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STATE OF WASHINGTON
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No. 40811-2-II

COURT OF APPEALS
DIVISION II
OF THE STATE OF WASHINGTON

Faith Freeman, *Appellant*

v.

State of Washington, Department of Social and Health Services

BRIEF OF APPELLANT

Paul A. Neal, WSBA No. 16822
Neal & Neal, LLC, Attorneys at Law
112 E. 4th Ave., Suite 200
Olympia, WA 98501
(360) 352-1907
Attorney for Appellant

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A. Introduction

Faith Freeman is a 25-year-old woman with Down's syndrome. She functions at a 5-year-old level and qualifies for institutionalization. Both Ms. Freeman and her guardians have struggled to care for her at home, saving the State the cost of institutionalization. This requires assistance from the Medicaid Personal Care (MPC) benefit. Ms. Freeman's claim for Medicaid benefits began on her 18th birthday and has followed a winding 7-year path of hearings, appeals, and cross appeals ever since. The course of proceedings has winnowed the central issues on appeal down to: 1) Did the Department of Social and Health Services (DSHS) fail to invoke the appellate jurisdiction of the DSHS Board of Appeals (Board) when it submitted its request for review after the filing deadline? and 2) Did the Superior Court judge err in finding that the supervisory care prescribed for Ms. Freeman in her Early Periodic Screening, Diagnosis, and Treatment (EPSDT) screening was outside the scope of the Medicaid definition of medical assistance?

DSHS, like any other party aggrieved by the initial decision of an Administrative Law Judge (ALJ) must follow DSHS's rules for invoking the Board's appellate jurisdiction. DSHS failed to do that in this case.

If the Court finds that the Board properly assumed jurisdiction, Ms. Freeman will show that the ALJ correctly ruled that the supervisory care prescribed in Ms. Freeman's EPSDT screening meets Medicaid's definition of medical assistance. EPSDT required DSHS to provide that level of service through Ms. Freeman's 21st birthday, even though it is higher than that authorized under DSHS's Comprehensive Assessment Reporting and Evaluation (CARE) tool.

B. Assignments of Error

1. Errors Assigned to DSHS final order:
 - a. The Review Judge erred in assuming original jurisdiction, rather than appellate jurisdiction, over this case. FOF nos. 13, 17, 20, 23, 24, 25, 30, 49, 51; COL nos.4 - 16, 32 - 57.
 - b. Other errors committed by DSHS's review judge were reversed by the Superior Court.
2. Errors Assigned to Superior Court Order
 - a. Order on Summary Judgment: The Superior Court erred in denying Ms. Freeman's motion for summary judgment of dismissal based on DSHS's failure to file a timely appeal.

- b. Order on Judicial Review:
 - i. The Superior Court Judge erred in finding the care prescribed by Ms. Freeman’s treating physician was outside the scope of Medicaid’s definition of “medical assistance.” COL 4, 5.
 - ii. The Superior Court Judge erred in subtracting from Ms. Freeman’s attorney’s fee award those fees incurred in pursuing her timeliness and EPSDT claims. COL 9.

C. Issues Pertaining to Assignments of Error.

- 1. Was the deadline for filing a petition for review of the ALJ’s initial order 21 days after the tribunal filed its initial order or 21 days after the tribunal filed its corrected order?
- 2. Does WAC 388-02-0555 provide no deadline if no appeal is filed?
- 3. Does Medicaid’s definition of “medical assistance” in 42 U.S.C. §1396d(a) include supervisory care?
- 4. Is the supervisory care prescribed for Faith Freeman by her treating physician’s EPSDT screening medically necessary?
- 5. Does EPST require Washington to provide the level of MPC

services prescribed by the treating physician to Medicaid eligible residents age 21 and younger without regard to limitations placed on adult MPC recipients by the state plan?

6. If Ms. Freeman succeeds on appeal, should she receive a full award of attorney's fees and costs?

D. Statement of the Case

1. Faith Freeman's Documented Level of Need.

25-year-old Faith Freeman is loved and cared for by her family. She was diagnosed with Trisomy 21, more commonly referred to as Downs' Syndrome, shortly after her birth. She is significantly mentally retarded and has the overall mental and intellectual functioning of a 5-year old. Ms. Freeman requires assistance to function adequately on a daily basis and poses a danger to herself if left alone. Her treating physician and DSHS agree she requires round-the-clock supervision. *See* DSHS Review Decision and Final Order, AR 62S, FOF no. 49, attachment A. Ms. Freeman's disability qualifies her for institutionalization.

As a minor, Ms. Freeman lived was a dependent of her parents and did not qualify for SSI or Medicaid. In anticipation of her 18th birthday on July 18, 2004, Ms. Freeman's parents began preparing to give her the tools and support she would need to transition to a life as independent as her

condition would allow. Ms. Freeman's parents filed an application for medical assistance with DSHS on her behalf. DSHS designated her as categorically needy and thus eligible for Medicaid beginning July 1, 2004. FOF no. 5, AR 51S.

On August 27, 2004, Ms. Freeman's treating physician, Dr. Henry DeGive conducted an EPSDT screening. Based on that screening, he testified at the hearing:

4. In my medical opinion, it is medically necessary that Faith continue to receive 24-hour 7 days a week assistance as a remedial service for the maximum reduction of Faith's physical and mental disability necessary to restore her to the best possible functional level.
5. The level of treatment I prescribed in the EPSDT screening is a health care and treatment measure medically necessary to correct or ameliorate Faith's trisomy 21 and physical illness which I identified and documented in the EPSDT screening.

AR 1175-1179, FOF nos. 31, attachment B; AR 58S, attachment A.

A second EPSDT exam was conducted on June 15, 2007 by Dr. Sciarrone who confirmed Dr. DeGive's assessment of the treatment medically necessary for Ms. Freeman. AR 1257-1263, attachment C. On July 18th, 2007, Ms. Freeman turned 21 and aged out of EPSDT eligibility.

Although Medicaid provides round-the-clock care as a type of medical assistance, Ms. Freeman's guardians have never expected

DSHS to pay for services 24/7. They recognize legitimate deductions when she is in the care of others and for sleep hours. At all other times they must actively attend to her. AR 1230-1231, attachment D.

Ms. Freeman presented evidence at the hearing that DSHS provides, or provided, supervisory care such as that prescribed by Ms. Freeman's EPSDT screenings under Medicaid. DSHS used to provide supervisory care as part of its MPC assessment. VRP I p. 206, l. 19 - p. 209, l. 3. Attachment E. DSHS expends Medicaid funds to pay for round-the-clock one-on-one supervision for profoundly disabled persons in their own home. VRP IV p. 39, l. 1 - p. 40, l. 2, attachment F. In the Olympia area Medicaid pays \$15.69 per hour for this service. Compensable supervision can include watching television with the client to be available to keep them out of danger and to change channels for them. VBR IV. p. 40, l. 8 - p. 42, l. 17, attachment F.

2. Procedural History.

Ms. Freeman's guardian's have fully provided for her needs throughout the pendency of her appeals. The level of services required to care for Ms. Freeman is not at issue. The issue is DSHS's obligation under

federal medicaid law to provide it.

DSHS conducted Ms. Freeman's initial CARE assessment in September of 2004, AR 51S, FOF no. 6, attachment A. None of the three CARE assessments at issue in this case¹ considered Dr. DeGive's EPSDT screening nor applied EPSDT in any way. "There is no evidence in the record that the department informed the Freemans about the EPSDT program. In fact, the evidence is to the contrary, that is that the Freemans informed the department about the EPSDT program." AR 058S, FOF no. 32, attachment A.

DSHS initially refused to allow Ms. Freeman to present EPSDT claims, arguing that its rules deprived the ALJ of jurisdiction to consider federal statutory claims. The Thurston County Superior Court, Judge Gary Tabor presiding, found DSHS erred in that conclusion and remanded for an adjudication of those issues. AR p. 386-388, *see* attachment G. Judge Tabor did not award attorney's fees because his order did not reach the merits of Ms. Freeman's claim.

a. The ALJ Granted Ms. Freeman's Petition.

On remand, after four days of hearings, AR 001, the administrative

¹ This appeal consolidates Ms. Freeman's appeal of her 2004, 2005, and 2006 CARE assessments. FOF no. 6, AR 051S, attachment A.

law judge (ALJ) accepted the EPSDT screenings of Dr. DeGive and Dr. Sciarrone and found that Ms. Freeman required constant care and attention. AR 23, 24, ALJ COL 24, 25, attachment H. She found the federal EPSDT law required DSHS to provide these benefits. AR 24, 25, ALJ COL 26-31, attachment H.

Recognizing that Ms. Freeman's guardians had been providing this service since her 18th birthday but had only been compensated for the level authorized by the CARE analysis, the ALJ ordered DSHS to provide back compensation owing for the period of EPSDT coverage, i.e. the three years between Ms. Freeman's 18th and 21st birthdays. Pursuant to evidence submitted by Ms. Freeman's guardian, the ALJ did not include school time, work time, or other informal support hours provided by others. *See* AR 1230 - 1232, attachment D. The ALJ also deducted 8 hours per day for time spent sleeping. AR 25, 26, COL no. 31, attachment D.

In the alternative to the EPSDT finding, the ALJ reviewed the 2004, 2005, and 2006 CARE assessments. Under her application of the CARE tool, the ALJ awarded Ms. Freeman 190 hours of MPCS services retroactive to July 1st, 2004. AR 21, 22, ALJ COL 32, attachment D.

b. DSHS's Review Judge Reversed and Denied Ms. Freeman's Petition.

Judge Habegger mailed her initial order on June 27, 2008, AR p. 30, 57, attachment I. The deadline to request review of that decision expired 21 days later on July 18, WAC 388-02-0035, 388-02-0580. On July 2nd, 2008, DSHS wrote a letter to Judge Habegger noting clerical errors and requesting "a corrected version of the order" AR p. 29, attachment J. DSHS did not request an extension of the deadline for requesting review under WAC 388-02-580(1). Its informal request, which was not a motion and did not cite any authority, simply requested a corrected order, i.e. one that "did not change the intent of the decision" WAC 388-02-540, 388-02-545. Judge Habegger issued a corrected initial order on July 3, 2008, AR p. 1- 28, attachment H. Counsel for DSHS called the secretary of the Board to inquire whether the deadline ran from the date of the original order or the corrected order. The Board secretary erroneously told him it ran from the date of the corrected order. AR 160s - 161s, attachment K.

Appellant filed a petition for review of portions of Judge Habegger's original initial decision on July 16, 2008, 2 days before the deadline, WAC 388-02-580 (2), AR p. 193S - 196S. Judge Habegger's initial order became a final agency order with respect to those issues not raised in Appellant's

request for review on July 18th, WAC 388-02-0555. DSHS filed its petition for review four days late on July 22nd, AR 172S - 185S. DSHS did not notify Ms. Freeman of its intent to appeal prior to July 18th.

Ms. Freeman moved to strike DSHS's appeal as untimely. DSHS's review judge denied that motion. AR 77S - 82S, COL no. 2, attachment A. He then reversed the ALJ's EPSDT ruling. He found that, as supervisory care was not a medical service, it was not ameliorative and thus was outside the scope of EPSDT. AR 91S, 92S, COL no. 7, attachment A.

The Review Judge also rejected the ALJ's CARE tool analysis, substituted his own analysis, significantly reducing the level of services authorized by the ALJ. AR 108s-109s, decision and order ¶¶, 4, 5, 6, attachment A.

c. The Superior Court Threw out DSHS's Final Order and Partially Reinstated the ALJ decision.

The Superior Court denied Ms. Freeman's summary judgement motion to dismiss due to DSHS's untimely appeal. It then reinstated the ALJ's application of the CARE tool, ordering payment of 190 hours of service per month retroactive to July 1, 2004. Order on Judicial Review, COL 6, 7, 8. CP 351-354, attachment L.

The Superior Court reversed DSHS's ruling that EPSDT coverage

was limited to medical service. COL no. 3, CP 352. While overturning DSHS's conclusion of law, the Superior Court denied Ms. Freeman's EPSDT claim, finding that the supervisory care prescribed in the EPSDT screening was not "medical assistance" under 42 U.S.C. §1396d(a). COL 4, 5, CP 352. The Court awarded Ms. Freeman partial attorney's fees, including a portion of the fees incurred in the proceeding before Judge Tabor, of \$14,243.24. Order ¶ 6, CP 354.

Ms. Freeman appealed the denial of her motion to dismiss for failure to file a timely appeal. She further appealed the Court's ruling that the services diagnosed by Ms. Freeman were outside the scope of 42 U.S.C. §1396(a)(13) and/or (24) and thus not within the coverage of EPSDT. DSHS cross-appealed the Court's award of MPCS benefits back to July 1, 2004 and the award of attorney's fees. Neither party appealed the Superior Court's reinstatement of the ALJ's application of the CARE tool. Neither party appealed the Superior Court's COL no. 3 reversing DSHS's final order's limitation of EPSDT to medical services.

E. ANALYSIS

1. Issues on Appeal.

Ms. Freeman's appeal has a long, complicated procedural history. As a starting point to this Court's review, it is important to note what issues are **not** on appeal. DSHS has not appealed the Superior Court's reinstatement of the ALJ's CARE tool analysis. Nor has it appealed the Superior Court's reversal of its conclusion of law limiting EPSDT to services performed by a medical professional.

Unappealed findings of fact and conclusions of law are a verities on appeal. *In re Detention of Durbin*, 160 Wn.App. 414, 432, 248 P.3d 124 (2011). The only factual issues on appeal are the additional facts found by the Superior Court supporting its award of Attorney's fees. The issues of law on appeal are whether: 1) DSHS failed to invoke the appellate jurisdiction of the Board by filing its appeal after the deadline; 2) The supervisory care prescribed by Ms. Freeman's physicians in her EPSDT screening qualify as "medical assistance" under 42 U.S.C. §1396d(a); 3) Ms. Freeman's benefit eligibility commenced on July 1st, 2004; and 4) The appropriate award of attorney's fees.

