BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: R.S., Claimant, vs. WESTSIDE REGIONAL CENTER, Service Agency.	OAH No. 2014020222

DECISION

This matter was heard by Humberto Flores, Administrative Law Judge with the Office of Administrative Hearings, on May 9, 2014, in Los Angeles, California.

Claimant did not appear at the hearing but was represented by his mother and father.

Lisa Basiri, Fair Hearing Coordinator, represented the Westside Regional Center (WRC or regional center).

Evidence was received and the matter was submitted for decision. The Administrative Law Judge makes the following findings, legal conclusions and order.

ISSUE

Should WRC continue to provide funding for health insurance co-payments for claimant's Applied Behavior Analysis service that is covered by claimant's or his family's insurance?

FACTUAL FINDINGS

1. Claimant is a 16-year-old boy who qualifies for regional center services based on a diagnosis of autism.

2. Claimant has deficits and/or difficulties in the areas of compliance and socialization. He also exhibits sensory issues. He also exhibits challenging behaviors that affect social interactions with peers and family.

3. Claimant currently receives Applied Behavioral Analysis services provided by CARD. These services have helped claimant improve his behavioral challenges but he continues to need these services.

4. Prior to July 1, 2013, WRC funded insurance co-payments for regional center clients (including claimant) receiving Applied Behavior Analysis (ABA), whose Individual Program Plan (IPP) identified the need for ABA services, and who enjoyed coverage for this service under the family's private insurance.

5. In a letter dated October 2, 2013, the regional center informed claimant's parents of a new statute (Welfare and Institutions Code section 4659.1) effective July 1, 2013, which limits the regional centers' discretion to provide funding for co-payments for services that are covered under private insurance for regional center clients. The letter further stated that regional centers were allowed to fund insurance co-payments under specific conditions, including (1) the service is paid, in part, by the client's or family's health insurance; (2) the client is covered under the plan; (3) the family has an annual gross income that does not exceed 400 percent of the poverty level; and (4) there is no third party having liability for the cost of the service or support.

6. On October 2, 2013, WRC issued a Notice of Proposed Action notifying claimant and his parents that the regional center would no longer provide funding for insurance co-payments for ABA unless the family's income is less that 400 percent of the poverty level. Claimant's parents submitted W-2 Statements indicating that claimant's

father earned $172,880 in 2012. On December 11, 2013, WRC issued a second Notice of Proposed Action notifying claimant and his parents that the regional center would no longer provide funding for insurance co-payments for ABA services effective December 11, 2013. WRC based its decision on Welfare and Institutions Code section 4659.1. On February 6, 2014, claimant filed a request for hearing.

7. Claimant's father testified that his income in 2013 was 161,400, and he expects his income to be less this year. Claimant's mother testified that the family has significant out-of-pocket costs including $500 a week for his one-to-one school aid, and approximately $1,300-$1,500 per month for homeopathic medications. The money paid to the one-to-one aide is voluntary on the part of claimant's parents because the school district provides claimant with a one-to-one aide. Claimant and his parents prefer a particular one-to-one aide so they pay this person $15 and hour over an above the $10 per hour she receives from the school district.

8. The undersigned takes Official Notice pursuant to Government Code section 11515, of a publication issued by the Department of Health Care Services, State of California, setting forth the Federal Poverty Levels based on family size. In 2013, annual poverty level for a family of three was $19,530. Therefore, the income cutoff for receiving insurance co-payment funding is $78,120.

9. Claimant did not present evidence of an existence of an extraordinary event that impacts his parent's ability to pay insurance co-payments or meet the care and supervisions needs of claimant. Nor did he present evidence of an extraordinary loss that would limit his parent's ability to make said co-payments. Claimant's expenses for homeopathic medications as set forth in Factual Finding 6 are significant. However, even when considering these expenses, the family's income would still be far above the maximum income allowable under Welfare and institutions Code section 4659.1.

LEGAL CONCLUSIONS

1. Welfare and Institutions Code section 4512, subdivision (b) of the Lanterman Developmental Disabilities Services Act states in part:

> "Services and supports for person with developmental disabilities" means specialized service 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 re-habilitation of an individual with a developmental disability, or toward the achievement and maintenance of independent, productive, normal lives. . . . Services and supports listed in the individual program plan may include, but are not limited to, . . . behavior modification . . . .

