BEFORE THE
DEPARTMENT OF DEVELOPMENTAL SERVICES
STATE OF CALIFORNIA

In the Matter of:

Claimant,

and

Harbor Regional Center, Service Agency.

DDS No. CS0026192

OAH No. 2025041181

PROPOSED DECISION

Nana Chin, Administrative Law Judge, Office of Administrative Hearings (OAH), State of California, heard this matter by videoconference on October 17, 2025.

Claimant was represented by his parents (Parents). (Names are omitted and family titles are used to protect the privacy of Claimant and his family.)

Harbor Regional Center (HRC or Service Agency) was represented by Latrina Fannin, HRC Manager of Rights and Quality Assurance.

Testimony and documents were received into evidence. The record was closed, and the matter submitted, on October 17, 2025.

ISSUES

1. Whether HRC should be required to increase the respite rate in Claimant's budget from $30.11 per hour to $36.03 per hour.

2. Whether HRC should be required to fund Myofunctional Therapy for Claimant.

EVIDENCE

Documents: Service Agency Exhibits: 2-4, 6-10, 12-16; and Claimant's Exhibits: A-I

Testimonial: Ricardo Orozco, Participant Choice Specialist; Jimmy Silvestre, Client Service Manager; Antoinette Perez, Director of Children's Services; Mother. (Father appeared and presented argument; he did not testify.)

FACTUAL FINDINGS

Jurisdictional Matters

1. Claimant qualifies for services under the Lanterman Developmental Disabilities Services Act (Lanterman Act) (Welf. & Inst. Code, § 4500 et seq.) based upon the diagnoses of intellectual disability (ID), autism spectrum disorder (ASD), and epilepsy. (All undesignated statutory references are to the Welfare and Institutions Code.)

2. On a date not established by the record, Parents requested multiple services from Service Agency, which were denied. On April 8, 2025, Service Agency

issued six Notices of Action, explaining the reasons for the denials and citing the laws, regulations, and policies that supported those notices.

3. Mother filed an appeal on Claimant's behalf on April 22, 2025. At the time of hearing, the only remaining issues on appeal are those identified above.

4. All jurisdictional requirements have been met.

Background

5. Claimant is a 12-year-old boy who lives at home with Parents and two siblings (one older and one younger) and attends a school in the Bellflower Unified School District. Father works from home and is starting a consulting business. Mother works part time from 3:00 p.m. to 8:00 p.m. as an independent facilitator, serves as Claimant's In-Home Supportive Services (IHSS) worker and is the primary caregiver for Claimant and his siblings.

2024 Individual Program Plan Meeting

6. On August 29, 2024, a virtual Individual Program Plan (IPP) Meeting was held with Mother, a family friend, and HRC Service Coordinator (SC) Susana Jones.

7. Mother shared information regarding Claimant's current status, providing information on Claimant's daily living needs, health, behavioral health, and school status.

8. Mother reported that Claimant requires ongoing prompts, reminders, supervision, and hands-on assistance for activities of daily living. He continues to have bladder and bowel accidents and communicates with brief utterances, though he can use multi-word phrases. He follows two-step directions with occasional reminders. He has, however, also shown progress. Claimant has become more independent with

dressing; he will clean his plates and put dirty dishes in the sink without reminders; and, with prompts, he puts his clothes into the laundry hamper, makes his bed, and organizes his shoes.

9. With respect to his health, Mother reported that Claimant's overall health is generally stable. She also reported that Claimant has been tongue thrusting and that Parents would be switching Claimant to a new orthodontist to address his orthodontic needs. Claimant's sleep habits are fair, typically going to sleep between 8:30 p.m. and 9:00 p.m. and waking as early as 5:00 a.m. three days a week.

10. With respect to his behavioral health, Mother reported that Claimant has been exhibiting frequent maladaptive behaviors, including noncompliance, tantrums, emotional outbursts, and aggression, which occur anywhere from a few times per week to daily and typically last 12 to 15 minutes. Though Claimant's aggression is usually directed at Mother and Sisters, it has recently begun to include Father.

