BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

CLAIMANT,

vs.

NORTH LOS ANGELES COUNTY REGIONAL CENTER,

Service Agency.

DDS No. CS0006374

OAH No. 2023060122

DECISION

Cindy F. Forman, Administrative Law Judge, Office of Administrative Hearings (OAH), State of California, heard this matter by videoconference on August 2, 2023.

Stella Dorian, Fair Hearing Representative, appeared on behalf of the North Los Angeles County Regional Center (NLACRC or Service Agency).

Claimant did not attend the fair hearing. He was represented by his mother. (Claimant and his family members are not identified by name to protect their privacy.)

This matter was consolidated for fair hearing with OAH numbers 2023060126, 2023060129, and 2023060139 under an order dated June 26, 2023. Separate decisions will be issued in each matter.

The ALJ heard testimony and received documentary evidence. The record was closed and the matter was submitted for decision on August 2, 2023.

ISSUE PRESENTED

Is claimant eligible under the Lanterman Developmental Disabilities Services Act (Lanterman Act) to obtain financial assistance from the regional center for funding insurance copayments for speech therapy and occupational therapy (OT)?

EVIDENCE RELIED UPON

In reaching this decision, the ALJ relied upon NLACRC's exhibits 1 through 27; claimant's exhibits A and B; and the testimony of the following witnesses: Consumer Service Coordinator Tami Dolin; Consumer Services Manager Silvia Renteria-Haro; and Mother.

FACTUAL FINDINGS

1. Claimant is a four-year-old boy who lives with his parents and seven siblings in the Santa Clarita Valley area. He is eligible for regional center services based on his diagnosis of autism. Three of his brothers also are consumers of regional center services. Another brother is a regional center consumer but his case is inactive.

2. NLACRC is one of the regional centers designated by the Department of Developmental Services to provide funding for services and supports to persons with developmental disabilities under the Lanterman Act. (Welf. & Inst. Code (Code), § 4500 et seq.)

3. On February 17, 2023, Mother sent an email to her children's service coordinators at NLACRC requesting NLACRC's assistance with co-payments required by certain of her children's healthcare providers. (Exhibit 22.)

4. On May 18, 2023, NLACRC sent Mother a Notice of Proposed Action (NOPA) finding claimant ineligible for regional center funding of insurance copayments for claimant's speech therapy. It did not address the co-pays for claimant's OT. The NOPA cited Code sections 4646, 4659, and 4659.1 in support of NLACRC's position. According to the NOPA, claimant's family's income did not meet the criteria for co-pay payment assistance or the exception criteria under Code section 4659.1. NLACRC further asserted claimant had not demonstrated he exhausted generic services to provide his OT or speech therapy or show that generic resources were not available to fund such services. (Ex. 5, p. A14.)

5. In her appeal dated May 23, 2023, Mother challenged NLACRC's denial of funding the co-pays for claimant's speech therapy. (Exhibit 1.)

Claimant's Request

6. Claimant is currently part of a health maintenance organization (UCLA Medical Group) insured by private insurance (Anthem Blue Cross HMO) through claimant's father's work. Claimant is also covered by Medi-Cal through LA Care. Claimant cannot choose the Medi-Cal provider; Anthem Blue Cross HMO and UCLA Medical Group are responsible for such selection. Because the private insurance carrier

requires the entire family (claimant's parents, claimant, and his seven siblings) to be covered under the plan, claimant cannot choose to be covered by only Medi-Cal.

7. There are a limited number of healthcare providers covered by both claimant's private insurance and Medi-Cal. Claimant's choice of healthcare providers is further restricted by where he resides; most of the doctors covered under UCLA Medical Group are located in the Westwood area of Los Angeles, which is approximately 30 miles from his home. As a result, it is difficult to locate healthcare providers that are both covered by claimant's private insurance and Medi-Cal as well as geographically convenient.

8. Claimant attends school in the Newhall School District (District). He has an Individualized Education Plan (IEP). Under the IEP, the District offers claimant limited speech therapy and occupational therapy (OT) supports. The therapy is offered in a group setting in claimant's special education classroom.

9. According to claimant's Individual Program Plan (IPP) dated April 7, 2022, the District offered to provide 15 minutes of group OT. (Exhibit 9, p. A117.) Claimant's parents were dissatisfied with the District's offer. They instead continued to pursue speech therapy twice a week and OT once per week at Progressive Steps. Claimant participated in therapy at Progressive Steps when he was in the Early Start program. Progressive Steps is an NLACRC-approved vendor and is covered by claimant's private insurance.

