REIMBURSEMENT OF HEALTH CARE CO-PAYMENT AND CO-INSURANCE COSTS POLICY

I. **Intent:** It is the intent of San Andreas Regional Center to provide funding or reimbursement for any applicable co-payments, ~~or~~ co-insurances, or deductible for medically-necessary services provided through the individual's health care service plan or health insurance policy which are identified in the Individual Program Plan or Individual Family Service Plan as required to maintain the ~~consumer~~ individual in the home and community and for which the Regional Center would otherwise be the funding source or when necessary to ensure the individual receives the service or support related to their developmental disability. The regional center shall implement this policy in compliance with all existing federal and state laws and regulations (e.g., California Welfare & Institutions Code §4659.1).

II. **Definitions**

Consumers, individuals served by the Regional Center, and persons we serve are terms that are used interchangeably throughout San Andreas Regional Center Purchase of Service policies to refer to those individuals who receive services from the Regional Center. These same terms are used throughout the Lanterman Developmental Disabilities Services Act.

Co-payments or "co-pays" are a specific charge that a health insurance plan may require for each use of a specific service or supply. The specific dollar amount is specified within the insured's health insurance policy and may vary based on type of service or supply.

Co-insurance refers to the amount the insured is required to pay for a health insurance claim apart from any co-payment and after the deductible. For example, a plan with a 20% co-insurance requirement but no co-payments would require the insured to pay $20 of a $100 claim.

Deductibles are a specific dollar amount that a health insurance plan may require be paid out-of-pocket annually before it begins to make payments for claims. Plans may have both individual and family deductibles, separate deductibles for specific services, or may not require a deductible.

Gross annual family income refers to all pre-tax income received from salary, fees, dividends, annuities, and all other sources of income received by the parents

or legal guardians of a minor child or an individual over the age of eighteen during the course of the calendar year.

Health care service plan or health insurance policy refers to a type of insurance coverage that pays for medical and surgical expenses that are incurred by the insured. Health insurance can either reimburse the insured for expenses incurred from illness or injury or pay the care provider directly. Most health insurance benefits, and terms of service are applied annually.

Out-of-Pocket Maximum is the health plan's limit on the insured's annual financial liability for claims and typically includes some or all amounts paid through co-pays, co-insurance, and deductibles. Health plans may set limits on the amount they will pay overall or for certain services annually or over the lifetime of the patient.

III. Policy: San Andreas Regional Center will advocate and assist the individual in accessing services deemed necessary in the Individual Program Plan/Individual Family Service Plan and which are available as a covered benefit through their health care service plan or health insurance policy. Services for which co-payments or co-insurances may be funded are those necessary for treatment of the individual and which the Regional Center would otherwise fund but are provided as a covered benefit of the ~~consumer's~~ individual's health care service or health insurance plan or policy. The Regional Center will consider requests for reimbursing co-payments or co-insurances regardless of whether an individual or their responsible party has met their deductible.

IV. Purchase of Service Standard: The assigned San Andreas Regional Center service coordinator shall, when funding of co-payment or co-insurance is requested, determine the following:

a. The requested payment is for a service agreed upon as necessary and appropriate under the Individual Program Plan/Individual Family Service Plan.
b. The individual is enrolled in their own or the parent or legal guardian's health care service plan or health insurance policy.
c. There is no other generic public or private source responsible for funding.
d. The family or adult individual is eligible for reimbursement.

Eligibility for reimbursement of co-payment, ~~or~~ co-insurance, or deductible is established through evaluation of the individual's (if eighteen or older), or

individual's parents or legal guardian's (if seventeen or younger) gross annual income does not exceed 400% of the Federal Poverty Level for their federal household size. It is the responsibility of the individual, their authorized representative, or their parent or legal guardian to provide information sufficient to make a determination of eligibility. By law, when income exceeds 400% of the Federal Poverty Level, individuals are not, with certain exceptions, eligible to receive reimbursement. Individuals or families participating in the Early Start program do not need to meet income requirements.

The individual or individual's representative shall provide documentation verifying the cost of co-payment, ~~or~~ co-insurance, or deductible in the form of the applicable portion of the policy language, monthly explanations of benefits from the insurance or health care service plan, and invoices from the service provider. If the service provider is also a provider of the regional center and has agreed to a direct-payment service code, the co-payment or the co-insurance may be paid directly to the provider. If the service provider is not a provider of the regional center, the individual or individual's family must register as a parent-vendor, provide proofs of payment, and will receive reimbursement through a purchase of service.

The individual or individual's representative will provide the service provider's service plans and progress reports to the regional center or will provide consent for the regional center to obtain the service plan and progress reports directly from the provider. The regional center will review these reports no less than semi-annually in order to determine the continued appropriate and cost-effective use of the service.

V. **Exception Process**: For individuals or families with an annual gross family income above 400% of the Federal Poverty Level, an exception may be granted if: an extraordinary event impacts the ability to pay, a temporary catastrophic event presents direct economic loss, or the family or adult individual has significant unreimbursed medical costs related to the care of the individual or another regional center individual; and that the service or support is necessary to successfully maintain the individual at home or in the least-restrictive setting.

The executive director has full discretion to authorize service purchases which are exceptions to the board-adopted purchase of service policies and standards. The Executive Director has designated that the Director and Associate Directors of Consumer Services are authorized to grant an exception in the executive director's stead; these individuals are referred to as director's designees.

The first formal discussion of a request for service takes place at the planning team meeting. If the request falls within the service policy, the request is granted.

If the request for service is not consistent with the policy, the service coordinator starts the exception review process by exploring the basis for the request.

A timeline for the director's exception review is set by agreement between the individual/family and the service coordinator but the timeline may not exceed fifteen (15) days. Within that time, another planning team meeting will be convened. In the meantime, the coordinator presents the information to the manager to determine whether a director's exception may be warranted.

At the scheduled planning team meeting the decision will be made. The director's designee will attend the planning team meeting if necessary.

If the exception is granted, the service coordinator amends the person-centered individual program plan, notifies the individual/family, and gives a copy of the amended plan to the individual/family.

VI. Notice of Action: If an exception is not granted, or if a decision is made to deny, reduce, or cancel the service without the agreement of the individual or the individual's representative, a Notice of Action and a Fair Hearing form will be sent.

DDS Approved: May 3, 2022
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