BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: SPENCER C., Claimant, v. EASTERN LOS ANGELES REGIONAL CENTER, Service Agency	OAH Nos. 2013040664

DECISION

Carla L. Garrett, Administrative Law Judge (ALJ), Office of Administrative Hearings, State of California, heard this matter on October 2, 2013, in Alhambra, California.

Elizabeth Ornelas represented the Eastern Los Angeles Regional Center (ELARC or Service Agency). Claimant Spencer C. (Claimant)[1] was represented by his mother (Mother).

Oral and documentary evidence was received, and the record remained open to give Mother an opportunity to submit a letter from her insurance company by November 8, 2013, and to give ELARC an opportunity to submit written objections, if any, by November 13, 2013. Mother timely submitted a letter from her insurance company, marked as Exhibit A. ELARC filed a timely response, which included documentation in the form of a continuance order issued in this matter on May 8, 2013, which was marked as Exhibit 9. ELARC's response related to Mother's previous request to continue this matter in

[1] Claimant is identified by first name and last initial to protect his privacy.

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order to have sufficient time to appeal her insurance company's decision, but failed to disclose this information during the October 2, 2013 hearing. It is ELARC's belief that Mother failed to seek an appeal as she initially represented when seeking a continuance of this matter. ELARC's response, if considered an objection to Mother's submission of Exhibit A, is overruled. Exhibit A is admitted. The conclusion reached by ELARC regarding her previous request to continue this matter does not constitute evidence, and will not be considered as such. On November 13, 2013, the record was closed and this matter was submitted.

ISSUE

Must the Service Agency continue to fund behavioral therapy services for Claimant?

FINDINGS OF FACT

1. Claimant is nine-years-old, and is a consumer of the Service Agency. He has been diagnosed with autism, and has engaged in maladaptive behaviors such as tantrums, aggression, non-compliance, hitting, kicking, scratching, screaming, and throwing objects when upset. Claimant is eligible for services pursuant to the Lanterman Developmental Disabilities Act (Lanterman Act), California Welfare and Institutions Code, section 4500, et seq.[2]

2. In April 2008, ELARC began funding behavior modification services for Claimant from California Pediatric & Family Services, Inc. (California Pediatric), in order to assist with decreasing Claimant's negative behaviors and increasing his positive behaviors.

3. On June 2, 2012, ELARC, in contemplation of legislation scheduled to go into effect on July 1, 2012, sent a letter to consumers diagnosed with autism that advised them that private insurers would be required to provide coverage for behavior health treatments

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

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for autism. On July 2, 2012, ELARC sent its consumers another letter requesting that they, among other things, do the following: (1) provide verification of insurance coverage; (2) request behavior treatment from their physician; (3) expect to receive a response in writing from their insurance carrier; (4) if approved for behavior services by the insurance company, contact the service provider for a schedule of approved services should the insurance company require the payment of copayments; (5) if denied for behavior services by the insurance company, appeal the decision; (6) pending the resolution of any appeal, expect that ELARC may fund for services if they are already in place; (7) provide ELARC, by September 1, 2012, with confirmation that the consumer as accessed his or her insurance plan, or have initiated an appeal with the insurer. The letter further advised that failure of the consumer to provide confirmation by September 1, 2012 would result in an issuance of a Notice of Action to deny or terminate the consumer's behavior service.

4. Wendy Torres, Claimant's service coordinator since 2007, testified at hearing. Ms. Torres and Mother began engaging in discussion in June 2012 about Mother exhausting Claimant's private insurance for behavior services. Mother contacted Claimant's insurance carrier, HealthNet, and learned that Claimant's service provider, California Pediatrics, was not a registered vendor. ELARC continued providing funding of Claimant's behavior services at California Pediatric.

5. Shortly thereafter, Claimant's insurance premiums at HealthNet became too expensive, which prompted Mother to switch Claimant's insurance company to ValueOptions, beginning in January 2013.