10. At the April 7, 2022 IPP meeting, Claimant's parents requested NLACRC's assistance in paying the co-pays for claimant's speech therapy and OT at Progressive Steps. (Exhibit 9, p. A117.) The IPP report indicates the NLACRC IPP team members explained the best way to obtain co-pay assistance would be to locate a vendor who

was covered by parents' private insurance and Medi-Cal. The report further indicates the IPP team would compile a list of programs covered by both Medi-Cal and claimant's insurance.

11. In an email correspondence to NLACRC, Mother asserted the District's speech program was too limited to provide sufficient support for claimant and it did not qualify claimant for one-to-one support. (Exhibit 22.) At Progressive Steps, claimant received one-to-one therapy and more intensive support, with a focus on speech pragmatics. Claimant recently stopped attending speech therapy at Progressive Minds because he completed the pragmatics program. Mother would like to receive reimbursement for the co-pays paid for the speech therapy claimant already received.

12. At hearing, Mother explained why the District's OT was inadequate for claimant's needs. She asserted the OT offered by the District focuses on small motor skills while the Progressive Steps program focuses on gross motor skills. At Progressive Steps, claimant works one-on-one with a therapist at a sensory gym that helps modulate his behaviors and anxiety reactions. The Progressive Steps therapist also concentrates on sensory dysregulation and claimant's physical safety.

13. When school is not in session, claimant attends OT therapy at Progressive Steps twice a week. When claimant returns to school, he will attend OT therapy at Progressive Steps once a week.

14. Claimant's father is a full-time animator. Claimant's mother is a psychiatrist who works on a part-time basis at night. Claimant's family's income exceeds the level required to qualify for financial assistance with copayments, coinsurance, or deductibles. To qualify, claimant's family's income must not exceed 400 percent of the federal poverty level, as defined by the Department of Health and

Human Services. According to claimant's parents' 2020 tax return, claimant's family had gross earnings of $291,402, $48,042 more than 400 percent of the federal poverty level for a family of 10. (Exhibits 20; 21.)

15. Claimant's speech therapy and OT at Progressive Steps require a co-pay of $35 for each session. From May 19, 2022, through July 11, 2023, claimant's parents paid $3,885 in co-pays for claimant's speech therapy and OT at Progressive Steps. (Exhibit A, p. B17.)

16. Mother testified Progressive Steps is not a Medi-Cal-approved provider, and Medi-Cal therefore will not pay the co-pays for claimant's speech therapy and OT. Mother has been unable to locate a vendor for claimant's OT and speech therapy needs that is covered by both her private insurance and Medi-Cal and that is also geographically convenient. Mother stated that although NLACRC identified therapy programs covered by both Medi-Cal and claimant's insurance, none were in the Santa Clarita area and thus they were too far away.

17. Mother does not contend any extraordinary or catastrophic events impacted the family's ability to pay the copayments or deductibles for claimant's OT and speech therapy.

18. Mother asserts the family's medical costs (medical, dental, and vision) are approximately $35,000 a year, including monthly insurance premiums of $1,355, deductibles, and co-pays. (Exhibit 23, p. A190.) Currently, claimant's family pays $70 a week in co-pays for claimant (two OT sessions a week each with a $35 co-pay), which will decrease to one OT session once claimant starts school. The family also pays one co-pay a week for two of claimant's brothers (two co-pays totaling $70), and another two co-pays a week for claimant's other brother (totaling $70). Claimant's parents

therefore pay at least $210 a week in co-pays for her four sons, all regional center consumers. Mother asserts these costs are financially burdensome and sufficiently significant to qualify for regional center assistance. Mother offered no evidence of any other significant costs impacting the family's income.

Service Agency's Position

19. In an email dated April 18, 2023, in response to Mother's request for financial assistance for claimant's speech therapy and OT co-pays, NLACRC Consumer Services Coordinator Tami Dolin referred Mother to the District to determine whether the District would offer such services. Ms. Dolin also indicated if the District would not provide the requested services, Mother should provide the District's denial as well as a speech therapy and OT assessment stating what services are required for claimant's benefit. (Exhibit 24, p. A196.)

20. NLACRC's Position Statement also makes clear the need for assessments and proof that Mother has attempted to access funding for claimant's speech therapy and OT from Medi-Cal. According to the Position Statement, NLACRC requested Mother to provide documentation for claimant and each of his three brothers of "having accessed funding for the desired therapies through Medi-Cal and the School District" and to "provide assessments for therapies [received by the four brothers] to determine the need for therapies Claimants are currently receiving." (Exhibit 27, p. A203.)

