of Community Options and Resources, the Arc, the Autism Society of America, Easter Seals, Mosaic, National Association of Qualified Mental Retardation Professionals, SABE, Self Advocates Becoming Empowered, the United Cerebral Palsy Associations, Inc.

Today, I want to focus attention on accountability rather than specific minimum standards, organizational processes or accreditation programs.

CQL and other leading national organizations in the field of intellectual disabilities define quality in terms of responsiveness to the individual in addition to compliance with regulations and organizational processes.

Compliance with standards and mandated processes provide uniform and routine performance requirements, but compliance with standards may not result in personal outcome attainment or performance improvement. Organizations must measure personal outcome attainment, and then constantly adjust standards and organizational processes to optimize outcomes.

Organizational accountability and quality performance requires outcome-based assessment. Basic assurances in the areas of health, safety, human security and legal rights require well-defined performance expectations for staff. Quality performance is linked to facilitating the outcomes that are important to the individual, to their family, to their friends, and the community that supports them.

Organizations staff professionals and families realize that each person is a unique sample of one, that each person has unique expectations for such important outcomes as best health, safety, respect, friendship and employment.

The distinction between outcome measurement and compliance with process is particularly important for service systems operating under close public scrutiny, government reform initiatives, and court oversight.

Standards and organizational processes, policy and procedure must facilitate outcomes. Public accountability, quality improvement and fiscal responsibility require the measurement of outcomes, not just compliance with minimum standards.

Finally, clear definition of outcomes provides the necessary platform for staff training and board of director education for all service providers. Board of director orientation and staff training are necessary components for organizational accountability and performance improvement.

Thank you very much.

[The prepared statement of Ms. Morrison follows:]

UNITED STATES HOUSE OF REPRESENTATIVES

Committee on Government Reform

Hearing on the Status of the District of Columbia's
Mental Retardation and Developmental Disabilities Administration (MRDDA)

Testimony of

Holly Morrison
Vice President and Chief Administrative Officer
The Council on Quality and Leadership (CQL)
100 West Road, Suite 406
Towson, MD 21204
410.583.0060
hollylneb@aol.com

June 16, 2006

Mr. Chairman, members of the House Committee on Government Reform:

My name is Holly Morrison and I am Vice President and Chief Administrative Officer of CQL (the Council on Quality and Leadership).

CQL Background

Leading professional, provider, and advocacy organizations established CQL in 1969 as the standards setting organization for services for people with intellectual disabilities (mental retardation and other developmental disabilities). CQL remains a private, non profit organization incorporated in the District of Columbia.

QCL envisions a world of dignity, opportunity, and community inclusion for all people.

The Mission of CQL is to provide leadership for greater world-wide inclusion and quality of life for people with disabilities.

CQL is sponsored by the leading national organizations in the field of intellectual disabilities. These organizations are:

- The American Association on Mental Retardation
- ANCOR (American Network of Community Options and Resources)
- The Arc
- Autism Society of America
- Easter Seals
- Mosaic
- National Association of Qualified Mental Retardation Professionals
- SABE (Self Advocates Becoming Empowered)
- United Cerebral Palsy Association, Inc

CQL Today

Today, CQL is the internationally recognized leader in the definition, measurement, and improvement of the quality of life for people with intellectual disabilities and the people, organizations, and communities who support them.

CQL provides services and supports to government, private providers, and communities in the United States, Canada, Ireland, Australia, and New Zealand.

These international services include the following:

- Design, field testing, and implementation of quality of life measures for people with disabilities and best practice guidance for organizations and communities that provide services.

- **Basic Assurances Certification** (in areas of health, safety, welfare, and rights) for individual service providers and networks of providers;
- Quality Improvement training and consultation
- Program evaluation and independent third-party monitoring (using standards and measures as required by Federal Courts, US laws and regulations, state requirement, and community mandates)
- **Certified Quality Analyst** competency based curriculum, certification, and continuing support and consultation
- Person-centered quality of life measurement, monitoring, and evaluation.
- Accreditation program that encompasses over 200 organizations in the United States, Canada, Ireland, and Australia.

CQL Standards and Quality Measures

National organizations founded CQL as the standard setting body in the field of intellectual disabilities. CQL has revised and published successive editions of its standards on a continuous bases. (1971, 1973, 1978, 1984, 1989, 1991, 1993, 1997, 2000, 2005).

These standards have regularly been incorporated into federal and state litigation and legislation:

- CQL Standards were incorporated in the Federal Medicaid Intermediate Care Facility for the Mentally Retarded program in 1973, 1984, and 1988 standard and regulations revisions
- CQL Standards were incorporated in the historic 1973 Partlow (Wyatt v Stickney) decision
- The requirement of CQL standards has been included in Federal Court Settlements such as Lelsz v. Cavanaugh in Texas and Arc v. North Dakota. The Pratt Decree in the District of Columbia required compliance with CQL Habilitation standards.
- State licensing standards since the late 1990s have routinely included a requirement for person-centered quality of life planning and measurement modeled after CQL's editions of its ***Personal Outcome Measures*** published in 1993, 1997, 2000, and 2005.

CQL maintains the highest standards for its own standards and quality measures. Since 1991 CQL has led the world in the design and development of person focused measures of quality (quality as defined by people and families receiving services and supports).

CQL requires all quality review and measurement staff to demonstrate a minimum .85 level of inter-rater reliability in the use of its quality measures as a condition for employment and continued employment.

CQL has demonstrated the scientific validity and reliability of its measures in its publications in the peer-reviewed journals *Mental Retardation* and *International Review of Research in Mental Retardation.*

Performance Measurement and Quality Improvement

Organizational accountability and quality performance requires outcome based performance assessment. Basic assurances in the areas of health, safety, human security and legal rights require well defined performance expectations for staff.

CQL defines, measures, and improves organizational quality performance through person centered outcome measures. Quality performance is linked to facilitating the outcomes that are important to the individual, their family, friends, and community supports.
Organizations, staff, professionals, and families realize that each person is a unique sample of one -- that each person has unique expectations for such important outcomes as best health, safety, respect, friendship, and employment.

Thus CQL and other leading national organizations in the field of intellectual disabilities define quality in terms of responsiveness to the individual in addition to compliance with regulations and organizational process.

This distinction between outcome measurement and compliance with process is particularly important for service systems operating under close public scrutiny, government reform initiatives, and court oversight.

Standards and organizational processes, policy, and procedure must facilitate outcomes. Public accountability, quality improvement, and fiscal responsibility require the measurement of outcomes.

Finally, clear definition of outcomes provides the necessary platform for staff training and board of director education for all service providers. Board of director orientation and staff training are necessary components for organizational accountability and performance improvement.

Compliance with standards and mandated processes provide uniform and routine performance requirements. But, compliance with standards may not result in personal outcome attainment or performance improvement. Organizations must measure personal outcome attainment and then constantly adjust standards and organizational processes to optimize outcomes.

Chairman TOM DAVIS. Thank you very much.

Ms. Campanella.

STATEMENT OF TINA M. CAMPANELLA

Ms. CAMPANELLA. Good morning, Chairman Davis.

My name is Tina Campanella, and I am the executive director of Quality Trust for Individuals with Disabilities, an independent nonprofit advocacy organization for people with developmental disabilities in the District of Columbia. Thank you for this opportunity to testify.

Our organization is a product of the 2001 settlement agreement in the *Evans* v. *Williams* class action lawsuit and was created to represent all citizens with developmental disabilities in D.C., not only the 665 Evans class members.

The situation for people with developmental disabilities in D.C. is very troubling. The current structure and framework for services is not working well at all. The critical question is how to make fundamental changes in the organization and operation of the service system. Quality trust issues are advocacy experience to inform our recommendations for change. I have included with my testimony a 4-page working document that describes the broad changes we feel are needed within the D.C. service system to make services responsive to the needs of the people it supports.

While we recognize and commend the efforts of the D.C. City Council Humans Services Committee Chair Adrian Fenty and Deputy Mayor Brenda Donald Walker, it is important to underscore that the D.C. service system cannot be improved without bold and dramatic action. The difficulties extend well beyond the individual appointed as administrator. The fragmented structure of the administration, funding and enforcement functions is at the root of problems with performance and accountability.

Our recommendations target essential elements of a functional system. These recommended actions will not fix the situation quickly, but they will advance the dialog about how to bring greater accountability to the administration, funding and oversight of services and supports to people. Some of these issues have already been mentioned so I won't go into detail here.

Obviously we need a comprehensive plan to manage the dollars that will be coming into the city to fund services to the Medicaid program, and that needs to cross over agency lines. The waiver application has also been made as a recommendation and a priority for many people, and we agree that must be made a primary priority.

Additionally, a coordinated strategy to ensure that providers enter the system with prerequisite qualifications, and that performance over time is tracked to identify areas where difficulties are encountered as needed.

