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

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

Plaintiffs,

v.

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

Defendants.

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

**CLASS ACTION**

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

**Hearing Date:** **November 8, 2012**
**Time:** **9:00 a.m.**
**Judge:** **Magistrate Judge Jacqueline Scott Corley**
**Address:** **450 Golden Gate Avenue San Francisco, CA 94102**
**Courtroom:** **F, 15th Floor**

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

2 I, LESLIE HENDRICKSON, do hereby declare:

3 1. I make this Supplemental Declaration in support of Plaintiffs' Motion for Enforcement
4 of Stipulated Judgment and for Appointment of Special Master. The opinions set forth herein are
5 based on my professional expertise, my review of materials provided to me by counsel, and other data
6 sources. My previous declaration in this matter is ECF Number 504.

7 2. I have been retained by Plaintiffs' counsel to, among other things, offer my opinions
8 about the following: (1) the characteristics of dual eligibles generally and dual eligibles in California
9 that participated in the Adult Day Health Center (ADHC) program, (2) the current situation in which
10 thousands of persons who attend Community Based Adult Services (CBAS) will no longer be able to
11 receive those services because CBAS services are only offered under managed care, and (3) make
12 recommendations for how the transition of CBAS to managed care for these participants can be
13 accomplished safely. I am being compensated by Plaintiffs at my customary hourly rate for similar
14 services.

15 3. My qualifications and experience are described in my previous declaration in
16 paragraphs 3-9, and in my Curriculum Vitae attached thereto. Hendrickson Decl., ECF No. 504,
17 Hendrickson Decl. Ex. A, ECF No. 504-1.

18 4. I have read the settlement agreement in *Darling v. Douglas* (ECF No. 438-1). In
19 addition to the documents identified in my previous declarations (ECF Nos. 287, 326, and 504), I
20 have been provided Attachment 1.2 (ECF No. 413-1) and Attachment 5 of the Settlement Agreement.
21 (ECF No. 438-1), the Declaration and Exhibits of Lydia Missaelides (Missaelides Decl., ECF No.
22 511; Ex. B, ECF No. 511-2; and Ex. C, ECF No. 511-3), the Declaration of Alex Eychis (Eychis
23 Decl., ECF No. 500) and the Declaration and Exhibits of Natalie Liberman (Liberman Decl., ECF
24 No. 509; Ex. B, ECF No. 509-2). I have also reviewed declarations of the following individuals:
25 Ruth and Reynaldo Baculanta, Simona Galynsky, Emilia Gurevitch, Polina Kats, Valentina Krugliak,
26 Armine Manukian, Anu Mohan, Inina Sark, Mahboubeh Sefidi, Bella Sviriduk, and Abram and
27 Feyga Volfson. In addition to these documents, I reviewed state documents available at the ADHC
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1 and CBAS websites of the Department of Health Care Services (DHCS) and the Department of
2 Aging, at http://www.dhcs.ca.gov/services/medi-cal/pages/adhc/adhc.aspx and
3 http://www.aging.ca.gov/ProgramsProviders/ADHC-CBAS. This document review encompassed
4 letters to CBAS providers promulgated by the CBAS branch of the Department of Aging, the CBAS
5 provider training materials, webinars, and provider information prepared by the Department of Health
6 Care Services, and the CBAS 1115 Bridge to Reform Waiver Amendment. I have reviewed the April
7 2012 Pacific Health Consulting Group's study of the 2011-2012 enrollment of seniors and persons
8 with disabilities into managed care.[1] A true and correct copy of this report, which I downloaded from
9 http://pachealth.org/docs/SPDImplementation_Wunsch_Linkins.pdf on October 31, 2012, is attached
10 hereto as Exhibit A. I have also read the Defendants' Opposition to Plaintiffs' Motion for
11 Enforcement (Defs' Oppo., ECF No. 532), and its following declarations and attachments: Javier
12 Portela (Portela Decl., ECF No. 534), Denise Peach (Peach Decl., ECF No. 536), and Jane Ogle
13 (Ogle Decl., ECF No. 538).

14 5. Based on my experience and my review of these materials, the central issue is the
15 state's requirement that CBAS participants choose between retaining their CBAS services or losing
16 their primary care and specialty physicians. In my opinion, the Defendants have not taken adequate
17 and timely steps to transition dually eligible CBAS participants into managed care safely.