2. Standard of Review.

Appellate review of disputed findings of fact is conducted under the substantial evidence standard. Trial Court findings of fact must be upheld if there is a sufficient quantum of evidence to convince a fair-minded person of the truth of the premise, even if the Court would have reached a different conclusion on its own, *Callegod v. Washington State Patrol*, 84 Wn.App. 663, 676, 929 P.2d 510 (1997).

The Court reviews interpretations of federal law de novo under the error of law standard, *Samantha A. v. DSHS*, 171 Wn.2d 623, 629, 256 P.3d 1138 (2011), substituting its judgment on issues of law, *Nationscapital v. Dep't of Fin. Insts.*, 133 Wn. App. 723, 737, 137 P.3d 78 (2006).

DSHS's interpretation of federal law is not entitled to the deference. Court's only accord that deference if the agency meets its burden to show the interpretation is an established matter of agency policy and not just the bootstrapping of a legal argument. *Sleasman v. City of Lacey*, 159 Wn.2d 639, 646, 151 P.3d 990 (2007), citing *Cowiche Canyon Conservancy v. Bosley*, 118 Wash.2d 801, 815, 828 P.2d 549 (1992). It cannot make that showing here, where DSHS's rationale for its desired result changes before each forum. The legal justification DSHS presents to this Court will

presumably change yet again, since it did not appeal the Superior Court's rejection of its last position. Whatever that argument is, the mere fact that DSHS proposes it will entitle it to any deference by the Court of Appeals.

3. DSHS Failed to Invoke Appellate Jurisdiction.

DSHS wrote the rules for appeal of initial orders, and cannot claim ignorance or confusion. "DSHS hearing rules delineate the authority of the review judge, and DSHS is bound by those rules." *Costanich v. Soc. & Health Servs.*, 138 Wn.App. 547, 554, 156 P.3d 232 (2007) . By not meeting the filing deadline established in its own rule, DSHS failed to invoke the Board's subject matter jurisdiction. Its untimely appeal should be dismissed. *City of Seattle v. Pub. Employment Relations Comm'n (PERC)*, 116 Wn.2d 923, 928-929, 809 P.2d 1377 (1991).

a. DSHS's Rules Bar its Request for Review.

DSHS' hearing rules provide two separate tracks for review of initial ALJ orders, one for clerical errors, and one for substantive, WAC 388-02-0530. Only DSHS's Board of Appeals may provide the substantive review² necessary to establish a new appeal deadline. ALJ review is limited to correction of clerical errors, WAC 388-02-0540. Judge Habegger's

²

An ALJ may reconsider a final order he or she has issued for those orders not subject to review by DSHS's Board of Appeals, WAC 388-02-0530(3), (4).

corrected order did not change the appeal deadline:

(2) If the ALJ corrects an initial order and a party does not request review, the corrected initial order becomes final twenty-one calendar days after the original initial order was mailed.

...

(4) Requesting a corrected initial order for a case listed in WAC 388-02-0215(4) does not automatically extend the deadline to request review of the initial order by BOA. A party may ask for more time to request review when needed.

WAC 388-02-0555(emphasis added). The deadline runs from the “original initial order.” A party, including DSHS, may only obtain an extension of the deadline by asking for it.

DSHS provides clear notice to all parties, including itself, of the 21-day appeal deadline, WAC 388-02-0580, how time is computed, WAC 388-02-0035, and the consequences late filing: “(3) If you miss a deadline, you may lose your right to a hearing or appeal of a decision.” WAC 388-02-0035. DSHS, and Courts at its urging, require strict compliance with jurisdictional time limits for filing administrative appeals, *Ruland v. DSHS*, Yakima County Cause No. 06-2-03813-3, p. 5, attachment M.

Judge Habegger’s corrected order did not change the July 18th jurisdictional appeal deadline, WAC 388-02-0555, nor did Ms. Freeman’s timely appeal: “If more than one party requests review, each request must

meet the deadlines in WAC 388-02-0580.” WAC 388-02-0570(2).

b. DSHS Must Follow its Own Rules

Ms. Freeman asks the Court to require DSHS to follow the same jurisdictional standard it uses to evaluate timeliness of citizen appeals. That standard was adjudicated in *Ruland v. State, Dept. of Social and Health Services*, 144 Wn.App. 263, 182 P.3d 470 (2008). DSHS found the Rulands neglected foster children in their care. In a separate action, their application for a new foster care license was denied:

The Rulands timely appealed both the neglect and licensing matters. During a prehearing conference, the assistant attorney general indicated that the neglect and licensing issues would be joined in the event the neglect finding was upheld. Later DSHS upheld the neglect finding. The Rulands failed to file a second request for review within 30 days as required by RCW 26.44.125(4) because they believed the matter had already been combined with the licensing issue. However, on the day of the hearing, which was one day after the filing deadline expired, the assistant attorney general moved to dismiss based on the Rulands’ failure to file an appeal.

Ruland, at 267, 268. “The ALJ was troubled by the State’s motion” *id* at 270 and allowed the appeal.

DSHS’s Board of Appeals was not troubled:

Jurisdiction to hear Ms. Ruland’s appeal of the CPS finding is properly found only after all regulatory and statutory

procedural requirements are satisfied. The time frames for submitting (perfecting) a hearing request are jurisdictional, and a presiding officer in the administrative hearing process only has authority to conduct a full hearing and render a decision on the merits of a case when a timely request has been submitted to OAH. Ms. Ruland's failure to file a written appeal of the CPS finding that was received by OAH within the proscribed 30-day period is a failure to timely appeal the CPS finding. Any other ruling, such as that made by the ALJ in this case, compromises, invalidates, or abrogates both a state statute and a Department rule.

In re Joshua and Janet Ruland, DSHS Board of Appeals Review Decision, p. 20, attachment N, CP 213-236. After being upheld by the Superior Court, the Board was reversed on appeal due to the compelling facts of the case, including the AAG's and the CPS worker's representations that the appeals had been combined, *Ruland*, 273-275.

Ms. Freeman's case contains no such circumstances. DSHS missed the deadline after being misinformed by the Board's secretary. DSHS's inquiry was well within the appeal deadline. Had it turned to its own rule instead of the telephone, it would have confirmed the appeal deadline remained July 18th.

DSHS should be held to the same standard it applied to the Rulands:
(1) Failure to perfect an appeal within the time limits requires dismissal for lack of subject matter jurisdiction; and (2) Any other conclusion is an error

of law that “compromises, invalidates, or abrogates” DSHS’s rule. DSHS must abide by its own rules. Absent the special circumstances present in *Ruland*, those rules require dismissal of DSHS’s untimely appeal.

4. EPSDT Requires the Level of Medicaid Services Prescribed by Ms. Freeman’s Treating Physician.

If the Court finds DSHS’s appeal was timely, Ms. Freeman respectfully requests the Court reverse the Superior Court’s construction of EPSDT and reinstate the ALJ’s finding of coverage.

a. DSHS Must Provide the Level of Service Required by Federal Medicaid Law.

“As a voluntary participant in the federal Medicaid program, Washington state must comply with Medicaid statutes and related regulations. DSHS administers Medicaid medical assistance programs in Washington state.” *Samanth A.*,supra, at 630. Those statutes require provision of EPSDT benefits to Medicaid recipients under 21. *Jackson v. Millstone*, 801 A.2d 1034, 1046 (Md. 2002) *citing* 42 U.S.C. §1396d(a)(1-5), (17), (21).

EPSDT services include:

...such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and

mental illnesses and conditions discovered by the screening services, whether or not such services are covered by the State plan.

42 U.S.C. §1396d(r) [emphasis added]; *see also S.A.H. ex rel. S.J.H. v. State, DSHS*, 136 Wn.App. 342, 349, 149 P.3d 410 (2006).

Under § 1396d(r)(5), states must "cover every type of health care or service necessary for EPSDT corrective or ameliorative purposes that is allowable under § 1396d(a)." *S.D. ex rel. Dickson v. Hood*, 391 F.3d 581, 590 (5th Cir.2004) (citing *Collins v. Hamilton*, 349 F.3d 371 (7th Cir.2003); *Pediatric Specialty Care, Inc. v. Ark. Dep't of Human Servs.*, 293 F.3d 472 (8th Cir.2002); *Pittman v. Sec'y, Fla. Dep't of Health & Rehab.*, 998 F.2d 887 (11th Cir.1993); *Pereira v. Kozlowski*, 996 F.2d 723 (4th Cir.1993)). Although states have the option of not providing certain "optional" services listed in § 1396d(a) to other populations, they must provide all of the services listed in § 1396d(a) to eligible children when such services are found to be medically necessary. Section 1396d(a) contains a list of 28 categories of care or services; these categories are fairly general, including descriptions such as "inpatient hospital services" and "private duty nursing services." 42 U.S.C. § 1396d(a)(1)-(8).

The EPSDT obligation is thus extremely broad.

Katie A., ex rel. Ludin v. Los Angeles County, 481 F.3d 1150, 1154 (9th Cir. 2007).

The scope of Medicaid coverage required of states under EPSDT has been analyzed by five different Circuit Courts of Appeals. All, including the

Ninth in *Katie A.*, supra, agree with the Fifth Circuit:

For these reasons, we conclude that a state Medicaid agency must provide, under the EPSDT program, (1) any medical assistance that a state is permitted to cover under §1396d(a) of the Medicaid Act, that is (2) necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening.

S.D. v. Hood, 391 F.3d 581, 593(5th Cir. 2004). See *Collins v. Hamilton*, 349 F.3d 370, 374 (7th Cir. 2003); *Pittman by Pope v. Sec'y Fla. Dep't of Health & Rehab.*, 998 F.2d 887, 892 (11th cir. 1983); *Pediatric Specialty Care, Inc. v. Ark. Dep't of Human Services*, 293 F.3d 472, 480-81 (8th Cir. 2002).

Ms. Freeman qualified for the level of benefits provided by EPSDT until age 21, Superior Court COL no. 2. To be covered by EPSDT, the services must meet the definition of medical assistance in 42 U.S.C. 1396a. MPC is included in that definition at 42 U.S.C. §1396(a)(24), *Samantha A. v. DSHS*, Thurston County Cause no. 07-2-02555-1, p. 6,7, COL 4-10, attachment O. If MPC services are found medically necessary as part of an EPSDT screening, DSHS must provide them without limitation:

(b) EPSDT services are exempt from specific coverage or service limitations which are imposed on the rest of the CN and MN program. Examples of service limits which do not apply to the EPSDT program are the specific numerical limits in WAC 388-545-300, 388-545-500, and

388-545-700.

(c) Services not otherwise covered under the Medicaid program are available to children under EPSDT.

WAC 388-534-0100 [emphasis added]. Washington’s State Medicaid Plan states that in providing services under EPSDT: “Limitations do not apply other than based on medical necessity.” AR 1171, 1172, attachment P.

The Superior Court recognized the weight of that legal authority in this case, finding Ms. Freeman qualified for EPSDT and that EPSDT required all medically necessary services that qualify as medical assistance under 42 U.S.C. § 1396d(a), COL no. 2, attachment L. The Judge went on to reject DSHS’s holding that the EPSDT was limited to services provided by a medical professional, COL no. 3. DSHS did not assign error to either conclusion. The Superior Court’s denial of Ms. Freeman’s EPSDT claim rests on the conclusion that 42 U.S.C. 1396d(a)’s definition of medical assistance does not include supervisory care, COL 4, 5. It is that conclusion to which Ms. Freeman takes exception.

b. The Services Prescribed are Medical Assistance under § 1396d(a).

i. Supervisory Care is Medical Assistance under MPC, 42 U.S.C. §1396d(a)(24).

The ALJ, the Review Judge, and the Superior Court all

recognized the services at issue were properly characterized as MPC services. AR 091S, COL no. 7 attachment A, Superior Court COL no. 5, attachment L. As acknowledged by DSHS witnesses, *see* attachment E, DSHS initially administered the MPC program to include protective supervision for clients like Ms. Freeman:

(38) “Personal care services” means both physical assistance and/or prompting and supervising the performance of direct personal care tasks and household tasks, as listed in subdivisions (a) through (q) of this subsection. Such services may be provided for clients who are functionally unable to perform all or part of such tasks without specific instructions. Personal care services do not include assistance with tasks performed by a licensed health professional.

...

(m) “Supervision” means being available to:

- (i) Help the client with personal care tasks that cannot be scheduled, such as toileting, ambulation, transfer, positioning, some medication assistance; and
- (ii) Provide protective supervision to a client who cannot be left alone because of impaired judgment.

WAC 388-15-202, Long-term care services definitions, repealed in 2003, attachment Q. Providing supervision to adults as part of MPC under the state plan was optional. Providing medically necessary supervision to children prescribed by an EPSDT screening is

mandatory.

DSHS's refusal to provide EPSDT benefits covered by Medicaid but outside the state plan recalls *S.D. v. Hood*, supra at 589. In *Hood*, the EPSDT screening for a teenage Medicaid beneficiary prescribed incontinence underwear. The State, whose Medicaid plan excluded coverage, refused to provide the supplies, saying they were neither medical in nature nor within the scope of its Medicaid plan.

The Court held the denial violated EPSDT because the services, although excluded by the State's plan, were within the scope of §1396d(a). The Court noted that the federal Medicaid agency has approved other state plans which included incontinence supplies as proof the service is coverable under §1396d(a). *Hood* at 596. Similarly here, supervisory benefits were formerly included in Washington's approved state plan as an MPC benefit. Those benefits meet the definition of MPC in §1396d(a)(24) and must be provided without limitation if prescribed in an EPSDT screening.

ii. **Supervisory Care Qualifies as Medical Assistance under 42 U.S.C. §1396d(a)(13).**

The services prescribed for Ms. Freeman also qualify as medical assistance under 42 U.S.C. §1396d(a)(13).

The breadth of EPSDT requirements is underscored by the statute's definition of "medical services." Section 1396d(a)(13) defines as covered medical services any "diagnostic, screening, preventative, and rehabilitative services, including any medical or remedial services...for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level."

...