11. With respect to his education, Claimant attends a Special Day Class with a full-day 1:1 aide under his Individualized Education Program (IEP). Mother reported there had been no behavioral incidents at school.

Orofacial Myofunctional Therapy

12. Parents consulted with Audrey Yoon, DDS, an orthodontist. Dr. Yoon is also a sleep specialist affiliated with Stanford Sleep Medicine Center and recommended during the consultation that Claimant undergo a sleep study and airway evaluation due to his tonsillar hypertrophy (i.e., enlarged tonsils), allergy, asthma, attention-deficit hyperactivity disorder (ADD/ADHD), epilepsy, snoring and mouth breathing. On October 1, 2024, Dr. Yoon referred Claimant for evaluations by an otolaryngologist (ENT) and a

myofunctional therapist, as well as for an overnight attended sleep study/polysomnogram.

13. On January 12, 2025, a sleep study was conducted at Kaiser Permanente (Kaiser). The report of the study, admitted into evidence as Exhibit B, recorded the impressions of the study as "Overall, Severe obstructive sleep apnea/hypopnea syndrome obstructive [Apnea-Hypopnea Index (AHI)] 10.8 Poor sleep efficiency due to episodes of prolonged waking, some following respiratory events and others not preceded by respiratory nor movement events. (Exh. B, p. B12.) (AHI is the average number of times you stop breathing and have shallow breathing events per hour of sleep and is a metric used in sleep studies to quantify the severity of sleep apnea.)

14. Paymon Ebrahimazadeh, DO, MPH, reviewed the results and made the following recommendations: "For pediatric pts, the definitive treatment for [obstructive sleep apnea (OSA)] is tonsillectomy and adenoidectomy; patient has been referred to ENT. Conservative treatment can be 'watchful waiting' with flonase nasal spray and montelukast as often a segment of pediatric mild OSA resolves over time." (Exh. B, p. B12.)

15. On November 6, 2024, Kaiser denied Claimant's request for an oral myofunctional therapy (myofunctional therapy or OMT) evaluation, noting it was not medically indicated for Claimant for the treatment of speech therapy deficits based on the following factors: (1) Claimant has normal motor function and sensation, myofunctional therapy is not medically indicated for treatment of Claimant's speech therapy deficits; and (2) Claimant demonstrated speech intelligibility at 90 percent to familiar and unfamiliar listeners. According to the notice, the denial was based on Kaiser's Utilization Management (UM) Criteria for the Provision of Speech and Language

Therapy Services Covered Under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Benefit for Medi-Cal Members Under the Age of 21.

16. Following the denial, Parents asked HRC to fund OMT to address Claimant's tongue positioning, which they believe is affecting his speech and may be affecting his sleep and teeth positioning. On March 25, 2025, SC Jones met with HRC speech-language pathologist (SLP) Melissa Greener and Client Services Manager (CSM) Jimmy Silvestre to review the request. According to the note of the meeting, Dr. Yoon requested OMT due to Claimant's tongue position related to speech; her notes indicated Claimant had tongue thrust and a lisp on "s" and "z" sounds. These findings were not replicated in the September 30, 2024 evaluation by the Kaiser SLP, who assessed Claimant's speech intelligibility at 90 percent, or in the April 18, 2024 evaluation by the school SLP, who also assessed his speech intelligibility.

17. SLP Greener recommended the service be denied, stating that within the field of speech-language pathology, OMT remains controversial; that the available studies and sample sizes are limited; and that the literature does not show clear, durable improvements or consistent evidence that OMT benefits articulation.

18. At hearing, Mother testified that Parents have been searching for answers to explain Claimant's daily struggles: persistent tiredness, irritability, and difficulty learning despite years of applied behavior analysis (ABA) therapy and other supports. Based on professional consultation and testing, Mother believes OMT is medically necessary for Claimant's health, learning, and quality of life.