The functions for licensing, certification and quality monitoring now spread over MRDDA and the Department of Health Regulatory Agency need to be linked and closely coordinated, and again, as you have heard, preferably with one agency taking the lead.

Case management again is a serious issue. We believe it needs to be grounded in the tradition of individual advocacy and support

for people's right to create lifestyles of their own choosing to the greatest extent possible.

An additional issue is that D.C. law provides that all individuals who are receiving residential services are entitled to an advocate. The structure in process in D.C. to meet this requirement is part of the D.C. Supreme Court Family Division. This function has not been implemented as envisioned, and it has no dedicated funding. Funding for this function has been included in the current budget request, and we believe must be funded.

And finally, funds and efforts should be devoted to developing a strategy for working together with families and providing support to people in their family home. In-home family supports provide an important alternative to group living arrangements and need to be part of D.C.'s long-term strategy for services and supports. The framework for funding exists, but will remain unused without specific efforts to develop the provider capacity needed to develop this support.

We are encouraged that D.C. has secured assistance from Ms. Cathy Sawyer. We are mindful, however, that these problems that she faces are substantial and cannot be fixed overnight through policy development and planning.

The solution requires everyone to remain clearly focused on the immediate planning and intervention needed to provide adequate and reliable supports for people today, while at the same time designing and implementing the structure and capacity needed for the future.

Further, we see great urgency to move forward quickly to ensure people with developmental disabilities are protected from any additional harm as they are supported to live full and productive lives.

Thank you again for the opportunity to testify, and I will be happy to answer any questions.

[The prepared statement of Ms. Campanella follows:]

5335 WISCONSIN AVE NW | SUITE 825 | WASHINGTON, DC 20015 | (202) 448-1450 | (202) 448-1451 FAX
WWW.DCQUALITYTRUST.ORG

Powering Change
Through Partnership

TESTIMONY OF TINA CAMPANELLA, EXECUTIVE DIRECTOR
QUALITY TRUST FOR INDIVIDUALS WITH DISABILITIES, INC.

DISTRICT OF COLUMBIA

RE: SERVICES AND SUPPORTS FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES IN THE DISCTRIC OF COLUMBIA

COMMITTEE ON GOVERNMENT REFORM
US HOUSE OF REPRESENTATIVES

REPRESENTATIVE THOMAS M. DAVIS
CHAIRPERSON

Friday June 16, 2006

Good morning Chairman Davis and members of the Committee. My name is Tina Campanella and I am the Executive Director of Quality Trust for Individuals with Disabilities, an independent nonprofit advocacy organization for people with developmental disabilities in the District of Columbia (DC). Thank you for this opportunity to testify before the Committee on Government Reform. Quality Trust exists to advance the interests of people with developmental disabilities in DC. Our organization is a product of the 2001 Settlement Agreement in the Evans v. Williams class action lawsuit. We represent all citizens with developmental disabilities in DC, not only the 665 Evans class members. An important part of our role is to ensure there is an independent voice for people with developmental disabilities in the DC.

The situation for people with developmental disabilities in DC is very troubling. The current structure and framework for services is not working well at all. The Mental Retardation and Developmental Disabilities Administration (MRDDA) is poised on the verge of receivership. The current MRDD waiver is due to expire in the fall of 2007 and without serious efforts to develop a viable and comprehensive plan for services funded through the waiver that addresses the increased national expectations for performance and quality, it is conceivable

that the federal government may not renew the city's 1915(c) Home and Community Based Services (HCBS) waiver.

Our efforts in day to day action and testimony before the DC City Council have focused on how to address both the pressing and immediate needs of people supported by MRDDA as well as the persistent structural problems that have plagued this agency. While Forrest Haven was closed in 1991, the community system created and still in existence today relies heavily on the same program and funding structures used at the institution – the Intermediate Care Facilities for People with Mental Retardation (ICF's/MR). The Home & Community Based Services (HCBS) Waiver program that exists to fund community based alternatives to Intermediate Care Facilities for People with Mental Retardation (ICF's/MR) has been underutilized. The critical question is how to make fundamental changes in the organization and operation of the service system. Quality Trust has used our advocacy experience to inform our recommendations for change. I have included with my testimony a four page working document that describes the broad changes needed within the DC service system to make services responsive to the needs of the people it supports.

We want to commend Councilmember Adrian Fenty, chair of the DC City Council Human Services Committee for his leadership and focus on accountability. I would also like to recognize the efforts of Deputy Mayor Brenda Donald Walker. Following her appointment in November 2005, she immediately began identifying ways to improve the system.

The DC system cannot be improved without bold and dramatic change. The difficulties extend well beyond the individual appointed as administrator. The fragmented structure of the administration, funding and enforcement functions is at the root of problems with performance and accountability. We experience this directly through our advocacy work, and have documented it in our report, "In Search Of Real Lives and Real Choice". In one instance not included in our report, a QT advocate worked with a woman who was living in an apartment dilapidated to the point of being a health risk. Despite intense efforts by the advocate and personal intervention from the court monitor and the Administrator of MRDDA it took nearly seven months to successfully transition this woman into a new living arrangement.

Our recommendations target essential elements of a functional system. These recommended actions will not fix the situation quickly, but they will advance the dialogue about how to bring greater accountability to the administration, funding, and oversight of services and supports to people with developmental disabilities. We highlight the following issues as critical starting points for fundamental change:

- A comprehensive plan to manage Medicaid dollars from all relevant funding options such as HCBS waiver and ICFs/MR funding and to

coordinate functions between MRDDA and the Medical Assistance Administration (MAA) is essential. Waiver funding currently represents less than 7% of Medicaid outlays on behalf of people using MRDD services in the city. The city must transition dollars spent supporting people in ICFs/MR into more integrated community services financed through the HCBS waiver program.

- Preparing the waiver application due to the CMS in spring 2007 must be a priority. We understand that the city has recently secured the assistance it needs to ensure that this task is completed. We will continue to emphasize and advocate for the meaningful involvement of people with disabilities, their families and advocates as well as other key stakeholders in this process. We look forward to working with the city on this effort.

- A coordinated strategy to ensure that providers enter the system with prerequisite qualifications and that performance over time is tracked to identify areas where difficulties are encountered is needed. Responsibilities for licensing, certification and quality monitoring now spread between MRDDA and the Department of Health through its Health Regulatory Agency (HRA) need to be linked and closely coordinated, preferably with one agency taking the lead. Any restructuring needs to ensure that MRDDA has adequate input into these functions as well as access to and control of information and cumulative data. As noted before, the city risks not qualifying for renewal of its DD waiver program unless it is able to articulate a coordinated quality management strategy that is consistent with the Center for Medicaid and Medicare Services "Quality Framework" required in the new HCBS waiver application template.

- Ensure case management practice is grounded in a tradition of individual advocacy and support for people's right to create lifestyles of their own choosing to the greatest extent possible. Case Managers need to actively pursue whatever it takes to provide individualized supports while assuring that standards for quality are met.

- According to D.C. Law (D.C. Code § 7-1304.13(a)) all individuals who are receiving residential services (committed or admitted) are entitled to an advocate. The structure and process in D.C. to meet this requirement is known as the District of Columbia Mental Retardation Volunteer Advocates Association, Inc. (DCMRVAA) and is part of the DC Superior Court, Family Division. This function has not been implemented as envisioned as it has no dedicated funding. Funding for this function has been included in the current budget request and must be funded.

- Finally, funds and efforts should be devoted to developing a strategy for working together with families and providing support to people in their

family home. In-home family supports provide an important alternative to group living arrangements and need to be part of DC's long term strategy for services and supports. The framework for funding exists but will remain unused without specific efforts to develop the provider capacity needed to deliver this type of support.

We are encouraged that DC has secured assistance from Ms. Kathy Sawyer, an experience administrator within solid expertise in this area. However, we are mindful that these problems are substantial and cannot be fixed overnight through policy development and planning. Further, there is great urgency to move forward quickly to ensure people with developmental disabilities are protected from any additional harm and supported to live full and productive lives. A solution requires everyone to remain clearly focused on the immediate planning and intervention needed to provide adequate and reliable supports for people **today** while designing and implementing the structure and capacity needed for the future. In our advocacy role we are committed to working with the city administrator, Deputy Mayor Brenda Donald Walker and staff of MRDDA to ensure people get the supports and services they need.

Thank you again for the opportunity to testify and I will be happy to answer questions.