18 6. The Defendants have created a false dilemma. There is no compelling necessity for
19 the Defendants to force CBAS participants into making a choice between CBAS and their medical
20 providers. There are other alternatives that minimize the quality of care complications for the persons
21 affected by the Defendants' decisions. For example, due to circumstances outside of the Settlement,
22 namely, the Coordinated Care Initiative (CCI) (discussed further below), Defendants are faced with a
23 need to conduct outreach, develop and provide accurate information, identify and remove barriers,
24 and forge new relationships when hundreds of thousands of dual-eligibles are shifted into Medi-Cal
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26 [1] Pacific Health Consulting Group, (2012, August), *A First Look: Mandatory Enrollment of Medi-Cal's Seniors and People with Disabilities into Managed Care*, A report prepared by the California Healthcare Foundation, Sacramento,
27 CA. Retrieved on 10-31-2012 from http://www.thescanfoundation.org/first-look-mandatory-enrollment-california%E2%80%99s-seniors-and-people-disabilities-managed-care
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1 and Medicare managed care in early 2013. If the CCI program were in effect now, all of the CBAS
2 participants would be required to go into managed care and there would be no need to choose
3 between retaining CBAS services and their physicians, hospitals, and medical services and supplies.
4 Indeed, the intensive work required on the part of the Defendants this coming year would presumably
5 provide solutions to the problems encountered with this group of dually eligible persons so that their
6 transition to managed care would be done efficaciously.

7 7. Persons in the ADHC/CBAS program have been independently assessed by the
8 Defendants and permitted to enroll in CBAS programs because the majority of the persons are
9 eligible for nursing home services and in need of the level of service that CBAS programs provide.[2]
10 A review of national and state research on dually eligible persons shows their higher acuity and
11 multiple comorbidities. A break in medical services that these persons are acknowledged to need, or
12 offering only a coercive "choice" between critical medical services, is poor policy.

13 **Lack of Data and Analysis**

14 8. I understand that as of November 1, 2012, thousands of CBAS participants will no
15 longer be eligible to receive CBAS because they have "opted out" of Medi-Cal managed care. Based
16 on my review of available information, DHCS lacks sufficient quantifiable information to understand
17 and monitor what happens to persons who lost or will lose ADHC/CBAS services. Without adequate
18 data, DHCS cannot possibly know what happens to these people in terms of human and fiscal
19 consequences.

20 9. A search of the Department of Aging and the Department of Health Care Services
21 websites shows occasional reporting of CBAS utilization statistics on the number of CBAS providers
22 and the number of persons using CBAS services. For example, the September 24, 2012 CBAS
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[2] To the best of my knowledge the Defendants have not published reports stating how many person are found eligible for
25 CBAS using each of the different eligibility routes into the program. The eligibility requirements for CBAS are presented
below. I am presuming that the majority of persons, more than half, are found eligible because they meet the NF-A level
26 of care. I also believe that the persons with multiple impairments in ADLs (activities of daily living) and IADLs
(instrumental activities of daily living) and traumatic brain injuries or advanced Alzheimer's would like be served in
27 nursing homes in California given the lack of residential programs such as assisted living in the California Medi-Cal
program.
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1 Provider Update Webinar Presentation contains information that in July 2012 there were 256 CBAS
2 Centers open, 31,877 Medi-Cal enrollees were receiving CBAS services, and 1,552 private pay
3 clients.[3]
4 10. State staff declarations (Portela Decl. ¶¶ 9-11, ECF No. 534; and Peach Decl., ¶ 9,
5 ECF No. 536) report frequent meetings, telephone calls and visits to organizations. In the absence of
6 publicly available quantitative information about the state's administration of the ADHC/CBAS
7 services, the mere recitation of process numbers such as the number of meetings held, does not
8 provide insight into the effectiveness of the work. Missing are quantitative descriptions of the
9 different eligibility and/or acuity groups that use ADHC/CBAS services and what is happening to the
10 persons comprising these groups. What is clear quantitatively is that thousands of persons will no
11 longer receive ADHC/CBAS services.
12 11. The May 2012 estimate of the Department of Health Care Services contains issue
13 analyses. The issue analysis of Regular Policy Change Number 16, Adult Day Health Care – CDA
14 used the assumption that there would be 29,295 persons using ADHC services in FY 2012-13.[4] As
15 noted above, in July 2012, 31,877 Medicaid enrollees were receiving services. In my previous
16 Supplemental Declaration (ECF No. 326 ¶ 6), I assumed that the average monthly number of ADHC
17 users was 38,000 because that is number of notifications sent by the state to ADHC recipients. I infer
18 that approximately 6,000 persons, (38,000-31,877), lost ADHC eligibility and did not make the
19 transition to CBAS during the initial assessment phase through March 31, 2012. To the best of my
20 knowledge, despite previously described monitoring plans, the Defendants have not in fact monitored
21 or reported on what happened to these persons who have previously lost ADHC services. Similarly,
22 there appear to be no plans to study what happens as a result of the loss of CBAS for an additional
23 5,000 people who have not enrolled in managed care (the "opt outs").
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[3] Retrieved on 10-28-2012 from http://www.dhcs.ca.gov/services/medi-cal/Pages/ADHC/ADHC.aspx
[4] *See* Regular Policy Changes section in May 2012 estimate. Retrieved on 11-2-2012 from http://www.dhcs.ca.gov/dataandstats/reports/mcestimates/Pages/may_2012_estimate.aspx