LEGAL CONCLUSIONS

Burden and Standard of Proof

1. A consumer seeking to obtain funding for a new service has the burden to demonstrate that the funding should be provided because the party asserting a claim or making changes generally has the burden of proof in administrative proceedings. (See, e.g., *Hughes v. Board of Architectural Examiners* (1998) 17 Cal.4th 763, 789, fn. 9.) As claimant is seeking funding for previously unfunded services, i.e., co-pays for speech therapy and OT, claimant has the burden of proving by a preponderance of the evidence that he is entitled to the requested services and funding. (See Evid. Code, § 500.) A preponderance of the evidence means evidence that has more convincing force than that opposed to it. (*People ex rel. Brown v. Tri-Union Seafoods, LLC* (2009) 171 Cal.App.4th 1549, 1567.)

Applicable Law

2. The purpose of the Lanterman Act is twofold: To prevent or minimize the institutionalization of developmentally disabled persons and their dislocation from family and community, and to enable them to approximate the pattern of everyday living of nondisabled persons of the same age and to lead more independent and productive lives in the community. (*Association for Retarded Citizens v. Department of Developmental Services* (1985) 38 Cal.3d 384, 388.) To accomplish these goals, the Legislature has directed regional centers to assist persons with developmental disabilities and their families to secure those services and supports "which maximize opportunities for living, working, learning, and recreating in the community." (Code, § 4640.7, subd. (a).) Those supports must be either directed toward the alleviation of the developmental disability, toward the social, personal, physical, or economic

habilitation or rehabilitation of a person with a developmental disability, or toward the achievement of an independent, productive, and normal life. Such supports include physical, speech, and occupational therapy, mental health services, and counseling. (Code, § 4512, subd. (b).)

3. The Lanterman Act requires an IPP to be developed and implemented for each individual who is eligible for regional center services. (Code, § 4646.) The IPP includes the consumer's goals and objectives as well as required services and supports. (Code, §§ 4646.5 & 4648.) The services and supports provided or secured by the regional center are to respect and support the family's decision-making, be flexible and creative to meet the claimant's unique and individual needs over time, recognize family strengths, natural supports, and existing community resources, and focus on the entire family. (Code, § 4685, subd. (b).) While a consumer and his parents' preferences and desires are to be considered in the planning process, regional centers are not authorized to purchase every service a consumer or his family may desire. The purchase must reflect a "cost-effective use of public resources." (Code, § 4646, subd. (a); see also Code, § 4512, subd. (b).)

4. The planning process for an IPP comprises "[g]athering information and conducting assessments to determine the life goals, capabilities and strengths, preferences, barriers and concerns or problems of the person with developmental disabilities." (Code, § 4646.5, subd. (a)(1).) Under section 4646.5, assessments are to be conducted by qualified individuals. The assessment includes information from the consumer, the consumer's family, the providers of services and supports, and other agencies. Based on the assessments, the IPP identifies the type and amount of services and supports to be purchased from the regional center or obtained from generic agencies or other resources to achieve the IPP goals and objectives as well as the

service providers responsible for attaining such goals and objectives. (Code, § 4646.5, subd. (a)(5).) The purpose of the assessments is to ensure the requested services meet the consumer's needs and are provided in a cost-efficient manner.

5. The regional center must utilize generic services and supports if appropriate to provide for the services and supports identified in the IPP. (Code, § 4646.4, subd. (a)(2).) Regional center funds cannot be used 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. (Code, § 4648, subd. (a)(8).)

6. Regional centers also are required to "identify and pursue all possible sources of funding" from governmental entities such as Medi-Cal, school districts, and private entities such as insurers. (§ 4659, subd. (a).) And, except in certain circumstances not applicable in this case, regional centers are prohibited from purchasing any service otherwise available from Medi-Cal or private insurance when a consumer or a family meets the criteria of this coverage but chooses not to pursue that coverage. (Code, § 4659, subd. (c).)

7. The regional center also cannot purchase medical 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. (Code, § 4659, subd. (d)(1).) However, regional centers may pay for medical services while coverage is being pursued but before Medi-Cal issues a denial. (Code, § 4659, subd. (d)(1)(A).)

8. A regional center may pay any applicable copayment, coinsurance, or deductible for a service or support "provided pursuant to a consumer's individual

program plan" and paid for, in whole or in part, by the consumer's health insurance policy, when it is necessary to ensure the consumer receives the service or support, under the following conditions:

> (1) The consumer is covered by their 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).