Contact Information:

Tina Campanella
Executive Director
Quality Trust for Individuals with Disabilities
5335 Wisconsin Avenue, NW, Suite 825
Washington, DC 20015
(202) 448-1442 Direct
(202) 448-1451 Fax
www.dcqualitytrust.org

Quality Trust
FOR INDIVIDUALS WITH DISABILITIES

5335 WISCONSIN AVE NW | SUITE 825 | WASHINGTON, DC 20015 | (202) 448-1450 | (202) 448-1451 FAX
WWW.DCQUALITYTRUST.ORG

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DRAFT

Initial Steps toward a Functional Developmental Disabilities Service System in DC

Background

In 2003, Quality Trust for Individuals with Disabilities initiated a project designed to demonstrate how people with developmental disabilities, living in Washington, DC, might experience more integrated and fulfilling lives. This project focused in on the specific needs of five (5) individuals with developmental disabilities supported by the Mental Retardation and Developmental Disabilities Administration (MRDDA) in the District of Columbia (DC). The lessons learned from involvement in the lives of these five people resulted in a project report, *"In Search of Real Choice and Real Lives"* which presented project conclusions and comprehensive recommendations for reform within the DC service system.

After the project report was released in January 2006, Quality Trust continued to focus its attention on defining the broad changes needed within the service system to make services responsive to the needs of the people it supports. From our advocacy experience and the recent reports filed by Court Monitor in the *Evans v. Williams* litigation, it is clear that the current system is not working and that improvements in system performance will not occur without significant and fundamental change. The city needs to make a firm break with the service traditions of the past and address the many serious challenges it faces with bold and decisive action. The specific steps proposed here represent immediate, specific short-term actions that can be taken to begin the process toward reform. It is important to remember however, that these steps outline just the beginning of a longer range strategy for broad based, systemic change.

Recommended Action Steps

1. Ensure a clear focus on the people being supported in legislation, policy and practice.

Supports and services must be grounded in principles that (a) recognize family and individual competence; (b) promote self-determination and living, working and attending school in the least restrictive living environment as basic rights of all people with developmental disabilities and (c) endorse individual choice. These foundational principles on which DC can build a framework for services should appear in both

legislation and administrative policies. New legislation is needed to replace the current statutory foundation for services known as the "Mentally Retarded Citizens Constitutional Rights and Dignity Act of 1978".

Once published, the statement of principles must be imbedded in practice. Central to reform will be replacing the congregate, program models and approaches reflected in the 1978 law with more individualized, person-centered approaches to supports and financing. Specific plans for supporting providers (both programmatically and fiscally) will be needed to facilitate the transition to the individually designed and person directed support approach.

2. Unify responsibility for all aspects of service administration with authority to cut across agency and departmental distinctions.

Bringing together in one District agency the responsibilities for planning, implementing, administering and financing services and supports for people with developmental disabilities is crucial to fixing what ails our service delivery "system". As it now stands, relative to Medicaid funding, MRDDA is responsible for the design and implementation of supports for people with developmental disabilities and the Medical Assistance Administration (MAA), within the Department of Health (DOH), manages and controls funding for those supports. This simply does not work. A comprehensive agreement between MAA and MRDDA that details how Medicaid long-term service dollars will be managed on behalf of people with developmental disabilities is needed. Centralizing accountability is essential to resolving the barriers that have impeded progress for so long.

The administrative arrangement we propose has ample precedents. Indeed, a 2002 survey commissioned by the federal Centers for Medicare and Medicaid Services (CMS) found that in two-thirds of the states day-to-day management of Medicaid MR/DD ICF/DD and waiver services had been delegated to the state MR/DD agency.[1] This type of arrangement is fully consistent with current CMS polices as underscored by the recently released instructions and technical guide that accompany the agency's new Section 1915(c) waiver application template.[2] The guide book states that:

> CMS recognizes that it may be efficient and effective for a state to locate the operation of a waiver with an agency other than the Medicaid agency and link the delivery of waiver services to other federal, state and local programs...

When a state chooses to delegate responsibilities to an agency other than the single state Medicaid agency (SSMA), the SSMA (MAA in the District) nonetheless must

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[1] Appendix A, ***Summary of Results: National Quality Inventory Survey of HCBS Waiver Programs***, prepared by for the Centers for Medicare and Medicaid Services by the Human Services Research Institute and The Medstat Group, Inc., 2003

[2] ***Instructions, Technical Guide and Review Criteria: Application for a Section 1915(c) Home and Community-Based Waiver***, Disabled and Elderly Health Programs Group, Center for Medicaid and State Operations, Centers for Medicare and Medicaid Services, November 2005.

supervise the performance of the functions performed by the operating agency. However, the waiver technical guide makes clear that

> Supervision does not mean that the Medicaid agency must review and approve each and every action taken by another entity. It is expected that the Medicaid agency will conduct or arrange for the periodic assessment of the performance of other entities in conducting the waiver administrative and operational activities to ensure that the waiver is operated in accordance with the approved waiver and applicable federal requirements.

With CMS's approval, states have developed various approaches to ensuring that their state Medicaid agencies have acceptable approaches to carrying out their performance oversight roles.

While there is a Memorandum of Understanding between MRDDA and MAA regarding implementation of the Medicaid waiver and an implementation arrangement that on the surface reflects this type of arrangement, in practice it has not worked as a partnership. As a result, basic information about service usage and funding is not available and is not used to guide current and future administrative activities. In addition, the regulatory control exercised by the Health Regulatory Agency (HRA), also within the DOH, in the certification of ICF/DD providers further fragments policy and administration. Close collaboration and coordination from HRA is critical to shift the system from the current "institutional bias" to the type of individualized and community oriented system we envision.

All agencies share some responsibility for this dysfunction. This disjointed and fragmented structure for key responsibilities leads to indecisive decision-making and a poorly managed service system. Consolidating the administrative and oversight responsibilities for Medicaid funded supports will go a long way toward promoting a clear, shared vision for using Medicaid funding to create high quality, cost effective services. Accomplishing this will require bold leadership.

3. Develop a comprehensive strategy for establishing and enforcing a clear set of performance expectations.

Setting and enforcing performance expectations plays a critical role in bringing performance in line with minimal expectations. There needs to be a coordinated strategy for ensuring providers enter the system with prerequisite qualifications, periodic assessments are made to ensure basic expectations are met and that performance over time is tracked to identify areas where difficulties are encountered. In addition, there is specific urgency for developing a comprehensive quality management strategy for HCBS waiver services consistent with CMS's "Quality Framework" in order to qualify for renewal of the city's Section 1915(c) waiver in 2007.

Responsibilities for licensing, certification and quality monitoring now spread between MRDDA and the DOH Health Regulatory Agency (HRA) need to be linked and closely coordinated, preferably within one agency taking the lead. Operating procedures need to clearly spell out how information will be shared and responsibilities for working to remedy performance issues. Finally, there need to be clear sanctions and consequences to

implement when performance problems persist and are not corrected.

A functional performance measurement system for is also needed for MRDDA and its employees with incentives for hitting standards and penalties for poor performance and poor outcomes. Performance benchmarks for critical operations must target areas that reflect priorities for the people who depend on MRDDA for support. Strategies for measuring performance should include independent assessment – at least from another city agency but ideally from an independent, nongovernmental organization.

Along with setting performance expectations, increasing the quality, diversity and number of services providers who offer the full range of supports and services, especially those eligible for waiver funding is critical. Efforts to expand provider capacity can play a key role with implementing improvements through:

- Shifting performance expectations from the "comprehensive" one stop model to an individual support approach to service delivery. The ability to customize services and support to individual needs and ensure that people are not over or under served must be seen as a fundamental performance criterion for provider operation.

- Developing incentives for providers to meet national performance standards. The best and most respected providers throughout the country have integrated practices of benchmarking and external evaluation into routine operations. A functional system would encourage and reward providers that pursue strategies that could enhance the effectiveness and efficiency of operations to produce the best possible outcomes for the people being supported.

- Developing specific plans, incentives and support strategies to accelerate transition from traditional, congregate services to individual support agencies within the existing provider community. Making this type of change in the approach to service delivery rarely occurs without a significant commitment of time and resources. Providers will need a variety of supports and incentives to begin the shift in practice. Once begun, the transition will only be successful if there are clearly outlined performance expectations and deadlines to ensure implementation.

4. Require annual reporting that accurately describes people, issues and challenges and links to identified priorities and performance benchmarks.

Annual data reflecting critical performance indicators across the system (such as numbers of people approved for specific services, numbers of people actually accessing those services and numbers of people requesting services that may not be available and why) provides the foundation needed for future planning. This type of data collection and reporting is the only way to reflect the priorities for individual and families that need to be addressed and to accurately describe the strengths and limitations of the system of support. Such data is also essential to inform administrative and budgetary decisions made by the executive and legislative branches of government.

Chairman TOM DAVIS. Thank you all very, very much.

I've got a few questions. I'm going to start, I think, Mr. Bobb, with you and Ms. Walker.

Does the city have any plans to regulate case management?

Ms. WALKER. We do have a case management work group as part of the systems improvement plan, and they're looking at all aspects of case management, including some different models. And the subject of regulation has not come up in my conversations specifically, but we'll make sure that's on the table.

