BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: C.J.M., Claimant, vs. NORTH LOS ANGELES COUNTY REGIONAL CENTER, Service Agency.	OAH No. 2014060808

DECISION

The hearing in this matter was held on July 28, 2014, in Santa Clarita, California, before Joseph D. Montoya, Administrative Law Judge (ALJ), Office of Administrative Hearings.

Claimant was represented by his parents, sometimes identified collectively by that term, or as Mother or Father.[1] The Service Agency, North Los Angeles County Regional Center (NLACRC or Service Agency) was represented by Ruth Janka, Contract Administrator.

Evidence was received, the case argued, and the matter submitted for decision on the hearing date. The ALJ hereby makes his factual findings, legal conclusions, and order.

[1] Initials and titles are used in the place of names in the interests of privacy.

ISSUE PRESENTED

Must the Service Agency cover the cost of the copayments made by Claimant's parents for behavioral interventions otherwise provided by the family's health insurer?

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FACTUAL FINDINGS

1. Claimant is a three-year-old boy who is eligible to receive services from the Service Agency pursuant to the Lanterman Developmental Disabilities Services Act (Lanterman Act), California Welfare and Institutions Code, section 4500 et seq.[2] Claimant is eligible for services because he suffers from autism.

2. On June 9, 2014, Claimant's parents submitted a Fair Hearing Request which requested reimbursement for copayment for ABA services (Applied Behavioral Analysis.) The record does not disclose whether the Fair Hearing Request was preceded by a Notice of Proposed Action, but it is clear that at some point prior to June 9, 2014, the Service Agency had made clear it would not pay the deductibles. This proceeding ensued. All jurisdictional requirements have been met. (Ex. 1, pp. 8-10.)

3. Claimant lives with his parents and his nine-month-old sister within the Service Agency's catchment area. He had received Early Start services prior to becoming eligible for services under the Lanterman Act. Both of his parents can be described as white collar professionals; Father is CFO of a financial company, and Mother is a workers compensation insurance consultant. (Ex. 8, p. 1.)

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[2] All statutory references are to the Welfare and Institutions Code, unless otherwise noted.

4. Claimant exhibits maladaptive behaviors, such as tantrums, throwing things, and hitting. He has hit his little sister, and the family's dogs, who have become scared of the boy. He has no sense of danger, and will elope from the house and down the street, or will run away in the community. He needs constant supervision. (Ex. 8, p. 2.)

5. Claimant is receiving ABA services through the family's health insurance provider, Anthem Blue Cross. (Ex. 3.) The therapy is performed by Behavioral Learning Center, Inc. (Ex. 2.) The therapy schedule is fairly robust, as there are 13 sessions per week with a paraprofessional, and 4 session per week with a supervisor. (*Id.*)

6. Under the health plan, the co-pay for each session is $20, and thus Claimant's parents are exposed to co-payments of $340 per week, or $1,440 per month. (Ex. 2.) However, under their health plan, such expenses are capped at $3,500 per year, or just under $300 per month. (Ex. 9.)

7. Claimant's parents requested that the Service Agency pay the $3,500 in yearly co-payments. They pointed to significant expenses, associated in part with the fact that each parent contributes to the support of the parent's mother. They also have significant transportation expenses, as they work in Los Angeles, but must commute from the Santa Clarita Valley. They work long hours, and need the assistance of a nanny; they pay her more than they might pay other caregivers because she has to manage Claimant's behaviors.

8. The Service Agency requested copies of the parents' tax returns or W-2 forms so that they could verify income. Those documents were not forthcoming.[3]

[3] During the hearing, the Service Agency's witness testified that neither document was produced; when parents testified they had a vague recall of submitting the W-2s to one of the Service Agency staff persons, not the witness or the service coordinator. The interdisciplinary staff, when considering the request, worked with the income figure

Instead, parents prepared a simple schedule, showing gross income, and a number of expense categories, such as mortgage expenses, food, car and home insurance, or food.

9. Parents' income and expense schedule, exhibit 4, states gross income of $304,884. This is more than four times the federal poverty level. Under the applicable statute, regional centers normally may not pay co-payments if the family annual gross income exceeds 400 per cent of the federal poverty level. (§ 4659.1, subd. (a)(2).) Four hundred percent of the federal poverty level, currently, is approximately $95,000. Thus, it appears that the family's gross income is approximately 1225 per cent of the federal poverty level. Further, if Claimant's family was a family of six, 400 per cent of the poverty level would be $127, 000 per year, and thus Claimant's family would exceed the federal poverty level by approximately 950 percent.[4]

10. Parent's income and expense schedule showed federal taxes of $60,607, with state taxes at just over $20,000, and property taxes of $7,500. Their mortgage is $36,600 and the annual expense for the nanny is $36,000. They contribute $23,400 per year to the support of their parents, have student loan debt that costs $15,000 per year, and insurance for their home, car, and health totals $12,200 per year. Car payments are just under $11,000 per year, and food is set forth at $15,000 per year. Gasoline for their commute is scheduled at $7,200 per year, entertainment as $4,800, and clothing at

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stated by parents on their schedule. (Ex. 7.) In all the circumstances, it must be found that parents did not submit their W-2s to the Service Agency.

