BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: CLAIMANT, vs. SAN ANDREAS REGIONAL CENTER, Service Agency.	OAH No. 2014120616

DECISION

Administrative Law Judge Dianna L. Albini, State of California, Office of Administrative Hearings, heard this matter on January 22, 2015, in Campbell, California.

James Elliott, Fair Hearing Specialist, represented the service agency, San Andreas Regional Center (SARC).

Claimant was represented by his father.

The record was left open for receipt of additional documentation from claimant and closing argument from the parties. Claimant's additional documentation was timely received, marked for the record as Exhibit L, and received in evidence. Claimant's closing and rebuttal briefs were timely received, marked for the record as Exhibits M and N, and considered. Rebuttal documentation received from the regional center on February 13, 2015, was marked for the record as Exhibit 9, but not received in evidence. The regional center's closing and rebuttal briefs were marked for the record as Exhibits 10 and 11 and considered.

The matter was submitted for decision on February 23, 2015. ALJ Albini is not available to prepare the decision. Pursuant to an agreement of the parties, a transcript

of the hearing was ordered and the matter reassigned to Administrative Law Judge Jill Schlichtmann for preparation of the decision in this case. The decision is based upon the transcript, the exhibits admitted in evidence at hearing, and any post hearing briefs or submissions authorized by ALJ Albini or ALJ Schlichtmann.

ISSUES

1. Is SARC obligated to fund the insurance copayments, coinsurance or deductibles for claimant's applied behavior analysis, occupational therapy and speech therapy services, pursuant to Welfare and Institutions Code section 4659.1?

2. Must SARC fund the copayments, coinsurance or deductibles pending the outcome of the fair hearing, pursuant to Welfare and Institutions Code section 4715?

FACTUAL FINDINGS

1. Claimant is a nine-year-old boy who is eligible for regional center services based upon a diagnosis of autism. Claimant lives at home with his parents and sibling.

2. The Lanterman Developmental Disabilities Services Act (Lanterman Act)[1] sets forth the services and supports available to developmentally disabled consumers of regional centers. The consumer's needs, and the services and supports required to meet those needs, are developed through the Individual Program Plan (IPP) process. (§§ 4620, 4646.) Occupational therapy, speech therapy and applied behavior analysis (ABA)[2] are

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[1] Welfare and Institutions Code, section 4500 et seq. Further statutory references are to the Welfare and Institutions Code unless stated otherwise.

[2] ABA is defined in the Lanterman Act as "the design, implementation, and evaluation of systematic instructional and environmental modifications to promote

services funded by regional centers pursuant to the Lanterman Act to meet the needs of its consumers.

3. Claimant's 2013 IPP provides for one and one-half hours per week of speech therapy, one hour per week of occupational therapy, and 22 hours per week of ABA services. These services are funded by the family's private insurer, pursuant to section 4659, subdivisions (a) and (b).

4. In 2014, SARC funded the insurance copayments for these services. Section 4659.1 limits the instances in which a regional center is permitted to reimburse a consumer for insurance copayments, coinsurance and deductibles charged by private insurer. Section 4659.1 provides that regional centers may fund copayments, coinsurance and deductibles when the family's annual gross income that is less than 400 percent of the federal poverty level.[3] Section 4659.1, subdivision (d), requires the parent of a consumer requesting a regional center to fund copayments, coinsurance or deductibles to certify the family's gross income 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. If the family's income exceeds 400 percent of the federal poverty level, the regional center may fund copayments only if the consumer can establish one of three exceptions: 1) the existence of an extraordinary event which impacts the ability of the parent to pay the copayment; 2) the existence of catastrophic loss (such as from a

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positive social behaviors and reduce or ameliorate behaviors which interfere with learning and social interaction." (§ 4686.2, subd. (d)(1).)

[3] For a family of four, 400 percent of the federal poverty level is approximately $96,000.

natural disaster or accident involving major injuries) that temporarily limits the parent's ability to pay and creates a direct economic impact on the family; or, 3) the existence of significant unreimbursed medical costs of the consumer's care. (§ 4659.1, subd. (c).)