19. Mother submitted a list of journal articles with hyperlinks, admitted into evidence as Exhibit D. Two, D-1 and D-2, were meta-analyses. (A meta-analysis is a statistical technique that combines the results from multiple independent studies.) In D-

1, the authors noted that the "main limitations of this review are the lack of available data regarding tongue motor skills, especially in children." (J Clin Sleep Med. 2024;20(9):1535–1549.) In D-2 and D-5, the authors noted that the results of randomized studies had shown that OMT is effective for the treatment of adult patients with mild and moderate OSA and with primary snoring and of children with residual apnea, but that high-quality studies were still rare, and the effects of treatment should also be analyzed on a long-term basis. (Nat Sci Sleep. 2018 Sep 6;10:271–286.) (The hyperlinks to D-2 and D-5 were to the same article.) D-3 was a discussion of a study performed by Dr. Yoon; D-6 was a case study of one patient; and D-5 was a study proposal.

Self-Determination Program

CLAIMANT'S SDP BUDGET

20. On November 1, 2023, Claimant was enrolled in the Self-Determination Program (SDP). At that time, his certified budget was $90,089.69. Each participant in the SDP is allocated funds, referred to as an individual budget, to purchase services and supports necessary to implement their IPP. The individual budget allocated to each participant is based on the total funds that were expended by the participant the prior year to purchase regional center services and supports, less any one-time costs. The budget may be increased as new needs are identified. A spending plan is developed, detailing how the participant's individual budget will be used.

21. Effective June 23, 2025, Claimant's SDP budget was increased to $104,997.69 to include, among other services, personal assistance for 16 weeks for five hours a day, five days a week, at $37.27 per hour.

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RATE REFORM

22. In 2016, the Legislature funded a statewide rate study because the DDS rate system was hard to understand, overly complicated, inconsistent across providers, and not linked to person-centered results. The study, completed in 2019, recommended, among other things, service-specific rate models that can be updated, regional cost adjustments, and a shift toward paying for quality and outcomes.

23. The rate increases were implemented in phases. Beginning April 1, 2022, service providers received 25 percent of the gap between their then-current rate and the model rate; from January 1, 2023, through December 31, 2024, rates moved to 50 percent of that gap. On January 1, 2025, rates were set at 90 percent of the model rate plus up to 10 percent as a quality incentive and were earned by meeting DDS-defined quality measures. Payments under Section 4519.10 are made through DDS rate models, and the statute expressly limits the quality-based increase to "a vendor." By contrast, direct-hire workers in the SDP are not tied to DDS rate models or vendor status, so the statute does not directly affect their pay rate.

24. On September 15, 2022, DDS issued a directive to regional centers explaining how rate reform applies in SDP. The directive states that an SDP participant's individual budget may be adjusted only in ways that would have occurred outside SDP. (§ 4658.8, subd. (m)(1)(A)(ii).) In practice, the regional center may: (1) raise the budget to comply with state minimum-wage increases; (2) adjust the budget when the rates for vendored services included in the individual budget calculation changes; and (3) adjust when the participant buys SDP services from a provider who is also vendored and the agreed SDP rate is equal to, or pegged to, that provider's vendored rate.

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25. Antoinette Perez, Director of Children's Services, oversees the team supporting Claimant and testified regarding HRC's implementation of rate reform. Director Perez explained that rate reform was the state's effort to create a systemic way of creating a consistent, fair method for setting provider rates. According to Director Perez, HRC implemented a 25 percent rate increase in January 2023, and another 25 percent increase in July 2023. She testified that HRC provided these increases to both vendored and non-vendored providers to address the rising costs of living and doing business.