6. Mother contacted ValueOptions in January 2013, and requested that it provide behavior services for Claimant by David Ung, Claimant's behavior consultant at California Pediatric. On February 21, 2013, ValueOptions sent Claimant a letter advising that Mr. Ung was not certified under Claimant's plan to provide behavior services, and therefore, Mr. Ung was not eligible to receive payments from ValueOptions. The letter

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directed Claimant to refer to his insurance summary plan description, particularly the section entitled, "What the Program Covers for Mental Health Treatment." Mother concluded that ValueOptions did not cover behavior modification services, but rather covered mental health services, which she concluded did not apply to Claimant. Mother submitted no evidence showing she referenced "What the Program Covers for Mental Health Treatment," or otherwise inquired about ABA services under the mental health portion of Claimant's plan. In addition, Mother sought no other service providers that were certified by ValueOptions to provide such services.

7. Mother provided a copy of the ValueOptions letter to Ms. Torres. Ms. Torres did not interpret the letter as a denial by the insurance company of behavior modification services, but rather as notice that Claimant could not use Mr. Ung as his service provider. Ms. Torres advised Mother of her interpretation of the letter, and requested that Mother provide her with documentation from Claimant's insurance company of an actual denial to provide no behavior modification services to Claimant. Mr. Torres received no such documentation from Mother.

8. On March 14, 2013, ELARC issued a Notice of Proposed Action (NOPA) to Mother advising that, for her failure to pursue behavioral services from Claimant's insurance carrier as requested, ELARC would be terminating Claimant's behavioral services with California Pediatric on April 30, 2013.

9. On April 8, 2013, Mother filed a Request for Fair Hearing on Claimant's behalf requesting that ELARC continue funding behavioral services, as Claimant still displayed behavioral issues in several areas.

10. It was ELARC's intent to continue funding of behavioral services for Claimant with California Pediatric during the pendency of this action. However, on July 30, 2013, California Pediatric terminated Claimant's services, as it had determined that Claimant no longer required its services, because Claimant's family had learned the skills necessary to

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manage Claimant's behaviors independent of its services.

11. Kelly Prieto, who is the Behavior Management Program Director at California Pediatric, testified at hearing. Mr. Prieto supervised Mr. Ung, and though he did not work with Claimant personally, was very familiar with Claimant's case based on his ongoing consultations with Mr. Ung, as well as on data collected by Mr. Ung.

12. California Pediatric provided behavior modification services to Claimant on a consultation basis, as opposed to on a one-on-one basis. The one-on-one program was for those clients who had less of a repertoire of skills, than those who participated in the consultation program. The goal of the consultation program was to provide parents with the training necessary to manage their children's behaviors. After more than five years of service, Parents demonstrated through logic tests and task analyses that they were competent to manage Claimant's behaviors without any more intervention from California Pediatric.

13. The decision of California Pediatric to terminate services was based solely on the competence level demonstrated by Parents, and had nothing to do with Claimant's appeal in the instant matter. Mr. Prieto explained that California Pediatric could have continued earning money by providing services to Claimant, even if the Service Agency ceased paying, because California Pediatric had become a vendor for ValueOptions on February 5, 2013, and, as such, could have received payments from Claimant's insurance company. However, ethically, California Pediatric could not do so, as Parents possessed the requisite skills to address Claimant's behaviors.

14. On October 10, 2013, Mother submitted Exhibit A to support her interpretation of the February 21, 2013 letter from ValueOptions that ValueOptions did not cover behavior modification services, but rather covered mental health services, which did not apply to Claimant. Specifically, Exhibit A consisted of a letter dated October 2, 2013 from ValueOptions referencing California Pediatric, which stated, in pertinent part, the following:

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> "You requested ABA services with a non-licensed provider.
>
> This letter is to inform you that . . . covered services must be determined to be medically necessary and must be provided by a licensed practitioner (psychiatrist, psychologist, clinical social worker, marriage and family therapist, registered nurse clinical specialist) or other mental health professional. ABA (applied behavioral analysis) services by a paraprofessional or by a BCBA certified provider, without being a licensed mental health provider, does not meet these qualifications. The provider is not eligible to receive reimbursement under the Plan."