6. Pursuant to SARC's policy, requests for exceptions pursuant to section 4659.1, subdivision (c), are made by the Executive Director after consideration by the Executive Director and the Exceptions Committee. Exceptions are granted on an annual basis and only apply for the calendar year. An annual exception does not constitute an ongoing service; a claimant must reapply for an exception for a subsequent year.

7. On September 25, 2014, claimant's father contacted SARC District Manager Kara Hernandez to inquire about the process for requesting an exception for 2015. On October 2, 2014, Hernandez advised claimant's father that the process had not changed and he should submit documentation in support of his request to claimant's service coordinator. On October 20, 2014, claimant's father submitted his request and the supporting documentation to Hernandez and claimant's service coordinator. Following several email messages in which Hernandez requested additional information, the packet was submitted to the Executive Director and the Exceptions Committee for consideration.

8. The Exceptions Committee reviewed the information submitted by claimant's father. After reviewing the family's annual gross income and the evidence of medical expenses presented, the Exceptions Committee determined that claimant did not establish grounds for an exception pursuant to section 4659.1, subdivision (c).

9. On November 17, 2014, SARC sent the family a notice of proposed action in which it denied funding for copayments, coinsurance or deductibles for 2015. Claimant did not receive the notice until December 7, 2015. On December 15, 2014, the regional center received a fair hearing request challenging the denial from claimant.

10. Claimant contends that although the family's gross annual income exceeds 400 percent of the federal poverty level, SARC should pay its copayments, coinsurance and deductibles because of the existence of significant unreimbursed medical costs of claimant's care. (§ 4659.1, subd. (c)(3).)

EVIDENCE IN SUPPORT OF REQUEST FOR EXCEPTION PURSUANT TO SECTION 4659.1, SUBDIVISION (C)(3)

11. Claimant's father estimates that the family's gross income for 2015 will be between $233,000 and $253,000.

12. In support of his request for an exception pursuant to section 4659.1, subdivision (c)(3), claimant submitted four types of unreimbursed medical expenses. The first category is coinsurance for ABA, occupational therapy and speech therapy services. Following a 2012 fair hearing, claimant was found to require 22 hours per week of ABA therapy, one and one-half hours per week of speech therapy, one hour per week of occupational therapy. These services are provided through claimant's 2013 IPP. The copayments for these services are estimated at between $3,000 and $3,500.

Claimant receives more ABA therapy, speech therapy and occupational therapy than is identified in the IPP. The cost of these services is borne by claimant's private insurance. The cost of the coinsurance for these services (including both those contained in the IPP and those provided beyond that which is contained in the IPP) is identified by claimant's father as $14,018.

13. The second category of unreimbursed medical expenses proffered by claimant's father is the annual cost of insurance premiums; the annual cost of insurance premiums estimated by claimant's father is $5,441. It appears that this cost is for the family's insurance, not just for a policy for claimant. Insurance premiums are the sort of expenses that are incurred, whether or not a family member is developmentally disabled.

14. The third category of unreimbursed medical expense is the cap on deductibles and copayments. The cap on the family's 2015 deductible and copayment costs is $6,000 for preferred providers and $12,000 for non-preferred providers. Thus, claimant adds a total of $18,000 to the calculation of unreimbursed medical expenses. Again, this cost appears to be for the entire family, rather than solely for claimant. Moreover, there is no evidence that these costs will be incurred; rather, this is the upper limit of the family's contribution to medical costs. In addition, it was not established why the copayments for claimant's ABA services, speech therapy and occupational therapy would not be included in this cost.

15. Finally, claimant estimates that he will pay $18,258 in dental work in 2015. As evidence of this request, claimant submitted a 2014 invoice in the amount of $25,000 for dental work; however, claimant's father acknowledged that the dentist and anesthesiologist involved in the work had forgiven a significant portion of the charges not covered by insurance. Claimant's father anticipates that claimant will require a similar amount of dental work in 2015, and reports that the dentist has cautioned him that future charges exceeding his insurance will not necessarily be forgiven in the future. No evidence from a dentist or medical provider documenting any anticipated dental work, and the cost to be borne by the family, was submitted in support of this claim.

16. Claimant therefore estimates that his unreimbursed medical expenses for 2015 will amount to $55,717. This is the total of $14,018 (ABA, occupation therapy and speech therapy coinsurance costs), $5,441 (annual insurance premiums), $18,000 (annual caps on preferred and non-preferred provider expenses) and $18,258 (anticipated unreimbursed dental work that may not be forgiven).

