BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

CLAIMANT,

vs.

EASTERN LOS ANGELES REGIONAL CENTER,

Service Agency.

OAH No. 2021050745

DECISION

Nana Chin, Administrative Law Judge (ALJ), Office of Administrative Hearings (OAH), State of California, heard these consolidated matters[1] by videoconference on July 28, 2021.

[1] Due to the similarity of issues and circumstances, this matter was consolidated for hearing purposes with OAH case number 2021050750.

Claimant's mother (Mother) [2] represented Claimant and claimant's twin brother, the claimant in OAH case number 2021050750.

Jacob Romero, Fair Hearing Coordinator, represented Eastern Los Angeles Regional Center (ELARC or Service Agency).

Evidence was received, the record was closed and the matter was submitted for decision on July 28, 2021.

ISSUES

1. Whether ELARC should be required to pay Medi-Cal $104 for the outstanding monthly premiums for the period from July to October 2019.

2. Whether ELARC should be required to back-date the approval of an "Institutional Deeming" waiver for Claimant to December 14, 2018, when Mother claims she first made the request.

3. Whether ELARC should be required to pay for Claimant's outstanding $20 co-payments from Kaiser Permanente that should have been billed to Medi-Cal.

Mother also contended that the present hearing should also address the issue of whether ELARC should be required to pay Claimant's outstanding $640 Easter Seals medical bill. However, this issue will not be addressed in this decision as:(1) the Fair Hearing Request did not indicate there was a dispute involving payment of an Easter

[2] Names are omitted and family titles are used to protect the privacy of Claimant and her family.

Seals bill nor was there a request that ELARC pay the Easter Seals bill as a means of resolving the dispute; and (2) Claimant did not request that ELARC pay the Easter Seals bill before the hearing.

EVIDENCE

Documents: Service Agency's Exhibits1-3, 5-9, 13-19; Claimant's Exhibits A-NN

Testimony: Cristina Ontiveros, ELARC Consumer Service Supervisor; Jesse Valdez, Residential Services & Federal Programs Manager; and Mother

FACTUAL FINDINGS

Jurisdiction

1. Claimant is a nine-year old ELARC consumer who lives with her parents, her older brother and her twin brother (Family) in the family home within the Service Agency's catchment area.

2. In a Notice of Proposed Decision (NOPA) dated April 28, 2021, the Service Agency notified Mother that her "request for ELARC to fund Medi-Cal Monthly Premiums in the amount of $104 has been denied." (Exh. A.)

3. Mother submitted a Fair Hearing Request dated May 8, 2021, to appeal the Service Agency's decision.

4. In the section of the Fair Hearing Request asking for the reason for the hearing, Mother stated:

> I am asking for [a] Medi-cal Institutional Wavier to be issued to [Claimant] effective July 2019 to eliminate the monthly premium of $13 for July-August-September-October, total $52[.]

(Exh. 2, p. 8, B. -Michel Exh. 2, p. 9, C)

5. In the section of the Fair Hearing Request asking for a description of what was needed to resolve the complaint, Mother stated as follows:

> I am asking for ELARC as the payer of last resort to pay outstanding co-payments that should have been billed to Medi-Cal. [On] July 18, 2019, Jesse Valdez, ELARC Federal Programs Manager confirmed that Institutional Deeming Waiver paperwork was not completed by ELARC.

(*Ibid.*)

6. All jurisdictional requirements have been met.

California Medical Assistance Program (Medi-Cal)

7. The California Medical Assistance Program, more commonly known as Medi-Cal, is California's Medicaid program and provides health care coverage to individuals whose income fall under certain thresholds. Depending on their income, individuals may be required to pay a monthly premium or bear their "share of costs" before they can access their Medi-Cal benefits. (Welf. & Inst. Code, §§14054, 14005.26.)

8. In certain circumstances, however, developmentally disabled minors may be deemed eligible for Medi-Cal benefits without consideration of parental income

through "Institutional Deeming," a special program that is part of the Home and Community-Based Services (HCBS) Waiver program (Medicaid Waiver). In order to be eligible for Institutional Deeming, the developmentally disabled minor must: (1) live in the family home; (2) be ineligible for Medi-Cal due to the family's income; (3) have two or more "qualifying conditions" in the area of self-help, motor and social/emotional functioning; special health care conditions; or extensive medical needs; and (4) receive at least one "qualifying service" from the regional center and use that service once a year. Like those individuals who qualify for Medi-Cal benefits based on family income, individuals who are deemed eligible for Medi-Cal benefits through Institutional Deeming are not exempt from the requirement to pay a monthly premium.

