

APPENDIX E

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OFFICE OF ADMINISTRATIVE HEARINGS

John XXXX,	}	Case OAH No.
vs.		CLOSING Hearing Brief
San Diego Regional Center,		DATE: October 01, 2020
Respondent.		TIME: 9:00am
		PLACE: San Diego Regional Center, 4355 Ruffin Road, San Diego

ISSUE

John XXXXX's ("Johnnie") administrative hearing was held on October 01, 2020, to appeal the (1) reduction to his respite hours from 72 hours per month to 40 hours per month and (2) to request an increase to 208 hours per month of respite instead of 72 hours, based on his needs.

INTRODUCTION

At the administrative hearing concerning Johnnie's respite, Claimant's counsel argued that Johnnie meets the ABx4 9 respite exemption requirements due to his intensive care needs. One additional issue discussed at the hearing was whether Johnnie, who is on the Medicaid Home and Community Based Services Waiver ("Waiver"), is entitled, as a Regional Center consumer, to "unlimited respite".

During the hearing a minimal discussion ensued on this issue and Claimant's attorney requested that the record be held open so she may provide a closing brief on the issue. San Diego Regional Center also agreed to brief the issue. Subsequently, Claimant's brief follows.

ARGUMENT

1. AS A CONSUMER ON THE WAIVER, JOHNNIE IS ENTITLED TO RESPITE THAT IS “NOT RESTRICTED...IN ANY PERIOD”.

A. The Waiver is implemented by Federal Medicaid laws not State laws.

Federal law allows some of the federal Medicaid rules to be waived so that a state can provide extra Medicaid services to a targeted group of people such as regional center clients.

“Section 1915(c) of the Act permits States to offer, under a waiver of statutory requirements, an array of home and community-based services that an individual needs to avoid institutionalization...” 42 CFR 441.302 Regional Centers receive federal financial participation (FFP) for enrolling eligible consumers on the Waiver. In these cases, neither Regional Center’s Lanterman Act provisions nor their internal policies can be more restrictive than the Medicaid laws which implement the Waiver.

42 USC § 1396n(c)(4)(B) states that, “A waiver granted under this subsection may, consistent with paragraph (2) - provide medical assistance to individuals (to the extent consistent with written plans of care, which are subject to the approval of the State) for case management services, homemaker/home health aide services and personal care services, adult day health services, habilitation services, respite care...” In addition, the statute is specific that, “Except as provided under paragraph (2)(D), the Secretary *may not restrict the number of hours or days of respite care in any period* which a State may provide under a waiver under this subsection.”¹

When a state agency receives federal funding, similar to Regional Center receiving funding for 1915(c) waivers from Medicaid, the agency must adhere to the federal law and requirements. In some instances the federal law will give the state agencies discretion to implement a program in a manner they see fit. The only discretion Medicaid has given to the State of California is the number of regional center clients they may place on the Waiver. Nowhere in the text of 1396n(c)(4)(b) does Medicaid give the state or Regional Centers the discretion to restrict the amount of respite it provides person on the 1915(c) waiver. However, when a

¹ 42 USC §1396n(c)(4)(b)

question arises concerning the legislative intent of a statute, it is important to review other documents, including the legislative history, which may offer insight to the purpose behind this section of law.

B. Inferred Legislative Intent

The purpose of the 1915(c) waiver is to offer services to people who are at risk for institutionalization so they may remain in the community. In the 1999 *Olmstead* decision, The Supreme Court affirmed the right of people with disabilities to receive public benefits in the most integrated setting appropriate to their needs. These waivers are a viable option for states to provide integrated community based services and supports. As part of this federal legislation Medicaid laid out some requirements for states to meet in order to receive funding. One requirement in particular is “ensuring that measures will be taken to protect the health and welfare of consumers”.² This would include providing enough supports and services to ensure that consumers can remain in the community and are safe doing so.

Respite was listed waiver service since the Medicaid 1915(c) waivers came into existence. However, in 1990 Congress added an amendment to 1396n(c)(4) as a part of the Omnibus Budget Reconciliation Act of 1990 (OBRA 90’). The law before this amendment did not specify the scope of respite. However, during House and Senate committee meetings, section 1396n(c)(4)(b) added the following language, “the Secretary *may not restrict the number of hours or days of respite care in any period* which a State may provide under a waiver under this subsection.”