Courts construing EPSDT requirements have ruled that so long as a competent medical provider finds specific care to be "medically necessary" to improve or ameliorate a child's condition, the 1989 amendments to the Medicaid statute require a participating state to cover it.

Rosie D. v. Romney, 410 F.Supp2d 18, 26 (2006) [emphasis in original].

The Superior Court Judge found the services prescribed for Ms. Freeman were not remedial under 42 U.S.C. §1396d(a)(13) because they were not restoring her to a prior level of ability. This analysis parallels the State's unsuccessful defense in *Parents League for Effective Autism Services v. Jones-Kelley*, 565 F.Supp.2d 905 (S.D.Ohio 2008):

Defendant concludes that the services at SBSA are not generally "habilitative" because the services are not "restoring" any skills that the child previously had. Taken to its logical conclusion, such a restrictive interpretation of "rehabilitative" would mean that no child who is born with a

disability, could ever receive rehabilitative services. This does not comport with the broad coverage afforded under the EPSDT mandate.

...

The Court's conclusion that the services required by the EPSDT mandate are more broad than Defendants would suggest, is supported by case law. In *Rosie D. v. Romney*, 410 F.Supp.2d 18 (D.Mass.2006) the Court found that section d(a)(13) does not contain a requirement that the services be "rehabilitative." Rather, in that case, the Court found that "if a licensed clinician finds a particular service to be medically necessary to help a child improve his or her functional level, this service must be paid for by a state's Medicaid plan pursuant to the EPSDT mandate." The Court used the word "improve" and not "restore" in concluding that the services were necessary.

Parents at 916, 917 and cases cited therein³.

DSHS provides supervisory services under Medicaid, i.e. it includes them as within the definition of medical assistance in 42 U.S.C. §1396d(a). Medicaid pays for round-the-clock supervision for severely disabled clients in the CHORE waiver program. This medically necessary care provided by Medicaid is provided by persons with a similar level of training and DSHS certification as Ms. Freeman's CARE providers. These services include supervision, such as watching TV with the client and being available to

³ In *Pediatric Specialty Care, Inc. v. Ark. Dep't of Human Services*, 293 F.3d 472, 480-81 (8th Cir. 2002), the Court required EPSDT coverage under 42 U.S.C. 1396d(a)(13) for prescribed early intervention day treatment, which the court described as "a type of day care program," *id.* at 476.

meet any emergencies that arise and to change the channel. VBR IV p. 40, l. 8 - p. 42, l. 17, attachment F. Medicaid also pays for 24/7 supervision, albeit in a more expensive and invasive form, at the DSHS institutions Ms. Freeman qualifies for.

The supervisory MPC services prescribed by Ms. Freeman's EPSDT screening are medical assistance are 42 U.S.C. 1396d(a). EPSDT requires DSHS to provide the prescribed level of services if medically necessary.

c. The Prescribed Treatment is Medically Necessary.

Federal law, cases and the department's rule all agree treatment must be medically necessary to be covered by EPSDT:

"Medically necessary" is a term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all.

WAC 388-500-0005. Dr. DeGive testified, and the ALJ correctly found, the prescribed treatment is medically necessary under DSHS's own definition, i.e. it is necessary to alleviate conditions in Ms. Freeman that

endanger her life, cause suffering or pain, threaten to aggravate a handicap, or cause physical malfunction.

DSHS has argued that the services prescribed for Ms. Freeman are not medically necessary because they are not provided by a medical professional. The ALJ rejected that claim, ALJ COL 29, AR 025, attachment D. DSHS's final order revived that argument. Instead of construing "medically necessary" to find EPSDT only covered medical services, the review judge focused on the requirement that EPSDT services be ameliorative. He reasoned that only medical services were ameliorative to support his conclusion limiting EPSDT to medical services. AR 89S-92S, COL 5, attachment A. The Superior Court judge properly rejected that conclusion, COL 2, CP 352, attachment L. DSHS should not be heard to argue on appeal that the services prescribed in the EPSDT screenings are not medically necessary.

Medically necessary services are not necessarily medical. Under WAC 388-500-0005 "mere observation" qualifies as a medically necessary course of treatment. DSHS employees Debbie Johnson and Chris Imhof identified a number of services that were not provided by a medical professional, yet were deemed medically necessary and compensated under

Medicaid. See DSHS response to Ms. Freeman’s interrogatories AR 1271-1293, VRP II 125, 126, attachment R.

In *Burnham v. DSHS*, 115 Wn.App. 435, 63 P.3d 816 (2003), the court considered whether providing a trained canine companion to a mentally ill Medicaid patient was a covered service. “DSHS found that Burnham’s service dog is ‘medically necessary.’ AR at 67. DSHS does not challenge that finding.” *Burnham, supra* at 439. If a provider need not be human for his services to be medically necessary, then clearly there is no requirement that the provider, if human, possess a medical degree.

That is not to say that the Freeman’s are unskilled. In order to qualify as providers eligible for any payment from DSHS they are required to undergo ongoing training to obtain and maintain DSHS certification. *Samantha A*, supra at p. 636. If treatment from a dog qualifies as medically necessary, certainly treatment from DSHS certified providers qualifies.

d. The EPSDT Screening is Controlling.

DSHS applies the same CARE formula to both children and adults determine the need for MPC services, *Samantha A*. Sup. Ct., FOF no. 8, 9, attachment O. CARE does not consider the medical opinion of the physician documented in EPSDT screenings, *id.* at COL 12. That is, the

CARE tool ignores EPSDT's federally mandated level of benefit eligibility for Medicaid recipients under 21. Federal law requires that the EPSDT screening, not the CARE tool, determines the level of services required for children. *See* discussion of distinction of Medicaid benefits for adults vis a vis EPSDT benefits for children in *S.D. v. Hood*, supra at 497.

An EPSDT screening is any assessment of treatment needs from the patient's health care provider.

Furthermore, we consider any encounter with a health care professional practicing within the scope of practice as an interperiodic (EPSDT) screen. As such, it does not matter whether the child receives the screening services while Medicaid eligible, nor whether the provider is participating in the Medicaid program at the time those screening services are furnished. Any necessary health care required to treat conditions detected as a result of a screen, must be provided.

Medicaid State Operations Letter #91-44, *See* AR 1173, 1174, attachment S, CP 599-600. The physician's reports provided by Dr. DeGive and Dr. Sciarrone are EPSDT screening. *See* attachment B and C.

In the event of a disagreement in required treatment between the state Medicaid agency and the screening physician, the opinion of the screening physician is controlling. If the treatment prescribed by the screening physician is available under 42 U.S.C. 1396d(a), the state must provide it regardless of whether it is available to the general Medicaid

population under the State plan. *S.D. v. Hood, supra* at 585-586, 593.

It is the physician who is to be the key figure in determining the utilization of health services...it is the physician who is to decide upon admission to a hospital, order tests, drugs and treatment.

S. Rep. No. 404 89th Cong., 1st sess. reprinted in 1965 U.S.C.C.A.N. 1943, 1986.

Washington’s Judiciary recently recognized EPSDT requires DSHS to provide medically necessary MPC services at the level determined in the EPSDT screening, *Samantha A. v. DSHS*, sup. ct., attachment O⁴. The federal Department of Health & Human Services (HHS) agreed: “Since PCS for children is a component of the mandatory EPSDT benefit, as discussed above, States generally cannot impose limitations on medically necessary services for individuals under age 21, because such limitations would be inconsistent with the EPSDT statutory benefit.” Attachment T., CP 595-596.

e. The CARE Tool Does Not Repeal EPSDT.

Medicaid covers supervisory care. Ms. Freeman’s EPSDT physician screening established that level of care is medically necessary. EPSDT

⁴ The Supreme Court upheld on other grounds and did not reach the EPSDT issue. *Samantha A.*, supra, fn. 10.

required DSHS to provide that level of service through Ms. Freeman's 21st birthday.

DSHS's denial stems not from a lack of coverage, but from the design of its system. The Legislative authorization for allocating personal care services the general Medicaid population requires allocation be based on funding: "The personal care services benefit shall be provided to the extent funding is available according to the assessed level of functional disability." The statute goes on to give direction for reducing levels of service due to funding cuts. RCW 74.09.520. MPC services to children under EPSDT, however, must be provided at the prescribed level despite budgetary pressures: "Moreover, a state may not ignore the Act's requirements 'in order to suit state budgetary needs.'" *Parents*, supra, at 911, quoting *Illinois Hospital Asso. v. Illinois Dep't of Public Aid*, 576 F.Supp. 360, 371 (N.D.Ill.1983).

MPC assessments under the CARE tool do not account for the requirements of EPSDT. *Samantha A. v. DSHS*, sup. ct., attachment O. DSHS can't get there from here because the CARE tool simply doesn't work that way. DSHS service mechanism does not change Ms. Freeman's entitlement: "The state may not shirk its responsibilities to Medicaid

recipients by burying information about services in a complex bureaucratic scheme.” *Pediatric Specialty Care*, supra at 481.

4. Ms. Freeman is Entitled to Attorney’s Fees.

The Superior Court properly awarded Ms. Freeman attorney’s fees for her success in overturning DSHS’s final order on appeal. The Superior Court limited Ms. Freeman’s recovery to 70% of fees incurred because it ultimately ruled against her EPSDT claim. The Court’s finding of reasonableness of the hourly rate of Ms. Freeman’s attorney, the reasonableness of amount of time spent on the case, and the portion of time devoted to successful claims are supported by substantial evidence and should be upheld.

If this Court finds in Ms. Freeman’s favor on the jurisdictional issue then Ms. Freeman is entitled to all attorney’s fees and costs incurred in judicial review as all those costs flowed from the Board’s erroneous assumption of jurisdiction. If this Court finds against Ms. Freeman on the jurisdictional issue but in her favor on the EPSDT issue then Ms. Freeman is entitled to all attorney’s fees and costs save for those incurred in arguing the jurisdictional issue.

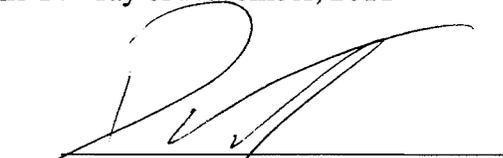
The award is not subject to the Equal Access to Justice Act (EAJA),

\$25,000 limitation, RCW 4.84.350. The Superior Court held Ms. Freeman qualified for an award of attorney's fees under both RCW 74.08.080(3) and the EAJA. Should Ms. Freeman's entitlement to fees exceeding \$25,000 she is entitled to an award under RCW 74.08.080(3), which does not contain the fee limitation found in the EAJA. *Samantha A. supra*, 637, 638.

C. Conclusion

By filing its appeal late, DSHS failed to invoke the jurisdiction of its Board of Review. Ms. Freeman asks this Court to dismiss that appeal and reinstate the ALJ's decision as the final agency order. In the alternative, if this Court finds appellate jurisdiction was properly invoked, Ms. Freeman asks this Court to recognize that the supervisory services prescribed in her EPSDT screenings qualify as medical assistance under 42 U.S.C. 1396d(a). EPSDT required DSHS to provide those medically necessary services through Ms. Freeman's 21st birthday, and award her full attorney's fees under RCW 74.08.080(3).

Respectfully submitted this 14th day of November, 2011



Paul Neal, WSBA #16822
Attorney for Faith Freeman.

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**IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON
DIVISION II**

FAITH FREEMAN

v.

STATE OF WASHINGTON,
DEPARTMENT OF SOCIAL AND HEALTH
SERVICES

Docket No. 40811-2-II

DECLARATION OF SERVICE

I, Paul Neal, declare that on November 14, 2011, caused to be filed Faith Freeman's opening brief with attachments to be filed with the Court of Appeals, Division II, in Tacoma. I served the copies of the same documents on the Assistant Attorney General for DSHS at 7141 Cleanwater drive SW in Tumwater on that same day.

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

Signed at Olympia, Washington on this 14th day of November, 2011.



Paul Neal, WSBA #16822

Declaration of Service

NEAL & NEAL LLC
Attorneys at Law
112 E Fourth Avenue, Suite 200
Olympia, Washington 98501
(360) 352-1907
Fax: (360) 754-1465

Attachment A

STATE OF WASHINGTON, DEPARTMENT OF SOCIAL AND HEALTH SERVICES

BOARD OF APPEALS

MAILED
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DSHS
BOARD OF APPEALS

In Re:)	Docket Nos.	09-2004-A-0143
)		11-2005-A-1878
)		12-2006-A-0855
)		
FAITH K. FREEMAN	)	REVIEW DECISION AND FINAL ORDER	
)		
	)	Developmental Disabilities	
)		
Appellant	)	Client ID No.	731698

I. NATURE OF ACTION

1. Administrative Law Judge Jane L. Habegger conducted an administrative hearing on April 16 and 17 and on May 20 and 21, all in 2008; and mailed an Initial Order on June 27, 2008. Pursuant to the Department's request, the administrative law judge (ALJ) corrected some typographical errors concerning the numbering of the ALJ's conclusions of law and issued a Corrected Initial Order on July 3, 2008. In her decision ALJ Habegger ruled that *"the Appellant is entitled to services under the EPSDT¹ as set forth above. Alternatively, she is eligible for 190 hours under the 2007 CARE retroactive to 2004 minus any hours in which her needs were met with 'informal supports' in school or work."*²

2. ALJ Habegger also issued an order on November 5, 2007, which related to the several Appellant motions for partial summary judgment. In her decision, the ALJ denied some of the Appellant's motions and granted others. The Appellant filed an interlocutory appeal of the ALJ's order on November 26, 2007, that stated, in part:

Comes now Appellant Faith Freeman by and through her counsel of record, Paul Neal of Neal & Neal, LLC, Attorneys at law and brings this appeal of portions of ALJ Jane L. Habegger's Initial Order of partial summary judgement dated November 5, 2007.

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¹ Early periodic screening, diagnosis and treatment services.

² Corrected Initial Order, page 27. The language "as set forth above" is construed by the undersigned to refer to the contents of Conclusion of Law 31, which arguably provides the framework under which the actual amount of the entitlement (expressed in hours of care) could be determined.

