BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: CLAIMANT, vs. EASTERN LOS ANGELES REGIONAL CENTER, Service Agency.	OAH No. 2015040222

DECISION

Howard W. Cohen, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter on July 23, 2015, in Alhambra.

Noriko Ikoma, Early Start Supervisor, represented Eastern Los Angeles Regional Center (ELARC or Service Agency).

Claimant's mother, his conservator and authorized representative, represented claimant, who was not present.[1]

Oral and documentary evidence was received. The record was closed and the matter was submitted for decision on July 23, 2015.

ISSUE

Whether the Service Agency is required to fund home visits by claimant's primary care provider.

[1] Family titles are used to protect the privacy of claimant and his family.

EVIDENCE RELIED UPON

Documents: Service Agency's exhibits 1-7; claimant's exhibit A.

Testimony: Noriko Ikoma; claimant's mother; Dr. Cheryl Gray.

FACTUAL FINDINGS

1. Claimant is a conserved thirty-one-year-old man. He is an eligible consumer of ELARC based on his diagnoses of profound intellectual disability and cerebral palsy spastic quadriplegia with severe impact. According to claimant's most recent Individual Program Plan (IPP), dated October 9, 2014, claimant has also been diagnosed with "scoliosis, post spinal fusion surgery, closed dislocation, congenital talipes quinovarus, anomalies of the urinary system, and dysikinesia [*sic*] of the esophagus. (Ex. 3.)

2. Claimant lives at home with his mother. "[Claimant] is non ambulatory, non verbal, and incontinent of both bowel and bladder." (Ex. 3.) Claimant's "[h]earing is within normal limits, vision loss is suspected." (*Ibid.*) "He is totally dependent on his mother as care provider for all his needs. He does not alert an adult when his diaper needs to be changed and he is unable to assist with his personal hygiene needs. He needs to be dressed completely by his mother. His diaper needs to be changed frequently to prevent skin break downs. Additionally, per mother's report, [claimant] requires a gurney for mobility since he goes into severe spasms when he sits and therefore cannot use a wheelchair. Other equipment include[s] an apnea monitor, Kangaroo Pump, Bi-Pap machine, oxygen, suction machine, pulmoaide, and vibrator." (Ex. 3.) Claimant is fed via G-tube. He "requires oxygen as needed, usually when ill and after suctioning." (*Ibid.*) He has thyroid tumors, for which he takes Synthroid. At the time of his IPP, claimant was taking over 20 different prescribed medications per day for his various medical conditions.

3. On February 19, 2015, claimant's mother requested funding, on claimant's behalf, for the services of a primary care physician, Dr. Cheryl Gray. Claimant's mother informed ELARC that she was having difficulty finding a physician willing to monitor claimant's health needs, and that she herself had been paying for Dr. Gray to visit claimant. The Service Agency, in a Notice of Proposed Action dated February 26, 2015, denied claimant's funding request on the ground that claimant "is eligible for Medi-Cal, which can cover physician visits." (Ex. 1.) Claimant's mother timely filed a request for a fair hearing.

4. Claimant's IPP recognizes several medical-care related goals, including receiving "necessary medical/dental services in order to maintain optimal health" (Ex. 3, p. 6), a neurological goal of having claimant's seizure activity "well controlled" (Ex. 3, p. 7), and being "provided with all necessary adapted and medical equipment (Ex. 3, p. 8.) The IPP identifies various services and supports needed in order to help claimant achieve those goals. The services and supports include claimant's mother arranging for medical treatments, and monitoring claimant's health daily and reporting to physicians any signs of acute illness, and inspecting adapted equipment for necessary repairs. They also include ELARC aiding claimant's mother in securing necessary equipment and repairs. Although the IPP provides that all medical care and equipment is to be provided through Medi-Cal, it also provides that ELARC shall "[c]onsider funding medical needs only if no other generic resource is available and Medi-Cal denies." (Ex. 3.)

