BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: CLAIMANT, vs. HARBOR REGIONAL CENTER, Service Agency.	OAH No. 2017051048

DECISION

Carla L. Garrett, Administrative Law Judge (ALJ), Office of Administrative Hearings, State of California, heard this matter on June 28, 2017, in Torrance, California.

Cheri Weeks, Manager of Rights and Quality Assurance, represented the Harbor Regional Center (HRC or Service Agency). Claimant's mother (Mother) and father (Father) (collectively, Parents), represented Claimant.[1]

Oral and documentary evidence was received, the record was closed, and the matter was submitted for decision on June 28, 2017.

ISSUE

Must the Service Agency continue funding Claimant's private health insurance copayments for Claimant's Applied Behavior Analysis (ABA) services?

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[1] Names are omitted to protect the privacy of the parties.

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FACTUAL FINDINGS

PARTIES AND JURISDICTION

1. Claimant is an eight-year-old boy who lives with Parents and his toddler brother within the Service Agency's catchment area. Claimant is autistic and eligible for services pursuant to the Lanterman Developmental Disabilities Services Act (Lanterman Act), California Welfare and Institutions Code section 4500, et seq.[2] Claimant displays elopement, aggression, noncompliance, and tantrum behaviors, among other things.

2. Parents' private health insurance company, Anthem Blue Cross (Anthem), funded ABA services for Claimant. Anthem required Parents to pay a co-payment of $1,225 per month, representing 20 percent of insurance costs.

3. In April 2015, Parents requested the Service Agency to fund their monthly co-payments. The Service Agency conducted an assessment of Parents' financial status to ascertain whether they met the criteria for funding. Specifically, the Service Agency, in compliance with section 4659.1, looked at Parents' annual gross income to determine whether or not it exceeded 400 percent of the federal poverty level. Parents' combined gross income for 2015 was $95,615. The Service Agency determined that Parents' collective income did not exceed 400 percent of the federal poverty level. As such, the Service Agency began funding Parents' monthly co-payments.

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

4. Claimant attends Arnold Elementary School (Arnold) in a setting designed for students with moderate to severe disabilities, and he receives special education services. Because Parents have full-time jobs and are therefore working when Claimant's school day ends, Claimant attends the after-school program at Arnold for two hours each day, except for Wednesday, when he attends for three. The YMCA operates the after-school program on Arnold's campus, and because Claimant has elopement, aggression, and other behavioral challenges, YMCA has required Claimant to have a one-on-one professional to shadow Claimant to make sure Claimant and the children around him remain safe. As such, Parents arranged for Claimant to receive one-on-one ABA services Monday through Friday at the after-school program and on Saturdays at Claimant's home, for a total of 14 ABA hours per week. These ABA services were delivered by Autism Interventions and Resources, Inc. (AIR) and funded by Anthem.

5. In order to ascertain whether it will continue to fund copayments, the Service Agency, on an annual basis, reviews the annual gross income of families who receive copayment funding, in order to ascertain whether they meet the criteria for funding. If the Service Agency determines a family's annual gross income exceeds 400 percent of the federal poverty level, it terminates copayment funding services.

6. In April 2017, Parents submitted to the Service Agency a copy of their 2016 tax returns. Parents' combined gross annual income for 2016 was $106,687, representing an $11,072 increase from the previous year. The increase was due to a raise in income Mother had earned as a result of completing graduate school studies. The Service Agency determined that the collective

annual gross income exceeded 400 percent of the federal poverty level, and, as such, concluded it could no longer fund Claimant's co-payments.

7. Claimant's service manager, Brenda Sanchez, informed Mother that her family's annual gross income had rendered them ineligible to receive co-payment funding services.

8. Parents had been paying childcare expenses for their toddler son, now 23months old, since December 2015, when he was four months old, after Mother returned to work from maternity leave. Mother explained to Ms. Sanchez that although she and Father earned $11,072 more income, their expenses exceeded the increase. Specifically, Mother explained that childcare expenses for their toddler son totaled $14,520 per year, and other childcare alternatives cost essentially the same. Consequently, the family operated at a financial deficit. As such, Parents lacked the funds necessary to pay the monthly co-payments, which would ultimately result in Anthem declining to pay for Claimant's much-needed ABA services. Ms. Sanchez told Mother that she would advise the Service Agency's interdisciplinary team regarding Parents' financial hardship to ascertain whether the Service Agency should reverse their decision to cease co-payment funding.

9. Additionally, Ms. Sanchez told Mother that the Service Agency would refer Claimant for MediCal insurance that could serve as secondary health insurance and cover future co-payment costs, should the interdisciplinary team decide that the Service Agency must terminate co-payment funding services. In that regard, Mother, pursuant to instructions received from MediCal, completed a packet of forms, and mailed the forms to MediCal on or before May 31, 2017, which was a deadline imposed by MediCal.

10. On April 17, 2017, Ms. Sanchez met with the interdisciplinary team and advised them of the financial hardship Parents were experiencing, their inability to pay the monthly co-payments, and the resulting risk of Claimant not receiving ABA services. The team assessed whether an exception applied under section 4659.1 that would permit the Service Agency to fund co-payment expenses notwithstanding the amount of Parents' income. Specifically, the team assessed whether there was (1) the existence of an extraordinary event impacting ability to support the household; (2) the existence of a catastrophic loss; and (3) the existence of significant unreimbursed medical costs associated with the care of Claimant. The team determined that there was no existence of an extraordinary event, catastrophic loss, or significant unreimbursed medical costs, noting specifically that Parents' financial hardship created no exception under the statute.