1. *Appellant's Name and Mailing Address.* The appellant is Faith Freeman. She is represented in the on-going adjudicative proceeding by her counsel of record, Paul Neal. Mr. Neal continues to represent her in this appeal of portions of Judge Habegger's initial order of partial summary judgement. All correspondence, notices, and orders arising from this action should be mailed to Mr. Neal at:

Paul Neal
Neal & Neal, LLC, Attorneys at Law 112 E. 4th Ave., Suite 200
Olympia, WA 98501 (360) 352-1907 cell: (360) 789-7722

2. *Docket Number:* This appeal consists of three consolidated appeals catalogued under the following combined docket no: 09-2004-A-0143, 11-2005-A-1878, 12-2006-A-0855

3. *Grounds for Appeal:* Appellant Faith Freeman appeals from the following portions of Judge Habegger's November 5, 2007, initial order of partial summary judgement:

a. Judge Habegger's conclusion that the results of the 2007 CARE evaluation should not be applied retroactively was an error of law and should be reversed;

b. Judge Habegger's conclusion that DSHS is not bound by the Social Security Administration's determination that Faith lives alone is an error of law and should be reversed;

c. Judge Habegger's failure to rule on Appellant's claim that DSHS violated federal requirements to provide notice to Ms. Freeman of her right to an EPSDT screening and evaluation was a failure to rule on an issue properly before her. Appellant is entitled to a decision granting her relief on that claim.

Appellant does not appeal from Judge Habegger's findings of fact, nor does she appeal from any portion of Judge Habegger's initial order not specifically listed in this paragraph no. 3.

4. *Procedure:* Judge Habegger's order was based on a motion for partial summary judgement. Other issues requiring the resolution of disputed issues of material fact will be brought before Judge Habegger in a full adjudicative proceeding. This appeal is brought at this time to ensure that Appellant properly pursues all areas of administrative relief open to her. Regardless of the result on the remaining issues before Judge Habegger, it is highly likely that the aggrieved party will appeal to this tribunal. Therefore, Ms. Freeman asks that this appeal be docketed and noted as timely filed, then held in abeyance pending the appeal of the remainder of the case. At that time, the cases can be rejoined and considered together by the Board of Appeals.

3. The ALJ held another prehearing conference on March 19, 2008, at which she entertained a motion filed by the Appellant for clarification of the November 5, 2007, order on

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summary judgment.³ On March 21, 2008, ALJ Habegger entered another order, this one entitled "Amended Initial Order" and in which the ALJ added a ruling that the Appellant was "eligible for *Medical Personal Care Services* commencing July 1, 2004."⁴ On April 1, 2008, the Department then filed an interlocutory appeal of the March 21st ruling relating to the retroactive eligibility for MPC. The appeal stated, in part:⁵

The Division of Developmental Disabilities (DDD) hereby petitions for review of the Amended Initial Order issued on March 21, 2008. This order amended the Initial Order issued on November 5, 2007.

I. PROCEDURAL HISTORY

This case has had a complicated procedural history. Docket No. 09-2004-A-0143 (0143) was remanded from Superior Court. Docket Nos. 11-2005-A-1878 (1878) and 12-2006-A-0855 (0855) had been stayed pending the outcome of 0143, so were consolidated with 0143 when it returned on remand. The remand order concluded, in relevant part, "DSHS erred in failing to allow Ms. Freeman to present evidence and argument on other federal claims raised in her petition for judicial review." In its oral ruling, the court made clear that it wanted a complete record to be made, including relevant federal law, but it lacked jurisdiction to order the Department to rule on the basis of federal law.

A pre-hearing conference was held on September 28, 2007, to hear argument on the Appellant's motion for partial summary judgment. The Initial Order resulting from that motion was issued on November 5, 2007, and the Appellant moved for partial reconsideration or clarification of the Initial Order. The Appellant also filed an interlocutory appeal to the Board of Appeals (BOA) for review of portions of the Initial Order. DDD did not file any response to that appeal since no argument was presented regarding the three issues identified and there had been no response from the ALJ on the motion for reconsideration or clarification. The BOA subsequently granted the Appellant's request to hold the interlocutory issues in abeyance pending issuance of a further initial order disposing of any remaining issues in the consolidated cases.

Another pre-hearing conference was held on March 19, 2008, in order to clarify remaining issues for hearing. At that time, counsel for the Appellant requested that the ALJ respond to the motion for partial reconsideration or clarification, since she had not previously done so. Counsel for DDD agreed that that would be appropriate and helpful. Subsequently, the ALJ issued an Amended Initial Order in which she provided clarification of the earlier order. Based on the clarification, DDD appeals a portion of the order - specifically, Conclusion of Law

³ This order was entitled "Initial Order" but its sole purpose was to address the Appellant's various motions for partial summary judgment.

⁴ The undersigned believes that the ALJ is referring to the *Medicaid Personal Care (MPC)* program

⁵ Many of the briefs filed by the parties which are reproduced *infra* contain footnotes. In order to clearly separate those footnotes from those inserted by the undersigned, the former will be italicized. It should also be noted that although the undersigned has changed the numbering of the parties' footnotes, those footnotes do appear in the correct location and order.

No. 7, and paragraph V of the Order section, holding that the Appellant became eligible for MPC on July 1, 2004.

II. FACTS RELEVANT TO APPEAL

The issue of when the Appellant became eligible to receive Medicaid personal care benefits (MPC) was decided by the BOA when it issued the Review Decision and Final Order for Docket No. 09-2004-A-0143 on August 31, 2005. Findings of Fact Nos. 9 through 15 provided the factual basis for the determination: the Appellant was initially assessed on July 9, 2004; Loren and Jean Freeman signed the assessment on August 27, 2004; and the Freemans were approved as the Appellant's care providers on September 7, 2004. Conclusion of Law No. 12 provided the Department rule that sets the date services are to begin (WAC 388-72A-0053).⁶ The Review Judge affirmed the Initial Order (and DDD's action) by concluding that the Appellant's eligibility to receive MPC benefits began on September 1, 2004.

III. ARGUMENT

The Appellant raises the issue of the date of her eligibility for MPC on remand as she did at the 2004 hearing. Consistent with the remand order, she now cites a federal statute and a federal regulation in support of her claim that she should have received MPC beginning on July 1, 2004. Specifically, she cites 42 U.S.C. § 1396a(a)(34) for the proposition that her eligibility for MPC should have begun three months prior to the date of her application for service, and 42 C.F.R. § 435.914(2)(b)⁷ for the proposition that she should at least receive MPC from the beginning of the month in which she became eligible for Medicaid. In the Amended Initial Order, the ALJ denied the first argument based on the Department rules that correspond to the aforementioned federal statute (WAC 388-416-0010(3) and WAC 388-416-0015(8)). However, the ALJ agreed that 42 C.F.R. § 435.914(b) supports several Department rules that authorize MPC to begin on the first day of the month that a client becomes eligible for SSI. Thus, according to the ALJ, since the Appellant's SSI eligibility began in July 2004, her MPC should have begun on July 1, 2004.

This decision is incorrect for several reasons. First, it ignores the Department rule that is specifically on point. At the time of the 2004 hearing and subsequent administrative orders, the relevant rule was WAC 388-72A-0053. The relevant rule now is WAC 388-106-0215.⁸ The other rules cited by the ALJ - WAC 388-416-0055(3), WAC 388-503-0515(1), and WAC 388-416-0010(1)(b) - are inapposite, since they refer to eligibility for general medical coverage. That is, they refer to eligibility to have one's medical and dental care be paid. Because personal care services require an assessment of need for the services, an agreement by a

⁶ "WAC 388-72A-0053 **Am I eligible for one of the HCP Programs?** You are eligible to receive HCP services if you meet the functional and financial eligibility requirements in . . . WAC 388-72A-0060 for MPC. . . . Functional eligibility for all HCP programs is determined through an assessment as provided in WAC 388-72A-0025. Your eligibility begins upon the date of the Department's service authorization."

⁷ The Appellant presumably meant 42 C.F.R. 435.19(b).

⁸ "WAC 388-106-0215 **When do MPC services start?** Your eligibility for MPC begins the date the department authorizes services."

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client (or her guardian) to accept the services, and an agreement by someone else to provide the services, MPC benefits cannot begin before they are authorized.

Secondly, to the extent that the ALJ made her decision based on federal rule, she violated WAC 388-02-0220 (ALJs must apply Department rules as the first source of law, and may only apply other law when no Department rule is relevant). Here, because there is a rule directly on point, it would be inappropriate to look to other sources of law. The order from Superior Court did not require that the Department look to federal law first - it only required that the Appellant be allowed to cite to federal law in order to fully develop the record. Thus, even if the federal law were contradictory to the Department rule, that law would not supersede the Department rule in an administrative hearing.

Finally, even if federal law were allowed to supersede the Department rule, it would not do so here. The regulation cited by both the Appellant and the ALJ, 42 C.F.R. § 435.914(b), does not mandate that Medicaid personal care begin at any particular date, since it only refers to Medicaid eligibility.⁹ In this case, there is no question that the Appellant was eligible for Medicaid on July 1, 2004. However, her willingness to accept personal care services in the amount determined by the Department's assessment was not established at that time, nor had her care providers agreed to provide services then. Her agreement (through her guardians) and her care provider's agreement only occurred at the end of August 2004. The Department took a few days to process those agreements, and initiated payments for personal care beginning September 1, 2004. The Department could not pay then - and should not pay now - for any services allegedly provided prior to that time that had not been agreed to by all parties.

IV. CONCLUSION

For the reasons discussed above, the Amended Initial Order should be reversed to the extent that it concludes that the Appellant's eligibility for MPC benefits should begin on July 1, 2004, rather than September 1, 2004. If the BOA cannot decide this issue until a further Initial Order is issued following the full hearing in this case, this issue should be held in abeyance and decided with any other appeal issues at that time.

4. On April 9, 2008, the Appellant filed a response to the Department's interlocutory appeal that stated, in part:

This letter is in response to the Interlocutory Request For Review filed by DSHS on April 1, 2008 and mailed to us on April 3, 2008. Due to the fact that my attorney has not been available to review this Request for Review, and that he will not have had a chance to even see it until the afternoon of April 9th, I have dispatched this letter in order to avoid missing the short deadline.

Complicating this situation is the fact that we are moving forward to conduct the hearing on remand on the above docket numbers on April 16th. Those deadlines coincide with the deadline on this Request for Review.

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⁹ Indeed, 42 C.F.R. 435.914(b) does not mandate anything - it merely allows a state to begin Medicaid eligibility at the beginning of the month in which eligibility is determined.

Should Faith Freeman's attorney be unable to respond in time, I am attempting to register more complete facts on this matter. If he is able to respond in time, you may certainly disregard this response in favor of his response.

Fact. Loren M. and Jean M. Freeman were qualified as Medicaid Personal Care Service contracted providers in May of 2004 - well before the dates of these services. Although they had not yet signed the specific care plan. they were Medicaid providers prior to July 1, 2004. They are not permitted to bill the Medicaid client for qualified services until those services are denied by DSHS by final order. They were providing all personal care services to a Medicaid eligible person during the period of Medicaid eligibility in question (i.e., July 1, 2004 onward).

A denial of payment for MPCS services for the period 7/1/04 through 8/31/04, as the department argues, means that a Medicaid eligible client will be responsible for payment of a Medicaid qualified service during a bona fide Medicaid eligibility period - such payment due to a Medicaid contracted provider who is and has been willing to bill Medicaid for the qualified service. The outcome of the department's argued interpretation of department rules is not reasonable, equitable or lawful. In addition, the department's argued interpretation is not consistent with department operations and practice.

By the department's own arguments in this case, the department authorizing action was made on September 7, 2004. At that time, the department made the beginning date September 1, 2004. The department's original actions are not consistent with their argued interpretation at this point in time.

In fact, the department chose, by normal operations and practice, a retroactive date for the beginning of MPCS services. This made it appropriate for the appellant to question whether or not the department chose the correct retroactive date. The department's normal interpretation of the rule in question interjected the need for an objective interpretation of the rule.

Clearly, the responsibility of the Administrative Law Judge was to interpret the relevant laws in a manner so that they agree together, if that [was] at all possible. It was incumbent upon the ALJ to apply the relevant laws to a unique set of circumstances affecting the life and finances of a Medicaid eligible client. It appears that the ALJ in this case ruled that the relevant laws, applicable in this particular instance, must be applied in a manner that will not have the unlawful and inequitable outcome that is described in the foregoing descriptions. The relevant laws, taken together and applied to this unique circumstance, require the initial decision that was made in this matter. We consider that decision to be proper. It is not in error and it is not in violation of any consistently applied DSHS rules.

5. Both interlocutory appeals were "pending" by the Board of Appeals at the mutual request of the parties while the case proceeded towards a decision on the merits. As noted above, the Initial Order was entered on June 27, 2008, and the Corrected Initial Order was entered on July 3, 2008.

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6. On July 16, 2008, the Appellant filed a Petition for Review that stated, in part:

COMES NOW, Faith Freeman, by and through her attorney of record, Paul Neal of Neal & Neal, LLC, and files the following petition for review of Administrative Law Judge Jane Habegger's corrected initial order Mailed on July 3, 2008.

I. Procedural History

Faith Freeman is a developmentally disabled categorically needy Medicaid client. She turned eighteen on July 18, 2004. In August 2004, DSHS assessed her eligibility for services using the CARE tool. DSHS did not consider the affect of the federal Early Periodic Screening, Diagnosis and Treatment law (EPSDT) on her eligibility for services. Ms. Freeman disagreed with the level of services authorized under the CARE tool and appealed her 2004 CARE assessment. The ALJ and the Board of Appeals refused to consider her claims for eligibility under federal law on the grounds that DSHS rules precluded that inquiry.

Ms. Freeman appealed this decision to the Thurston County Superior Court. Judge Gary Tabor found in her favor and remanded the matter for further hearing consistent with his order. During the pendency of Ms. Freeman's appeal of her 2004 CARE assessment, two more assessments were completed and appealed. Those appeals were stayed pending the outcome of the appeal of her 2004 assessment. On remand the three appeals were consolidated.