5. Claimant's mother testified at hearing that she has attempted to obtain treatment for claimant from physicians who accept Medi-Cal. They have refused, telling her that claimant's condition is too complicated for them to treat, or that they will not be reimbursed in an amount that would make it worth their while to treat him. Claimant's mother testified that one physician told her Medi-Cal would not pay him enough to turn on the lights in order to treat claimant. Claimant uses a dental clinic,

seeing a different dentist each time he visits. He sees an endocrinologist, a neurologist, and a pulmonologist. The pulmonologist no longer wants to provide care to claimant. Claimant requires treatment by a dermatologist, for acne. Claimant also needs a referral to a gastroenterologist, as he uses a G-tube and has a polyp and other problems with his stomach. Two licensed vocational nurses who are paid by Medi-Cal come to claimant's home, working about 12 hours per day, but they do only what claimant's mother does—give claimant his medications, care for his cyst, operate his nebulizer and suction machines, change his diaper, and reposition him. When the nurses are not present, claimant's mother provides his care, which he requires 24 hours per day. Claimant's mother has made numerous attempts to find specialists who will treat claimant's various medical conditions and to find a physician who can provide primary care and coordinate claimant's treatment by his specialists. Claimant's mother has also repeatedly contacted the Medi-Cal program for assistance in resolving her difficulties in obtaining medical care for claimant, with no success. She has filed a complaint with Medi-Cal; Medi-Cal said it would investigate the complaint, but has communicated nothing further to claimant's mother.

6. Dr. Gray visits and treats claimant in his home. She testified that she started seeing claimant in June 2014. She reviewed his medications and equipment needs, and obtained an exemption for claimant out of the Medi-Cal managed care program. Her visits last two to three hours. She examines him completely, head to toe, checks his vital signs, reviews with his mother and the nurses their concerns, and reviews information from visits to specialists. She also talks to claimant's mother by telephone for 30 minutes once per week about claimant's needs. For example, claimant had to visit an emergency room due to dehydration, so Dr. Gray reviewed with claimant's mother his eating and hydration schedules. Dr. Gray oversees claimant's care and treatment plan for the nursing service. Dr. Gray testified that home visits avoid the need for putting

claimant on a gurney, transport, and long waits for services, especially in light of claimant's spasticity. She believes she can manage his overall care by visiting his home and stabilizing him, making sure he sees appropriate specialists as needs arise, recognize symptoms and signs leading to seizure, and see if there are issues with claimant's equipment. For example, due to claimant's copious secretions, claimant uses a percussive vest, which caused an adverse reaction; Dr. Gray examined the vest, determined the pressure was set too high, and sent claimant back to the pulmonologist for reevaluation.

7. At the hearing, Dr. Gray reviewed claimant's medically-related IPP goals, and the services and supports identified to help claimant achieve each of those goals. Dr. Gray testified that the services and supports were insufficient to allow claimant to achieve those medical goals. According to Dr. Gray, claimant requires the oversight and coordinating services provided by a primary care physician. A physician consulting for ELARC, Dr. Figueroa, does not disagree. In a Physician Consultant Record Review prepared for the Service Agency on July 1, 2015, Dr. Figueroa recommended that claimant "may benefit from receiving coordinated care including primary care and specialist care at one location." (Ex. 6.) Although it has not been possible for claimant to receive all of his care at one location, it is possible for claimant to receive care coordinated by a primary care physician, such as Dr. Gray.

8. Dr. Gray's rate for primary care physician services is $100 per home visit. Since August 2014, she has visited claimant five times. She is not contracted with Medi-Cal or with any managed care provider. She can prescribe medications for claimant, to be funded by Medi-Cal, if she documents that she believes the medication is medically necessary after she conducts an examination. Dr. Gray is not a Service Agency vendor, and the Service Agency has not offered to vendorize her.