9. The Centers for Medicare and Medicaid Services (CMS) and the California Department of Health Care Services (DHCS) are jointly responsible for the statewide administration of Medi-Cal while county welfare departments are responsible for its local administration. In Los Angeles County, the county welfare department responsible for local administration of the Medi-Cal program is the Department of Public Social Services (DPSS).

2018 Individual Program Plan Meeting

10. On December 14, 2018, an Individual Program Plan (IPP) meeting was held in the family home with Family and Claimant's Service Coordinator Cindy Soto Funes.

11. At the time of the 2018 IPP, Mother, who was the primary informant, was generally disinclined to share information regarding the services Claimant was receiving from other agencies. During the meeting, Mother advised that she was not interested in applying for In-Home Supportive Services (IHSS) benefits and even

though she applied for IHSS benefits with ELARC's assistance relative to the 2017 IPP, she refused to provide ELARC a copy of the IHSS Notice of Action. Mother also reported Claimant had been diagnosed with autism and epilepsy, was sensitive to the sun and had a hearing deficiency but refused to sign a consent form which would allow ELARC to have access to Claimant's medical records. Mother also reported that Claimant was attending an integrated kindergarten class and that the school district was providing Claimant with "special education services through Autism placement and deaf and hard of hearing services." (Exh. G. p. 6.) Mother, however, refused to provide ELARC with either: (1) copies of Claimant's school records, specifically the IEP, the psycho-educational assessment conducted by LAUSD, and hearing and vision screening; or (2) a signed a consent form which would allow ELARC to obtain copies of Claimant's school records.

12. The 2018 IPP notes that though Claimant had private healthcare insurance coverage through Kaiser Permanente, Claimant maintained her Medi-Cal eligibility. There is no indication in the 2018 IPP that the Family expressed any issues related to Claimant's healthcare insurance coverage.

Medi-Cal Eligibility

13. On February 19, 2019, the DPSS notified Mother it would require information from Mother to confirm Claimant's continued eligibility for Medi-Cal benefits. Mother provided Medi-Cal with the requested income information about every member of the household. Mother indicted that her household consisted of herself, Claimant and her twin, and provided Medi-Cal with her income information. Mother did not provide any Medi-Cal with any information regarding Father or Claimant's older brother.

14. Based on the income information Mother provided DPSS, it was determined that the family income was equal to or less than 200 percent of the federal poverty level and Claimant certified as eligible for full-scope benefits with no share of cost. (Welf. & Inst. Code, §14005.26, subd. (a).) Mother's income, however, was more than 160 percent above the federal poverty level. Mother was therefore assessed a monthly premium of $13 per month per child with a maximum contribution of $39 per family for Medi-Cal coverage. (Welf. & Inst. Code, §14005.26, subd. (d)(1).)

15. On April 10, 2019, Mother received a Notice of Action notifying her that Claimant and her twin brother qualified for Medi-Cal. The determination was based on the household size and income information Mother provided.

16. The NOA states,

> For Medi-Cal, your household size is 3 and your monthly household income is $4,715.40. The monthly Medi-Cal income limit for your household size is $4,729.00. Your income is below this limit, so you qualify for Medi-Cal.

(Exh. P.)

17. Mother was also notified that her household size and income required her to pay a monthly premium between $13 and $39 in order for Claimant to remain eligible for Medi-Cal. (*Ibid.*) Mother received a second notice regarding the monthly premiums for Medi-Care on May 16, 2019. Both notices advised Mother of her hearing rights and explained that: (1) she had 90 days to ask for a hearing if she disagreed with the county's action, or (2) if she was not able to ask for a hearing within the 90 days, she may still file for a hearing if she provided good cause. (*Ibid,* Exh. R.) There is no evidence Mother requested a hearing with respect to these notices.

18. Medi-Cal subsequently sent billing statements, dated June 30, 3019, July 20, 2019, August 20, 2019, and September 20, 2019, and other correspondence warning Mother that her children may lose Medi-Cal benefits if the monthly premium was not paid. Despite these notifications, Mother did not pay any of the monthly premiums.