(Code, § 4659.1, subd. (a).)

9. If a consumer's family's income exceeds 400 percent of the federal poverty level, a regional center may pay insurance costs for a service or support authorized by a claimant's IPP if the service or support is necessary to successfully maintain the child at home and one or more of the following conditions are met:

> (1) The existence of an extraordinary event that impacts the ability of the parent . . . to meet the care and supervision needs of the child or impacts the ability of the parent . . . 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 . . . 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.

(Code, § 4659.1, subd. (d).)

10. Claimant's school district is a generic resource that is responsible for providing appropriate services to meet claimant's needs, as outlined in his IEP, in order to allow him to access a free and appropriate public education. (20 U.S.C. § 1437 (a)(8).) A school district must also meet its responsibility for providing needed services, even when the student also falls under the responsibility of another agency, such as a regional center.

Claimant's Eligibility for Funding

11. The Lanterman Act provides that speech therapy and OT are the kinds of specialized services the regional center can secure or provide on claimant's behalf. However, the Lanterman Act makes clear that a regional center cannot assume responsibility to provide or fund such services until it determines that the service cannot be provided or funded by any generic resource. (Legal Conclusions 2, 5–7.)

12. Although Mother explained why the District's current speech therapy and OT were inadequate to meet claimant's needs, she offered no evidence the District, a potential generic resource, was unable or unwilling to provide the needed therapies to address those needs. Nor did Mother offer any assessment from the District, Progressive Steps, or any other service provider evaluating the nature and scope of claimant's speech therapy and OT needs and why the District's services are inadequate. The fact that claimant's family disagrees with or does not prefer the speech therapy or OT offered by the District is not sufficient to relieve NLACRC from its obligation to first look to the District to fund claimant's therapies. NLACRC therefore cannot consider whether the co-pays paid for claimant's speech therapy and OT are eligible for funding until it determines that the District either cannot or refuses to provide such therapies and the therapies are necessary to meet claimant's needs.

13. Additionally, Mother has not provided documentation that claimant's Medi-Cal Managed Care Plan (Plan) will not cover the speech therapy or OT provided to claimant and, if does provide such coverage, that the Plan does not include a geographically convenient provider who is also covered by claimant's private insurance. While such a request may be futile based on Mother's research, Code section 4659, subdivision (d)(1), requires claimant to provide documentation of such denial. However, if claimant can show the requested therapies are necessary and cannot be provided by the District, NLACRC is not precluded from providing funding assistance for the co-pays for such services while coverage is being pursued, but before a denial is made. (Code, § 4659, subd. (d)(1)(A).)

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14. Claimant also failed to prove by a preponderance of the evidence that his co-pays are eligible for funding under Code section 4659.1 at this time. Although claimant's medical costs are covered by the family's health insurance policy, NLCRC proved by a preponderance of the evidence that claimant's family's gross income exceeds 400 percent of the federal poverty level. Thus, the Lanterman Act precludes NLACRC from providing copay assistance for claimant's speech therapy and OT unless certain conditions are met.

15. Claimant's family does not presently meet any of the exceptions stated in Code section 4659.1, subdivision (d). Claimant's family has not experienced an extraordinary event that impacts the parents' ability to meet claimant's needs or pay the copayment. Claimant's family also has not experienced a catastrophic loss that has temporarily limited or impacted their ability to pay any co-pay.

16. It is also premature to determine whether the family has experienced significant unreimbursed medical costs, as claimant has not yet shown generic resources are insufficient or unavailable to meet claimant's speech therapy or OT needs. NLACRC therefore cannot consider whether the co-pays paid for claimant's speech therapy and OT are eligible for funding until it is determined that the District either cannot or refuses to provide such therapies, the therapies are necessary to meet claimant's needs, and claimant's family has at least initiated efforts to pursue coverage with Medi-Cal. Only then can NLACRC consider whether claimant's co-payments combined with those of his siblings are significant per Code section 4659.1, subdivision (d)(3).

ORDER

Claimant's appeal is denied.

DATE:

CINDY F. FORMAN
Administrative Law Judge
Office of Administrative Hearings

NOTICE

This is the final administrative decision. Each party is bound by this decision. Either party may request a reconsideration pursuant to subdivision (b) of Welfare and Institutions Code section 4713 within 15 days of receiving the decision, or appeal the decision to a court of competent jurisdiction within 180 days of receiving the final decision.