EVIDENCE OF FAMILY EXPENSES

17. Claimant also submitted documentation of family expenses, including but not limited to, the cost of private school tuition for the claimant and his sibling,

donations to the school foundation, additional family mental health, medical and chiropractic treatment, taxes, food, insurance, and mortgage payments. Claimant asserts that if the amount of the family's gross income is considered in determining whether an exception applies, the family's expenses should also be considered. Claimant's father asserts that the family's annual expenses are great and make it difficult to fund the insurance copayments for claimant's ABA services, occupational therapy and speech therapy.

LEGAL CONCLUSIONS

STATUTORY AUTHORITY

1. Under the Lanterman Act, the State of California accepts responsibility for persons with developmental disabilities. Individuals with developmental disabilities have the right to services and supports directed toward the achievement of the most independent and normal lives possible. (§ 4502, subd. (b).) The Lanterman Act authorizes the Department of Developmental Services to contract with regional centers to provide developmentally disabled individuals with access to the services and supports best suited to them throughout their lifetimes. (§ 4620.)

2. In providing needed services and supports, regional centers are enjoined not to supplant the budget of any agency that has a legal responsibility to serve the general public and that receives public funds for providing those services. (§ 4648, subd. (a)(8).) Such agencies are often referred to as "generic resources."

3. While a consumer and his parents' preferences and desires regarding goals and objectives and services and supports are to be given consideration in the planning process, regional centers are not authorized to purchase any and all services a consumer or his family may desire. (See §§ 4640.7, 4646, 4646.4, 4646.5, 4659, 4686.2.)

Regional center design must "reflect the maximum cost-effectiveness possible" (§ 4640.7, subd. (b).)

4. When purchasing services pursuant to an IPP, regional centers must ensure:

1) Conformance with the regional center's purchase of service policies, as approved by the department [of developmental services] pursuant to subdivision (d) of Section 4434.
2) Utilization of other sources of services and funding as contained in Section 4659.
3) Consideration of the family's responsibility for providing similar services and supports for a minor child without disabilities.

(§ 4646.4, subd. (a).)

5. Regional Centers are also required to "identify and pursue all possible sources of funding" from governmental entities such as Medi-Cal, and private entities such as insurers. (§ 4659, subd. (a).) Except in certain circumstances not applicable in this case, section 4659 provides that:

(c) Effective July 1, 2009, notwithstanding any other provision of law or regulation to the contrary, regional centers shall not purchase any service that would otherwise be available from Medi-Cal, Medicare, the Civilian Health and Medical Program for Uniform Services, In-Home Support Services, California Children's Services, private insurance, or a health care service plan when a consumer or a family meets the criteria of this coverage but chooses not to pursue that coverage. . . .

* * *

(d)(1) Effective July 1, 2009, notwithstanding any other provision of law or regulation to the contrary, a regional center shall not purchase medical or dental services for a consumer three years of age or older unless the regional center is provided with documentation of a Medi-Cal, private insurance, or a health care service plan denial and the regional center determines that an appeal by the consumer or family of the denial does not have merit.

6. In this matter, claimant's IPP provides for ABA services, occupational therapy and speech therapy, and SARC does not contest that the services are appropriate. However, due to changes in the law, regional centers are only permitted to fund ABA services, or copayments for those services, under certain conditions. Section 4659.1 was enacted as an urgent measure effective June 27, 2013, as part of AB 89 (Stats. 2013, c. 25, section 7). In pertinent part, section 4659.1 provides that effective July 1, 2013, regional centers may fund insurance copayments only when 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).

7. Section 4659.1, subdivision (c), contains several exemptions to the prohibition against funding insurance copayments for a service identified in the consumers IPP, where the family's or consumer's income exceeds 400 percent of the federal poverty level, the service is necessary to successfully maintain the consumer at home, and the parents 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.