Administrative Law Judge (ALJ) Jane Habegger issued an initial order partially granting and partially denying Appellant's motion for partial summary judgement. Appellant filed an interlocutory appeal of portions of that ruling. On January 9, 2008, the Board of Appeals granted Appellants request to hold the issues identified in her interlocutory appeal in abeyance pending a post-hearing initial order from the ALJ stating: "The Appellant may include the interlocutory issues presently appealed either by restatement withing the body of the new appeal, or by simply incorporating interlocutory issues by reference." Appellant hereby incorporates her earlier interlocutory appeal within this appeal by reference.

On June 27, 2008, the ALJ issued an initial order. On July 3, 2008, the ALJ issued a corrected initial order. Appellant appeals from those portions of that order listed below.

II. Assignments of Error

Appellant makes the following assignments of error:

1. *Finding of Fact no. 5: Judge Habegger erroneously found that DSHS determined that Ms. Freeman was eligible for Medicaid benefits beginning September 1, 2004. DSHS found Ms. Freeman categorically needy and eligible for Medicaid effective July 1, 2004. The Department erroneously found that her eligibility for services did not commence until September 1, 2004, following its CARE assessment.*

2. *Conclusion of Law No 18: Judge Habegger erroneously concluded that Appellant's parents cannot qualify as her care-givers for Medicaid Personal Care services under 42 USC § 1396d(a)(24). Appellant's parents are not disqualified by the cited language. As noted by DSHS in footnote 2 in its closing brief. "Subsection*

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(B) of this definition would seem to rule out Mr. and Mrs. Freeman as providers of personal care, since they are obviously members of Appellant's family. However 42 CFR § 440.167(b) which is largely identical to 42 USC §1396d(a)(24), clarifies that for purposes of personal care, 'family member means legally responsible relative.' The Freemans no longer have legal parental responsibility for Faith and Washington has not interpreted the phrase "legally responsible relative" to include guardians."

3. Conclusion of Law No. 31: Judge Habegger erred when she disallowed 8 hours per day during which she presumed Appellant was sleeping. The EPSDT screening called for twenty-four hours a day supervision. Judge Habegger's apparent conclusion that the Freemans were not required to, and did not, provide supervision during those hours is an error of law and not supported by substantial evidence.

III. Relief Requested

Appellant requests that the Board of Appeals timely issue a final order upholding those portions of Judge Habegger's order that have not been appealed by Appellant and holding for Appellant on those issues identified in Appellant's interlocutory appeal and in this request for review, and such other relief as the Board deems just.

7. On July 22, 2008, the Department filed a Response to the Appellant's petition that stated, in part:

Department of Social and Health Services, Division of Developmental Disabilities, hereby responds to the Appellant's Petition for Review of the Initial Order in this case. The Appellant assigns three errors to the order. Those assignments will be responded to in the order presented by the Appellant.

Finding of Fact 5. This issue is addressed in the Department's Interlocutory Petition for Review of Amended Initial Order, submitted April 1, 2008. As noted in that brief, a client's Medicaid eligibility is separate from the client's eligibility for personal care services. Personal care services cannot be authorized until a need level is assessed, a plan of care has been approved by the client or guardian, and a provider has agreed to provide the service. All of these preconditions did not occur for Faith Freeman until September 1, 2004.

Thus, to the extent that the term "medical assistance" in the second sentence of this finding is actually a reference to Medicaid personal care services, the finding is accurate. It would be more accurate if it actually said "Medicaid personal care services" instead of "medical assistance."

Conclusion of Law 18. For the reasons noted in footnote 2 of the Department's Closing Brief and footnote 2 of the Department's Petition for Review of Corrected Initial Order, the Department agrees with the Appellant that the ALJ erred in finding that the Freemans are ineligible to provide personal care services to Faith.

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Conclusion of Law 31. The Appellant's assignment of error to the ALJ's conclusion that the Freemans were not providing supervision of Faith while they slept is further evidence of the problem with the claim for any reimbursement for "supervision." The Appellant is here asserting that supervision can be provided equally well when the provider is sleeping as when awake. Further, the provider can provide supervision 24 hours a day, 7 days a week. Since it would be impossible for anyone to provide an active service around the clock indefinitely, this clearly means that "supervision" is simply another way of referring to being available.

There is no question that the Freemans have been available to Faith whenever she needed them. However, nothing in Medicaid rules or anywhere else supports the proposition that the state is required to pay an hourly rate much less the personal care hourly rate, as proposed by Mr. Freeman- for family members simply to be available to clients in the event of need. The Department obviously pays for the assistance rendered when the need arises (assuming the need is for assistance with a personal care task). It also pays for round-the-clock provider availability in other settings, such as adult family homes and group homes. But it does not pay individual providers for the time not providing any active assistance.

In short, the Appellant correctly points out that Conclusion of Law 31 is in error, but incorrectly identifies the error. The error is not that the ALJ concluded that the Freemans did not provide supervision while they were sleeping. The error is the conclusion that Faith Freeman is entitled to paid supervision by her parents at all.

8. Also on July 22, 2008, the Department filed their own Petition for Review that stated, in part:

The Division of Developmental Disabilities (DDD) hereby petitions for review of the Corrected Initial Order issued on July 3, 2008.

I. ASSIGNMENTS OF ERROR

1. *The Results and Order sections are improper because of the errors noted below.*
2. *Finding of Fact 3 is accurate as a statement of the ALJ's previous rulings, but ruling V. is in error for the reasons discussed in the Department's Interlocutory Petition for Review of Amended Initial Order.*
3. *Conclusion of Law 16 is in error insofar as it implies that it is only the Department that characterizes the care provided by the Freemans as "supervision." More significantly, this Conclusion of Law is also in error when it characterizes the care provided by the Freemans as personal care services.*
4. *Conclusion of Law 18 is in error when it states that Faith cannot receive personal care services from her parents.*
5. *Conclusion of Law 23 is in error insofar as it states that the services recommended by Dr. deGive are remedial services which were provided by the Freemans.*
6. *Conclusion of Law 31 is in error when it states that "Faith was entitled to care from her parents during the period at issue under the EPSDT program." It is*

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also in error when it concludes that the Freemans are entitled to be paid for 469.5 hours per month for the period in question.

7. Conclusion of Law 32 is in error insofar as it asserts that a review of the 2004 CARE assessment was necessary. More importantly, this Conclusion is also in error when it holds that Faith is entitled to the number of hours determined in the 2007 CARE assessment for the years 2004 through 2006.

II. PROCEDURAL HISTORY

The procedural history of these consolidated cases is largely summarized in the Departments Interlocutory Petition for Review of Amended Initial Order, submitted on April 1, 2008. Since that time, a full hearing on the merits was held in April and May of this year. Not mentioned in the previous summary but important to note here is the fact that the hearing on Docket No. 09-2004-A-0143, held in 2004, fully considered the CARE assessment of Faith Freeman administered by the Department earlier that year. That hearing was appealed to the DSHS Board of Appeals, then to the Thurston County Superior Court. The court then remanded the case for several reasons, but none of them was for further fact finding on the 2004 CARE assessment. Rather, the remand was entirely to allow the Appellant to present evidence and argument regarding various federal claims made in her petition for judicial review. See Finding of Fact I.

III. FACTS RELEVANT TO APPEAL

The Department does not disagree with any of the Findings of Fact in the Initial Order. However, certain facts are omitted which help explain why the conclusions reached in the order are incorrect. First, Faith Freeman has had two EPSDT screenings by two physicians. The first was by Dr. deGive on August 27, 2004 (Exhibit 21), and the second by Dr. Sciarrone on June 15, 2007 (Exhibit K). The latter screening is not noted in the Findings of Fact, but is referenced in Conclusion of Law 25. In the Orders section of Dr. Sciarrone's screening, there is no mention of supervision or any other services that could or should be provided by a nonmedical provider. Exhibit K at 4. The Department subsequently sent Dr. Sciarrone a letter asking her whether Faith required 24-hour supervision and what other skilled services Faith required. Exhibits L and 34. Dr. Sciarrone responded that Faith does need 24-hour supervision and also requires assistance with "self-care/toileting." *Id.* The Department then sent Dr. Sciarrone another letter asking her to clarify her response to the first letter. Exhibit 37. Dr. Sciarrone responded with essentially the same statement ("The patient needs to be aided in self care activities such as her toilet and bathroom use.") Exhibit M and 38.

Second, Dr. Sciarrone did not testify at the hearing, but Dr. deGive did. On cross-examination he stated that Faith's condition, Trisomy 21, cannot be ameliorated, but associated problems to her condition can be ameliorated. He further noted that supervision of Faith would not prevent worsening of her condition, but would prevent tragedy as a result of her poor judgment.

Third, although Mr. Freeman testified that in 2004 he did not know the definition of various terms used in the CARE tool, both he and Kris Jorgensen Dobson testified that all assessments involved considerable interchange between the Freemans and Ms. Jorgensen Dobson. Furthermore, Mr. Freeman reviewed all assessments before they were finalized and made a number of comments and

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corrections. He also affirmed on cross-examination that if he did not object to an item, he could be assumed to agree with it.

Finally, on cross-examination Mr. Freeman was asked about adult family homes as an alternative placement for Faith. He noted that he was aware of the option, but had rejected it.

IV. ARGUMENT

A. Faith Freeman Is Not Entitled To Payment Under EPSDT For Undefined Services Provided By Her Parents

Under the terms of a 1989 amendment to the Medicaid Act, any medically necessary service that is recommended by a physician must be provided to Medicaid eligible children age 20 and younger, regardless of whether the service is covered under the state plan for adults. This requirement is known as the "EPSDT" program, which is an acronym for early and periodic screening, diagnosis, and treatment. All 28 of the listed types of "medical assistance" in 42 U.S.C. § 1396d(a) must be available to eligible recipients if prescribed by a physician. 42 U.S.C. § 1396d(r); *Rosie D. v. Romney*, 410 F. Supp. 2d 18, 25-26 (D. Mass 2006). EPSDT requirements are further described in federal regulations. See 42 C.F.R. § 440.40(b); 42 C.F.R. § 441.56 through 441.62. Washington recognizes the duty imposed by EPSDT, and has codified the requirement in chapter 388-534 WAC, which references federal rules. See WAC 388-534-0100(2) ("Access and services for EPSDT are governed by federal rules at 42 C.F.R., Part 441, Subpart B which were in effect as of January 1, 1998.") Thus, there is no dispute in this case that Faith Freeman, as a Medicaid eligible child between the ages of 18 and 21, was eligible for all medically necessary services. The question here is whether the services at issue were medically necessary.

The first problem is defining what services are actually at issue. The ALJ states that the Department characterizes the services as "supervision," but she goes on to say that "[t]he care which the Freemans provide as Faith's caregivers is more properly characterized as personal care services, which are provided under Medicaid and the EPSDT program." Conclusion of Law 16. This statement is wrong for several reasons. First, the Department is not alone in characterizing the Freemans' care as "supervision" - this was the term repeatedly used by Mr. Freeman and Faith's counsel prior to this hearing. See, e.g., Exhibit 7, at 4; Exhibit 36, at 2-3; Appellant's Prehearing Brief at 16. During the course of the hearing, Mr. Freeman described an expanded scope of services he and his wife provide to Faith,¹⁰ but he also continued to stress that he and his wife provide ongoing supervision for Faith. More importantly, as discussed below, supervision is almost entirely what Faith's doctors recommended for her.

But even if the services provided by the Freemans include both supervision and other undefined services, they are not personal care services. Conclusion of Law 17 accurately recites the federal statutory definition of personal care, but Conclusion of Law 18 focuses on the wrong clause in that definition.¹¹ The key

¹⁰ E.g., taking Faith to the library and church, and helping her bathe and cook independently.

¹¹ The ALJ held that sub-section (B) of the definition of personal care prohibited Mr. and Mrs. Freeman from acting as providers of personal care for Faith, since that sub-section limits providers of personal care to non-family members. However, 42 CFR 440.167(b), which is largely identical to 42 USC 1396d(a)(24), clarifies that for the purposes of personal care, "family member means legally responsible relative." The Freemans no longer have legal parental

clause is (A): personal care services are "authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State." 42 U.S.C. § 1396d(a)(24) (emphasis added). In Washington, personal care is not authorized by a physician but is authorized for the individual in accordance with a service plan approved by the State. See WAC 388-106-0010 (definition of "plan of care"). The service plan approved for the Appellant here, as for all state recipients of personal care services, is for personal care as defined in WAC 388-106-0010. That rule defines personal care as "physical or verbal assistance with activities of daily living (ADL) and instrumental activities of daily living (IADL) due to your functional limitations." ADLs and IADLs are also defined in the rule. Because the federal definition of personal care defers to the state service plan, the specific tasks that make up personal care are only what the state defines them to be (subject to approval by the federal Centers for Medicare and Medicaid Services). Since the state definition obviously does not encompass passive supervision or other habilitative services, those activities are not personal care services.

The ALJ next finds that sub-section (13), the catchall sub-section of 42 U.S.C. § 1396d(a), covers the services provided by the Freemans. Breaking down that section into its essential elements, she notes that the Freemans are providing "remedial services" which were recommended by a physician "for the maximum reduction of physical or mental disability and restoration of Faith to the best functional level." She bases that determination on a declaration from Dr. deGive (Exhibit 21) that uses those words verbatim. However, that declaration only identifies "supervision" and "assistance" as the services he is recommending. By way of clarification, the declaration specifically references Dr. deGive's EPSDT screening, which states "[p]atient requires 2417 supervision," and further notes that Faith has no concept of personal danger, cannot take the bus by herself, and has no concept of money. In his testimony Dr. deGive said virtually the same thing (as noted in Finding of Fact 29). Thus, the services at issue, according to Dr. deGive, are protective supervision, assistance with taking the bus, and assistance dealing with money. Likewise, Dr. Sciarrone recommended that Faith receive round-the-clock supervision and "[aid] in self care activities such as toilet and bathroom use." Exhibits 34, 38.