15. It is not necessary to make a determination of whether California Pediatric is a contracted vendor under ValueOptions, as Mr. Prieto testified, or whether, contrary to Mr. Prieto's testimony, California Pediatric is not a licensed provider, as set forth in the October 10, 2013 letter from ValueOptions. The question is whether ValueOptions provides ABA services or not under Claimant's plan, whether by California Pediatric or by some other provider. The plain reading of the October 10, 2013 letter indicates that ValueOptions does, in fact, provide ABA services, but that those services need to be determined medically necessary by a mental health professional.

LEGAL CONCLUSIONS

The Service Agency is not required to continue funding behavior therapy services for Claimant, as discussed in more detail below:

1. In enacting the Lanterman Developmental Disabilities Act, section 4500 et seq., the Legislature accepted its responsibility to provide for the needs of developmentally disabled individuals and recognized that services and supports should be established to

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meet the needs and choices of each person with developmental disabilities. (§ 4501.) "Services and supports should be available to enable persons with developmental disabilities to approximate the pattern of everyday living available to people without disabilities of the same age. Consumers of services and supports, and where appropriate, their parents, legal guardian, or conservator, should be empowered to make choices in all life areas. These include promoting opportunities for individuals with developmental disabilities to be integrated into the mainstream of life in their home communities, including supported living and other appropriate community living arrangements. . . ." (*Id.*)

2. The Lanterman Act gives regional centers, such as Service Agency, a critical role in the coordination and delivery of services and supports for persons with disabilities. (§ 4620 et seq.) Thus, regional centers are responsible for developing and implementing individual program plans, for taking into account consumer needs and preferences, and for ensuring service cost-effectiveness. (§§ 4646, 4646.5, 4647, and 4648.)

3. Section 4512, subdivision (b), defines the services and supports that may be funded, and sets forth the process through which such are identified, namely, the IPP process, a collaborative process involving consumers and service agency representatives. Through this process, Claimant and Service Agency have determined that behavior modification services constitute necessary and appropriate services to address Claimant's developmental disability needs.

4. At issue in this case is the manner in which the agreed-to services are to be funded. Section 4659, subdivisions (c) and (d), provides:

> "(c) Effective July 1, 2009, notwithstanding any other provision of law or regulation to the contrary, regional centers shall not purchase any service that would otherwise be available from Medi-Cal, Medicare, the Civilian Health and Medical Program for Uniform Services, In-Home Support Services, California Children's Services, private insurance, or a health care service plan when a consumer or a family meets the criteria of this coverage but chooses not to

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pursue that coverage. If, on July 1, 2009, a regional center is purchasing that service as part of a consumer's individual program plan (IPP), the prohibition shall take effect on October 1, 2009.

"(d) (1) Effective July 1, 2009, notwithstanding any other provision of law or regulation to the contrary, a regional center shall not purchase medical or dental 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. If, on July 1, 2009, a regional center is purchasing the service as part of a consumer's IPP, this provision shall take effect on August 1, 2009. Regional centers may pay for medical or dental services during the following periods:

"(A) While coverage is being pursued, but before a denial is made.

"(B) Pending a final administrative decision on the administrative appeal if the family has provided to the regional center a verification that an administrative appeal is being pursued.

"(C) Until the commencement of services by Medi-Cal, private insurance, or a health care service plan.

"(2) When necessary, the consumer or family may receive assistance from the regional center, the Clients' Rights Advocate funded by the department, or area boards on developmental disabilities in pursuing these appeals."