CLAIMANT'S REQUEST FOR FUNDING OF COPAYMENTS, COINSURANCE AND DEDUCTIBLES

8. Claimant's family's gross income exceeds 400 percent of the federal poverty level. Consequently, SARC is statutorily prohibited from funding the family's copayments unless, pursuant to section 4659.1, subdivision (c), "the service or support is necessary to successfully maintain the child at home . . ., and the parents or consumer demonstrate one or more" situations warranting an exemption. A party in an administrative hearing, like SARC, generally has the burden of proof in seeking a change

from the status quo. (*Brown v. City of Los Angeles* (2002) 102 Cal.App.4th 155.) However, section 4659.1 shifts the burden to claimant's family to prove that one of the three stated exemptions applies.

9. SARC is the steward of public funds that are intended to provide needed services to thousands of consumers. Before granting an exception to section 4659.1, SARC must carefully analyze the evidence submitted by a family that despite a gross income exceeding 400 percent of the federal poverty level, it should expend funds to cover the cost of a consumer's copayments. In this matter, claimant has failed to meet his burden of demonstrating that he qualifies for an exemption that would permit SARC to fund his insurance copayments.

Claimant submits that the family will pay $14,018 in copayments for ABA services, speech therapy and occupational therapy. Of that amount only between $3,000 and $3,500 are for services contained in the 2013 IPP. (Factual Finding 12.) Claimant has not established the need for these additional services or documented the anticipated costs from the provider.

Claimant states that the family will pay $5,441 for insurance premiums in 2015. (Factual Finding 13.) This amount appears to be the cost of insurance for the entire family of four, not just for claimant. Insurance premiums are costs normally borne by a family, whether they are caring for a developmentally disabled child or not. The statute allows for an exception based upon significant unreimbursed medical costs associated with the consumer's care, not the cost of a family's insurance premiums.

Claimant also adds his insurance policy caps of $6,000 for preferred providers and $12,000 for non-preferred providers. (Factual Finding 14.) It appears that these are the family's caps rather than claimant's caps. Moreover, the caps are not evidence of actual anticipated medical expenses; rather the caps represent the most the family could pay for medical expenses incurred throughout the year. It was not established why the

$14,018 claimant anticipates paying toward ABA services, speech therapy and occupational therapy would not be counted toward the caps.

In addition, the estimate of $18,258 for dental expenses is indefinite. Claimant initially submitted an invoice indicating that he owed $25,000 in dental bills in 2014; however, claimant's father conceded that the dentist and anesthesiologist forgave a substantial portion of the bill. The family is unsure if such costs will be forgiven in the future. Importantly, however, there is no evidence from a dentist or other medical provider that these costs will be incurred in 2015. (Factual Finding 15.)

Claimant has not met his burden of establishing any unreimbursed medical costs which would allow the regional center to fund copayments pursuant to section 4659.1, subdivision (c).

REQUEST FOR FUNDING OF COPAYMENTS PENDING THIS APPEAL

10. Section 4715, subdivision (a), provides that if a request for hearing is postmarked or received by the service agency no later than 10 days after receipt of the notice of proposed action, services that are being provided pursuant to a recipient's individual program plan shall be continued during the appeal up to and including the tenth day after receipt of the final decision.

Claimant requested a hearing within 10 days of receiving the notice of proposed action from SARC. (Factual Finding 9.) Claimant therefore requests that the copayments be funded by SARC through the tenth day after receipt of this decision.

SARC contends that a request for an exception to section 4659.1, subdivision (c), must be made annually and is not an ongoing service. Although SARC funded copayments in 2014, SARC argues that a new request for an exception was required for 2015, and therefore, this is not an ongoing service being provided, and it is not subject to section 4715, subdivision (a). (Factual Finding 6.)

SARC's argument has merit. The Executive Director granted an exception

pursuant to section 4659.1 for the 2014 calendar year. In order to qualify for an exception for 2015, claimant was required to submit a request with his evidence to the Exception Committee. The committee reviewed the evidence and found it did not establish grounds for an exception for 2015. The request was for a new year and was based on new evidence. The committee denied a request for a new exception, rather than seeking to discontinue an ongoing service. Therefore, section 4715 is not implicated. The request for funding of insurance copayments from January 1, 2015, until 10 days following the receipt of the decision in this matter is denied.

ORDER

Claimant's appeal is denied.

DATED: April 28, 2014

_____/S/_____

JILL SCHLICHTMANN

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.