Money management is an instrumental activity of daily living (IADL) under WAC 388-106-0010, as is taking the bus (at least to medical appointments). Toilet use is an activity of daily living (ADL) under WAC 388-106-0010. Those activities are already part of the CARE assessment determination of personal care hours, and need no further prescription or reimbursement. If Dr. deGive mentioned money management and taking the bus only as examples rather than as the complete list of activities for which Faith needs assistance, he was still referring to her general need for assistance with personal care tasks for which the Department already compensates the Freemans. Thus, the only non-compensated service either Dr. deGive or Dr. Sciarrone recommended was supervision.

But supervision is not a Medicaid service, since it is not remedial and does not reduce disability or restore Faith to her best functional level. The term "remedial" is not defined in federal statute or rules. It is defined in Webster's II New

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responsibility for Faith, and Washington has not interpreted the phrase "legally responsible relative" to include guardians. Thus, although the services at issue here are not personal care services, the Freemans can (and do) provide personal care services to Faith.

College Dictionary as "1. Providing a remedy; 2. Meant to correct, esp. poor study or reading habits." Supervision is not a remedy, nor is it intended to correct Faith's judgment. Rather, it is intended to compensate for Faith's judgment when it threatens to put her at risk.

Even if supervision could be characterized as remedial, it does not reduce Faith's disability or restore her to her best functional level. Indeed, it has no effect on her disability at all, since her disability is essentially static, as Dr. deGive himself noted. And it does not restore her to a functional level at which she had previously been. It is a maintenance activity. It helps keep Faith from harm due to her impaired judgment. Simply because Dr. deGive's declaration carefully uses the wording of the federal statute, his recommendation of "supervision" is not therefore transformed into a medically necessary service any more than if he had recommended that Faith eat green vegetables or wear warm clothes in the winter. His recommendation may be valid and helpful, 'but it is not for compensable services under Medicaid.

To be sure, Mr. Freeman testified that he and his wife did other activities with Faith that are presumably beneficial for her, such as including her in all family activities and helping her to become more independent with her ADLs. However, those are not the activities recommended by either Dr. deGive or Dr. Sciarrone. The doctors only recommended supervision and personal care tasks.

It is worth noting here that no case law supports the assertion that supervision is a compensable service under EPSDT. Although a number of cases have examined the scope of services covered by the EPSDT mandate, the Department has been unable to find any that have not involved the provision of professional, skilled services; none have involved the kind of passive, unskilled "supervision" at issue here. Conclusions of Law 26 through 28 review much of the relevant case law,¹² and the ALJ acknowledges that all of them involve skilled professionals or a medical supply. They are all self-evidently medical services. The ALJ's order that the state pay family members for providing simple monitoring and oversight far exceeds the boundaries established in federal court for medically necessary services.¹³

In short, the services recommended by Dr. deGive and Dr. Sciarrone are not medically necessary services within the meaning of federal or state rules, and are therefore not compensable under EPSDT.

B. Even If Supervision Were Considered Medically Necessary And Thus Compensable, The Department Has Not Contracted With The Freemans To Provide It, And Would Not Do So In Any Event

It is certainly true that clients are supervised in Department programs that are funded by Medicaid. However, supervision is not a separate service for which a provider is paid a specific hourly rate. Rather, it is part of a package of services

¹² The ALJ might also have added *Chisholm v. Hood*, 133 F. Supp. 2d 894 (E.D. La. 2001) (involving services from a licensed psychologist) and *Pittman ex. rel. Pope v. Sec y, Fla. Dept of Health & Rehab. Servs.*, 998 F.2d 887 (11th Cir. 1993) (involving organ transplants), and she could have noted that in *Rosie D. v. Romney*, 410 F. Supp. 2d 18 (D. Mass, 2006), the state was criticized by the Court for relying on providers who lacked requisite skills and training.

¹³ It should be noted here that Mr. Freeman has calculated that the Department owes Faith - who in turn owes her parents - approximately \$250,000.00 in back payments. While cost is not a consideration in mandatory Medicaid services, this is an extraordinary amount for 3 years of providing the same service for Faith that the Freemans had provided for the previous 18 years - essentially, being available for their daughter.

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provided by facilities or supported living providers. In adult family homes, providers are paid a daily rate based on the overall needs of the client. Testimony of Kris Jorgensen-Dobson. Group homes and supported living agencies are paid a per-client rate which takes into consideration the overall needs of the client. Testimony of Saif Hakim. The client's need for supervision is a consideration in each of those settings, but it is the setting itself =adult family home, boarding home, or supported living service- that is the Medicaid service.

But even - if supervision were considered a separately compensable service, the Department is still not required to pay for that service in whatever setting and by whichever provider the client requests. If Department funds can be construed as paying for supervision at all, such funds do so only in certain defined settings over which the Department has considerable oversight. It does not authorize or pay for supervision in a client's home except when the client is in a supported living program.

In this case, the Freeman's told the Department that it must pay for their daughter's supervision needs, and that they were the persons who would provide the supervision. As their daughter's guardians, they were certainly entitled to speak on her behalf and to express her choice of providers. However, a client's choice of providers is limited to qualified providers (42 C.F.R. § 441.61(b); 42 C.F.R. § 431.51(b)(1)(i)), and the qualification necessary for the provision of supervision is licensure as an adult family home or boarding home, or certification as a supported living provider. The Freemans are not qualified providers of supervision since their house is not a licensed AFH or boarding home, nor are they certified providers of supported living services.¹⁴ Moreover, the Department never entered into a contract with them to provide supervision, since the Department does not contract with individual providers to provide supervision.

When clients choose to live in their own homes, the Department expects that any extra needs they have - beyond those for which the Department pays - will be met through informal care. When needs exist for which informal care is unavailable, the Department offers other residential options. Faith Freeman has been eligible for admission to an adult family home since she turned eighteen and became Medicaid and EPSDT eligible. The Freemans have rejected that option and kept Faith at home. Testimony of Mr. Freeman. At the same time, they have asserted that supervision of Faith must be a paid service. They cannot do both. To the extent supervision is a paid service, it is paid in certain settings only. If the Freemans believe that persons providing supervision of Faith must be paid, then they must place her where that can occur. The most appropriate setting for paid supervision of Faith would be an adult family home, since it is a home-like environment within the community that would provide the same personal care services that Faith currently receives.

In testimony, Mr. Freeman indicated that adult family homes were inadequate to meet his daughter's care needs. As evidence, he stated that "one of the best" adult family homes was in his neighborhood, but that it was dirty and housed ten unrelated adults. Mr. Freeman can certainly testify to his observations, but he is not qualified to pronounce on how one adult family home compares to all others. Furthermore, if his observations were accurate, the home was in violation

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¹⁴ The fact that the Freemans are not qualified providers of supervision does not, of course, mean that they are incompetent to do so. Family members are often capable of providing unskilled and even some skilled services. However, the Department properly does not pay anyone for providing a service for which he or she has not met the specific qualifying criteria.

of Department requirements, since AFH's are permitted to house no more than six unrelated adults and are required to maintain strict hygiene standards. See RCW 70.128.130(2); WAC 388-76-10000; WAC 388-76-10685 through 10795. Indeed, adult family homes are highly regulated, and are subject to unannounced inspections. Chapter 388-76 WAC. Thus, the home would absolutely not be "one of the best" if Mr. Freeman's description were accurate. The Freemans may choose not to place Faith in an adult family home, but there is no basis to find that such a placement would not meet Faith's needs.

The fact that Dr. deGive specifically identified the Freemans as the persons who should provide supervision for Faith is irrelevant to the question of who can or must provide the paid service. As a physician, he is authorized to define what sort of medical treatment a patient needs, but he is not authorized to say which practitioner must provide the treatment. He can no more specify the particular provider for supervision than he can name a particular podiatrist or optometrist that a patient must see - especially if (as would be analogous here) the podiatrist or optometrist he recommended had not passed the requisite boards for that specialty.

In summary, even if supervision were a separately compensable Medicaid service, the ALJ's conclusion that the Department is required to pay the Freemans for providing it is inapposite. The Department has had no contract with the Freemans to provide such a service, and an ALJ cannot order the Department to pay on a non-existent contract. More importantly, the Department would not contract with the Freemans for this service, since it does not contract with individual providers for this service. The Department only contracts for this service with agency providers who supervise clients as part of a package of services over which the Department has a significant level of oversight.

C. Because Annual CARE Assessments Must Be Reviewed On The Evidence Available At The Time, The Determination By DDD Of Personal Care Hours For Faith Freeman In 2004, 2005, And 2006 Should Be Affirmed

In Conclusion of Law 32, the ALJ states that were she not to have found the Appellant eligible for compensable care hours under EPSDT, she would have applied the determination of personal care hours from the 2007 CARE assessment to the previous three years. However, to do so would be clear error, since the very purpose of an annual assessment is to make a determination of care needs based on that year's assessment. Each assessment is independent of the one before and the one following, and they must all be reviewed on their own merits. The Department would not seek an overpayment if a new assessment awarded fewer hours than the previous year,¹⁵ and should not make retroactive payments when a new assessment awards more hours than previous assessments unless there was an error in the assessment based on the information available at the time. The fact that an ALJ reviews an assessment de novo does not mean that subsequent assessments should affect the assessment at issue. This is true even where, as here, the Department has stipulated that the rule requiring review of the most recent CARE assessment (WAC 388-106-1310)

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¹⁵ If, for example, a new medical assessment determined that Faith did not have aphasia after all, the Department would not seek reimbursement from the Freemans for the additional hours incorrectly awarded due to the earlier diagnosis.

would not act to prevent the 2005 and 2006 assessments from being reviewed on their merits.¹⁶

CARE assessments are based on a 7-day look-back period for ADLs and 30-day lookback period for IADLs (WAC 388-106-0010), and involve a careful interview of the client and family by the case manager. An item might be wrongly coded if, say, a respondent misunderstood the assessor's question and thus provided incorrect information in response, or the assessor failed to follow directions as to level of support needed for an ADL. But an item would not be wrongly coded simply because a respondent wished to change his or her answer at some later date, or as noted above, if a new assessment arrived at a different determination of hours.

The testimony of Kris Jorgensen-Dobson and Mr. Freeman was consistent insofar as both agreed that considerable time and care went into all of the assessments. Ms. Jorgensen-Dobson immediately shared with the Freemans almost everything she wrote down during the interview, and the Freemans asked frequent questions. Ms. Jorgensen-Dobson always forwarded the pending assessment for the Freeman's review prior to finalizing the document, and Mr. Freeman then made a number of comments and corrections on the assessment document. See, e.g., Exhibit G at 27; Exhibit H at 28. He also testified in cross examination that if he did not specifically object to an item, he could be assumed to agree with what the assessment said.

In this case, potential errors affecting the determination of total hours in 2005 and 2006 were alleged regarding the ADLs of eating, toilet use, locomotion outside room, and medication management. Regarding the first three, Kris Jorgensen-Dobson testified that she failed to consider the time Faith spent in school when she (Ms. Jorgensen-Dobson) administered the 2004 and 2005 assessments, but did include that consideration in the 2006 assessment. She noted that Faith was in school 6 hours per day, 5 days per week, or approximately 130 hours per month.¹⁷ Thus, because Faith would be sleeping about half the remaining time, it was reasonable to allocate at least one quarter of the assistance she needed for eating, toilet use, and locomotion outside room¹⁸ to the school.

Regarding toilet use in particular, Mr. Freeman testified that Faith has always needed the same level of assistance as she currently does, but that level was not reflected in the 2005 assessment. However, Kris Jorgensen-Dobson testified that she recorded the level of assistance based on the input from the Freemans at the time of each assessment. The Freemans did not challenge the determination in 2004 and 2005 that Faith required limited assistance. It was only after the determination was made in 2006 that Faith required more than limited assistance that any claim was made that the 2005 assessment was in error. Mr. Freeman provided no credible testimony that a misunderstanding or miscoding occurred at the time of the 2004 or 2005 assessment. Thus, there is every reason to believe that the questions regarding toilet use were properly asked, and the

¹⁶ The Department did not stipulate that the 2004 assessment also could be reviewed. That assessment was thoroughly reviewed in the hearing on Docket No. 09-2004-A-0143, and the remand order from superior court did not include revisiting the factual determinations of that part of the hearing. The 2007 assessment was separately appealed under Docket no. 08-2007-A-1618

¹⁷ This figure was confirmed by Mr. Freeman.

¹⁸ The determination that Faith's need for assistance with locomotion outside room was partially met $\frac{1}{4}$ to $\frac{1}{2}$ of the time was based not just on school but on informal support provided by the Freemans. Since the Freemans have declined to provide any unpaid informal support, this should have been recorded as partially met $\frac{1}{4}$ to $\frac{1}{2}$ of the time. This change would not affect Faith's total hours.

determination of the level of assistance needed was properly based on the responses to the questions.

Regarding medication management, a question was raised in hearing as to whether crushing medications and putting them in food was properly coded as "assistance required" in 2005 and 2006. While the criteria for self performance for most ADLs is defined under "Self performance for ADLs" in WAC 388-106-0010, self performance with medication management has a separate definition within that rule ("Assistance with medication management"). Sub-section (b) of that definition notes that medication management should be coded as "assistance required" when, among other things, the client uses an enabler to help her get the medication into her mouth, or the medication is altered for administration. Thus, "assistance required" was the appropriate category in 2005 and 2006.¹⁹

No other item was identified in the 2005 or 2006 CARE assessments that, if altered, would affect the total hours of personal care determined by the assessment. Therefore, the determination of personal care hours in those assessments should be affirmed.

V. CONCLUSION

The Corrected Initial Order is improper on both bases by which it found that Faith Freeman is entitled to retroactive payments. First, she is not entitled to payments for supervision provided by her parents. "Supervision" is not a separately reimbursable service under Medicaid, and even if it were, it is not reimbursable to individual providers. Second, she is not entitled to payments for personal care services based on assessed need in subsequent years. Because the CARE assessments for 2004, 2005, and 2006 were accurate based on the information available at the time, the determination of personal care hours for those years should be affirmed, and the Corrected Initial Order should be reversed.