12. Based on the information I reviewed, in addition to the 5,000 CBAS participants who are losing CBAS because they have "opted out" of Medi-Cal managed care, others may lose CBAS when and if their CBAS provider shuts down or downsizes because they have so many opt outs.[5] I understand that generally, these centers are in Los Angeles. Based on the loss of revenue, it is likely that some number of these centers will shut down, which could represent a sudden and significant loss of CBAS provider capacity. A loss of 5,000 persons in Los Angeles will affect the operation of programs. Even when these 5,000 persons have their eligibility for CBAS restored next year upon implementation of the Coordinated Care Initiative and mandatory enrollment of dual eligibles in Medi-Cal managed care in Los Angeles and seven other counties, the program they attended may or may not still be there or have the capacity to serve them.

13. Without a clear baseline of who is being served now, their characteristics, needs, and geographic location, it will be impossible to monitor outcomes and costs for these individuals. I have not seen any information available either publicly or provided by Defendants that even points to an intention to monitor these people.

**Characteristics of "Dual Eligibles"**

14. Persons who met the separate eligibility requirements for both Medicaid and Medicare are "dually eligible." Some ADHC centers reported that as much as 83% percent of their ADHC participants were dual eligibles. (Missaelides Decl. Ex. I at 3, 13-15, ECF No. 245-9).

15. National statistics on the health problems of Medicaid/Medicare enrollees were presented in my earlier declaration (ECF No. 287 ¶ 19; ECF Nos. 287-4, 287-5). A 2012 Kaiser Report states that dual eligibles comprise 20% of Medicaid enrollment and 32% of its Medicaid spending and 15% of Medicare enrollment and 39% of its Medicare spending. Kaiser also reports that dual eligibles compared to other Medicare enrollees are:

- Eight times more likely to have under $10,000 in income;
- More likely to be female, or from a racial minority;

[5] According to the declaration of Denise Peach, 48 CBAS centers have at least 20% of their participants opting out. Peach Decl. ¶ 19, ECF No. 534.

- Twice as likely to have fair or poor health, and a cognitive or mental impairment; and
- Eight times more likely to be in nursing home or other institution. [6]

California statistics are comparable to the national statistics. Department of Health Care Services (DHCS) studies of dual eligibles show that they have higher rates of illness and they cost more. For example, DHCS has reported that dual eligible persons who have a physical disability have substantively more comorbidities than Medi-Cal recipients with a disability who are not dually eligible; 31.8% of dual eligible persons with a disability have between 10-19 health conditions compared to 19.2% of Medi-Cal only persons with a disability. About 13.4% of dual eligibles with a disability have 20 or more health conditions whereas only 4% of Medi-Cal only persons with a disability have 20 or more health conditions.[7] According to DHCS' materials on the Coordinated Care Initiative, "California's 1.1 million dual eligible beneficiaries often have serious and chronic medical conditions, reside in nursing homes, frequently use emergency room services and suffer from functional or physical impairments." [8] A review of the level-of-care eligibility required for CBAS also shows the acuity required to be made CBAS eligible. There are five routes to eligibility:

- Nursing Facility level-of-care A (NF-A) or above;
- Individuals who have been diagnosed by a physician as having an Organic, Acquired or Traumatic Brain Injury, and/or have a Chronic Mental Illness and require assistance and/or supervision in ADL and IADL categories;
- Individuals have moderate to severe Alzheimer's disease or other dementia characterized by the descriptors of, or equivalent to, Stages 5, 6, or 7 Alzheimer's disease;
- Individuals who have mild cognitive impairment or moderate Alzheimer's disease or other dementia, characterized by the descriptors of, or equivalent to, Stage 4

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[6] Musumeci M. (2012, May), *Dual Eligibles*, Kaiser Commission for Medicaid and the Uninsured of the Kaiser Family Foundation, Retrieved on 10-29-2012 from http://www.kff.org/medicaid/kEDU_dual_eligibles_tutorial_052312.cfm

[7] *See* DHCS study retrieved on 10-28-2012 from http://www.dhcs.ca.gov/Documents/Dual Eligibles National Data Snapshot.pdf

[8] *See* DHCS description of CCI. Retrieved on 11-1-2012 from http://www.chhs.ca.gov/Documents/Item%204%20Coordinated%20Care%20Initiative%20Fact%20Sheet.pdf pg. 2.

Alzheimer's disease and meet all current ADHC eligibility and *Medical Necessity Criteria, and require assistance and/or supervision in ADL and IADL, and

- Individuals with Developmental Disabilities.[9]

16. As noted in my previous Supplemental Declaration (ECF No. 326, ¶ 9), The Defendants' data shows that of the 37,780 persons who received services on June 30, 2011:

- 25.5% had dementia;
- 6% had mental retardation;
- 46.6% had a psychiatric diagnosis;
- 38.7% were incontinent of bowel or bladder;
- 49.8% needed either physical or occupational therapy;
- 62.4% did not speak English, and
- 76.1% needed skilled nursing services.

17. Given the indisputably high needs and associated high costs of the dually eligible population, operational protocols should be in place to ensure their care is not unnecessarily disrupted or their access to their health care is constricted. As shown by the Defendants, persons who are dually eligible often have precarious health conditions, exacerbated by age, poverty, language, and cultural barriers, that require care coordination as these persons traverse through the multiple specialists, hospitals, home health agencies, lab and X-ray, and primary care providers that form the mosaic of their health care services.

**California's Coordinated Care Initiative (CCI), or "Duals Demonstration Project"**

18. California's Coordinated Care Initiative (CCI) was passed by the Legislature and signed into law in July 2012 (pursuant to Senate Bills 1008 and 1036). DHCS plans to implement the CCI in 2013 in eight counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, Santa Clara, San Diego, and Santa Clara, pending federal government approval.

[9] Description of eligibility taken from California Department of Health Care Services, (2011, December 12), *CBAS Eligibility Determination Tool (CEDT) Instructions*. Retrieved on 10-29-2012 from http://www.dhcs.ca.gov/services/medi-cal/Pages/ADHC/ADHC.aspx

19. The CCI includes two parts:

(1) Mandatory enrollment of all Medi-Cal beneficiaries (including those dually eligible for Medicare and Medi-Cal) into managed care for all Medi-Cal benefits, including long term services and supports (LTSS). In the CCI, LTSS includes In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), CBAS, and nursing facilities. Peach Decl. Ex. C at 5, Q. 19.

(2) Optional enrollment into integrated managed care that combines Medicare and Medi-Cal benefits, known as the "duals demonstration."

20. DHCS plans to start sending letters to beneficiaries about the requirement to enroll in Medi-Cal Managed Care in December 2012. Peach Decl., Ex. C at 5-6 Q. 19, ECF No. 536-3.

21. As defined in statute, the Demonstration seeks to enable Medicare-Medicaid enrollees to receive a continuum of services that maximizes access to, and coordination of, benefits between Medicare and Medi-Cal. The purpose of the CCI is to "transform California's Medi-Cal care delivery system to better serve the state's low-income older adults and persons with disabilities."[10]

22. An estimated 560,000 dual eligibles statewide will be required to enroll in Medi-Cal managed care under the current CCI plan. *Id*. Of these, an estimated 343,674 dual eligibles are in Los Angeles County. California Department of Health Care Services, Los Angeles County Fact Sheet, http://www.calduals.org/lacounty/. Accessed November 1, 2012.