26. Director Perez explained increases beyond those described above were not provided to non-vendored service providers. According to Director Perez, the statute tied the remaining 50 percent rate increase to specific requirements. To be eligible for the additional 40 percent, the provider must be listed in the provider directory, and the final 10 percent is available through the quality incentive program. Non-vendored service providers do not qualify for these increases because they are not vendored and therefore cannot be in the provider directory.

27. With respect to Claimant's SDP, Director Perez explained that the respite payment rate did not include the additional 50 percent because Claimant uses a non-vendored provider. She stated that if Claimant used a vendored provider, HRC would revise Claimant's SDP budget accordingly. She also acknowledged that Claimant received the higher rate for the personal assistance because it was a new service and the authorized amount for new services was calculated to match what would have been approved under the traditional system.

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PARENT'S POSITION

28. Parents argued that, had they had entered the SDP system now, Claimant would have received a larger individual budget. They point to the approved personal assistance hours, which were funded at the higher rate, as evidence HRC can authorize funding at that level. In their view, HRC's refusal to apply the higher rate to Claimant's respite hours reflects an inconsistent application of budget policy and argued that it creates an unequal and arbitrary outcome, undermining both the principle of equity and the intent of the Self-Determination Program.

LEGAL CONCLUSIONS

Standard and Burden of Proof

1. 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 proof by a preponderance of the evidence. (Evid. Code, § 115.)

2. Claimant, as the party seeking additional funding, has the burden of proving by a preponderance of the evidence that the additional funding is necessary to meet his needs. Claimant has not met his burden.

Applicable Law

3. In enacting the Lanterman Act, the Legislature accepted its responsibility to provide for the needs of developmentally disabled individuals and created a

comprehensive scheme to provide "an array of services and supports . . . sufficiently complete to meet the needs and choices of each person with developmental disabilities, regardless of age or degree of disability, and at each stage of life and to support their integration into the mainstream life of the community." (§ 4501.) The purpose of the scheme is twofold: (1) to prevent or minimize the institutionalization of developmentally disabled persons and their dislocation from family and community (§§ 4501, 4509, 4685); and, (2) to enable developmentally disabled persons to approximate the pattern of living of nondisabled persons of the same age and to lead more independent and productive lives in the community. (§§ 4501, 4750-4751.)

4. The consumer's needs are determined through the IPP process. (§ 4646.) The IPP is developed through a collaborative effort involving the appropriate regional center, the consumer and/or the consumer's representatives. (§4646, subd. (d)). The IPP process includes gathering information from the consumer, the consumer's family and others to identify and accurately assess a consumer's needs. (§4646.5, subd. (a).)

Request for OMT

5. Notwithstanding a consumer's entitlement to services and supports, regional centers must implement the IPP in a cost-effective manner. (§§ 4512, subd. (b), 4646, subd. (a).) Regional centers are also prohibited from purchasing "experimental treatments, therapeutic services, or devices that have not been clinically determined or scientifically proven to be effective or safe or for which risks and complications are unknown. Experimental treatments or therapeutic services include experimental medical or nutritional therapy when the use of the product for that purpose is not a general physician practice." (§ 4648, subd. (a)(17).)

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6. The record does not demonstrate that OMT is medically necessary for this Claimant. HRC reportedly received a prescription from Dr. Yoon for OMT to address issues related to the intelligibility of Claimant's speech. Dr. Yoon, however, was the only provider to express these concerns. The school SLP assessed Claimant's speech intelligibility at approximately 80%, and the Kaiser SLP assessed intelligibility at approximately 90%; neither SLP recommended therapy or treatment to address a speech intelligibility deficit.

7. Even if Dr. Yoon's prescription were read broadly to encompass OMT for the treatment of Claimant's OSA, the record does not show that OMT is an accepted pediatric OSA therapy. After reviewing the results of Claimant's January 12, 2025 sleep study, Dr. Ebrahimazadeh referred Claimant to an ENT, noting that the "definitive treatment for OSA" in pediatric patients is tonsillectomy and adenoidectomy. Dr. Ebrahimazadeh also identified conservative management as "watchful waiting" with intranasal fluticasone (steroid nasal spray) and montelukast (a nonsteroidal asthma/allergy medication)), noting that some mild pediatric OSA improves over time. (Exh. B, p. B12.) OMT was not identified as a standard or indicated treatment for OSA.