Chairman TOM DAVIS. Yeah. I'll tell you why I say that. There is a report that's scheduled to be released on June 22nd, and the court monitor states there is a lack of standards relating to the case management in MRDDA and that the individual support plans fell short of implementation. And that may be where you start on this.

Ms. WALKER. I was a little confused by your word "regulate," but certainly the adoption of standards and case management, monitoring and a whole system is definitely needed and is part of the short-term plan.

Chairman TOM DAVIS. Now on August 4, 2005, Deputy Mayor Albert notified the court of plans to reorganize MRDDA, and to do so the parties agreed to the 90-day initiative which was designed to demonstrate the District's ability to increase meaningful systematic reorganization.

Does the District still plan to reorganize MRDDA, and can you give us a sketch of what you're looking at?

Mr. BOBB. Yes. MRDDA, this department was part of the larger Department of Human Services, and so what we want to do is, make it a single agency itself and give it the independence that it needs as a single agency. So part of our work this coming Monday is to look at, although we've separated it from the Department of Human Services, our work is to take it even further in terms of how we restructure it as a single agency with a lot more independent authority than it currently has, and also to ensure some of the issues that have been raised with respect to interagency collaboration that's really needed at the end of the day to make this agency function even better.

Chairman TOM DAVIS. The city put a lot of effort into regaining control of the agencies that were in court ordered receivership, a lot of effort. And of course we worked with the city on that. Mayor Williams even hired a separate counsel to spearhead the effort. But back in 2003 the judge in the Evans case found it necessary to order the city to appoint a Deputy Mayor or other senior official to coordinate the agencies responsible for various aspects of compliance with the court order.

Does the Mayor plan to appoint a special counsel or other senior official to reform services for the developmentally disabled?

Mr. BOBB. Yes, one of the discussions—I've been involved in the Jerry Young case, for instance. So in my office I have kind of an internal receiver that works with me and I work directly with the plaintiffs in that case; and we're looking at a similar model with respect to this agency itself.

Chairman TOM DAVIS. Do you have any plans to alter the relationship between MRDDA and the Medical Assistance Agency, which is the State Medicaid agency?

Ms. WALKER. We certainly are looking at that and have that as a major agenda item, because that is mentioned time and time again, as it has been today, that it's important to have some more coordination if not colonization. I do want to caution the committee, as I do our team, that at this point MRDDA really needs to focus on its core mission, and that is delivering high quality services to the consumers that the agency serves. And certainly we know the importance of the interagency coordination, and I have found all of our agencies, including MAA, to be very responsive. And with the Mayor's directive and the city administrator's support, that we—supporting MRDDA is a top priority where we are certainly going to be doing that over the next few months while we look at the best organizational structure. We just have a lot to do over the next few months.

And I want to add, my former agency, CFSA, did have some independent authority in certain areas that has been suggested that might be beneficial for MRDDA, but I also know that it took 3 to 4 years to build that infrastructure, which takes away from the core services. And so my direction is that we have to focus on the basics first, while at the same time we're looking at all of the structural impediments or opportunities to make MRDDA better.

Chairman TOM DAVIS. Could you elaborate on the systems improvements plan, Ms. Walker? What is the objective of the plan? And then I'm going to ask anybody else on the panel to comment on that, if they have a comment on it.

Ms. WALKER. My assessment of the agency is that some of the basic systems have just not been in place. I think that there has been a lot of improvement over the last few years in a lot of different areas, but you don't have the basic infrastructure laid to just operate smoothly. And so we're focusing again on a number of areas, but the provider monitoring and accountability is a critical area and one that we get criticized, and I think rightfully so, by the court monitors and others because we don't have a centralized system for really evaluating and being able to respond quickly to problems with our providers or when consumers have problems with services. We need a centralized system, and we have that, we developed that for CFSA, and I'd like to look at a similar model. But basically it's where all of the information comes together so that you're making informed decisions about who is a good provider, who is not, is case management business being done on time, and while that information comes together, right now it is very chaotic.

So provider accountability is one key area. Contracts management is another area that goes to our ability to access better services, including the waiver services.

The feasibility of waiver operations, we're looking at day programs and the whole case management model, as well as basic training. So we have that, and we have details. If you'd like us to forward the plan to the staff, we'd be happy to do that.

Chairman TOM DAVIS. Ms. Thompson, the District brought on two new contractors to take on 16 group homes. Several agencies

had to help with this transition. Could you walk us through some of the steps you had to take?

Ms. THOMPSON. Yes, I'd be pleased to do that, sir. Let me start at the end and work back to the beginning.

The end was having people in place, providing services in legally licensed safe environments. To get there, each of those providers had to get an inspection from our Health Regulation Administration, and they had to the get the inspection on the day they were taking over. It could not be before they took over. That is just our regulation.

Prior to them getting the inspection, they had to submit a Certificate of Occupancy, which means that they had to go through our agency that handles the building permits, which is normally a difficult process, but we were able to negotiate that properly.

Before they got a Certificate of Occupancy, they had to have a signed lease for the facility that they were going to operate. Before they could have a signed lease, they had to have an agreement with the District which guaranteed them that they would have funding with which to pay the lease. To get the agreement with the District, they had to negotiate a budget and a contract with our Office of Contracts and Personnel.

To negotiate the contract, first they had to respond to a public request for proposals. So all of this was a tightly organized, quickly moving train. But it had many, many, many stops it had to make along the way.

In the end, everything came together well. It took my interagency coordination with the Medicaid Administration, Contracting and Personnel, Consumer Regulatory Affairs, the Health Regulation Administration, the D.C. Fire Department, MRDDA itself, and the advocate agencies and the court monitor. And it was a huge job to get done. And those agencies did a very good job following with me every single step.

It was a nightmare but it was something that had to happen and I think the people will be better served by those folks.

Chairman TOM DAVIS. Thank you.

Mr. Gettings, what steps need to be taken, in your opinion, to develop an effective interagency agreement between the Medical Assistance Administration in the Department of Health and MRDDA in the Department of Health Services that would govern the management of Medicaid dollars for services for the mentally disabled?

Mr. GETTINGS. I think that, first, there are plenty of models around in other States where that has been done.

But the principles behind this, the management agreement between the two, are that you manage a unified budget across Medicaid and city dollars, that has a single focus on creating a sense of accountability for how the system is going to operate.

Again, the problem that the District has faced in the past is not unique. Other States have faced exactly the same problem of saying we have a single State Medicaid agency that manages our Medicaid program, and we have a program agency that is responsible for making this happen.

The task is to bring those things together and define in clear terms what the interaction between those two accountable agencies

has to be, so that there is an absolutely unified approach to developing policy and funding services.

Chairman TOM DAVIS. Thank you, very much. Ms. Morrison. Let me start with Ms. Bobby Walker. Does the city plan to require accreditation caregivers?

Ms. WALKER. We are looking into accreditation. We have a team looking at that. Our recommendation is that we do not pursue that in this next year. That is a very involved process in that it's very labor intensive. We can adopt standards and we can—in terms of our whole QA process we are going to be moving in that direction, but it's my recommendation that we not pursue formal accreditation. At least not this year.

Chairman TOM DAVIS. Mrs. Campanella, let me ask you, when the city meets the court's requirements in the *Evans* case, services to class members will obviously be improved. What do you foresee the need for reforms that go beyond Evans' compliance to make sure non-class members receive adequate care and service?

Ms. CAMPANELLA. Good question. Basically where we are focusing our efforts around quality is not at setting the bar at the floor, which is what we see the compliance with the Evans plan as defining the minimum standards, but going beyond that to begin to look at the kind of individually responsive services and individually supportive services that Ms. Morrison described earlier.

So we have begun to focus on the basic assurance areas of health safety rights, safe environments, and other kinds of supports like that to really assist providers to think broader than just minimum compliance.

Chairman TOM DAVIS. Thank you very much. I have more questions. I am going to go—although I may or may not make it back—I am going to turn the gavel over to Ms. Norton. If I don't get back, I want to thank everybody for this. We may have some other additional questions for the record. Again we don't like to get into these things, but given what has transpired and the length, and really the severity of the problem, we are going to continue to exercise some oversight. But I just want to thank everybody for being here today and trying to work to get this resolved.

Ms. NORTON [presiding]. Thank you, Mr. Chairman. The chairman does turn the gavel over to me. In the past I've always turned it back. I am kind of like a trustee in the jail. You know, you let the trustee have greater freedom because the trustee is not going to break out. One of these days I may have to break out. But because we have a bill pending, maybe that will be unnecessary.

Let me start with what appeared to be a loss of confidence by the counsel in the ability of the agency to improve itself, taking the drastic step of denying funding. Was this a denial of increase in funding? Very harsh step considering the vulnerability of those involved.

One, is this a denial of an increase in funding? And what is the effect?

Mr. BOBB. Thank you. Well, we stated to city council that we have several requests them before them. One was a request to address the budget pressures in the current fiscal year, as well as a request for additional funding in the 2007 budget.

