BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

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| In the Matter of:<br>CLAIMANT<br>vs.<br>INLAND REGIONAL CENTER,<br>Service Agency. | OAH No. 2013090539 |

# DECISION

Abraham M. Levy, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter on October 23, 2013, in San Bernardino, California.

Leigh Ann Pierce, Consumer Services Representative, represented Inland Regional Center (IRC), the service agency.

Claimant was represented by his mother.

Documentary evidence and testimony were received, and the matter was submitted on October 23, 2013.

## ISSUE

Must IRC continue paying claimant's insurance co-payments for Applied Behavioral Analysis (ABA) behavioral services?[1]

[1] Copayment is a payment by an insured person each time a medical service is accessed.

## FACTUAL FINDINGS

1. Claimant is a 15-year-old boy eligible for regional center services based upon his diagnosis of Autism. Claimant resides in his family's home with both parents. He is in the 7th grade at a public school where he receives special education services.

2. Claimant has severe behavior issues. He is very aggressive with his mother; he hits her, grabs her, pulls her by the arms, and falls down on top of her. He constantly interrupts her to an extreme degree. He is in constant motion and will not stop talking to the point that his lips become chapped. He will ask the same question repeatedly. Claimant is difficult to redirect and will have tantrums if he is interrupted.

3. According to his July 2013 Individual Program Plan (IPP), claimant receives weekly ABA services in his home.[2] Claimant's ABA services are partially paid by the insurance his father has through his employer with a copayment of $20 per session. Claimant's parents have seen some improvements in his behavior and have learned important strategies to deal with claimant's behaviors from the ABA services. Each copayment is $20, for a total monthly payment of $80.

4 Until July 2013, IRC paid the copayments for claimant's ABA services. Effective July 2013, pursuant to Welfare and Institutions Code section 4569.1, IRC stopped paying these copayments. Welfare and Institutions Code section 4569.1 prohibits regional centers from paying the copayments for

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[2] ABA is a method for teaching individuals with autism a wide variety of skills in order to reduce problem behaviors.

services where a family's income exceeds 400 percent of the federal poverty level, subject to certain defined exceptions.

5. Both of claimant's parents work and have a combined annual gross income of $87,599. This income exceeds $78,120, which is 400 percent of the federal poverty guidelines for a family of three.

6. The ABA services are helping claimant to calm himself and minimize his aggressive behaviors. Due to claimant's parent's medical expenses, the new statutory provision requiring parents to pay for the ABA copayments, effective July 1, 2013, caught claimant's family unprepared. They are not financially able to absorb the additional, copayment expense.

7. Claimant's father suffers from severe and chronic diabetes. Due to a change in his health coverage, he recently became responsible to pay for a diabetic pump that cost approximately $600.

8. In addition, claimant's mother required medical attention over the summer that required her to go to the emergency room and urgent care. The costs associated with her treatment were approximately $500.

9. Claimant's mother and father credibly testified that their recent medical expenses make them unable to pay the $80 per month in ABA services for claimant while they make payments towards the costs associated with the diabetic pump and the medical expenses incurred by claimant's mother. As a result, claimant's mother testified that they could afford one session per month at most. His mother added that the ABA services have improved claimant's problem behaviors, and without these services over the last several months, due to the change in health coverage, his problem behaviors have increased.

10. Jennifer Cummings, Program Manager for Legal Affairs at IRC, testified on behalf of IRC. Ms. Cummings explained the process IRC undertook to

assess whether IRC was obligated to continue funding copayments for claimant's ABA services pursuant to Welfare and Institutions Code section 4659.1, Ms. Cummings commented that there are three categories of exceptions under this law for families with gross income over 400 percent of the federal poverty level, and if any one of these were applicable to claimant, IRC would be required to fund the copayments. Ms. Cummings did not believe the exceptions applied to claimant.

11. Tiffany Pineda, Consumer Service Representative, also testified that based on her review of claimant's matter, claimant did not meet any of the applicable exceptions.

## LEGAL CONCLUSIONS

1. A regional center seeking to change a service previously approved has the burden to demonstrate its proposed change is correct. (See Evidence Code section 500, which states "[e]xcept as otherwise provided by law, a party has the burden of proof as to each fact the existence or nonexistent of which is essential to the claim for relief . . . that he is asserting.") As no other statute or law specifically applies to the Lanterman Act, the standard of proof in this case is preponderance of the evidence. (Evid, Code, § 115.) In this case, IRC bears the burden of establishing that it is not required to continue paying the copayments for claimant's ABA in light of Welfare and Institutions Code section 4659.1. Claimant, in turn, bears the burden of establishing that he qualifies under the exceptions set forth under Welfare and Institutions Code section 4659.1, subdivision (c).

2. The Lanterman Development Disabilities Services Act (Lanterman Act)[3] sets forth a regional center's obligations and responsibilities to provide services to individuals with developmental disabilities. As the California Supreme Court explained in *Associaton for Retarded Citizens v. Department of Developmental Services* (1985) 38 Cal.3d 384, 388, the purpose of the Lanterman Act is threefold: It is to prevent or minimize the institutionalization of developmentally disabled persons and their dislocation from family and community, to enable them to approximate the pattern of everyday living of nondisabled persons of the same age, and to enable them to lead more independent and productive lives in the community.

3. In enacting the Lanterman Act, the Legislature accepted responsibility to provide for the needs of developmentally disabled individuals and recognized that services and supports should be established to meet the needs and choices of each person with developmental disabilities. (Welf. & Inst. Code, § 4501.)