8. During HRC's review of the request for OMT, SLP Greener recommended denial, explaining that within speech-language pathology OMT remains controversial; available studies and sample sizes are limited; and the literature does not show clear, durable improvements or consistent evidence that orofacial strengthening exercises improve articulation. The journal articles Mother submitted (Exh. D) also support the conclusion that OMT is still an experimental therapy. The two meta-analyses acknowledge material limitations in OMT studies: D-1 (J Clin Sleep Med. 2024;20(9):1535–1549) notes a lack of pediatric data on tongue motor skills, and D-2 (Nat Sci Sleep. 2018;10:271–286) reports some positive findings for adults with mild–

moderate OSA and for children with residual apnea after other treatment, while emphasizing that high-quality trials are rare and long-term outcomes remain uncertain. The remaining items in Exhibit D—a discussion of a study by Dr. Yoon, a single-patient case report, and a study proposal—do not overcome these limitations or establish OMT as a generally accepted treatment for pediatric OSA or as necessary to remediate a documented speech intelligibility deficit here. Taken together, the literature shows that OMT remains investigational, particularly for pediatric OSA.

9. Because the Lanterman Act prohibits funding for experimental treatments and OMT has not been shown necessary to address a documented need in this case, Claimant has not met his burden to establish that HRC should fund OMT.

Self-Determination Budget

10. The SDP was implemented to provide participants and their families increased flexibility and choice and greater control over decisions, resources and the services and supports needed to implement the IPP within an individual budget. (§ 4685.8, subd. (a).) A participant's individual budget is "the total amount of the most recently available 12 months of purchase-of-service expenditures for the participant." (§ 4685.8, subd. (m)(1)(A)(i).) The amount may be adjusted if the IPP team determines there has been a change in the participant's circumstances, needs or resources that would increase or decrease purchase-of-service expenditures, or if the team identifies previously unaddressed needs or resources that would have altered those expenditures. (§ 4685.8, subd. (m)(1)(A)(ii)(I).)

11. Pursuant to section 4519.10, the Legislature enacted rate reform for the regional center system. Commencing April 1, 2022, DDS implemented an increase equal to one-quarter of the difference between each provider's current rate and the fully

funded rate model beginning on April 1, 2022;. Commencing January 1, 2023, and continuing through December 31, 2024, DDS adjusted rates to one-half of that difference (with additional funding available for the quality incentive program). Commencing January 1, 2025, DDS implemented the fully funded rate models using two components: a base rate equal to 90 percent of the model and a quality incentive of up to 10 percent tied to DDS quality measures. (§ 4519.10, subd. (c)(1)(A)–(C).)

12. These rate-reform provisions apply to vendored providers (i.e., services with DDS rate models and current rates), not to direct-hire workers in SDP. Nothing in Section 4685.8 authorizes importing vendor-only rate increases into a non-vendored arrangement absent a qualifying budget adjustment (for example, a documented change in needs or circumstances, or an earlier need that was missed). (See § 4685.8, subd. (m)(1)(A) (ii)(I) Vendorization also carries added oversight and costs—insurance, training/documentation requirements, listing in the provider directory, and other operational standards—that do not apply to direct-hire workers. The record, if anything, suggests that compensation paid to a direct-hire worker can exceed what would be payable to a comparably situated vendored provider, which points to using alternative methodologies for setting or adjusting the SDP budget where appropriate. (See § 4685.8, subd. (m)(4).)

13. Accordingly, the request to increase the respite rate paid to a non-vendored worker is not supported by section 4685.8, subdivisions (m)(1) and ((m)(1)(A)(ii)(I). The evidence shows Claimant is receiving the services and supports necessary to implement his IPP within the established budget.