19. Mother received a NOA dated October 7, 2019, notifying her that as of November 1, 2019, Medi-Cal benefits for Claimant and her twin brother had been renewed for the next following year. DPSS advised Mother that they used the following information to make their determination: (1) the household size is 3; (2) the monthly countable household income is $4,715.40; (3) Mother's filing status is "Dependent;" (4) Mother's marital status is "Never Married;" and (5) her citizen/immigration status is "Citizen." (Exh. DD.)

20. Mother subsequently received another NOA dated October 10, 2019, advising her that Claimant and her twin brother's Medi-Cal coverage was going to be terminated on October 20, 2019, because the monthly premiums had not been paid for two consecutive months. Mother filed an appeal requesting a hearing.

Institutional Deeming Waiver

21. Mother asserts that she had requested the Service Agency initiate a referral for an Institutional Deeming Waiver during the December 2018 IPP meeting and that she completed the DDS Waiver Referral form (DHS 7096) for Claimant and her brother at that time.

22. Mother was clearly under the misapprehension that an Institutional Deeming Waiver would exempt her from paying the monthly Medi-Cal premiums as reflected in her e-mail communications with the Service Agency. There was no

evidence that mother contacted either Medi-Cal or the Service Agency to express any concern that she was being billed a monthly premium by Medi-Cal until July 15, 2019, when she e-mailed Claimant's new service coordinator, Veronica Nunez, with a copy to SC Nunez's supervisor, Cristina Ontiveros. In the email, Mother states that she had asked SC Soto Funes "for the Institutional Deming [*sic*] 'Waiver'" during the December 2018 IPP meeting and asked for advice on what steps to take "to get this situation clarified with Medi-Cal that Institutional Deming [*sic*] 'waiver' does not require a monthly premium." (Exh. U.)

23. As neither SC Nunez nor SCS Ontiveros were familiar with the Medi-Cal wavier process, Mother was referred to Jeff Valdez, ELARC's Residential Services & Federal Programs Manager. Manager Valdez explained to Mother that as Claimant and her twin brother qualified for full Medi-Cal benefits with no share of cost, Medi-Cal generally would not process an Institutional Deeming referral as the waiver is intended for households who were not eligible for Medi-Cal due because their income was too high or their income requires the individual to pay a share of cost. Manager Valdez, however, suggested that Mother ask her current Medi-Cal worker to assist with the process as the Medi-Cal referral would likely be rejected if it went through the Waiver Unit. Mother, however, insisted that the referral be processed through the Waiver Unit, suggesting that SC Soto Funes' failure to process the referral after the December 2018 IPP was the reason Mother was being charged a monthly premium. Manager Valdez advised Mother that he did not know what occurred with SC Soto Funes but explained to Mother that even if she had been approved for the Institutional Deeming Waiver, she would have still been charged a monthly premium if her household income had not changed. When Mother asked Manager Valdez about the process to stop Medi-Cal from billing for monthly premiums, he advised her to speak with her Medi-Cal worker but let her know that in previous cases where parents had appealed the monthly

premium, they had been upheld as the premiums are based strictly on family household income. (Exh. X.)

24. On July 23, 2019, SC Nunez sent Mother a letter advising her that Claimant had been referred for evaluation for Medi-Cal benefits under the special intuitional deeming rules. A second letter was sent that same date advising Mother that claimant's twin brother had also been referred for evaluation.

25. Mother requested a state hearing appealing Medi-Cal's decision. Mother later withdrew her appeal because she was advised that "one or more agencies is taking steps to fix your issue." (Exh. GG.)

26. At hearing, Manager Valdez explained that regional centers encourage eligible consumers to enroll in Medi-Cal as certain expenditures made by regional centers on behalf of enrolled consumers are shared by the federal government. The federal government reimburses the state for the expenditures, thereby increasing overall available funds. If the consumer consents to being enrolled in Medi-Cal, the regional center will refer the consumer to the county welfare department for a Medi-Cal eligibility determination. If the consumer does not qualify for Medi-Cal based on their income, the regional center will refer the consumer for Medi-Cal redetermination through the waiver program and submit the DDS Waiver Referral form (DHS 7096). Medi-Cal eligibility determinations are not made by the Service Agency. At ELARC, the local Medi-Cal field office generally takes 60 days from the day consumers (or their families) submit all the requested information to complete the application process and make an eligibility determination.