4. "Services and Supports for persons with disabilities" means:

> Specialized services and supports or special adaptations of generic services and supports directed toward the alleviation of a developmental disability or toward the social, personal, physical, or economic habilitation or rehabilitation of an individual with a developmental disability, or toward the achievement

[3] Welfare and Institutions Code section 4500 et. seq.

> and maintenance of independent, productive, normal lives. (Welf. & Inst. Code, § 4512, subd. (b).)

5. Appropriate services and supports include diagnosis, evaluation, treatment, mental health services, protective services, and emergency and crisis intervention. The determination of which services and supports are necessary for each consumer shall be made through the IPP process. (Welf. & Inst. Code, § 4512, subd. (b).)

6. The Lanterman Act gives regional centers, such as IRC, a critical role in the coordination and delivery of services and supports for persons with disabilities. (Welf. & Inst. Code, § 4620 et. seq.) It is the intent of the Legislature to ensure that the IPP and provision of services and supports by the regional center system is centered on the individual and the family of the individual and that takes them into account the needs and preferences of the individual and the family, where appropriate, as well as promote community integration, independent, productive and normal lives, and stable and healthy environments.

7. Welfare and Institutions Code section 4646.4, subdivision (a) provides:

> Regional centers shall ensure, at the time of development, scheduled review, or modification of a consumer's individual program plan developed pursuant to Sections 4646 and 4646.5 or an individualized family service plan pursuant to Section 95020 of the Government Code, the establishment of an internal process. This internal process shall ensure adherence with federal and state law and regulation,

and when purchasing services and supports, shall ensure all of the following:

(1) Conformance with the regional center's purchase of service policies, as approved by the department pursuant to subdivision (d) of Section 4434.

(2) Utilization of generic services and supports when appropriate.

(3) Utilization of other services and psources of funding as contained in Section 4659.

8. Welfare and Institutions Code section 4659, subdivision (a), provides that a regional center shall identify and pursue all possible sources of funding for consumers receiving regional center services. These sources shall include, but not be limited to, governmental, other entities, programs or private entities.

9. Welfare and Institutions Code section 4659, subdivision (b), provides that regional centers may not pay for medical or dental services for a consumer over the age of three unless the regional center is provided with documentation that a health care plan, private insurance, or Medi-Cal denied coverage and unless the regional center determined that the denial does not have merit.

10. In relevant part, Welfare and Institutions Code section 4659.1 provides that, effective July 1, 2013, regional centers may fund co-payments or co-insurance when: (1) the service or support is paid for, in whole or in part, by the health care service plan or health insurance policy of the consumer's parent; (2) the consumer is covered by his or her parent's health plan or health insurance; (3) the family has an annual gross income that is less than 400% of the federal

poverty level; and (4) there is no third party with liability for cost of the service or support.

11. Welfare and Institutions Code section 4659.1, subdivision (c), contains an exception to the prohibition when the service or support is necessary to successfully maintain the consumer at home in the least restrictive setting and the parents or consumer demonstrates one or more of the following:

(1) The existence of an extraordinary event that impacts the ability of the parent, guardian, or caregiver to meet the care and supervision needs of the child or impacts the ability of the parent, guardian, or caregiver, or adult consumer with a health care service plan or health insurance policy, to pay the copayment or co-insurance.

(2) The existence of a catastrophic loss that temporarily limits the ability to pay of the parent, guardian, or caregiver, or adult consumer with a health care service plan or health insurance policy and creates a direct economic impact on the family or adult consumer. For purposes of this paragraph, catastrophic loss may include, but is not limited to, natural disasters and accidents involving major injuries to an immediate family member.

(3) Significant unreimbursed medical costs associated with the care of the consumer or another child who is also a regional center consumer.

EVALUATION

Of the three exceptions under Welfare and Institutions Code section 4659.1 only one possibly applies to claimant. This subdivision (1) concerns "an extraordinary event" that impacts the parents' ability to pay the copayments. The essential question is whether the costs associated with a diabetic pump and the health issues of claimant's mother this last summer qualify as "extraordinary

event(s)" and if so, did these events impact the parents' ability to pay the copayments. The definition of "event" includes the following: "something that happens; a noteworthy happening**;** a social occasion or activity; an adverse or damaging medical occurrence."[4] Consistent with this definition, one event was this change in the family's health coverage, which caused the parents to have to pay $600 for a diabetic pump. Second, claimant's mother suffered a health related event that, similarly, resulted in unexpected costs. Her illness was an event. Both events have impacted claimant's ability to pay the copayments. Therefore, claimant meets the exception requirement set forth in Welfare and Institutions Code section 4659.1, subsection (c)(1).

However, IRC is not obligated to continue paying the copayments indefinitely because the costs at issue are one-time expenses. Since the change in health coverage occurred in July 2013, fourteen months from that date is sufficient time for claimant's family to pay the costs associated with the diabetic pump and the costs associated with his mother's medical care this past summer.[5] This 14 month period is derived from a calculation of $80 per month, the monthly copayment amount for ABA services, and the approximately $1100 in costs incurred by claimant's family, and then by dividing $1100 by $80. Thus, IRC should continue paying the copayments through September 30, 2014.

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[4] http://www.merriam-webster.com/

[5] Claimant has not incurred copayments since July 2013 because he has not been receiving ABA services because of the change in the family's health coverage.

## ORDER

Claimant's appeal is granted. The Inland Regional Center shall continue paying the copayments for claimant's behavioral services through September 2014.

DATED: November 4, 2013

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ABRAHAM M. LEVY

Administrative Law Judge

Office of Administrative Hearings

## NOTICE

This is the final administrative decision in this matter. Each party is bound by this decision. An appeal from the decision must be made to a court of competent jurisdiction within 90 days of receipt of the decision.