We also during the course of our budget deliberation, have reduced the budget by approximately——

Ms. NORTON. You wanted funds for this fiscal year plus an increase next year?

Mr. BOBB. That is correct. We need additional funding this current fiscal year, as well as additional funding in the 2007 budget effective October 1st. And so we have been working through both of those issues with the city council.

Ms. NORTON. I thought the city council had made a decision. And what was the decision that was made?

Mr. BOBB. They made one decision last week, which was to provide us with, I think, $10 million of one funding request. And that decision was made last week.

We still have a decision pending before the city council with respect to the 2007 budget.

Ms. NORTON. So they have, in fact, given you $10 million that you wanted for this year's budget?

Mr. BOBB. That's correct.

Ms. NORTON. And what made them decide to do that?

Ms. WALKER. If I could address that, having had to testify many times about the budget needs of the agency, the chairman of the Human Services Committee told us point blank that he withdrew an opposition to our funding request in view of the management changes that we made and the systems improvement plan and the mayor's and city administrator's commitment to stand behind the agency and to drive this reform.

But the $10 million that was improved last week, we still have another close to $8 million pending before the council for this year. So, this year there is $18 million——

Ms. NORTON. Why were those funds needed?

Ms. WALKER. Well, there are several reasons. One, the agency received a budget cut last year for fiscal year 2006 and did not adjust its spending accordingly.

So the budget cut of, there was a budget cut of $5 million——

Ms. NORTON. Is that a budget cut or not as much money as it requested?

Ms. WALKER. Last year it was a cut as part of the budget process. But going in when you know your budget has been reduced $5 million, then it's the responsibility of the agency to just adjust its spending plan accordingly. But that didn't happen——

Ms. NORTON. Why didn't that happen?

Ms. WALKER. A management issue. We also had some unusual circumstances this year. The closure of the local forming group homes that has been mentioned before, which was written in the papers, what a bold step and necessary step, and I commend the former administrator for doing that. What that meant is the providers had a number of homes that were Medicaid-funded homes, the ICFMRs. When they come in as new providers, they have to go through the process to get certified again, which meant that for a period of—we are projecting 90 days and we are close to the end of the 90 days—to get them certified, then we have to take them off the Medicaid dollars and they get funded totally with local dollars. So that was another $4 million total for that period of time.

So that was an unforeseen expenditure but one we felt was necessary due to the performance of those agencies.

And then the other primary driver of the budget issues this year was that, as Ms. Campanella and other advocates in our Evans parties push us to do, is to provide placements for clients in the least restrictive environment, and which we support, but the agency has done that irrespective of the funding available.

And so decisions have been made, policy and practice decisions, that have not been consistent with the budget authority to fund them. And so we find that we have more and more clients who are in apartments, who need a lot of individualized services that our current waiver does not cover.

Now, those are decisions that, you know, always have to be weighed out. But certainly if those are the practices an agency is going to undertake, then it has to have the budget authority in order to do that. So you have those things running, pushing the budget into a major deficit this year.

Ms. NORTON. Which brings to us the waiver. If what we are talking about is the Federal Government picking up part of services that otherwise you would be providing, I can't think of more of an incentive to try to get a waiver. What stands in the way of a larger Medicaid waiver?

Ms. WALKER. Well it's the process. It is a long and involved process——

Ms. NORTON. It is not the process.

Ms. WALKER. Part of it is——

Ms. NORTON. It is the same process for everybody in the United States. So it's not the process.

Ms. WALKER. The process should have been started a long time ago. It was started but it was wasn't completed. Here is where we are today. We do have the expert consultants on board. We have signed a contract to take us to the place where we can finally fully submit a completed application to the Federal Government to expand the waiver and——

Ms. NORTON. So somebody missed the process and the consultants are in the process now?

Ms. WALKER. Yes. Yes. There already has been an application. A large part of the application has been completed. There are two sections that have to be done, and that is where we needed the expert consultants——

Ms. NORTON. Are you going to seek this larger waiver or simply the renewal of the existing waiver?

Ms. WALKER. No. We are seeking a larger waiver that is more expansive and will cover more services and more hours for the types of services that our consumers need.

Essentially, right now the local government is paying, like you said, a disproportionate amount under our current waiver. So we want to refine that waiver, have that expanded and that will be part of the renewal application for the waiver, so we would go in for renewal with the expanded waiver.

Ms. NORTON. I am very pleased to hear that. You owe that not only to these residents, you owe that to the taxpayers of the District of Columbia.

Ms. WALKER. I totally agree.

Ms. NORTON. Because they're picking up the rest. I am interested in that because I have put in a bill—I have a series of bills called the Free and Equal D.C. Series. When we got the increase in Medicaid, we still were left paying, as the District of Columbia, a larger share than any city in the United States, even New York, which is the only other city that pays 25 percent. We pay 30 percent. That is much better than before.

But this bill seeks to put the District in the same position that any city would be in. So it asks that at least part of this be picked up by the Federal Government, as the quote states.

Now, obviously, if the waiver process in the District is all out of kilter, that would seriously interfere with Congress, seriously considering my bill.

I haven't heard anyone—I was out of the room for a moment, but I understand that no one has advocated receivership. Does anyone at the table believe that receivership is necessary at this time?

Ms. THOMPSON. I only believe that would be necessary if Mr. Robert Bobb does not take over the agency and manage it as an internal receiver, as he has done with DYRS.

Ms. NORTON. Mr. Bobb, do you believe that the agency should report directly to you? MRDDA should report directly to you?

Mr. BOBB. Technically it does.

Ms. NORTON. How technically?

Mr. BOBB. We have the deputy mayors work directly with these agencies with respect to their daily operations, but at the end of the day they are accountable to me and the mayor.

Ms. NORTON. They're accountable, yes. I am now talking about—would you speak to Ms. Thompson's notion—is it your belief that improvements would be made—let me give you some background here. A number of us have some bills over here involving FEMA, following the Katrina disaster.

None of them—all of them—they differ somewhat, but all of them believe that FEMA should report directly to the President of the United States and should not have to go through any bureaucracy; in other words, if an agency has a mission that is either difficult or important, it may be that what would otherwise make sense—and here we have the Department of Homeland Security—would otherwise make sense, may not make sense for this particular agency. Given the long history of problems in this agency I ask whether or not Ms. Thompson's suggestion should be considered?

Mr. BOBB. Yes, it definitely has been under consideration. Let me just say we had a similar situation——

Ms. NORTON. I know that is putting a lot of, I don't know how much you can put on one person but you know, that is like saying I don't know how much I should put on the President of the United States. It's his job to make sure that it works, so.

And I recognize, Mr. Bobb, that you are the real problem solver in the government. I know from firsthand experience.

So I ask you, not only as a structural matter, I have run a big troubled agency in the Federal Government. I ask you as a pragmatic matter, is this suggestion feasible?

Mr. BOBB. Yes, it is feasible.

Ms. NORTON. So you are considering doing that?

Mr. BOBB. Yes, we are considering.

Ms. NORTON. Is it likely to happen?

Mr. BOBB. After consulting with the Mayor we will be able to say, what we did, just as a point of contact, what we did with the Department of YSA, the former Youth Services Administration which has been in receiver for 20-plus years as well, is while that agency reports directly to the Deputy Mayor, I have an internal receiver that works with me and the Mayor's personal attorney, executive lawyers for the Mayor. So I have a lawyer that works for me that helps to move the reforms forward with the director. And then I meet personally with the plaintiffs in the case.

And so I am directly engaged with the lead counsel for the plaintiffs in the Jerry M. case, for example. So to that extent I am very, very involved in pushing the reforms in that case. And so we are looking at a similar model with respect to this agency.

Ms. NORTON. That is very wise if you want to avoid receivership. Does anyone else believe that receivership is, should or should not be considered or appointed?

Ms. CAMPANELLA. Ms. Norton quality trust fully understands why the plaintiff's attorneys have filed for receivership in this case. As I stated in my testimony, the situation for people in the city is very troubling.

There have been continued promises, continued deadlines missed, and, unfortunately, continued harm that has come to people who rely on the service system here. So while we are very encouraged by some of the things that have happened, the time is past for when we can actually wait for some sort of a solution. As we all know, receivership takes time to work through the system.

At such time that considers—receivership is actually considered by the courts, the substantial administrative changes have been made by the district, and possibly we can reconsider at that point, you. But at this point, the needs of people with disabilities in the District of Columbia are too significant and not being supported enough for us to say that pursuing receivership is not a reasonable course of action.

Ms. NORTON. So you favor receivership?

Ms. CAMPANELLA. I favor the course of action in seeking receivership that the plaintiffs have taken.

Ms. NORTON. You favor the shot across the bow in applying for receivership, in hoping they get their act together so the court will not have to do so.