9. On July 31, 2008, the Appellant, believing that the Department's petition was untimely, moved to dismiss it. The motion stated, in part:

Respondent DSHS filed its petition for review of the initial order in this case more than twenty-one days after the initial order was mailed. DSHS has failed to invoke the subject matter jurisdiction of this tribunal. Its request for review should be dismissed.

I. FACTS

Administrative Law Judge Jane Habegger mailed an initial order in this matter on June 27, 2008. See first page of order, exhibit 1. The deadline to request review of that decision expired on July 18, 2008, WAC 388-02-0035, 388-02-0580. On July 2nd, 2008, DSHS noted clerical errors in the order as defined in WAC 388-02-540 and requested a corrected order under 388-02-545. DSHS did not request an extension of the deadline for requesting review. See exhibit 2. Judge 000030 S

¹⁹ The change of coding to "must be administered" in the 2007 assessment related to the additional need to apply topical medication. Testimony of Kris Jorgensen-Dobson.

Habegger issued a corrected initial order on July 3, 2008. See first page of order, exhibit 3.

On July 22nd, 2008, DSHS filed a petition for review of the initial order. See first page of request for review, exhibit 4. DSHS's petition was filed after the deadline for requesting review and should be dismissed. The Board mailed notice of DSHS's request for review on July 24, 2008. The deadline to respond to DSHS's request for review expires Monday, August 4, WAC 388-02-035.

II. ANALYSIS

DSHS had clear notice of the deadline for filing a request for review, WAC 388-02-0580. By filing its request after the deadline, DSHS has failed to invoke the Board's subject matter jurisdiction. Its request for review is properly subject to dismissal, *Corona v. Boeing*, 111 Wn.App. 1, 6-7, 46 P.3d 253 (2002).

DSHS must be held to the same standard that it holds administrative appellants to. In *Ruland v. State*, 182 P.3d 470 (2008) appellants filed their request for administrative review after the 30 day filing deadline. DSHS moved to dismiss, arguing that the untimely filing deprived the ALJ of jurisdiction to hear it, *Ruland*, 473. The ALJ disagreed, but the Board of Appeals dismissed the appeal, "finding that Ms. Ruland's failure to follow proper appeal procedures deprived the ALJ of jurisdiction to hear the neglect finding." *Ruland*, 474. The Superior Court agreed, ruling that filing an appeal within the legally allotted time was a "jurisdictional prerequisite." *Ruland*, 474.

The Court of Appeals acknowledged that timely filing was a jurisdictional prerequisite. It reversed however, finding that since DSHS had actual notice of appellant's intent to appeal within the time limit the *Ruland*'s substantially complied. *Ruland*, 474, 475. It also found DSHS equitably estopped from moving for dismissal based upon representations made by the Department's AAG and CPS supervisor to the *Rulands* and their counsel. *Ruland* 476. Nothing like those special circumstances appear in this case. DSHS is subject to the standard it urged upon the Court in *Ruland*.

It is impossible to substantially comply with a statutory time limit in the same way [as a service requirement]. It is either complied with or it is not.

Ruland, 475, quoting *City of Seattle v. PERC*, 116 Wn.2d 923, 928-29, 809 P.2d 1377. DSHS did not comply with the time limit here. There is therefore no assignment of error properly before the Board on the issues included in DSHS's belated request for review. "Appellate courts will only review claimed error which is included in an assignment of error." *Hines v. Data Line Systems*, 114 Wn.2d 127; 152, 787 P.2d 8 (1990) citing *Bender v. Seattle*, 99 Wn.2d 582, 599, 664 P.2d 492 (1983).

Judge Habegger's issuance of a corrected order did not change the filing deadline:

(1) When a party requests a corrected initial or final order, the ALJ must either:

(a) Send all parties a corrected order; or

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(b) Deny the request within three business days of receiving it.
(2) If the ALJ corrects an initial order and a party does not request review, the corrected initial order becomes final twenty-one calendar days after the original initial order was mailed.

(4) Requesting a corrected initial order for a case listed in WAC 388-02-0215(4) does not automatically extend the deadline to request review of the initial order by BOA. A party may ask for more time to request review when needed.

WAC 388-02-0555 (emphasis added). DSHS's rule could not be clearer. A request for a corrected initial order does not extend the deadline to request review. A party must request such an extension. DSHS did not. Its deadline to request review of the initial decision expired on July 18, 2008. Its request for review filed on July 22, 2008, should be dismissed for failure to meet the jurisdictional prerequisite established in its own rule.

In view of Appellant's motion to dismiss DSHS's request for review, Appellant hereby requests additional time to respond to DSHS request for review, should it not be dismissed.

10. On August 1, 2008, the Department filed a response to the Appellant's motion to dismiss that stated, in part:

The Appellant claims that the Department's Petition for Review of Corrected Initial Order should be dismissed as untimely. The claim is inapposite. While it is certainly true that the petition was filed after the deadline for the original initial order, it was filed well within the deadline for the corrected initial order. The latter order included a "NOTICE TO PARTIES" on its last page, in bold capital letters. That notice stated, in relevant part, "This order becomes final on the date of mailing unless within 21 days of mailing of this order a petition for review is received by the DSHS Board of Appeals" (Emphasis added). The Corrected Initial Order was mailed on July 3, 2008. The Department filed its petition on July 22, 2008, 19 days after the Corrected Initial Order was issued. Thus, the Department's petition was timely.

The Appellant misinterprets WAC 388-02-0555(2). That sub-section refers to the situation in which neither party requests review following issuance of a corrected initial order. In that situation, the corrected initial order becomes final 21 days after issuance of the original initial order. However, that is not the situation here, since the Department obviously did request review. (For that matter, the Appellant also requested review.) The rule pointedly does not say, "If the ALJ corrects an initial order and a party does not request review within twenty-one calendar days of the original initial order. . . ." Thus, all the rule indicates is the effective date of the order in the event review is not requested within the timeline of the corrected initial order.

The Appellant also misinterprets WAC 388-02-0555(4). That sub-section does not require that the deadline based on the original initial order be maintained unless more time is requested. Rather, it advises parties that they should not automatically expect an extension of the deadline following the issuance of a corrected initial order.

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In this case, the undersigned did in fact contact the Board of Appeals to confirm that the deadline for requesting review was 21 days after issuance of the corrected initial order, not the original initial order. On or about July 11, 2008, the undersigned spoke by phone with Shelly Tencza, Legal Secretary 3 at the BOA, who confirmed the deadline based on the corrected initial order. Declaration of Bruce Work (attached). Subsequently, on or about July 17, 2008, Ms. Tencza called the undersigned to reiterate that the relevant deadline was 21 days after issuance of the corrected initial order. Id.

Finally, even if Petitioner's interpretation of WAC 388-02-0555 were correct, WAC 388-02-0580(3) authorizes a review judge to accept a request for review after the deadline if the request is received within 30 calendar days after the deadline and good cause is shown. In this case, the deadline based on the original initial order was July 18, 2008. The Department's petition was submitted on July 22, 2008, 4 days later and well within the 30-day timeline. Good cause for late submission certainly exists, since (1) the corrected initial order specifically notified the parties a request could be submitted within 21 days of that order; (2) WAC 388-02-0555 is ambiguous; and (3), the BOA itself affirmed that the deadline was 21 days after issuance of the corrected initial order. WAC 388-02-0020 defines "good cause" as "a substantial reason or legal justification for failing to appear, to act, or respond to an action." Given the circumstances, there can be no doubt that the Department had good cause to submit the request for review when it did.

11. On August 6, 2008, the Appellant's attorney prepared and faxed to the Department's attorney a Reply to Response to Appellant's Motion to Dismiss. For some reason, this reply was not received at the Board of Appeals until August 22, 2008. The reply provided, in part:

Respondent DSHS admits it filed its petition for review more than twenty-one days after the initial order was mailed. It asks to be excused from complying with its own jurisdictional rules, rules which it tenaciously enforces against others. DSHS has failed to invoke the subject matter jurisdiction of this tribunal. Its request for review should be dismissed.

I. The ALJ's Order Did Not Extend the Deadline

DSHS's main argument is that the language of Judge Habegger's corrected initial order extended the deadline. This argument is desperate. When issuing a corrected order, an ALJ only changes clerical orders noted in the request for a corrected order, WAC 388-02-0540. The appeal deadline given in the original order was not an error, and therefore was not changed,

The language referred to by DSHS is standard language included in all initial orders to give parties notice of their appeal rights. If DSHS's argument is correct, then every corrected order automatically extends the appeal date. The fatal flaw in that argument is found in DSHS's own rule:

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Requesting a corrected initial order for a case listed in WAC 388-02-0214(4) does not automatically extend the deadline to request review of the initial order by BOA. A party may ask for more time to request review when needed.

WAC 388-02-0555(4). DSHS's argument contradicts its own rule and, if correct, renders it superfluous. Clearly, the rule controls. "Statutes must be interpreted and construed so that all the language used is given effect, with no portion rendered meaningless or superfluous." *State v. J.P.*, 149 Wn.2d 444, 450, 69 P.3d 318 (2003).²⁰

II. The Unappealed Portions of the Initial Order Became Final on July 18, 2008.

WAC 388-02-0555(2) clearly states that an unappealed order becomes final twenty-one days after the mailing date of the "original initial order." It is true that interlocutory appeals were filed by both parties following Judge Habegger's initial order on Appellant's motion for summary judgment. It is also true that Appellant, after consulting DSHS's rule, filed a timely appeal of select portions of Judge Habegger's order. Appellant did not appeal Judge Habegger's decision that EPSDT applied in this case, nor Judge Habegger's award of service hours under the CARE tool.

"Appellate courts will only review claimed error which is included in an assignment of error." *Hines v. Data Line Systems*, 114 Wn.2d 127; 152, 787 P.2d 8 (1990) citing *Bender v. Seattle*, 99 Wn.2d 552, 599, 664 P.2d 492 (1983). Under DSHS's own rule, the Board only has subject matter jurisdiction over those assignments of error filed with the Board twenty-one days after the mailing of the initial order. All other issues are final, WAC 388-02-0555(2).

III. The Deadline Was Not Extended.

Rather than consulting DSHS's WAC, DSHS counsel called a legal secretary at the Board. She apparently misinformed him about the effect of the corrected order. This did not extend the deadline. DSHS rule provides for deadline extensions:

A review judge may extend the deadline if a party:

- (a) Asks for more time before the deadline expires; and (b) Gives a good reason for more time.

WAC 388-02-0580(2). Ms. Tencza is not a review judge and so had no authority to extend the deadline. Mr. Work did not ask for more time, nor did he give a reason. He contacted her well before the July 18th deadline and had the same opportunity afforded the appellant to request review.

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²⁰ "Rules of statutory construction apply to administrative rules and regulations, particularly where . . . they are adopted pursuant to express legislative authority." *Cannon v. DOL*, 147 Wn.2d 41, 56, 50 P.3d 627 (2002). (quoting *City of Kent v. Beigh*, 145 Wn.2d 33, 45, 32 P.3d 258 (2001)).

IV. *Failing to Consult The Rule Is Not Have [sic] a Good Reason for Missing a Deadline.*

Finally, DSHS counsel asks for the acceptance of a late request under WAC 388-02-0580(3). The rule requires that the party show "good reason" for missing the deadline. Good cause requires "a substantial reason or legal justification" for failing to act. Examples of a substantial reason include hospitalization or inability to comprehend the language the notice was written in, WAC 388-02-0020(2). A common thread runs through both examples in the rule.. Good cause must be some circumstance beyond your control. Failing to consult and comply with your own rule is not such a circumstance.

The Department argues that (1) it reasonably interpreted the corrected initial order as changing the appeal deadline; (2) it couldn't understand its rule; (3) counsel's action of calling a secretary rather than consulting the rule insulates it from the rule. The first two reasons are not a substantial legal justification for relieving DSHS from its duty to comply with its rule. The third reason was not, as claimed by DSHS counsel, an action of the Board itself.

Missing the appeal deadline is not something that happened to DSHS beyond its control. It cannot present "good reason" as required by WAC 388-02-0580(3). Its inquiry to the Board's secretary was well within the appeal deadline. If counsel had turned to DSHS rule instead of the telephone to answer his question, he would not have been misinformed. It is nowhere near the level of the substantial reason required by WAC 388-02-0020. DSHS adopted a rule clearly defining the effect of the issuance of a corrected initial order on the deadline for appeal. All it needed to do was follow its own order. It did not, and the Board should apply the same consequence it applied to the Appellants who missed their appeal deadline in *Ruland v. State*. 182 P. 3d 470, 474.

By relying on a phone conversation with the Board secretary, DSHS counsel is essentially making an estoppel argument against the Board:

Under certain circumstances, where justice so requires, the application of equitable estoppel against a government agency may be warranted. Kramarevcky v. Dep't of Soc. & Health Servs., 122 Wash.2d 738, 743-44, 863 P.2d 535 (1993). This relief is of an extraordinary nature and will usually not be applied unless the equities are clearly balanced in favor of the party seeking relief. Id. at 744, 863 P.2d 535 . . .

A party asserting equitable estoppel against a state agency must show evidence of (1) an admission, statement, or act inconsistent with its earlier claim; (2) reliance on the statement; (3) injury to the relying party if the agency were allowed to contradict or repudiate its earlier admission; (4) the necessity of estoppel to prevent a manifest injustice; and (5) no impairment of government functions if estoppel is applied. Kramarevcky, 122 Wash.2d at 743-44, 863 P.2d 535. Agency rules also provide for estoppel against DSHS. See WAC 388-02-0495.

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Ruland at 476.

The first problem with DSHS claiming estoppel is that the party against whom they seek to apply it, Faith Freeman, made no statement inconsistent with an earlier claim. It claims a Board secretary made a statement inconsistent with DSHS rule. This does not give rise to estoppel against Ms. Freeman. Further, DSHS's reliance on the secretary's statement was not reasonable and therefore its imputed injury is not due to the Board secretary's representation. There is no manifest injustice to prevent here. DSHS must be held to its own rules. Finally, applying estoppel here would impair a government function. The proper administration of the appeal process requires compliance with appeal deadlines and the dismissal of appeals that fail to comply with them.