[4] The Service Agency pointed to the figure for a six-member family because Claimant's two grandmothers receive financial assistance from his parents; this was an effort to take that generosity into account even though the grandmothers don't actually live in the household. However, that attempt to manipulate the basic requirement is unavailing in this case.

$3,000 per year. There are miscellaneous expenses of $1,500, utilities at $7,200, and day care of $8,400 per year. The parents contribute $34,000 per year to a 401(k) plan, as they have no pension or other retirement plan through their employers. All told, parents showed net cash flow after the aforementioned expenses of $1,659 per year, or $138.25 per month. (Ex. 4.)

11. Parents assert that their expenses qualify for an exemption under the applicable statute, on the grounds that their expenses are extraordinary, especially in light of their support of their mothers.

LEGAL CONCLUSIONS

JURISDICTION

1. Jurisdiction was established to proceed in this matter, pursuant to section 4710 et seq., based on Factual Findings 1and 2.

LEGAL RULES OF GENERAL APPLICATION

2. Services are to be provided in conformity with the consumer's Individual Program Plan (IPP), per section 4646, subdivision (d), and section 4512, subdivision (b). Consumer choice is to play a part in the construction of the IPP. Where the parties cannot agree on the terms and conditions of the IPP, a Fair Hearing may establish such terms. (See § 4710.5, subd. (a).)

3. The services to be provided to any consumer must be individually suited to meet the unique needs of the individual client in question, and within the bounds of the law each client's particular needs must be met. (See, e.g., §§ 4500.5, subd. (d), 4501, 4502, 4502.1, 4512, subd. (b), 4640.7, subd. (a), 4646, subd. (a), 4646, subd. (b), 4648, subd. (a)(1) &. (a)(2).) Otherwise, no IPP would have to be undertaken; the regional centers could simply provide the same services for all consumers. The Lanterman Act

assigns a priority to maximizing the client's participation in the community. (§§ 4646.5, subd. (2); 4648, subd. (a)(1) & (a)(2).)

4. Section 4512, subdivision (b), of the Lanterman Act states in part:

> 'Services and supports for person with developmental disabilities' means specialized service and supports or special adaptations of generic services and support 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 and maintenance of independent, productive, normal lives. . . . The determination of which services and supports are necessary shall be made through the individual program plan process. The determination shall be made on the basis of the needs and preferences of . . . the consumer's family, and shall include consideration of . . . the effectiveness of each option of meeting the goals stated in the individual program plan, and the cost-effectiveness of each option. Services and supports listed in the individual program plan may include, but are not limited to, diagnosis, evaluation, treatment, personal care, day care, . . . physical, occupational, and speech therapy, . . . recreation, . . . *behavior training and behavior modification programs*. . . respite, . . . social skills training, . . .and transportation services necessary to ensure delivery of services to persons with developmental disabilities. (Emphasis added.)

5. Services provided must be cost effective (§ 4512, subd. (b), *supra*), and the Lanterman Act requires the regional centers to control costs as far as possible and to otherwise conserve resources that must be shared by many consumers. (See, e.g., §§ 4640.7, subd. (b), 4651, subd. (a), 4659, and 4697.) It is clear that the regional centers' obligations to other consumers are not controlling in the individual decision-making process, but a fair reading of the law is that a regional center is not required to meet a consumer's every possible need or desire, in part because it is obligated to meet the needs of many children and families.

6. The regional centers are required to utilize the service coordination model, in which each consumer shall have a designated service coordinator "who is responsible for providing or ensuring that needed services and supports are available to the consumer." (§ 4640.7, subd. (b).)

7. The IPP is to be prepared jointly by the planning team, and services purchased or otherwise obtained by agreement between the regional center representative and the consumer or his or her parents or guardian. (§ 4646, subd. (d).) The planning team, which is to determine the content of the IPP and the services to be purchased, is made up of the disabled individual, or their parents, guardian or representative, one or more regional center representatives, including the designated service coordinator, and any person, including service providers, invited by the consumer. (§ 4512, subd. (j).)