9. At the hearing, the Service Agency did not contest that the services of a

primary care physician could assist claimant in reaching his IPP goals. The Service Agency did not deny that claimant has had tremendous difficulty obtaining the care he needs to achieve those goals, or that claimant's mother's attempts to obtain help from Medi-Cal to find physicians have been fruitless. The Service Agency argued, however, that because Medi-Cal is a generic source of funding for which claimant is eligible, he must obtain payment for all his medical care from Medi-Cal. The Service Agency explored no other options, insisting that claimant continue to attempt to obtain medical services from physicians who accept payment from Medi-Cal, and continue to attempt to resolve with Medi-Cal the many issues that continually impede claimant's attempts to obtain the care he needs. The Service Agency has not referred claimant to any appropriate medical service providers.

10. The only qualified provider who is currently known to claimant's mother and who has the time and inclination to provide primary care physician services to claimant is Dr. Gray. The Service Agency does not argue that $100 per visit for four or five annual visits exceeds the amount the Service Agency is allowed to pay for such services. It argues only that she is not a Medi-Cal provider. The Service Agency also established that Dr. Gray is not a provider vendored by ELARC.

LEGAL CONCLUSIONS

1. The Lanterman Developmental Disabilities Services Act (Lanterman Act) governs this case. (Welf. & Inst. Code, § 4500 et seq.)[2]

2. Under the Lanterman Act, issues concerning the rights of persons with developmental disabilities to receive services must be decided under the appeal and fair hearing procedures set forth in section 4700 et seq. (§ 4706, subd. (a).) As the party

[2] All further statutory references are to the Welfare and Institutions Code.

seeking services not agreed to by the Service Agency, claimant bears the burden of proving that the denial of services was improper and that he should receive funding for those services. (See § 4712, subd. (j); *Lindsay v. San Diego Retirement Bd.* (1964) 231 Cal.App.2d 156, 161 [disability benefits].) Claimant must prove he is entitled to the funding by a preponderance of the evidence, because no law or statute requires otherwise. (Evid. Code, § 115.)

3. Cause exists to grant claimant's appeal, as set forth in Factual Findings 1 through 10, and Legal Conclusions 4 through 12.

4. The Legislature's intent in enacting the Lanterman Act was to ensure the rights of persons with developmental disabilities, including "[a] right to treatment and habilitation services and supports in the least restrictive environment. Treatment and habilitation services and supports should foster the developmental potential of the person and be directed toward the achievement of the most independent, productive, and normal lives possible." (§§ 4502, subd. (a), 4640.7.)

5. The Legislature also explicitly intended "to ensure that the provision of services to consumers and their families be effective in meeting the goals stated in the individual program plan, reflect the preferences and choices of the consumer, and reflect the cost-effective use of public resources." (§ 4646, subd. (a).) Medical services are among the services and supports to be funded by regional centers. (§ 4512, subd. (b).)

6. Each consumer must have an IPP. The IPP must include "[a] statement of goals, based on the needs, preferences, and life choices of the individual with developmental disabilities. . . ." and "[a] schedule of the type and amount of services and supports to be purchased by the regional center or obtained from generic agencies or other resources in order to achieve the individual program plan goals and objectives, and identification of the provider or providers of service responsible for attaining each objective, including, but not limited to, vendors, contracted providers, generic service

agencies, and natural supports." (§ 4646.5, subd. (a).)

7. Welfare and Institutions Code section 4648 states in pertinent part:

> In order to achieve the stated objectives of a consumer's individual program plan, the regional center shall conduct activities including, but not limited to, all of the following:
>
> (a) Securing needed services and supports. [¶] . . . [¶]
>
> (4) [A] regional center may contract or issue a voucher for services and supports provided to a consumer or family at a cost not to exceed the maximum rate of payment for that service or support established by the department. . . . [3]
>
> (5) In order to ensure the maximum flexibility and availability of appropriate services and supports for persons with developmental disabilities, the department shall establish and maintain an equitable system of payment to providers of services and supports identified as necessary to the implementation of a consumers' individual program plan. The system of payment shall include provision for a rate to ensure that the provider can meet the special needs of consumers and provide quality services and supports in the least restrictive setting as required by law. [¶] . . . [¶]
>
> (g) Where there are identified gaps in the system of services and supports or where there are identified consumers for whom no provider will provide

[3] When developing IPPs for consumers, the regional center is to be guided by section 4685. (§ 4646.5, subd. (a)(3).) Under that section, regional centers are authorized to use "innovative service delivery mechanisms, including but not limited to, vouchers . . ." (§ 4685, subd. (c)(3); see also § 4651.)

services and supports contained in his or her individual program plan, the department may provide the services and supports directly.

