ATTACHMENT C

RESPONDENT(S) ARGUMENT(S)

January, 22, 2024

Respondent's Argument *Ref. No. 2023-0123*

Board Services Unit Coordinator

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This letter reaches you after 5 years of struggle with the administrative process of Calpers.

When I purchased this policy for my mother there were limited options for aging, hospital care, a nursing home and home care.

At that time, a Comprehensive policy was offered which cost slightly more than a facilities policy because the expectation was that it would start sooner and provide a low dollar amount each month for aides in the home to cook, clean and help. This would prolong aging in the home before someone had to enter a nursing home, at which point the Comprehensive policy would pay the same higher dollar rate as a facilities policy in monthly payments for a nursing home or skilled nursing.

Since that time, these policies have been expanded to include assisted living centers, homes with 2 to 6 people known as REAFs which now qualify as a facility, In New York state, a home with one person known as an RAL now qualifies as a facility. Hospice and Palliative care are now provided regardless of place and now qualify to be paid out under a facility care policy.

There was an institutional change over time that came to recognize these new services that provided better care at a lower cost. On both Calpers and Illumina's websites, they now proclaim new programs and services enhancing aging in place because aging in place provides better outcomes at lower cost.

In the EOC -- the very heart of the Alternative Care Provision – it asks the Qualifying question – Does this care provide better outcomes at lower cost?

New York State, unlike any other state in the country, developed RAL, (Residential Assisted Living) a nursing home diversion program, which provides skilled nursing care to individuals. It is called the MLTC program, and just like hospice, it brings skilled nursing and Palliative care to the elderly patient in their home. It is licensed by the New York State Health Department as the equivalent of a skilled nursing facility and was developed to divert patients from skilled nursing homes. New York faces an ongoing acute shortage of Beds for skilled nursing which was greatly exacerbated by Covid. This program has proven again and again that it can provide better outcomes for patients at lower costs thereby meeting the very definition of the ACPP.

This is the beginning of the next generation of Patient Centered Care, an early extension of hospice providing palliative care. For my mother ,all we ever wanted was to provide palliative care to relieve her constant intense pain that she suffered; there was never any hope that we could change the outcome.

Health care and health insurance has changed and progressed dramatically in the last 25 years, it has moved from hospital centered care to more outpatient and home care. Procedures which used to take weeks of hospital recovery are now performed as outpatient procedures with recovery taking place at home.

Long-term care as defined by the federal government is chronic health insurance. Long term care insurance needs to become more like health insurance and needs to become more patient centric and to deliver appropriate care to the patient regardless of place. Therefore, it is time to recognize that the ACPP and such clauses in contracts need to be utilized and put into use for chronic health care to adapt to new technology and realities.

Why is the ACPP clause even in the contract if it has never been used for a facilities policy?

This case began in 2018, and I have followed the administrative procedures outlined by Calpers for more than five years. In following these administrative procedures, Calpers was able to narrowly define and frame this case as if I were trying to expand the facilities policy to a comprehensive policy and get a payment for “home care”.

Yet this case is not about home care, it is about enabling access to skilled nursing care during a time of an extraordinary global pandemic when there were no facilities available, particularly in New York State, which saw more deaths in nursing homes than any other state in the country. The only programs that were offered and licensed by the New York State Department of Health at that challenging time were RALs which were licensed programs deemed as equivalent to a skilled nursing facility.

This is a Case that is also about a systematic denial of payment of policy claims by LTC for over 5 years, and a massive failure of Calpers care advisory services to recognize that my mother needed skilled nursing care and not assisted living. Care advisory claimed that there were assisted living centers available however my mother needed skilled nursing care.

I first placed my mother in Facilities care in December of 2018 and I consulted with Calpers Advisory services. Given that 4 doctors wrote letters stating she had 5 ADLS, I thought that Calpers would pay this claim. When I submitted the claims to LTC they denied the claims saying that she did not have the requisite ADLs.

When I resubmitted the claim, it was again denied.

When I had a Calpers Nurse evaluate my mother in June of 2019, the visiting Nurse agreed and stated my mom had 5 ADLS and should be eligible for skilled nursing care.

On April 27, 2020 Calpers sent a letter to my Mom Granting her Home Care and recognized her 5 ADLS. After receiving that news of Calpers granting her care and then after submitting the claim, Calpers again refused to pay for the claim. The letter is attached.

During the hearing, Jason Yorek, the Expert from Calpers also stated that my mother was eligible for skilled nursing care starting in 2018.

When Calpers would not pay these claims, I had to remove my mother from facility care because we could not afford the costs. Instead, we had to enroll her in the MLTC program in New York state as it was the only option available to her because Calpers would not pay.

Had Calpers honored their contract, my mother would have been in a facility when Covid struck. This evidence was presented to the Court as part of the hearing, yet there is no record of it in the judgement.

When Covid started, in New York state the hospitals closed and moved their Covid patients into skilled nursing homes because they were running out of supplies and Oxygen in the hospitals. The nursing homes became hotbeds of Covid and Covid deaths, as was illustrated during the trial.