8. When developing IPP's for children, the regional center is to be guided by the principles, process, services, and support parameters laid out in section 4685. (§ 4646.5, subd.(a)(3).) Section 4685 makes it a clear legislative priority that disabled children remain with their families, and the regional centers are to be innovative so that the goal can be met. (§ 4685, subd. (c)(1).) With that in mind, it should be remembered that the regional centers are specifically authorized to utilize "innovative service delivery

mechanisms, including but not limited to, vouchers, . . ." (§ 4685, subd. (c)(3).) The intent that the regional centers be innovative and economical in the practices used to reach the goals set out in IPP's is also set forth in section 4651.

9. Section 4648, subdivision (a)(8), provides that "Regional center funds shall not be used to supplant the budget of any agency which has a legal responsibility to serve all members of the general public and is receiving public funds for providing those services." Section 4659 has long provided that the regional centers shall identify and pursue all possible sources of funding for consumers receiving services.

LEGAL CONCLUSIONS SPECIFIC TO THIS CASE

10. Section 4659 underwent substantial revision in 2009. The statute retained its mandate for the regional centers to pursue sources of funding for their consumers, such as generic resources (school systems, Medi-Cal, etc.). The statute now provides that the regional centers shall not purchase services that could be obtained by the consumer from traditional generic resources, as well as "private insurance, or a health care service plan when a consumer or family meets criteria of this coverage but chooses not to pursue that coverage." (§ 4659, subd. (c).)

11. It must be observed that the recent budget crises, and especially of 2009, drove a number of changes to the Lanterman Act, and in many cases those changes limited the scope of services that could be provided, even if the list of services set out in section 4512, subdivision (b), was not specifically modified. Hence, limits on how much respite could generally be provided were put in place. Social recreational services, including camping, were all but eliminated, and restrictions were put in place regarding behavioral therapies. (§ 4685.5 [limiting respite hours]; § 4648.5 [suspending camping and social recreation services]; § 4686.2, [behavioral services].)

12. The legislature required health insurance carriers in California to provide behavioral interventions for persons such as Claimant. This had the effect of shifting

much of the burden of providing such services from the taxpayers, who fund the regional centers, to those participating in the health insurance system, people like Claimant's parents. Thus, in the case of Claimant's family, which has health insurance, the Service Agency is not obligated to provide behavioral therapies, notwithstanding section 4512, subdivision (b).

13. It is undisputed that Claimant's family has health insurance that would provide behavioral interventions. It follows that under section 4659, subdivision (c), the Service Agency may not continue to purchase the behavioral interventions for Claimant.

14. Section 4659.1 was enacted in 2013, becoming effective late in June of that year. It governs the payment, by the regional centers, of co-payments, co-insurance, and deductibles. Subdivision (a) of the statute provides that a regional center "may, when necessary to ensure that the consumer receives the service [provided by an insurer or health care plan] pay any applicable copayment . . . if all of the following conditions are met:

(1) The consumer is covered by his or her parent's, guardian's, or caregiver's heath care service plan or health insurance policy.

(2) The family has an annual gross income that does not exceed 400 percent of the federal poverty level.

(3) There is no other third party having liability for the cost of the service or support, ..."

The statute also provides some exceptions, for where a family's income exceeds the 400 percent rule quoted above. That exemption is discussed below.

15. In any case where the consumer's parents seek regional center assistance for payment of the copayments, they must provide documentation to the regional center. Thus, section 4659.1, subdivision (d), provides:

> The parent . . . with a health insurance policy shall self-certify the family's gross annual income to the regional center by providing copies of W-2 Wage Earner's Statements, payroll stubs, a copy of the prior year's state income tax returns, or other documents and proof of other income.

That has not occurred in this case, as the statement provided by the parents does not meet the test set out above. (Factual Finding 8.) That alone might be considered fatal to the case, but in all the circumstances, will not be deemed as cause to deny their request.[5]

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[5] Implicit in the Act's requirement that IPP's be reviewed at least every three years is the requirement that necessary assessments be conducted. (See § 4646.5.) The regional centers cannot discharge their duties if they do not have the right to obtain information, and the power to obtain that information. This is based on a long-accepted legal concept. (See Hohfeld, Some Fundamental Legal Conceptions as Applied in Judicial Reasoning, 23 Yale L.J. 16 (1913).) At the same time, a person who seeks benefits from a regional center must bear the burden of providing information, and submitting to reasonable exams and assessments. (See Civ.Code, § 3521.) Further, a request for services essentially waives objection to the regional center and its staff and consultants having access to otherwise private information. That does not mean, however, the information can otherwise be disseminated for any purpose other than to assess a consumer and provide services. Thus, a consumer must cooperate in reasonable requests for assessments and evaluations, to assist the regional center in discharging its responsibility. Where the law requires a certain method of proving entitlement to a service, that entitlement must be demonstrated accordingly.