5. Recent legislation requires private insurers to provide coverage for behavioral health treatment for autism, including ABA. Health and Safety Code section 1374.73, which was enacted pursuant to Senate Bill 946, provides, in pertinent part:

“(a) (1) Every health care service plan contract that provides hospital, medical, or surgical coverage shall also provide coverage for behavioral health treatment for pervasive developmental disorder or autism no later than July 1, 2012. The coverage shall be provided in the same manner and shall be subject to the same requirements as provided in Section 1374.72.

“(2) Notwithstanding paragraph (1), as of the date that proposed final rulemaking for essential health benefits is issued, this section does not require any benefits to be provided that exceed the essential health benefits that all health plans will be required by federal regulations to provide under Section 1302(b) of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

“(3) This section shall not affect services for which an individual eligible pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.

“(4) This section shall not affect or reduce any obligation to provide services under an individualized education program, as defined in Section 56032 of the Education Code, or an individualized service plan, as described in Section 5600.4 of the Welfare and Institutions Code, or under the Individuals with Disabilities Education Act (20 U.S.C. Sec. 1400, et seq.) and its implementing regulations.

“(b) Every health care service plan subject to this section shall maintain an adequate network that includes qualified autism service providers who supervise and employ qualified autism service professionals or paraprofessionals who provide and administer behavioral health treatment. Nothing shall prevent a health care service plan from selectively contracting with providers within these requirements. . . .”

6. As set forth in Legal Conclusion numbers 1, 2, and 3, the Lanterman Act guarantees certain services and supports to individuals with developmental disabilities, such as Claimant. These entitlements are recognized in Health and Safety Code section 1374.73, subdivision (a)(3), which provides that services for which a developmentally-disabled consumer is eligible under the Lanterman Act shall not be affected by the private insurer's obligation to fund the services. It thus appears that the Legislature intended to shift the funding of autism services from taxpayers to insurers without impacting the entitlement to the services.

7. Here, the evidence established that Claimant has private insurance which will cover ABA services, if such services are deemed medically necessary by a mental health professional. However, while Mother arbitrarily concluded that mental health treatment under Claimant's plan would not address Claimant's ABA needs, there is no evidence that Mother either referenced "What the Program Covers for Mental Health Treatment," or otherwise inquired about ABA services under the mental health portion of Claimant's plan. As set forth above, regional centers are required to fund behavior modification services only when a consumer's private insurance refuses to pay, even after the appeals process has been exhausted. In the instant matter, it remains unclear whether ValueOptions will provide ABA services for Claimant, as Mother has yet to fully exhaust the private insurance process. Specifically, Mother has not sought ABA services for Claimant under the mental health portion of his plan, and she has also failed to explore other providers that are certified to provide the service, assuming California Pediatric is not. Consequently, it has not been established that Claimant's private insurance will not pay, and his behavior modification program will not "otherwise be available" within the meaning of section 4659, subdivision (c). As such, the Service Agency is prohibited from funding the services at this time.

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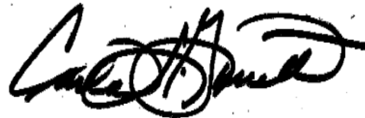
8. The Service Agency contends, in essence, that even if Mother had fully exhausted the private insurance process, and learned that Claimant's insurance company refused to fund ABA services, the Service Agency still would not have been required to fund these services, as California Pediatric had deemed Claimant no longer required such services. However, the decision of California Pediatric to terminate Claimant's services occurred on July 30, 2013, more than four months after ELARC issued its NOPA. Consequently, its NOPA did not cite California Pediatric's decision as a reason for ceasing its funding of Claimant's ABA services. The NOPA cited only Mother's failure to pursue behavioral services from Claimant's insurance carrier as requested. As such, and in order to maintain Claimant's due process rights, all arguments relating to California Pediatric's conclusions supporting its decision to terminate Claimant's services cannot be regarded in this matter.

ORDER

Claimant's appeal is denied.

Date: November 20, 2013



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.

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