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. CS0006379

OAH No. 2023060126

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 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 were not identified by name to protect their privacy.)

This matter was consolidated for fair hearing with OAH numbers 2023060122, 2023060129, and 2023060139 pursuant to 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 his cognitive behavioral therapy (CBT)?

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 15-year-old boy who lives with his parents and seven siblings. 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 also a regional center client but has an inactive case.

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 assist 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 CBT with Tamar Apelian, Psy.D., of Growing Minds. 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 to qualify for any exception under Code section 4659.1. NLACRC further asserted claimant had not demonstrated he exhausted generic services who could provide the needed therapy or show that generic resources were not available to fund such services. NLACRC recommended parents select a vendor that was in-network with both their private insurance and Medi-Cal managed care plan to avoid any fee for services. (Ex. 6, p. A19.)

5. In her appeal dated May 23, 2023, Mother challenged NLACRC's denial of funding the co-pays for claimant's CBT. (Exhibit 2.)

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. The

private insurance HMO dictates the Medi-Cal managed care group covering claimant. 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 claimant's private insurance and Medi-Cal. Claimant's choice of healthcare providers is further limited because of 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). As of fall 2022, he was in a mainstream classroom but has an Individual Education Plan (IEP). At school, according to his 2022 Progress Report, claimant receives occupational and speech therapy, as well as counseling. (Exhibit 11, p. A144.). Per the 2022 Progress Report, parents informed NLACRC claimant receives CBT once a week with Dr. Apelian, who focuses on claimant's behaviors and addresses his anger and aggression. (*Id.,* pp. A143, A144.) Claimant's parents indicated they were not interested in Applied Behavior Analytics (ABA) therapy for claimant. (*Id.*, p. A145.)

9. According to Mother, Dr. Apelian specializes in autism and is a "critical support" to claimant and his family. Dr. Apelian is available to the family, 24 hours a day, seven days a week. She also treats two of claimant's brothers, both of whom are regional center consumers. Mother also explained the District's counseling was not sufficient for claimant because it focuses on academics and does not include CBT. Mother has found CBT to be more effective for her children than ABA therapy.

10. Claimant's CBT is covered by claimant's private medical insurance. Dr. Apelian does not accept Medi-Cal. Mother asserted Medi-Cal therefore will not cover claimant's co-pays. There is a co-pay of $35 for each session. In 2021, claimant's parents paid Dr. Apelian co-pays for claimant's counseling totaling $170. (Exhibit A, pp. B22–B23.) In 2022, claimant's parents paid Dr. Apelian $780 in co-pays for claimant's counseling. (*Id.*, pp. B24–B25.) From January 4 to June 28, 2023, claimant's parents paid Dr. Apelian $805 in co-pays for claimant's counseling. (*Id.*, pp. B26–B27.)

11. 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' 2022 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.)

12. Mother did not contend there were any extraordinary or catastrophic events impacting claimant's parents' ability to pay the copayments or deductibles for claimant's CBT.

13. 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 $35 a week in co-pays for claimant's CBT. They also pay a $35 co-pay once a week for one of claimant's brothers, and two co-pays a week for claimant's other two brothers (totaling $140). 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 Response

14. In response to Mother's request for financial assistance for claimant's CBT co-pays, NLACRC Consumer Services Coordinator Tami Dolin stated the Service Agency would consider the service to constitute mental health services. Ms. Dolin therefore requested Mother pursue all reimbursements directly through claimant's insurance and Medi-Cal. Noting that Dr. Apelian is out-of-network with claimant's Medi-Cal Managed Care Plan, Ms. Dolin recommended selecting a different managed care plan that would reimburse claimant for the associated co-payments. (Exhibit 24, p. A196.)

15. The NOPA is unclear as to whether Service Agency deemed claimant's CBT to constitute a mental health service independent of the District or related to the counseling already provided by the District. (Exhibit 6, p. A19.) NLACRC's Position Statement also is unclear as to how it categorizes claimant's CBT. According to the Position Statement, NLACRC has 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 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 CBT, 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 and choices for living, working, learning, and recreating in the community." (Code, § 4640.7, subd. (a).) Those services and 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 services and 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 decisionmaking, 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 available and appropriate. (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 are also 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. (Code, § 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 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, the regional center may pay for medical costs while coverage is being pursued but before a denial is made. (Code, § 4659, subd. (d)(1)(A).)

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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.

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Claimant's Eligibility for Funding

11. The Lanterman Act provides that mental health services and counseling 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. If CBT is considered to be akin to counseling, Mother has offered no evidence that the counseling provided by the District, a generic resource, is inadequate to meet claimant's needs, or that the District has no program to meet such needs. Nor has Mother provided an assessment from Dr. Apelian, the District, or any other entity evaluating the scope and nature of claimant's mental health needs. NLACRC therefore cannot consider whether the co-pays paid for claimant's CBT are eligible for funding until a determination is made that the CBT differs from the counseling offered by the District, the District either cannot or refuses to provide the counseling required, and the counseling is necessary to meet claimant's needs.

13. Moreover, regardless of whether claimant's CBT is considered a mental health support or counseling, Mother has not provided documentation stating that claimant's Medi-Cal Managed Care Plan (Plan) will not cover CBT provided to claimant or, if it will 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 CBT is necessary and cannot be provided by the District, NLACRC is not precluded from funding the co-pays for such services while coverage is

being pursued, but before a denial is made. (Code, § 4659, subd. (d)(1)(A).) Ms. Dolin's suggestion that claimant locate another Medi-Cal managed care plan to cover claimant's co-pays ignores the constraints imposed by claimant's primary coverage and therefore is unworkable.

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 is covered by his family's health insurance policy, 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 CBT unless certain conditions are met.

15. Claimant's family does not presently meet any of the conditions provided in Code section 4659.1, subdivision (d). Claimant's family has not experienced an extraordinary event that impacts the ability of the parents to meet claimant's needs or impacts the parents' ability to 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 shown generic resources are insufficient or unavailable to meet claimant's CBT needs. NLACRC therefore cannot consider whether the co-pays paid for claimant's CBT are eligible for funding assistance until it is determined that the District either cannot or refuses to provide such therapy, the therapy is 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.