2. The services to be provided to any consumer must be individually suited to meet the unique needs of the individual client in question. Within the bounds of the law each client's particular needs must be met, taking into account the needs and preferences of the individual and the family. This requires an active participation by the consumer and her legal guardians. (See Welf. & Inst. Code, §§ 4646, subds. (a) & (b), and 4648, subd. (a) (2).)

3. Services provided must be cost effective (Welf. & Inst. Code § 4512(b), *supra*), and the Lanterman Act requires the regional centers to control costs so far as possible, and to otherwise conserve resources that must be shared by many consumers. (See, e.g., Welf. & Inst. Code, §§ 4640.7, subd. (b), 4651, subd. (a), 4659, and 4697.) To be sure, the obligations to other consumers are not controlling in the decision-making

process, but a fair reading of the law is that a regional center is not required to meet a disabled child's every possible need or desire, in part because it is obligated to meet the needs of many children and families.

4. Welfare and Institutions Code section 4659.1 limits regional centers' discretion to provide funding for insurance co-payments for consumer services that are covered by private insurance. Section 4659.1 provides in pertinent part:

> (a) If a service or support provided pursuant to a consumer's individual program plan under this division or individualized family service plan pursuant to the California Early Intervention Services Act (Title 14 (commencing with Section 95000) of the Government Code) is paid for, in whole or in part, by the health care service plan or health insurance policy of the consumer's parent, guardian, or caregiver, the regional center may, when necessary to ensure that the consumer receives the service or support, pay any applicable copayment or coinsurance associated with the service or support for which the parent, guardian, or caregiver is responsible if all of the following conditions are met:
>
> (1) The consumer is covered by his or her parent's, guardian's, or caregiver's health 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, as provided in subdivision (a) of Section 4659 and Article 2.6 (commencing with Section 4659.10).
>
> [¶ . . . ¶]
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> (c) Notwithstanding paragraph (2) of subdivision (a) or paragraph (1) of subdivision (b), a regional center may pay a copayment or coinsurance associated with the health care service plan or health insurance policy for a

service or support provided pursuant to a consumer's individual program plan or individualized family service plan if the family's or consumer's income exceeds 400 percent of the federal poverty level, the service or support is necessary to successfully maintain the child at home or the adult consumer in the least-restrictive setting, and the parents or consumer demonstrate 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 coinsurance.

(2) The existence of 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.

(d) The parent, guardian, or caregiver of a consumer or an adult consumer with a health care service plan or health insurance policy shall self-certify the family's gross annual income to the regional center by providing copies of W-2 Wage Earners Statements, payroll stubs, a copy of the prior year's state income tax return, or other documents and proof of other income.

5. In this case, the evidence established that claimant's ABA is covered by his family's health insurance. Claimant's family has not suffered a catastrophic loss or

experienced an extraordinary event which would impact the family's ability make insurance co-payments or meet claimant care and supervisions needs. Further, claimant's un-reimbursed expenses for homeopathic medications are not "significant" in relation to the family income. Reducing the family income by these expenses would still place it far above the maximum allowable income for a family of three under Welfare and Institutions Code section 4659.1. Finally, the payments made to claimant's one-to-one school aide are not considered an exception to Welfare and Institutions Code section 4659.1. In any event, this expense is voluntary on the part of claimant's parents because the school district provides for and pays the salary of the claimant's one-to-one aide. However, claimant and his parents prefer a particular one-to-one aide so they pay this person $15 an hour over and above the salary she receives from the school district. Therefore, the evidence did not establish that claimant is eligible to receive regional center funding for insurance co-payments.

6. Cause exists to affirm the decision of the Westside Regional Center to terminate funding for insurance co-payments for claimant's ABA services that are covered by his family's health insurance. This decision is based on the facts set forth in findings 1 through 9, the application of Welfare and Institutions Code sections 4512, 4646, 4648, 4659, subdivision (c), and 4659.1, to the facts of this case.

ORDER

The decision of the Westside Regional Center terminating funding for insurance co-payments for claimant's ABA services is affirmed. Claimant's appeal is denied.

DATED: May 21, 2014

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HUMBERTO FLORES

Administrative Law Judge

Office of Administrative Hearings

NOTICE

This is the final administrative decision. Both parties are bound by this decision. Either party may appeal this decision to a court of competent jurisdiction within 90 days.