**Loss of CBAS for Managed Care "Opt-Outs"**

23. I have been asked to offer my opinion about the current situation in which thousands of persons who attend Community Based Adult Services (CBAS) programs will no longer be able to receive services because CBAS services are only offered under managed care and they have, or will "opt out" of Medi-Cal managed care.

24. Continuity of care, including medication management, is a long recognized and essential activity in managing the care of older adults and persons with a disability. For example, when I worked as a manager in the home and community based services program in Oregon in the late 1980's, everyone was case managed. The State of Washington's program was similarly designed

[10]Department of Health Care Services, (2012, August 24), *Coordinated Care Initiative Executive Summary*, Retrieved on 11-1-2012 from http://www.calduals.org/wp-content/uploads/2012/08/CCIOverview082312.pdf

1 and both states acquired a reputation for providing choice and having cost effective programs that
2 served the majority of its enrollees outside of institutions.

3 25. Current Federal policy is replete with programs emphasizing care coordination: Duals
4 Demonstration, the Multi-Purpose Senior Services Program (MSSP), and the Community Care
5 Transition Program to name a few. MEDPAC is the acronym for the Medicare Payment Advisory
6 Commission, a congressional advisory panel. In its annual June report to Congress for the last three
7 years, MEDPAC has published a chapter on care coordination of dual eligibles. Research literature
8 continually and uniformly stresses the importance and impact of good care coordination.[11]

9 26. Given the importance of care continuity, I observe that participants in the ADHC
10 program have not been afforded continuity of care. The declarations I have read assert that CBAS
11 participants who have opted out of managed care have done so for reasons that include
12 misinformation by their doctors and being told that they will no longer be able to *See* current medical
13 providers, including being admitted to the same hospital where their doctors have admitting
14 privileges. Difficulties with other services such as non-emergency medical transportation are also
15 described in the declarations, (Liberman Decl. ¶ 9, Volfson Decl. ¶ 9, and Eychis Decl. ¶ 8). The
16 Defendant has proffered no analyses of these problems or their current or potential effect on quality
17 of care.

18 27. These are people who have been assessed to qualify for CBAS, have not indicated that
19 they no longer want to attend CBAS, and who are being forced to choose between two services—
20 CBAS or primary care doctors and specialists. It is poor care planning that forces the impoverished

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22 [11] For example recent reports in 2012 highlighting the importance of care management and continuity of care include: Claffey, T., et al. (2012, September), *Payer-Provider Collaboration in Accountable Care Reduced Use and Improved Quality in Maine Medicare Advantage Plan*, Health Affairs, Vol. 31, No.9 pp. 2074-2083. Retrieved on 9-5-2012 from, http://content.healthaffairs.org/content/31/9/2074.abstract Full article is only available by subscription. *See* also, Anderson, L. (2012, August), Patient Medical Group Continuity and Healthcare Utilization American Journal of Managed Care, Vol. 18, No. 8 pp. 450-457. Retrieved on 9-6-2012 from, http://www.ajmc.com/publications/issue/2012/2012-8-vol18-n8/Patient-Medical-Group-Continuity-and-Healthcare-Utilization *See* also, Brown, R. et al. (2012, June), *Six Features of Medicare Coordinated Care Demonstration Programs That Cut Hospital Admissions Of High-Risk Patients,* Health Affairs, 31, no.6 (2012):1156-1166. Full article requires a subscription, but *See* abstract, retrieved on 9-4-2012 from http://content.healthaffairs.org/content/31/6/1156.abstract *See* also, Nelson, L. (2012, January), *Lessons from Medicare's Demonstration Projects on Disease Management, Care Coordination, and Value-Based Payment,* Congressional Budget Office Working Paper 2012-01, Washington, D.C. Retrieved on 9-4-2012 from http://www.cbo.gov/publication/42924
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1 elderly and persons with disabilities to choose between which health care services they are going to
2 do without. Given the unresolved problems identified in Plaintiffs' declarations, a rational policy
3 would not force CBAS participants into making a critical decision prematurely. First, because dual
4 eligibles will be mandatorily enrolled in Medi-Cal managed care under the CCI in early 2013, the
5 need for any "choice" between CBAS and Medicare providers will be avoided entirely. Second,
6 since a purpose of the CCI is to provide the coordination that is absent from the present system, the
7 State will have adequate time to resolve the issues in this major policy shift so that the problems
8 identified in Plaintiffs' declarations may be resolved.