Institutionalized care is extremely costly for the State and it is much more cost effective to provide supports and services to people in the community. The purpose of OBRA 90’ was to find ways to cut spending and deal with the deficit. It can be inferred that, since language about not restricting respite was part of OBRA 90’, Congress believed that providing more respite to consumers on the waiver would help cut costs by preventing costly institutionalization.³

In this case, without 208 hours of respite Johnnie may be at risk for institutionalization for many reasons. However, Regional Center argues that they can limit the hours to what they see is fit. Regional Center’s interpretation of 42 USC 1396n(c)(4)(b), is that the Secretary of Department of Healthcare Services

² Center for Medicare & Medicaid 1915(c) information

³ H.R CONF. REP. 101-964

cannot limit what States can provide, but that states can limit respite. If the code is read in a way that gives Regional Centers the latitude to limit respite for consumers on the Waiver, then the purpose of the code would not be effectuated. The purpose of the code is to prevent institutionalization, thus cutting costs for the state. But in this situation it would do the opposite. And for this reason the added amendment should be interpreted as the Secretary cannot restrict the scope of respite thus no state agency may restrict the scope of respite. State laws may not be more restrictive than federal laws, especially if they are contrary to the purpose of a code.

C. Any Changes Made to the Waiver Must be Formally Requested by the State to the Centers for Medicare and Medicaid Services (CMS).

When a State receives Waiver funding it affirms, “that it will abide by all terms and conditions set forth in the waiver (including Appendices and attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid agency. Upon approval by CMS, this waiver request will serve as the State’s authority to provide home and community services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments”.⁴ The regional center has provided no evidence that the State has made a request that respite for regional center clients be restricted. Since the legislative intent is to provide unrestricted respite to people who are at risk for institutionalization, Regional Center may not change this portion of the Waiver without requesting a formal amendment. There is no evidence that this request has ever been made.

2. AS A CONSUMER ON THE WAIVER, JOHNNIE IS ENTITLED TO HAVE HIS RIGHTS DETERMINED UNDER THE LANTERMAN ACT AND THE WAIVER.

The hearing procedure for Regional Center consumers is different when one of the issues at hearing concerns the Waiver. Disputes about Waiver eligibility or services under the Waiver are handled through the regular Lanterman Act fair hearing procedures. The Administrative Law Judge (ALJ) will first look to see if the matter can be resolved favorably for the consumer under the Lanterman Act. If not, the ALJ will then look at rights under the Waiver and the State and Federal Medi-Cal/Medicaid program. In addition, Welfare and Institutions Code section 4706(b)

⁴ State of California Department of Health Services, Request for Renewal Application, Home and Community Based Services Waiver for Developmentally Disabled, Control Number 0336, Oct. 2006 – Sept. 2011, p22. (for full text go to <http://www.dhcs.ca.gov/services/medi-cal/Documents/DDRenewalApp2006TO2011.pdf>)

states, “ Whenever a fair hearing under this chapter involves services provided under the Medicaid home and community-based services waiver, the State Department of Health Services shall retain the right, as provided in Section 4712.5, to review and modify any decision reached under this chapter”.

In this case, Johnnie is on the Waiver therefore he is entitled to have this matter determined under the Lanterman Act and if necessary under the Waiver.

CONCLUSION

In conclusion, although Claimant’s counsel asserts that Johnnie is entitled to unlimited respite that is not what is being requested. Through testimony and documentary evidence provided at hearing, Claimant has met the burden of proof under the Lanterman Act that because of his intensive needs he requires 208 hours of respite to remain safely in the community. In addition, 42 USC 1396n(c)(4)(b) should be interpreted in a way that effectuates the purpose of the code, which is to provide unrestricted respite to Waiver recipients so they may remain in the community. Further, if the State wants to place any restrictions on the provision of respite for regional center clients it must do so by making a formal request for a waiver amendment to CMS. Failure to do so violates federal law. As the regional center has provided no evidence that the State has made a request to formally amend the Waiver Johnnie is entitled to 208 hours of respite per month to meet his needs.

Respectfully Submitted by:

Wendy Dumlao
11/15/2020