LEGAL CONCLUSIONS

Jurisdiction

1. An administrative hearing to determine the rights and obligations of the parties is available under the Lanterman Act to appeal a contrary regional center decision. (Welf. & Inst. Code, §§ 4700-4716.) Claimant timely requested a hearing following the Service Agency's denial of Claimant's request, and therefore, jurisdiction for this appeal was established.

Standard and Burden of Proof

2. When a party seeks government benefits or services, he bears the burden of proof. (See, e.g., *Lindsay v. San Diego Retirement Bd.* (1964) 231 Cal.App.2d 156, 161 [disability benefits].) Where a change in services is sought, the party seeking the change bears the burden of proving that a change in services is necessary. (See, Evid. Code, § 500.) As no other statute or law specifically applies to the Lanterman Act, the standard of proof in this case is preponderance of the evidence. (See, Evid. Code, § 115.)

3. Claimant, as the party seeking payment for previously unfunded services, has the burden of proving, by a preponderance of the evidence, that the additional services are necessary to meet his needs.

Applicable Law

4. In enacting the Lanterman Act, the Legislature accepted its responsibility to provide for the needs of developmentally disabled individuals and recognized that services and supports should be established to meet the needs and choices of each

person with developmental disabilities. (Welf. & Inst. Code, § 4501.) The Lanterman Act gives regional centers a critical role in the coordination and delivery of services and supports for persons with disabilities. (Welf. & Inst. Code, § 4620, et seq.)

5. The consumer's needs are determined through the IPP process. (Welf. & Inst. Code, § 4646.) "Individual program plans shall be prepared jointly by the planning team. Decisions concerning the consumer's goals, objectives, and services and supports that will be included in the consumer's [IPP] and purchased by the regional center or obtained from generic agencies shall be made by agreement between the regional center representative and the consumer or, where appropriate, the parents, legal guardian, conservator, or authorized representative at the program plan meeting." (Welf. & Inst. Code, § 4646, subd. (b).)

6. The IPP must set forth goals and objectives for the consumer, contain provisions for the acquisition of services (which must be provided based upon the consumer's developmental needs), and reflect the particular desires and preferences of the consumer and the family when appropriate. (Welf. & Inst. Code, §§ 4646, 4646.5, subds. (a)(1), (a)(2), and (a)(4), 4512, subd. (b), and 4648, subd. (a)(6)(E).)

7. Although an IPP must reflect the needs and preferences of the consumer, a regional center is not mandated to provide all the services a consumer may request. A regional center's provision of services to consumers and their families must "reflect the cost-effective use of public resources." (Welf. & Inst. Code, § 4646, subd. (a).) A regional center also has discretion in determining which services it should purchase to best accomplish all or any part of a consumer's IPP. (Welf. & Inst. Code, § 4648.) This entails a review of a consumer's needs, progress and circumstances, as well as consideration of a regional center's service policies, resources and professional judgment as to how the IPP can best be implemented. (Welf. & Inst. Code, §§ 4646,

4648, 4624, 4630, subd. (b), and 4651; *Williams v. Macomber* (1990) 226 Cal.App.3d 225, 233.)

Analysis

8. Mother's appeal of the Service Agency's denial for reimbursement relies largely on Mother's mistaken belief that had Claimant been approved for an Institutional Deeming Waiver, Mother would not have to pay any premiums. This belief is incorrect. Monthly premiums for Medi-Cal are set by statute. All families who, like Mother have a household income of more than 160 percent of the federal poverty threshold, are required to pay a monthly premium in order to maintain their benefits whether the coverage is based on traditional Med-Cal rules or due to an Institutional Deeming Waiver. As Mother established that her income had not changed, there is no legal basis warrant granting her appeal and requiring ELARC to pay the outstanding premiums and Kaiser co-pays.

9. Further, the Service Agency does not have the authority to back-date the approval date of an Institutional Waiver for Claimant. The Service Agency does not make Medi-Cal eligibility determinations and does not have the authority to back-date an Institutional Waiver for Claimant.

ORDER

1. Claimant's Appeal is denied.

2. ELARC is not required to pay Medi-Cal $104 for outstanding monthly premiums for the period between from July and October 2019.

3. ELARC is not required to back-date the approval of an "Institutional Deeming" waiver for Claimant to December 14, 2018, when Mother claims she first made the request.

4. ELARC is not required to pay for Claimant's outstanding $20 co-payments due to Kaiser Permanente that should have been billed to Medi-Cal.

DATE:

NANA CHIN
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.