9 28. The denial of needed CBAS services is coercive. Given the characteristics of the
10 persons served by the CBAS providers, as noted above in the discussion of CBAS eligibility and the
11 medical conditions of dual eligibles, it is inappropriate for the state to force these elderly and disabled
12 persons to choose between losing services and enrolling in managed care at this time.

13 29. The CBAS participants who opt out are following advice received from their
14 physicians who say they will no longer be able to treat them in a managed care program. (Peach
15 Decl. ¶ 8, ECF No. 536; Galynsky Decl. ¶¶ 5-8, Gurevich Decl. ¶ 7). Other than extending the
16 implementation of CBAS into managed care for two months and offering an "easy way back", it is
17 not clear the state has plans for working with the 5,000 persons who will lose their CBAS services.

18 30. From the declarations I have reviewed, it appears there are implementation problems
19 in the transition of these ADHC/CBAS participants to managed care. These problems appear to be
20 similar to the implementation problems encountered in the 2011—2012 mandatory enrollment of
21 seniors and persons with disabilities, who were Medi-Cal-only recipients, into managed care. *See*
22 Exhibit A. The conclusions of the Pacific Health Consulting Group regarding the necessity of care
23 coordination, the need for more time to implement the new program, the difficulty of accessing new
24 services, and the state's inadequate communication to providers, find parallels in the declarations I
25 have read in preparing this and may earlier declarations.
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31. I have reviewed the Defendants "easy way back" concept and think it does not address the underlying reasons why persons opted out of managed care.[12] Giving persons two more months to change their minds is not a remedy. While "easy way back" could ameliorate the situation for some people, I simply think that the action is insufficient to deal with issues that generated the need for the two-month extension.

**Possible Solutions**

***Coordination of CBAS Managed Care Enrollment with Duals Demonstration***

32. A reasonable remedy would be to permit the 5,000 persons who have opted out of Medi-Cal managed care, and others who make that decision after experiencing problems in managed care, to continue to receive CBAS services and maintain their continuity of care with Medicare and Medi-Cal providers, including hospitals, until the CCI is implemented in their counties. Mandatory Medi-Cal managed care enrollment will likely occur within months. This period of time will provide an opportunity for policy decision makers to review what is happening and fix the kinds of problems that the Pacific Health Consulting Group referred to. The Pacific Health Group report addressed a different population but the problems appear similar.

33. As far as the barriers and problems regarding access to Medicare doctors, hospitals, and Medi-Cal services, it is likely they will have to be addressed by that time. If not, they are problems that will confront hundreds of thousands more people but are unrelated to access to CBAS.

***Transition Process before Termination of CBAS***

34. Another reasonable remedy would be for the Defendants to create a process for conducting individual, targeted outreach to CBAS participants—in a language and manner they can understand, and to Medicare providers. From the declarations I have reviewed, there has been some success with this approach, but it is time intensive and there needs to be time to do this type of outreach before people lose CBAS. In addition, during this time, DHCS needs to review, with

[12] CBAS Branch, (2012, October1 9), *Phase II CBAS Transition: Fee for Service Participant Choice Deadlines and an "Easy Way Back" to CBAS Services*, California Department of Aging. Retrieved on 10-31-2012 from http://www.aging.ca.gov/ProgramsProviders/ADHC-CBAS/All_Center_Letters/

managed care plans and hospitals, the actual services, providers, and hospitals utilized by CBAS participants, identify barriers to continuity of care, and resolve those barriers before a transition occurs. In this way, problems can be avoided before they happen and opt-outs after enrollment can be halted. This approach would require sufficient time and attention, as well as collaboration by the CBAS providers, DHCS, managed care plans, hospitals, and medical providers and suppliers. I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on November 2, 2012, in East Windsor, N.J.

By: /s/
Leslie Hendrickson, Ph.d.

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

By: /s/
Elissa Gershon
Attorney for Plaintiffs