16. Claimant does not meet the requirements of section 4659.1, subdivision (a), as the family income is far in excess of the limit set by the statute. (Factual Finding 9.)

17. (A) There is one exception to the aforementioned rule, referred to as an exemption by the parties during the hearing. Section 4659.1, subdivision (c), provides that a regional center may pay the copayments associated with a health insurance policy, when connected to a service that is needed by a consumer, and where the family income exceeds 400 percent of the federal poverty level. However, there are certain conditions that must be met.

(B) First of all, subdivision (c) requires that any such payment by the regional center is necessary to successfully maintain the child in the home. That has not been demonstrated in this case.

(C) Even if it is shown that payment by the center is needed to maintain the child successfully in the home, the parents of the consumer must demonstrate either that there has been an extraordinary event that impacts the ability to meet the care and supervision needs of the child or which impacts the parents' ability to pay the copayment, or, that there has been a catastrophic loss that temporarily impacts the ability to pay the copayments, or, that there are significant unreimbursed medical costs associate with the care of the consumer or another child who is also a consumer of regional center services. (§4659.1, subd. (c)(1)-(3).)

(D) Catastrophic losses are defined to include events such as natural disasters and accidents involving major injuries. Claimant's parents have not cited such an event. Nor can they point to large unreimbursed medical expenses for Claimant or his sister, who in any event is not a regional center consumer, and therefore could not bring the family within the exception.

18. (A) Parents point to the provision allowing payment where there has been an extraordinary event, at subdivision (c)(1). While "extraordinary event" is not itself defined, it must, under the statute, be an event that impacts the ability of the parents to meet the care and supervision requirements of the child, or to make the copayments.

(B) There has been no event, let alone an extraordinary one, that is preventing Claimant's parents from making the capped copayments. That they support their mothers is laudable, but is not extraordinary; many adults support their parents, whether through a payment of monies every month, or moving them into their homes, or by paying for care in a facility. Likewise, the expenditures that parents list are not, themselves, driven by some extraordinary circumstance.

(C) At bottom, the law will require parents to spend a little more than one percent of their gross income in order to provide badly needed services for Claimant. This apparently will cause a change in the family's expenditures. It may require a reduction, but not elimination, of spending in a few categories, i.e, a few hundred dollars less in entertainment, clothes, and retirement contributions. In the future it may mean that parents have to drive a car longer after it is paid off. This is the sort of things that familyies all over America do when some illness or malady strikes a child. Fortunately, parents in this case are better equipped to meet this challenge than some family that has a gross income of $135,000. And, plainly, if they made less than $95,000 per year, the $3,500 in deductible payments would be more significant, while at the same time they would not be able to afford a full-time nanny, or a mortgage of $3,000 per month.

(D) Parents voiced concern over the long term expense associated with the behavioral interventions, i.e., the possibility of paying $35,000 over a 10 year period. It might be more than that if costs change. Perhaps it will be less than that if the need for the services decreases, or if another source of assistance arises. At the same time, perhaps some family expenses will decrease; i.e., once Claimant is in school some costs

associated with his care might go down. In any event, experience teaches that early intensive behavioral interventions can be crucial to ameliorating the effects of autism, and have the best chance of success. Thus, such expenditures should be made if they will bring results, and sacrifices should be made if necessary to obtain them. That the Legislature has made it very difficult, at best, for the regional centers to assist middle class families in cases of this type cannot legally be denominated a form of discrimination, even if the ALJ does not agree with the policy; the ALJ is barred from declaring a statute unconstitutional or unenforceable. (Cal.Const., art. III, § 3.5.) This leaves such families to pursue coverage from their health insurer, and to do all they can with whatever resources are available, just as they might if their child had some congenital condition that did not make him or her eligible for regional center services.

ORDER

Claimant's appeal is denied. The Service Agency will not be required to make any copayments for Claimant's behavioral therapy.

August 11, 2014

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Joseph D. Montoya
Administrative Law Judge
Office of Administrative Hearings

NOTICE

THIS IS THE FINAL ADMINISTRATIVE DECISION IN THIS MATTER, AND BOTH PARTIES ARE BOUND BY IT. EITHER PARTY MAY APPEAL THIS DECISION TO A COURT OF COMPETENT JURISDICTION WITHIN NINETY (90) DAYS OF THIS DECISION.