This left a severe shortage of skilled nursing care beds in New York State. I applied and put my mother on waiting lists for skilled care facilities, but there was a two year wait for a bed and my mother died on the waiting list for a bed.

As I explained to the Judge there are three levels of care in New York state, Assisted living, ALP, and Skilled Nursing. No matter how hard I tried, all of the Assisted living facilities and ALP facilities in New York would not take my mom because her care was too intensive. She needed skilled Nursing care and while Calpers stated that there were facilities that were available in the area, these were not skilled nursing facilities. Calpers never proved there were skilled nursing beds available in the area.

In Calpers own phone logs in the area where my mother resided, the call logs show that the skilled nursing facilities told Calpers that there were no beds available in the area. Yet, the advisory care services insist that there were beds available, when in fact there were none. This was at a time when the number of deaths in these facilities due to Covid were at extreme and unacceptable levels. This evidence came from discovery of Calpers records and yet there is no mention of it in the judgement.

This was a massive failure and misdirection from the care advisory services which should be available to help direct care resources and carefully evaluate the nursing reports coming in from the field. Had they paid attention to the nursing reports of those on the ground, they would

have recognized, as clearly stated, that my mom had five ADLS and needed skilled nursing care. Care advisory services should have followed through on these claims rather than disregarding their own nurses' recommendations.

In a time of crisis, with no other options available to her, we used the only option that was available to us. It was the only Alternative Care that was available and anyone reading the contract would see that we met every single criteria under the ACPP. My mom needed skilled nursing care, not home care, and during this time of crisis, during Covid, the Alternative Care provision should have been honored and used.

The only time that the ACPP has been used by Calpers is when the insured lived in a rural area and there were no beds available. In my mom's case she lived in a very rural area and there were no beds available during the time of covid. Clearly this is another instance when the ACPP should have been applied and used.

After spending 5 years attempting to get this resolved and attempting to work with Calpers to settle this claim at a lower cost and provide better care, I don't see any alternative except to bring suit in New York State, under New York State law which would recognize the Managed Long Term Care program as a diversionary program and the equivalent of a skilled nursing facility. The EOC states that the prevailing law should be determined by the state of residence of the insured.

I believe that the administrative Judge did not understand the full scope of the case and in following this administrative procedure provided by Calpers and that this case was too narrowly defined by Calpers. As such, I respectfully request the Board to reconsider this decision and at a minimum, return the premiums paid for this policy.

I believe that this decision should not be designated as precedent as it fails to recognize emerging programs trying to address issues with our current system and technologies available that provide better care at lower cost. This decision also failed to recognize the severity of the covid crisis in New York and did not provide an alternative level of care, when there was no facility care that could provide a solution. After years of care for my mom, I had to give her morphine as she died on a waiting list for skilled nursing care. That should not be the precedent set by this case.

April 27, 2020

SANDRA Y DEGOLYER
[redacted]

RE: Sandra Y DeGolyer
[redacted]

Dear Sandra DeGolyer:

We have reviewed your Request for Benefits and we have determined you meet the eligibility requirements. Your benefit eligibility has been approved from April 17, 2020 through June 7, 2020 provided you continue to meet the eligibility requirements during this time. Any eligible expenses incurred on or after June 8, 2020 will not be reimbursed or applied to your Deductible Period until a reassessment of your eligibility for benefits is completed and it is determined that you continue to qualify for benefits. Please refer to your policy for details pertaining to this provision.

Attached is a Plan of Care Summary which documents the details of your claim approval. It includes the care providers and dates of service that are eligible for reimbursement under the terms of your policy, in addition to any providers and/or dates of service which are not covered and not reimbursable. Eligibility requirements and payment of benefits is subject to all terms and conditions of your policy, including, but not limited to, maximum benefit amounts. Benefits will be provided after satisfying your policy's Deductible Period (if applicable) and that do not exceed the approved frequency of services as outlined in your attached Plan of Care.

It is important to contact us before changing providers or making any changes to the type, level and/or frequency of care, so any change to this Plan of Care may be reviewed and updated. If you make changes without prior notification to us, ongoing benefits may not be provided. If we determine at any time prior to June 7, 2020 that you no longer meet the eligibility requirements, your benefit end date will be the date we determine you were no longer eligible.

In order to receive payment for eligible expenses, the following items must be submitted by you or your provider:

- Home Health Care - a caregiver timesheet or detailed invoice and daily visit notes (DVN's) must be submitted by you or your caregiver for all dates of service. This required documentation must be completed at the time care is provided, and be signed and dated by both your caregiver and you or your legal representative. The signatures attest to the accuracy of the information. A new timesheet must be completed for each week of care. Timesheets and DVN's should be completed accurately each day, reflecting all services provided and specific hours and days worked. Your timesheets and DVN's should not be copied from one day to another.

If you have any questions regarding this matter, please call our Claims Representatives at 1-800-982-1775, Monday through Friday, between 8:00 a.m. and 6:00 p.m. Pacific Time, or e-mail us at calpersltc@LTCG.com.