8. The California Supreme Court has stated that, while "regional centers have 'wide discretion' in determining *how* to implement the IPP [citations], they have no discretion at all in determining *whether* to implement it: they must do so [citation]." (*Assn. for Retarded Citizens v. DDS* (1985) 38 Cal.3d 384, 390, original italics.) Regional centers must refer consumers to available generic sources of payment, and assist consumers in their attempts to obtain funding to which they are entitled, but regional centers must act as payers of last resort where such funding cannot be obtained. (§ 4659 et seq.; see also 4659.10 (regional centers "shall continue to be the payers of last resort" in cases involving third-party liability).) If a regional center does not act to provide a consumer with funding for a primary care physician when generic sources of funding prove intractable, the regional center must provide the services; it is authorized to pursue reimbursement under Code section 4659. Failing to do so violates the central purpose of the Lanterman Act: to provide needed services to persons with developmental disabilities. (§§ 4502, subd. (a), 4646, subd. (a), & 4648, subd. (a).) If it chooses to do so, a regional center may also initiate legal action to pursue a funding source for consumers receiving services. (73 Ops.Cal.Atty.Gen. 156, 157 (1990).) The Legislature's insistence on having the needs of persons with developmental disabilities met by the provision of services is so significant that the Legislature directs DDS itself to provide services directly to consumers in cases where there appear to be "gaps in the system of services and supports or where there are identified consumers for whom no provider will provide services and supports contained in [his] individual program plan." (§ 4648, subd. (g).)

9. The Service Agency also bears responsibility for coordinating services provided to its consumers. "[S]ervice coordination shall include those activities necessary

to implement an individual program plan, including, but not limited to, . . . securing, through purchasing or by obtaining from generic agencies or other resources, services and supports specified in the person's individual program plan; coordination of service and support programs; . . . and monitoring implementation of the plan to ascertain that objectives have been fulfilled and to assist in revising the plan as necessary." (§ 4647, subd. (a).)

10. Here, the Service Agency must implement claimant's IPP by acting as the payer of last resort. The evidence presented at hearing demonstrates that claimant has had uncoordinated and at times, for some of his needs, nonexistent medical service for at least one year, despite an acknowledged and IPP-documented need for such services, due to the unwillingness of many Medi-Cal physicians to treat claimant and the lack of a primary care physician to provide care oversight and coordination.

11. The Service Agency shall implement claimant's IPP by funding appropriate medical care for claimant while also assisting claimant's mother in pursuing Medi-Cal funding and appropriate providers who accept Medi-Cal payments. Until such time as Medi-Cal funds the care that claimant requires, the Service Agency shall reimburse claimant's mother, or provide her with vouchers, for the costs incurred in using Dr. Gray's services beginning on the effective date of this Decision. On this record, there is no question of the cost-effectiveness of Dr. Gray's services. (Factual Findings 6-8.) The Service Agency may also vendorize Dr. Gray, or arrange for another vendorized primary care physician to provide required care to claimant.

ORDER

Claimant's appeal is granted. The Service Agency shall approve a cost-effective rate of pay to engage a primary care physician who will provide claimant with the medical treatment and treatment-coordinating services he requires to ameliorate the effects of his qualifying disability and to help him meet the goals set forth in his IPP.

Until such time as the Service Agency vendorizes Dr. Gray or provides claimant with another vendorized primary care physician, or until such time as Medi-Cal funds the medical services claimant requires to meet his IPP goals, the Service Agency shall reimburse claimant's mother, or issue her payment vouchers, for costs incurred in using Dr. Gray's services from the date of this Decision forward, at the rate of $100 per visit.

DATE: August 5, 2015

/s/

HOWARD W. COHEN

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.