BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: M.J., Claimant, vs. NORTH LOS ANGELES COUNTY REGIONAL CENTER, Service Agency.	OAH No. 2013110578

CORRECTED DECISION

On April 10, 2014, the undersigned issued his decision in this matter. Thereafter, it was noted that the Decision set forth the wrong date of the hearing; it stated that the hearing was held on March 26, 2011, rather on the correct date, March 26, 2014.

The statement of the incorrect date resulted from the inadvertence and mistake of the undersigned in the course of editing and completing the decision. It is deemed a technical mistake, subject to correction by the undersigned. (See *Russ v. Smith* (1968) 264 Cal.App.2d 385, 391.) Following is the decision, corrected to set forth the proper date of the hearing, with no other changes.

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The hearing in the above-captioned matter was held on March 26, 2011, before Joseph D. Montoya, Administrative Law Judge, Office of Administrative Hearings.

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Claimant was represented by Claimant's 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 Stella Dorian, Fair Hearing Representative.

Evidence was received, the case argued, and the matter submitted for decision on the hearing date. Claimant submitted documentary evidence at the hearing, pertaining primarily to medical expenses. The evidence was organized by category, but not clearly identified. It is therefore identified and received in evidence, as follows:

The documents identified as "outstanding medical bills" are made exhibit A.

The documents identified as "family prescriptions" are made exhibit B.

The documents identified as "insurance premiums" are made exhibit C.

The documents identified as "medical bills paid" are made exhibit D.

The documents identified as "family EOB's" are made exhibit E.

The letter from Brian Rice is made exhibit F.

Because the documents contain sensitive private information, including medical and financial information, the exhibits will be sealed, subject to a protective order that shall prevent inspection except by OAH staff or a court of competent jurisdiction.

The AL J hereby makes his factual findings, legal conclusions, and orders, as follows:

ISSUE PRESENTED

May the Service Agency terminate funding for behavioral services, on the grounds that Claimant's parents have health insurance that could provide the services, despite the parents' assertion that they cannot afford the deductible and co-payments?

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

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FACTUAL FINDINGS

1. Claimant is a ten-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 October 13, 2013, the Service Agency issued its Notice of Proposed Action (NOPA), stating that it intended to terminate funding for behavioral services because Claimant has private insurance. The Service Agency cited section 4659, subdivision (a)(2), as authority for its proposed action.

3. Mother filed a Fair Hearing Request in a timely manner, and this proceeding ensued. All jurisdictional requirements have been met. (Ex. 1, pp. 13, 14.)

4. Claimant lives with his parents and his younger brother within the Service Agency's catchment area. He receives special education services from his school district. His school district is funding a non-public school for him. That placement occurred in recent months, but in 2013 there was a period of approximately nine months when he was not in school, because an adequate placement could not be found.

5. Claimant presents significant behavioral challenges for his family and others in his life, such as teachers or fellow students. NLACRC does not dispute the need for behavioral services, which it has funded for a significant period of time. At the time of the hearing, the Service Agency was funding 10 hours per week of behavioral interventions, along with eight hours of supervision per month by the provider, Pacific Child and Family. (See Ex. 1, p. 18.)

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

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6. Claimant is covered by health insurance that would provide behavioral therapy for him. The issue for Claimant's family is the cost of the deductible that must be met before his insurance company would begin to pay for the services. That deductible is $3,000 for Claimant; there is a separate deductible for each of the four family members regarding their medical expenses.

7. Claimant's family is under considerable stress, much of which is a function of Claimant's significant behavioral issues, behavioral issues emerging with Claimant's younger brother, and health problems that both parents face. The medical problems add additional financial strain.

8. (A) Mother has been diagnosed with Multiple Sclerosis, and treating it, especially when it flares up, can be very expensive. Not only must she purchase medications, and seek treatment from physicians, the testing can be very expensive, and the health insurance carrier may or may not authorize payment. As of the hearing date, the family was struggling with unpaid medical bills, some of which had gone to collection in 2013 and early 2014; the amount owed on such outstanding bills exceeded $3,000. (Ex. A.)

(B) By August 2, 2013, Mother had met her $3,000 yearly deductible. During 2013, the family paid approximately $3,500 in co-pays, and as its share of various medical bills. Approximately $1,000 of those payments was made for charges incurred in the latter half of 2012, which further indicates the difficulty in meeting medical expenses.[3]

(C) Father suffers from Bi-Polar Disorder, which had been manageable for many years. In recent months, it has become a bigger issue, requiring medication, and

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[3] These figures are derived from exhibit D, a series of statements from various medical providers, or their collection agencies. The ALJ approximated their amount, rounding the numbers; the same is true for other figures cited.

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threatening his ability to work. (Father is the family breadwinner.) Claimant requires some medication as well, although the cost is nominal.

9. In 2013, the family medical insurance premiums exceeded $9,650, up from $7,920 in 2012. (Ex. C, pp. 2-3.)

LEGAL CONCLUSIONS

1. Jurisdiction was established to proceed in this matter, pursuant to section 4710 et seq., based on Factual Findings 1through 3.

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., Code §§ 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. (A) 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

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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.)

(B) It must be observed that the budget crises of 2009 drove a number of amendments to the Lanterman Act, and in many cases those amendments 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

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[limiting respite hours]; § 4648.5 [suspending camping and social recreation services]; § 4686.2, [behavioral services].) The effect of other amendments is discussed below.

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 shall 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, and services and support parameters laid out in section 4685. (§ 4646.5, subd.(a)(3).) Section 4685 makes it a clear legislative priority that disabled

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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.

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 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.

12. Claimant's parents are concerned with paying the deductible. Plainly, it adds a substantial expense for a family already faced with difficult medical bills. However, under the law the Service Agency cannot pay the deductible; no exception was written into the statute as to the deductible. (§ 4659.1, subd. (g).) This expense, under the law, must be borne by Claimant's parents.

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13. During the proceeding, the issue of making the co-payments was raised. That issue is not properly before the ALJ. As noted by Ms. Dorian, there are some exceptions in the statute that could allow for the Service Agency to assist with the co-payments. (§ 4659.1, subd. (c).)

14. As noted by the ALJ during the hearing, sections 4659 and 4659.1, subdivision (g), raise the specter of some families being unable to meet their part of the obligation to purchase badly-needed behavioral services, while leaving the regional centers without authority to assist consumers in obtaining badly-needed services. Such circumstances would hardly be consonant with the provisions of section 4501. However, it cannot be found, on this record, that Claimant's parents cannot make the sacrifices necessary to pay Claimant's deductible.

15. In normal circumstances, payment for the behavioral services could end 10 days after receipt of the final order in this case. (§ 4715, subd. (a)(3).) Given that some time may be needed to bring the health insurer's program on line, a gap in service may occur, which would be detrimental. Therefore, it shall be ordered that services shall be provided for 30 days after receipt of this decision by the parties.

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ORDER

Claimant's appeal is denied. The Service Agency may cease providing behavioral therapy 30 days from the receipt of this decision.

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April 10, 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.

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