

ATTACHMENT B
STAFF'S ARGUMENT

STAFF’S ARGUMENT TO ADOPT THE PROPOSED DECISION

The Long-Term Care Act (Act) was enacted by the California Legislature in 1990 to establish a voluntary insurance program for long-term care for public employees, retirees and certain family members. The Act requires that the CalPERS Board of Administration (Board) administer the CalPERS Long-Term Care Program (Program). When the Board established the Program, the Board elected to provide self-funded plans. Univita (formerly known as the Long-Term Care Group, Inc.) administers the Program for the Board. Under the Act, the Board has a fiduciary duty to Program enrollees to permanently maintain viable long-term care plans that are voluntary and paid for entirely by enrollees’ premiums. Accordingly, maintaining and enforcing adequate criteria for receipt of benefits is an essential part of carrying out this duty.

Franklin Green (Respondent) was eligible to apply for coverage under the Program. Respondent applied for coverage under the Program’s Comprehensive Plan (Plan). Respondent’s application was approved and Respondent was enrolled in the Plan, effective September 1, 1997. In 2007, Respondent filed a claim under the Plan. He was assessed and approved to receive benefits under the Plan. The basis for approving Respondent to receive benefits was functional as he needs assistance in performing more than two Activities of Daily Living (ADL’s).

The Plan’s Evidence of Coverage (EOC) is the contract between the Program and Respondent. The EOC contains the terms and conditions of the Plan, including, but not limited to, provisions concerning benefits, claims and payment of claims. Applicable provisions of the EOC include the following:

Covered Expenses

Covered expenses for home and community care means fees charged for:

- **Home Health Care Services;**
- **Personal Care Services;**
- **Homemaker Services Incidental to Personal Care;**

.....

Home Health Care Services means:

- Part-time or intermittent skilled services by licensed nursing personnel provided by a **Home Health Agency;**
- Home health aide services provided by a **Home Health Agency;**

.....

Where a **Care Advisory Services Agency** has determined that no **Home Health Agency** exists in the area, **Home Health Care Services** may be provided directly by an individual who is licensed or certified to provide **Home**

Health Care Services and who is an Eligible Provider of Home Health Care Services.

.....

Plan of Care means a written individualized plan of services approved by a **Care Advisory Services Agency** designated by **Us** which specifies **Your** long term care needs and the type, frequency and providers of services appropriate to meet those needs, and the costs, if any, of those services. The **Plan of Care** will be modified as required to reflect changes in **Your** medical or social situation, **Your** functional, behavioral or cognitive abilities and **Your** social needs.

Eligible Providers for Home Health Care Services

Home Health Care Services may be provided by personnel from a **Home Health Agency** that is state licensed, accredited, or certified by **Medicare** to provide **Home Health Care Services**, or, when a **Care Advisory Services Agency** has determined that no **Home Health Agency** exists in the area, directly by an individual who is licensed or certified to provide **Home Health Care Services** and who is bonded or holds appropriate liability insurance.

Eligible Providers for Personal Care Services

Personal Care Services may be provided by a nurse aide, a home health aide or other person or entity qualified by training and/or experience to provide care, and who is bonded or holds appropriate liability insurance. If a state license, registration, or certificate is required to provide the service, the person or entity must have the appropriate license, registration or certification. The entity must provide ongoing supervision and training to its employees appropriate to the services to be provided. However, it is not required that the provision of **Personal Care Services** be at a level of certification or licensure greater than that required by the eligible services or that those services be provided by Medicare-certified agencies or providers.

ALTERNATE CARE PAYMENT PROVISION

.....

We Reserve the Right to Authorize Alternative Benefits and Services

We reserve the right to authorize benefits for providers, treatments, or services not otherwise specified in the Evidence of Coverage, or when conditions specified in this **Agreement** are not otherwise met, if **We** determine that it:

- Is cost-effective;
- Is appropriate to **Your** needs;
- Is consistent with general standards of care;
- Provides **You** with an equal or greater quality of care; and

- Meets all requirements for “qualified long-term care services” under federal law.

The total of all benefits paid under this Rider and the Evidence of Coverage will not exceed **Total Coverage Amount**. We also reserve the right to decline to authorize alternative benefits and services. (Emphasis added.)

.....

Respondent requested that Daryle LaRose be approved as his Independent Provider (IP). By the terms of the EOC, Mr. LaRose did not qualify to serve as Respondent’s IP. However, under the Alternate Care Payment Provision (ACPP), Univita, as the third party administrator, approved Mr. LaRose to provide personal care services to Respondent. The approval of Mr. LaRose to serve as Respondent’s IP was an exception and subject to future review, modification and/or termination, dependent upon changed circumstances.

The Plan of Care clearly sets forth that Respondent is required to serve as Mr. LaRose’s employer, which requires Respondent to submit timely and accurate timesheets, documenting the services provided by Mr. LaRose to Respondent, which would, in turn, serve as the basis for paying benefits, or reimbursements, to Respondent. Respondent signed the Independent Provider Acknowledgement of Terms and Release of Liability form, which included, in relevant part, the following conditions:

“1. Any employer/employee relationship or contractual relationship concerning the provisions of care is strictly limited to you and the Independent Provider. ...

.....

5. Benefits cannot be assigned to an Independent Provider. This means that payment will be made only to you, upon receipt of timesheets and other documentation of the services provided. The CalPERS Long-Term Care Program will not make payment to the Independent Provider.

6. A Care Manager must recommend the Plan of Care to be provided, and must remain involved to monitor the appropriateness of the Plan of Care and the Independent Provider on an ongoing basis. CalPERS reserves the right to terminate approval of the Plan of Care at any time if the Care Manager determines that use of any Independent Provider is no longer appropriate.” (Emphasis added.)

In June 2008, the Program informed Respondent that, although he continued to qualify to receive benefits, the program had determined that Mr. LaRose did not meet the requirements under the ACPP for continued approval as Respondent’s IP.

Respondent exhausted all internal appeals or requests for reconsideration regarding the decision to discontinue approval of Mr. LaRose as his IP. Respondent appealed Program’s determination and a hearing was held on November 1, 2012.

At the hearing, testimony and documentary evidence was submitted on behalf of Respondent.

Angie Forsell, the Vice-President of Clinical Services for Univita, testified at the hearing. Ms. Forsell was knowledgeable regarding the terms and provisions of the EOC and how the Program is administered. Ms. Forsell explained that the Program could not continue to approve Mr. LaRose to serve as Respondent's IP because there had been a history of inadequate record keeping. Mr. LaRose was receiving disability benefits and Mr. LaRose had not demonstrated that he provided care that was equal or of greater quality than Respondent could receive from another provider, approved by the terms of the EOC.

Respondent knows Mr. LaRose well, trusts him implicitly, and was well satisfied with the nature and quality of care Mr. LaRose provided to him. The Administrative Law Judge (ALJ) found that the evidence regarding Mr. LaRose receiving Social Security Disability benefits did not prevent him from serving as Respondent's IP. The ALJ found that the problems with accurate record keeping had been adequately addressed by Respondent.

Accordingly, the ALJ concluded that the evidence did not support Program's determination to not continue to approve Mr. LaRose to serve as Respondent's IP. The ALJ granted Respondent's appeal. CalPERS argues that the Board adopt the Proposed Decision.

Because the Proposed Decision applies the law to the salient facts of this case, the risks of adopting the Proposed Decision are minimal. The member is not likely to file a Writ Petition in Superior Court seeking to overturn a Decision of the Board in his favor.

February 21, 2013



RORY J. COFFEY
Senior Staff Attorney