11. On May 4, 2017, the Service Agency sent Parents a letter advising that after reassessing their need for co-payment assistance, it determined that no extenuating circumstances existed under the purview of section 4659.1 that permitted the Service Agency to continue providing co-payment funding. The Service Agency stated that it would terminate co-payment funding services on June 5, 2017.

12. On May 16, 2017, Mother filed a Fair Hearing Request on Claimant's behalf. Consequently, the Service Agency has continued providing co-payment funding services pending the outcome of Claimant's matter.

13. On June 12, 2017, when Mother called to inquire, MediCal acknowledged its receipt of Parents' paperwork. However, as of the day of hearing, Parents were still awaiting approval from MediCal.

PARENTS' CONTENTIONS

14. Parents' contend that, despite the Service Agency's conclusion, their financial hardship does, indeed, create an extraordinary circumstance, and therefore falls under an exception of section 4659.1. They argue they will not be able to afford the monthly co-payments, Claimant will not be able to receive ABA services, thereby impacting Claimant's ability to attend his after-school program. Parents also noted that the Service Agency never presented Parents with any other afterschool options in which Claimant could attend without the requirement of one-on-one professional services.

15. Parents request that, in the event their financial hardship does not constitute an exception, the Service Agency be required to continue funding the co-payments until they receive approval for coverage under MediCal.

LEGAL CONCLUSIONS

1. Proper jurisdiction was established by virtue of the Service Agency's decision to cease making copayments and the Fair Hearing Request on behalf of Claimant. (Factual Findings 1 through 12.)

2. The standard of proof in this case is the preponderance of the evidence, because no law or statute (including the Lanterman Act) requires otherwise. (Evid. Code, § 115.) The burden of proof is on the entity who seeks to change the status quo. (See Evid. Code, § 500, Party who has the burden of proof: "Except as otherwise provided by law, a party has the burden of proof as to each fact the existence or nonexistence of which is essential to the claim for relief or defense that he is asserting.") The Service Agency has the burden of proof in this matter.

3. ABA services are defined in section 4686.2, subdivision (d). As of July 1, 2012, insurance companies were required to provide coverage for ABA services such as those provided to Claimant, under Health and Safety Code section 1374.73.

4. Regional centers are required to explore other sources for funding or provision of services, such as school districts, community programs, or generic sources. Under section 4659 regarding sources of funding for regional center services, as of July 1, 2009, regional centers were instructed to no longer purchase services that were otherwise available from listed sources such as MediCal and private insurance. If private insurance denied the service, families could appeal the denial and the regional center could pay for the service under certain conditions. The statute was clearly designed to identify and pursue alternative funding sources for services that were previously funded by regional centers. However, subdivision (e) provides added protection for families; it states: "This section shall not be construed to impose any additional liability on the parents of children with developmental disabilities, or to restrict eligibility for, or deny services to, any individual who qualifies for regional center services but is unable to pay."

5. Another legislative enactment is specific to copayments. Section 4659.1 was effective June 27, 2013. Under subdivision (a), when a service is provided under an Individual Program Plan, and "is paid for, in whole or in part, by the health care service plan or health insurance policy of the consumer's parent . . ., 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," under certain conditions, including that the consumer is covered

by the parent's health insurance plan. One condition in subdivision (a)(2) is the family "has an annual gross income that does not exceed 400 percent of the federal poverty level." As noted in Factual Findings 3 and 5 through 10, Claimant's family previously met these conditions, but now does not.

6. Section 4659.1, subdivision (c) and (c)(1) states:

> (c) Notwithstanding paragraph (2) of subdivision (a) or paragraph (1) of subdivision (b), a regional center may pay a copayment, coinsurance, or deductible 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:
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> (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, coinsurance, or deductible.

(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.

7. In this case, there is no dispute that Parents' annual gross income exceeds 400 percent of the federal poverty level, and thus, they are not entitled to insurance co-payment funding assistance unless one of the three exceptions applies. Parents presented no evidence demonstrating that they have suffered a catastrophic loss or that they have significant unreimbursed medical costs; however, they contend that their financial hardship constitutes an extraordinary event that interferes with their ability to meet Claimant's care and supervision needs. Specifically, given the daycare costs they are required to pay for Claimant's toddler brother, which exceed the amount of the increase in their annual gross income from the year prior, Parents contend that they are placed in a financially untenable position.

8. Parents' financial difficulties stemming from the childcare expenses of their toddler son do not constitute the kind of "extraordinary" event

contemplated by the statute in that the payment of childcare expenses was no new or unanticipated circumstance, and Parents offered no evidence demonstrating that the childcare costs had increased exponentially in the recent past. As difficult as Parents' financial situation may be, section 4659.1 clearly and plainly sets forth the type of financial hardship that will trigger a regional center's obligation to pay for copayments, which exceptional circumstances are not present in this case.

9. With respect to Parents' request that the Service Agency be required to continue funding the co-payments until they receive approval for coverage under MediCal, Parents provided no case, statutory, or regulatory authority to support such a request and, as such, it shall be denied.

ORDER

Claimant's request that the Service Agency provide co-payment funding assistance is denied.

DATED:

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CARLA L. GARRETT

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.