Ms. CAMPANELLA. Again, I am going to say based on my 4 years of experience in the District of Columbia, again, we have worked very seriously and we are very committed to working in concert with the District, Ms. Brenda Donald Walker, and at various times we have seen many players change. I don't question the earnesty of any of those folks. But the bottom line and the actual track record remains that some serious and significant changes have not been made as evidenced by where we are today with the waiver. So yes, given the situation as it is today, we do support the filing for receivership.

Ms. MORRISON. Ms. Norton, obviously from my testimony, I am here representing an organization that defines, measures, and improves quality for people with disabilities.

And we would like to say that receivership or no receivership, it really won't matter if we don't start looking at outcomes for individual people, if we don't look at being responsive to people rather than layering different levels of organizational process and playing the compliance game. Bringing in a receiver that would not pay attention to individual personalized outcomes would only add another layer and make it even more difficult to get things done.

So I think the issue of paying attention to personnel outcomes, measuring that, and moving forward in designing the system based around what people with disabilities say is important to them.

Mr. GETTINGS. Ms. Norton, I would just add to that, having watched situations in which the courts have intervened in such a radical manner to appoint a receiver, that one of the things that has to be taken into account is, what is the end gain? Where does accountability ultimately reside? And serious situations call for serious interventions.

And I agree with Ms. Campanella that if you look at the testimony that is presented to the court, it certainly justifies some radical interventions to correct the situation as it exists for a very, very long period of time.

At the same time, I don't think a receivership should be—is a solution, unless you have a very clear plan for how government is going to reassume responsibility. So the best of all possible courses of action is that you avoid it. And I think, I hope that would not happen in this situation because it carries——

Ms. NORTON. Receiverships don't operate that way. They are open-ended and they end when the court says they end. And it could be years and years, and we know because we have been through that before. I am agnostic on it.

Let me ask the Members of the panel from what you have head here today, for example, that they have hired a consultant, that they think they are going to get a comprehensive Medicaid waiver, does anything you heard here today indicate to you that a receiver may well not be necessary?

Ms. CAMPANELLA. Again, let me start. I think, again, and I included in my testimony, a commendation for Deputy Mayor Brenda Donald Walker, because I think she has taken on a very serious job with a very serious approach and has begun to organize people in a way that would address some of these significant issues.

I am glad to hear that they have the consultants on board and they're going to pursue the new application. But, at best, we are looking at implementing a new expanded waiver in the fall of 2007.

Ms. NORTON. That would happen whether or not there is a receiver, wouldn't it? Because if you got to have—the court can't mandate or won't mandate the Medicaid—more comprehensive Medicaid waiver, it would have to work it through as well in order to decide, I mean, what I am saying is I don't see what you are saying has to do with receiver.

When it would start, when the waiver would start, yes, and over here it is, here the Federal Government, it's slow as molasses. But you have—D.C. hasn't even gotten it in and the taxpayers of the District of Columbia are paying for what the Federal Government should be paying for. And the expanded waiver has enormous implications for the improvements that you are indicating. So the only

question about the receiver end and Medicaid is whether or not the receiver facilitates that or not. You could argue that the receiver delays that, because I can say without fear of contradiction that the agency is quite unlikely to give a Medicaid waiver while something is in court.

Ms. WALKER. Ms. Norton, if I could respond to this whole receivership and what we are doing, I ran an agency that had been under receivership. And when we took over the agency in 2001, it was after they had negotiated a settlement to end the receivership and the mayor elevated this to a Cabinet-level agency—we took over that agency and it was in shambles. There were no structural foundations. We had to build everything from scratch.

And the same thing is true about the Department of Mental Health which exited receivership at the same time. So we are vigorously opposing the notion of receivership.

Ms. NORTON. I understand that. But the point is—what my question is, in order to get the comprehensive Medicaid waiver it does seem to me you would have to show such substantial improvement. It may even be a proxy for——

Mr. GETTINGS. That is very true, because essentially what the city——

Ms. NORTON. Proxy for a receiver.

Mr. GETTINGS. Is requesting a special dispensation under Medicaid policy to gain that waiver and, yes indeed—and that is why I said in my written testimony, there is a lot of work to be done in order to get to the point where you can do that. I am very encouraged by the commitment that I have heard here today and I hope we can move ahead rapidly on it.

Ms. NORTON. I don't see anything inconsistent with what has been said here. And, Mr. Campanella I don't know if you had wanted to say something further.

Ms. CAMPANELLA. I would just add I am encouraged by the focus on the new application. I would encourage, and I have encouraged, this administration to continue to be focused on what can change today about how we implement the local rules that govern the waiver program. Because we believe there is potential there to make some improvements long before 2007.

Ms. NORTON. In the chairman's opening testimony, he detailed some of the abuses that brings a matter like this to the attention of the Congress, these, of course, are anecdotal but they are so horrendous that even a few of these leads people to believe that there is something wrong that has not been reported. He spoke about charges of sexually abusing a patient or burning a patient.

But what was most, most troubling was the part of his opening statement that said that the monitor had said that for a period of over a year the District failed to notify the providers where these residents lived or the results of the investigations, even though these investigations were conducted by the District's own reviewer.

And then, of course, he said—here I am quoting the chairman—as a result—no, no I am not quoting the chairman. He is quoting the article I think. As a result, corrective actions were never discussed, let alone implemented or evaluated.

Yes, Ms. Thompson.

Ms. THOMPSON. Congresswoman Norton, in 2004 when I was an employee of MRDDA, my job at that point was to work with the Evans compliance piece. And I followed a committee called the Mortality Review Committee, which began at that time to share those evaluations and recommendations and the actual reports from Columbus with the providers, the hospitals etc.

I was moved from that position to work for the deputy mayor to oversee the health care plan.

In late April, early May, I was sent back to MRDDA as the interim administrator, at which time, by the way, we only had about a month's worth of funding in the pot. When I got back there, there were so many things to fix that it took me a few months to recognize that the committee had stopped meeting when I left.

So I reinstituted it in November 2005 and broadened it to include the monitor staff, case management staff, the quality trust, and many others. So we put a process in place to ensure that these recommendations and reports were distributed appropriately to everyone who touched the client at the time.

So that has restarted——

Ms. NORTON. You are telling me that these reports are now always made available?

Ms. THOMPSON. Now they are. Now they are.

Ms. NORTON. All right. Let me go to what is my real concern here. You would think that is the least that could be done.

I noticed that in Ms. Campanella's testimony—I am not interested—of course, I am interested in finding out what happened and preventing it and so forth. But you see it should be, if somebody has been seriously hurt you wonder how, what the agency is doing to make sure that doesn't happen. And she says in her testimony, she speaks about the advocate. "Each person by law is entitled to an advocate," and says that there is no dedicated funding, although funding has been included in the current budget request. Now, let me ask, because the point here is to have somebody who will watch over me, as they say, "somebody to watch over me."

And very often there is no relative, and even if there is somebody, the relative may not feel it is his responsibility to perform this function.

Is the advocate the best way to prevent this kind of abuse, the fact of actually going and monitoring the residents often? Is there now dedicated funding? Does every resident in one of these group homes have an advocate?

Ms. THOMPSON. Ma'am, the answer to the last part of your question is no. Every person in those group homes does not have an advocate. A critical function that I think when we are really sort of dancing around the edges is the role of active and advocacy-based case management where the intent of case management is around advocating for the client as though that person is your best friend or your family member.

And until that intent of case management is properly developed——

Ms. NORTON. I am not talking about intent of case management? Are you talking about case workers?

Ms. THOMPSON. Yes, I am.

Ms. NORTON. Are there sufficient case workers? Once I hear you talk about case workers, my eyes really begin to roll, because it's so hard to find people to deal with people in many different kinds of situations. So, is the answer that every person should have a case worker that comes so often that, in fact, burning somebody or sexually abusing somebody is deterred?

Ms. THOMPSON. I think that is part of the answer, Ms. Norton.

Ms. NORTON. How often do case workers——

Ms. THOMPSON. They are supposed to see people as far as I know now, at least once per month. But that is the floor. That is not what real case management advocacy is about.

Ms. NORTON. What is real case management advocacy about? I am interested in somebody watching over. I only have one question. If they know somebody is, if they knew I was going to come in there very often, they are less likely to harm the person I am coming to see. And all I am asking is, and when you tell me about case management and case workers, then I really get scared because we have had hearings on foster children, we know nobody is going into social work. I don't want to go through that one again.

So, I was caught by this notion of an advocate because I can't ask the District to do the impossible.

Mr. GETTINGS. There are several issues that are being raised here. One of them is the issue of an individual legal advocate. That is through the Superior Court.

That's not budgeted as part of the city's budget, and when Ms. Campanella talks about a budget request there is a budget request that has gone forward to the superior court to put in funding for those advocates. That is an act of Congress. It is not an act of the city government, by the way.