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ORDER

1. Claimant's appeal of Service Agency's denial of funding of oral myofascial therapy is denied.

2. Claimant's appeal of Service Agency's denial to increase the hourly rate for Claimant's respite services is denied.

IT IS SO ORDERED.

DATE:

NANA CHIN
Administrative Law Judge
Office of Administrative Hearings

BEFORE THE
DEPARTMENT OF DEVELOPMENTAL SERVICES
STATE OF CALIFORNIA

In the Matter of:

Claimant, OAH Case No. 2025041181

vs. **DECISION BY THE DIRECTOR**

Harbor Regional Center,

Respondent.

ORDER OF DECISION

On October 27, 2025, an Administrative Law Judge (ALJ) at the Office of Administrative Hearings (OAH) issued a Proposed Decision in this matter.

After a full and independent review of the record in this case, and for the reasons explained below, the attached Proposed Decision is ADOPTED in part and REJECTED in part based on the following:

1. The ALJ's ruling that denied claimant's request that Harbor Regional Center (HRC) permit claimant to use his Self Determination Program (SDP) funds to purchase Orofacial Myofunctional Therapy (OMT) is ADOPTED. Welfare and Institutions Code section 4648, subdivision (a)(17), prohibits regional centers from purchasing "experimental treatments, therapeutic services, or devices that have not been clinically determined or scientifically proven to be effective." Claimant failed to demonstrate that OMT is clinically determined or scientifically proven to be effective at improving his articulation and speech, or alleviating symptoms of his developmental disability.

2. The ALJ's ruling that denied claimant's request that HRC should be required to increase the respite pay rate in claimant's SDP budget from $30.11 per hour to $36.03 per hour is REJECTED. Welfare and Institutions Code section 4685.8, subdivision (m)(1)(A)(ii)(II), requires that the amount of funding in an individual budget must be based upon services the regional center would have funded regardless of the individual's participation in the SDP to meet the individual's Individual Program Plan (IPP) goals. Regardless of whether an SDP participant intends to purchase services from regional center vendors, when calculating an initial SDP budget, the regional center is required to certify that the regional center expenditures for the individual budget, including any adjustment, would have occurred regardless of the individual's participation in the SDP. In claimant's case, these services

include respite, and thus claimant's initial SDP budget allocated funds based on the costs of these services by a respite vendor.

3. Furthermore, pursuant to Welfare and Institutions Code section 4685.8, subdivision (a), the purpose of SDP is to "provide participants and their families, within an individual budget, increased flexibility and choice, and greater control over decisions, resources, and needed and desired services and supports to implement their IPP." HRC refusal to increase the respite pay rate in claimant's SDP budget undermines the purpose of SDP's intent to increase the flexibility and choice of claimant's services and supports to implement his IPP, As claimant's parents credibly stated at the hearing, HRC's decision to not change the rate for the respite service vendor to the current rate of the respite service vendor that was used in the individual budget creates an unequal and arbitrary outcome for claimant given that participants who join SDP after claimant will receive the higher rate for their respite service as part of their individual budget calculation.

This is the final Administrative Decision. Each party is bound by this Decision. Either party may request a reconsideration pursuant to Welfare and Institutions Code section 4712.5, subdivision (a)(1), 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. Regardless of whether an SDP participant intends to purchase services

Attached is a fact sheet with information about what to do and expect after you receive this decision, and where to get help.

ORDER

Claimant's appeal of HRC's denial of funding for Orofacial Myofunctional Therapy is DENIED. Claimant's appeal of HRC's denial of increasing the respite pay rate in claimant's SDP budget from $30.11 per hour to 36.03 per hour is GRANTED.

IT IS SO ORDERED on this day: November 26, 2025.

Original signed by:
KATIE HORNBERGER
Deputy Director
Division of Community Assistance and Resolutions