Ms. NORTON. But what does the advocate do and how often does the advocate come?

Ms. CAMPANELLA. The court-appointed advocate would work under the supervision of the D.C. Superior Court Family Division. And the idea in their volunteer advocacy program is that it would introduce into the lives of people with disabilities, who may not have family, someone who is committed to going and visiting that person and staying involved in that person's life, over time.

Ms. NORTON. Mr. Bobb, please. I am trying to get, how many advocates do we have? And how often do you believe the advocate should come in order to have at least a deterrent effect on abuse?

Ms. CAMPANELLA. Again, my best estimate at this point is for an estimate of 1,200-plus people who should be accessing an advocate. There are around an average of 200 advocates available.

So they assess AREAs. Any people that don't have an advocate.

The advocacy program, as it currently exists, is not supervised. It has a half-time clerk assigned to it, and it is not really staffed to oversee any of the recruitment and supervision activities that it would need to make it a functional program.

Ms. NORTON. Now let's get to the funding. You say in your testimony that there hadn't been dedicated funding in the budget request. Mr. Bobb or Ms. Walker or Ms. Thompson, again, is the money—budget—has this been approved in a budget which, by the way, is already over here? Then, Bob, the answer to the question is no. We don't have this as a "be candid," this is the first time I

have known, seen this D.C. law. You know this particular code. And I don't know that if this is a requirement if it's a requirement that the D.C. government, and no one has called this to my attention, if it is a requirement of the courts. And we should be advocating with the court to provide this funding.

Ms. CAMPANELLA. Again, Ms. Norton, just to clarify, we have been advocating over the past 4 years with the D.C. Superior Court to acknowledge and figure out how to address and implement the responsibilities associated with this.

It is my understanding that Judge Rufus King in the D.C. Superior Court has included just under $1 million in the budget request that was sent to Congress for the superior court.

Ms. NORTON. In the court budget.

Ms. CAMANELLA. The court budget. Yes, because this was supervised and overseen by the D.C. Superior Court.

Ms. NORTON. And these are volunteers?

Ms. CAMPANELLA. It's a volunteer advocacy program. Again it was designed back in, I believe, 1978 when the law was designed. The local D.C. law is the Citizens with Mental Retardation Rights Act of 1978, I believe. And it defines individuals' rights to have access to an advocate to help them understand what's happening to them. And when this program works well, and as we have seen at least in a few individuals, it introduces again into the person's life somebody who is there, that cares about them, and who will ask the hard questions not because they're paid to, but because they just care about the individual. Which is a significant safeguard.

Ms. NORTON. I want to know where we have something involving Federal funding, I do wish people would be in touch with me. I am very pleased that the court, the court has been very vigilant now, particularly now that we have done that court, put a lot of money into that court. But I had no idea, and I am very pleased that Judge King has indeed put this in. But I didn't even know about it.

This is the best way, short of the complicated notion of case management that the District still has to do to assure somebody will be there for the advocate, and perhaps we can prevent some of the incidents that have been in the paper and that were——

Mr. GETTINGS. It's a piece.

Ms. NORTON. I am not suggesting—look, we have discussed the whole—excuse me—darn thing. And you know, it's very nice for us to talk about structural stuff. I am trying to deal with the fact that these people need to be taken care of right now.

So while they're getting their act together—and nobody suggested an advocate or even a case worker can do this job—but meanwhile people are sill sitting in these group homes now. And I picked this up, really, from Ms. Campanella's testimony, because it seemed to me that even what you've described, Ms. Thompson, going in and catching it, going back and evaluating it after it's done, is a terrible thing to have to do. There should be very few of those.

So what's the answer? The answer is I am at the mercy of this group home, with nobody to watch over me. Then of course, I have no confidence in myself that there will not be some minimum wage person untrained or whatever, who may abuse somebody.

But, let me ask you, is there another way—other than the advocates or redoing the whole case management which they are in the process of doing—is there another way, other than the advocate to get this kind of frequent oversight by one person dedicated to the client—or is this really the best way to do it and deter it? Because if there is another way, I want to know about that other way, too.

But if it's let's reform the system, yes, of course. But meanwhile there are people that could be abused today, tomorrow, and the next day while you're reforming the system which hasn't been reformed in a very long time.

Ms. THOMPSON. In today's terms I think that is probably the very best way to go right now.

Ms. NORTON. Let me tell you one thing. That's a Federal matter because the courts come under us. I am going to be in touch with Judge King. They have run their programs well. Do you believe this $1 million funding would be enough for every resident in a group home to in fact have an advocate?

Ms. CAMPANELLA. Again, based on what I've seen, I don't know if it is totally enough but I think it's a good—it provides a good foundation and starting point.

Ms. NORTON. I'm going to call Judge King and ask him. And if it's not enough, the budget has beautifully gone through the House without any attachments. When they were cutting to smithereens, we were able to keep things from being cut that were critically needed. But the budget has not yet gone through the Senate.

So I would like you to—this is my counsel. I would like to know by the end of the day from Judge King, whether or not the million dollars is enough to cover an advocate for each of the clients? How many are there, please?

Ms. CAMPANELLA. Approximately 1,200 people that we estimate need an advocate.

Ms. NORTON. That would be the total pool.

Ms. CAMPANELLA. There is approximately just under 2,000 served by MRDDA Service System but I think it is only certain people that are in residential services that need the advocacy.

Ms. NORTON. But Federal funds a lot of this may have happened, and I am just pleased to know about it. I understand that there is a consulting firm that investigates these deaths. But the district has been hammered because these reports are not made public. I don't understand what the, "privacy concerns" would be. Somebody has been killed while literally a ward of the State. That is the worst intrusion of privacy I ever heard of.

But I don't understand the privacy concerns. Once there is a death, that is a matter of public record, I thought. No matter who it was, there is a death. So I want to understand why it is that this is not routinely disclosed; if it would be disclosed with, for example, the investigative work that Ms. Thompson has described, and what is the state of that?

Because that makes a city look worse than ever, if the people get killed or abused and get investigated and then nobody is told. Then you get the press going after you, and you get people no longer having confidence in you because you don't report things that are—that have happened are untold. Look, something is going to happen that is untold. This is not a perfect world. And it's been inves-

tigated and you can then at the same time talk about what the investigation shows and what you have done. I don't see that the city is going to be held to the standard of perfection. It is held to that standard though when people only find, when the press or somebody else hammers them. So I would like to know if there is a systematic way to report the deaths, particularly the deaths or other such concerns along with what the city is doing to correct it.

Ms. WALKER. The answer is, yes, Ms. Norton. There is a systematic way. There is a citywide fatality review committee. The debate about the records is the amount of redacting or protecting the confidentiality that is tied into a lot of other legal issues such as HIPAA, the family members. And I think, though, that we can certainly respond more openly with the council and our other stakeholders in this, even though you can redact and protect an individual's confidentiality, we certainly need to be held responsible for reporting on what the findings were, what we have done in response, and if there are certain providers where you have multiple occurrences, then we have to be forthcoming with that information. And we are still working through that with the city council as far as the level of information that is provided. It is pretty much of a legal battle.

Ms. NORTON. Well, if it's a legal battle, then of course, what can be reported should be reported.

Ms. WALKER. Correct.

Ms. NORTON. The public has a lot more confidence when the government comes forward and reports on it itself than it does when a FISA or something has to be filed by the press, who can always then find out. And apparently the press has found out. So I don't know what these privacy concerns are if the press can find out.

Let me close with this hearing, I am very pleased with the notion of this advocate, that restores some confidence in me that a system that is spread all out in the city, nobody can possibly know what is going on every moment, the best you can do is to try to deter it. And if you know that somebody is coming in there, it does seem to me the deterrent effect can be extremely important here.

There was a report from a hearing, a recent hearing, that 47 out of 1,800 patients get the, "requisite monthly visits each year."

What is that about? Is that about the case management system?

Ms. THOMPSON. Yes, ma'am.

Ms. NORTON. Is that, in turn, dependent upon hiring more case workers? Are we back into the revolving issue that has never been solved and I am convinced will never be solved? Unless we can get to the point where we can get something like what we have in the school system, paraprofessionals or something, you will never convince women—and that is who you are talking to—who can now be anything they want to be, that they ought to take the low pay that goes along with being a case worker, which means you have some sort of social work background, rather than using that same background on something that pays better.

So I would like to know what you are going to do about the case worker personnel problem. Or is there one? Maybe you don't have that problem.

Ms. WALKER. I think it's a matter of training accountability, and effectively——

Ms. NORTON. I am asking one question so we won't go on. The chairman is back. He said my 5 minutes were up.

The CHAIRMAN. Almost. Almost.

Ms. NORTON. I am asking—I am talking about one visit, 47 out of 1,800 patients got the required one visit per month. Now I am trying to deal with part of this through the advocate.

But if we are talking about case workers, then my question: what are we talking about, case workers?

Ms. WALKER. Yes. We are talking about staff case workers from MRDDA.

Ms. NORTON. If we are talking about case workers, then unless you have had something to happen to the District that has not yet been reported, there is a severe shortage of case workers.

Ms. WALKER. MRDDA actually has an adequate number of case workers.

Ms. NORTON. Who, in fact, visit once every month.

Ms. WALKER. Yes. Their caseload ratio is among the lowest in the country.

Mr. GETTINGS. Absolutely.

Ms. NORTON. Go right ahead.

Ms. WALKER. This is why I get to accountability and training and oversight——

Ms. NORTON. Training? Just going out there once a month?

Ms. WALKER. Maybe it's accountability and oversight. And I understand the issue about not having enough case workers and social workers. I have had that with CFSA. That's not the case here.

Ms. NORTON. Are these trained social workers, do they have to have a college degree?

Ms. WALKER. No. But they do have a college degree. No.

Ms. NORTON. They don't have to have a college degree, it seems to me. That is why I talk about paraprofessionals or something——

Ms. WALKER. I believe they fall in that category. Ms. Thompson would know better about the requirements.

Ms. NORTON. You think the reason they have not been going out once a month, if they had been going out once a month maybe we would have less of what was in the chairman's testimony. But between the caseworkers going out once a month, and we got enough case workers, and the advocates going and spelling when they go out does seems to me to go a long way toward preventing abuse and deaths.

Why have they not gone out? That doesn't take training. It just says go out there and report whether you have gone and sign this thing here that you have gone out there.

Ms. WALKER. I have to turn it over to Ms. Thompson.

Ms. THOMPSON. Basically I think the reason, I think what is two things: you have somebody go out and come back and don't report that they have been out. I have run into that myself in the homes. And then I go back and I check on the internal information management system and they haven't put their notes in. And then the other issue is the ones that just don't go out. And they don't go out. It was the building was wrong or they didn't know who they were supposed to see, or they had no way of getting there because MRDDA doesn't provide the transportation.

There is, again, the issue of caring and intent, and understanding what case management is supposed to be about and wanting to do that. And wanting to have a good government job is one thing, and wanting to be a good case manager is, say, a separate thing. And those two just don't meet right now in MRDDA's case management work force.

However, when I left I was hopeful, because I was beginning to see the turnaround, the change, in case management interest. They were beginning to want to go out, and I mean, that is where it comes down to.

Ms. NORTON. Maybe that is what Mrs. Walker meant when she said training and, of course, accountability.

Let me ask one more question. This comes from Ms. Campanella's testimony. I am very leery of anecdotal evidence but they do tell us things. And she spoke about a woman who was found living in a dilapidated apartment, so dilapidated her health was threatened. And then she says that despite intense efforts by the advocate and the personal intervention from the court monitor and the administrator of MRDDA, it took nearly 7 months to successfully transition this woman into a new living arrangement.

Are you talking about somebody who was going to be put into a new apartment?

Ms. CAMPANELLA. Yes, ma'am.

Ms. NORTON. That may explain it all, Mrs. Campanella, because if you are trying to find a new apartment for anybody in the District of Columbia, the average person in the District of Columbia, good luck. Because at least I think MRDDA may be willing to pay rents that the average person here can no longer afford.

And then you are trying to place somebody in an apartment who is so troubled that she was living mired in health risk in her own apartment. How do you find apartments for people like that in the District of Columbia?

Ms. THOMPSON. Ma'am, let me respond a little. This person apparently has lived on her own with her husband for a number of years. Their living situation was deplorable from what I found myself. I think that there was some communication issues back and forth between what they felt they would be obligated to submit to intrusiveness as opposed to their choices to live the way they were living.

And it was a matter of education and urgency and diplomacy on the part of case management at MRDDA. And when Mrs. Campanella's staff and the court monitor staff brought it to my attention—I worked with Mr. Brian Willbom and we were quickly—when we had our hands around it—we were quickly able to convince them, yes, you don't want to live there when you could live here.

And guess what——

Ms. NORTON. You were able then to find—it was a question of them not wanting to live——

Ms. THOMPSON. Yes, it was a communications issue, I really believe, but it was resolved.

Ms. NORTON. I was concerned about that because if in fact this so troubled a person anywhere she lived, might in fact get her in the same situation. I think it would be hard to find a living ar-

rangement for her in her own apartment even if she were able to take care of herself. But then maybe somebody coming in and helping her would be all that was needed.

Ms. CAMPANELLA. It underscores and illustrates many of the things that have been discussed here this afternoon that need to be urgently addressed about case management and communication.

Ms. NORTON. I compliment Mrs. Thompson that she was willing—they went all the way to the top and she was willing to step in.

Ms. CAMPANELLA. We do too.

Ms. NORTON. Testimony, very, very helpful. You heard from the Congress; I am sure you don't need to hear from us again. Thank you very much, Mr. Chairman.

Chairman TOM DAVIS. Thank you all very much. I want to thank you for being here we look forward to working with you as we try to get this program in shape. This hearing is adjourned.

[Whereupon, at 11:55 a.m., the committee was adjourned.]

[The prepared statements of Hon. Henry A. Waxman and Hon. Diane E. Watson follow:]

Statement of
Rep. Henry A. Waxman, Ranking Minority Member
Committee on Government Reform
Hearing On
Disabled Services in the District of Columbia: Who is Protecting the Rights of D.C.'s Most Vulnerable Residents?

June 16, 2006

Chairman Davis, thank you for convening this hearing to discuss services for the mentally disabled in the District of Columbia. This is a gravely serious matter and I am glad this Committee is directing its collective attention to the rights of some of D.C.'s most vulnerable residents.

Problems of neglect and abuse in the District's mental health facilities are not new. Thirty years ago, the Justice Department joined in a lawsuit against the District for failing to protect the safety and health of disabled individuals living in the Forest Haven mental health facility. The facility was closed in 1991, but the transgressions continued in other D.C.-run facilities.

Six years ago, the *Washington Post* published an exposé on conditions in the community-based group homes where developmentally disabled wards of the city now receive care. The *Post* documented 190

cases of medical neglect, 46 cases of physical abuse, 44 cases of overdrugging, and 80 cases of misappropriated funds.

Four years ago, another independent evaluation showed that group home residents were routinely deprived basic nutrition, held in uninhabitable and unsafe housing, abused, and discriminated against. When these reports came to light, Mayor Williams pledged to reform the facilities. But the abuse did not end. Just last month, the Justice Department released papers documenting fourteen "preventable and questionable" deaths of group home residents that occurred in the last three years.

We have heard rhetoric, but where is the reform? The Mental Retardation and Developmental Disabilities Administration (MRDDA) has had 18 directors in the last 12 years. This agency needs strong leadership and meaningful oversight. I do not want to see MRDDA in receivership, but something has to change. The city can and must do more.

Moving forward, I can only hope that a renewed commitment to change can overcome the unconscionable complacency that has mired this issue for decades. Today we share a common objective: learn from the past to improve services and conditions for disabled D.C. residents.

I look forward to hearing from today's witnesses about how they plan to achieve this goal.

Congresswoman Diane E. Watson
Government Reform Committee
Hearing entitled, "Disabled Services in the District of Columbia: Who is Protecting the Rights of D.C.'s Most Vulnerable Residents?"
Opening Remarks
June 16, 2006

Thank you Mr. Chairman.

The disabled in America are sometimes overlooked in the land where everyone supposedly has a voice. Americans with disabilities are Americans just the same. According to the constitution of the United States, the disabled are afforded the right to life, liberty, and the pursuit of happiness, exactly the same as any other citizen. Whether or not the disability is from a birth defect, an amputation, an accident, blindness, or deafness, the disabled should have a voice.

I understand that there are numerous challenges in life for every human being, and a disability adds a few more. As a long time public servant, I believe that it takes a very strong individual to overcome many of the obstacles in our society. I also believe that good public policy works to ensure the well being of all citizens, which is sometimes a difficult task, but a standard to strive for. Unacceptably, government action in some areas has let the disabled community down.

One area that I would like to highlight is education. As a former educator, disabled Americans are very close to my heart. Education can equip an individual, with or without a disability, to engage in society. It is a shame that the District's Mental Retardation and Developmental Disabilities Administration has not been able to settle the issues underlying the 30 year old lawsuit of Evans vs. Williams. A public servant's greatest goal is to maximize the quality of life in the least restrictive environment for our disabled constituents. While community living situations are the main component of the Evans vs. Williams complaint, education and practical living skills are the cornerstone of assisting our fellow Americans.

Mr. Chairman, I hope that the witnesses will provide constructive testimony on how to move forward. Let's provide a positive model in D.C. that the rest of the country can look at. Let's treat the disabled community as the United States citizens that they are. Proper funding, proper oversight, and proper services are the ingredients to proper governance.

Mr. Chairman, I yield back.

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