DSHS failed to invoke the subject matter of the Board on the issues contained in its request for review. It has not presented a good reason for that failure. It has no grounds for estoppel. Its request for review should be dismissed.

12. On August 14, 2008, the Appellant's attorney signed and mailed a Supplemental Reply to Response to Appellant's Motion to Dismiss to both the Board of Appeals and the Department's attorney. This supplemental reply was received by the Board of Appeals on August 15, 2008, and stated, in part:

The supplemental reply to Respondents' response to Appellants' motion to dismiss is submitted under the authority of the Board's notice of right to respond mailed on August 7, 2008. The purpose of this supplemental reply is to apprise the Board of additional relevant material that was discovered by Appellants' counsel after the submission of the first reply.

Fairness demands that DSHS be held to the same standard it demands of Appellants. In this case, that means dismissing appeals that are filed after the deadline. As recently stated by DSHS counsel in its June 8, 2008, motion to strike a pleading submitted after the deadline:

First, the Appellant is represented by counsel. A pro se appellant might not understand the importance of deadlines in legal matters, but attorneys certainly should. Attorneys cannot claim to be unaware of the potential consequences of the failure to take timely actions in a case....*

Second, the essential feature of a deadline is that it is a requirement, not a suggestion. WAC 388-02-0035(3) states that missing a deadline means that an appellant may lose the right to a hearing or appeal. Nowhere in Chapter 388-02 WAC is there any indication that deadline means anything other than its normal definition. Allowing the Response to be admitted in this situation would drain the word "deadline" of all meaning.

Third, even if there could be reasonable grounds to allow documents to be submitted after a deadline has passed, no such grounds exist here. ...the explanations provided by Appellant's attorney have no claim of unavailability.

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**A deadline, as the word is universally defined and understood, is the date by which an action must occur. Websters New College Dictionary defines "deadline" as "1. A time limit, as for the payment of a debt or completion of an assignment. 2. A boundary line in a prison that prisoners can cross only at the risk of being shot."*

See exhibit 1.

DSHS's motion was, apparently, granted. All of the arguments brought forward by DSHS apply with equal force to its failure to meet the deadline in this case. DSHS counsel cannot claim ignorance of a standard that he himself stridently enforces. The word "deadline" means just what he says it does. Finally, he acknowledges that "good cause" requires unavailability. Failure to consult the Department's own rule is not such a circumstance.

The judicial policy of finality is an important part of due process. DSHS is just as subject to it here as it was in *Beckman v. DSHS*, 102 Wn. App. 687 11 P.3d 313 (2000), where it attempted to avoid the consequences of its failure to file a timely appeal:

The State was not "reasonably diligent" in attempting to file a timely appeal. Reichelt, 52 Wn. App. at 765-66. It fails to demonstrate "extraordinary circumstances" and "a gross miscarriage of justice" that would allow this court to overlook the late filing. RAP 18.8. Therefore, "the desirability of finality of decisions outweighs the privilege of a litigant to obtain an extension of time." The State's motion to extend time to file its notice of appeal is DENIED, and Respondents' motion to dismiss the appeal is GRANTED.

Beckman, at 696.

13. On September 4, 2008, the Board of Appeals received the Department's Response to the Appellant's Reply.²¹ This response stated, in part:

Per the notice issued by the Board of Appeals (BOA) on August 25, 2008, the Department of Social and Health Services, Division of Developmental Disabilities (DDD) hereby responds to the Appellant's reply to DDD's response to the Appellant's motion to dismiss DDD's petition for review of the Corrected Initial Order in this case.²²

I. ARGUMENT

A. The Notice On The Corrected Initial Order Specified The Proper Deadline

²¹ Review Judge footnote: See paragraph 11, page 20 - 23, *supra*, for the particular appellate brief from the Appellant to which this Department brief refers.

²² For reasons that are unclear, the Appellant's reply brief attached to the August 25 notice from the BOA is date stamped "Received August 22, 2008, DSHS Board of Appeals." Since the deadline for reply to DDD's response brief was ten days after August 7, 2007, the Appellant's brief appears to have been received by the BOA after the deadline. However, DDD received the Appellant's brief directly from Appellant's counsel on August 7, 2008. DDD therefore does not object to the Appellant's reply brief on the basis of untimeliness.

The Appellant first characterizes as "desperate" DDD's argument that the language of the corrected initial order extended the deadline to request review. Apart from the fact that the Appellant cannot know DDD's (or its counsel's) state of mind, the implication that DDD's position is legally weak is simply wrong. It was not just the language of the Corrected Initial Order that extended the deadline -it was the fact that the language was contained in a highlighted notice that stated that the deadline for requesting review from the BOA was "within 21 days of mailing of this order." (Emphasis added.) The express language of the notice cannot be read in any way other than that there was a new later deadline.

The Appellant claims that despite the express language of the notice, it should be disregarded because it is a standard notice on all initial orders. This argument suggests that OAH is either incapable of changing the notice or uninterested in any potential for misinterpretation by recipients. The first possibility is certainly untrue -OAH could easily change its notice language- and the second possibility adds no support to the Appellant's argument. Plain language notices cannot and should not be ignored simply because one suspects they are boilerplate. In this case, there is absolutely no reason to assume that OAH or Judge Habegger did not mean what the plain language of the notice indicated.

B. The Deadline Indicated By The Corrected Initial Order Is Not Contradicted By WAC 388-02-0555

WAC 388-02-0555(4) does not, as the Appellant argues, contradict DDD's position here. That rule states that "requesting a corrected initial order ... does not automatically extend the deadline to request review of the initial order by BOA." (Emphasis added.) In this case, DDD did not assume that requesting that the initial order be corrected would necessarily extend the deadline. It was only when the corrected order was issued with a new deadline that DDD reasonably concluded that the deadline had in fact been extended. To ensure that this interpretation was correct, DDD's counsel checked with BOA. Because both the plain language of the notice on the Corrected Initial Order and the statement from BOA indicated that the deadline had been changed, DDD did not request more time to file its request for review. DDD could obviously have made that request, but there was no reason to do so since no additional time was needed based on the new deadline.

The Appellant correctly paraphrases WAC 388-02-0555(2) to state that "an unappealed order becomes final twenty-one days after the mailing date of the original initial order." Reply brief at 2. However, there was no unappealed order in this case -the corrected initial order was appealed by DDD (as well as the Appellant). As noted in DDD's previous briefing on the matter, the rule would need additional language in order to be read as precluding DDD's request for review in this case.

The Appellant also correctly notes that the deadline was not extended by Ms. Tencza. DDD does not suggest that it was. Rather, Ms. Tencza simply confirmed the proper deadline. DDD did not request an extension because, as previously noted, it did not need one. Furthermore, the Appellant's discussion of equitable estoppel is irrelevant, since DDD is not asserting that it relied on Ms. Tencza's statement. Rather, it relied on the notice from OAH, a separate state agency; Ms. Tencza merely confirmed that DDD's counsel and the BOA had the same understanding of the situation.

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DDD has been unable to find any cases specifically on point. However, *Ruland v. State, Department of Social and Health Services*, 144 Wn. App. 263 (2008) is indirectly instructive, though not in the way suggested by the Appellant.²³ In that case, the Court of Appeals overturned the BOA's determination that an ALJ lacked jurisdiction to hear a case because the appellants missed a filing deadline. The Court noted that the appellants reasonably misunderstood the deadline and substantially complied with the statutory procedural requirements. *Id.* at 273-275.

Here, DDD had a solid basis for its understanding of the appropriate deadline. The rules that the Appellant claims contradict that understanding do so, if at all, only under one of several possible interpretations. In *Ruland*, by contrast, the statute at issue was unequivocal.²⁴ DDD's actions are thus more justified than the appellants in *Ruland*, and there should be no finding that it exceeded the deadline for requesting review of the initial order in this case.

C. DDD Had Ample Justification And Therefore "Good Cause" For Its Determination Of The Proper Deadline

Finally, the Appellant claims that DDD lacked good cause for missing the deadline. Since DDD did not in fact miss the deadline, good cause is irrelevant. However, in the event the Appellant's interpretation of WAC 388-02-0555 is upheld by the BOA, DDD's actions certainly were supported by good cause. The criterion for a showing of good cause is not that there was a circumstance beyond DDD's control, as the Appellant claims. Rather, WAC 388-02-0020(1) states that "good cause is a substantial reason or legal justification" for failing to act.²⁵ (Emphasis added.) The examples in WAC 388-02-0020(2) are simply that: nonexclusive examples. Here, the clear notice on the Corrected Initial Order, confirmation by the BOA, and language in WAC 388-02-0555 that is amenable to several interpretations constitute substantial reason and legal justification for submitting DDD's brief within the deadline set by the Corrected Initial Order.

II. CONCLUSION

For the reasons discussed above, the Appellant's motion should be denied and DDD's petition for review of the Corrected Initial Order should be admitted.

14. On August 25, 2008, the Board received the Department's Response to Appellant's Supplemental Reply. As noted before, one of the Appellant's replies had been

²³ The Appellant oddly urges BOA to apply the same standard it did in *Ruland* (Reply brief at 4), even though the Court overturned BOA's order in that case.

²⁴ RCW 26.44.125(2) ("Within twenty calendar days after receiving written notice from the department under RCW 26.44.100 that a person is named as an alleged perpetrator in a founded report of child abuse or neglect, he or she may request that the department review the finding. The request must be made in writing. If a request for review is not made as provided in this subsection, the alleged perpetrator may not further challenge the finding and shall have no right to agency review or to an adjudicative hearing or judicial review of the finding.")

²⁵ WAC 388-02-0020(1) also notes that the provisions of CR 60 should be used as guidelines. Those provisions relate to relief from a judgment, so are not clearly applicable to this situation. Nevertheless, they are by no means all circumstances beyond one's control. For example, a judgment, may be overturned due to mistake, inadvertence, misconduct of an opposing party, or "any other reason justifying relief from the operation of the judgment." CR 60(b).

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delayed in its appearance at the Board of Appeals and therefore the Board received them "out of order." The Department's response stated, in part:

In his supplemental reply, Counsel for the Appellant has attached a brief - written by the undersigned for another administrative hearing - for the apparent purpose of showing that the Department's position on deadlines differs depending on the case. However, a review of the facts of that case demonstrates that the Department's position is consistent in that case and this. There is no conflict between the Department's assertion there that deadlines are important and its assertion in this case that its petition for review was timely.

In the Kauzlarich case, counsel for the Appellant submitted documents two weeks and six weeks after the deadlines established in a pre-hearing order. There was no ambiguity regarding what the deadlines were. Counsel's explanation for why she failed to meet the deadlines did not meet the standard of "good cause" as defined in WAC 388-02-0020, according to both the ALJ and Review Judge involved in the case. And she had repeatedly missed deadlines in that and related cases.

In contrast, as noted in the Department's response to Appellant's motion to dismiss in this case, the Department's petition for review was not submitted after the deadline at all. The deadline for the petition was 21 days after the Corrected Initial Order was issued. Counsel dismisses the fact that the deadline instructions were plainly written on the Corrected Initial Order (in bold capital letters), and asserts that the order only corrected those aspects of the original Initial Order that were requested to be changed. It is unclear how Counsel knows this, since he provides no support for that assertion.²⁶ Instead, he infers that that the Office of Administrative Hearings knowingly left the wrong deadline instructions on the Corrected Initial Order, apparently assuming that those instructions would be ignored. Nothing in the Corrected Initial Order supports that view. At the very least, the notice on the Corrected Initial Order raises reasonable doubt about the deadline, which is categorically different from either the Kauzlarich or Beckman cases cited by counsel in those cases, there was no question whatsoever what the deadlines were.

Had the appellant in the Kauzlarich case submitted the documents within the timeframe indicated on a plain language notice from the tribunal, the undersigned absolutely would not have moved to have the documents stricken, even if the prehearing order or even Department rules set a different deadline.

That sort of situation creates a reasonable presumption of a deadline, even if it is in conflict with some other standard. Any party has the right to rely on clear statements from the issuing tribunal, and there is simply no way a party could be faulted for accepting that the terms of the notice were exactly as stated. It is appropriate to try to clarify any ambiguity,²⁷ but even if no attempt were made to do so, the party should not be held to any other deadline.

The appellant's attorney in the Kauzlarich case did not submit documents within any presumed or established deadline. She submitted the more significant

²⁶ In his first reply brief, counsel cites WAC 388-02-0540 as support for the claim that "an ALJ only changes clerical errors noted in the request for a corrected." However, that rule does not say that. And even if it did say that, that does not imply that because notice instructions were left unchanged they still apply to the date of the original initial order, not to the corrected initial order.

²⁷ This is what the undersigned did in this case by consulting the BOA as to the correct deadline.

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of the two documents six weeks after the deadline. She did not claim that she believed the deadlines to be other than what they were. Therefore, the comparison between that case and this is inapt.

In short, counsel's attempts to draw parallels between the Kauzlarich case and this are entirely misplaced. The undersigned does not seek to hold appellants to stricter standards than he holds himself.

15. The Appellant's July 31, 2008, Motion to Dismiss also contained a conditional request for an extension of the deadline of the time to respond to the Department's Petition for Review filed on July 22, 2008.²⁸ The undersigned granted that request on September 11, 2008, and sent out an order to the effect that the deadline for the Appellant to file a response was extended to September 22, 2008. On that date the Appellant filed two responsive pleadings. The first was to the Department's appeal from the Amended Initial Order entered on March 21, 2008, and provided, in part:

DSHS asserts that the ALJ erred in ruling that Appellant was entitled to Medicaid Personal Care Services (MPCS) retroactive to her first date of eligibility, July 1, 2001. The fact that it took longer for DSHS to process her eligibility does not change the date of eligibility.

DSHS must pay for Medicaid services retroactively up to three months prior to the date of application. 42 U.S.C. 1396a(a)34. Further, that eligibility extends to the first of the month if the individual was eligible at any time during the month. 42 C.F.R. 914(2)(b). Faith applied for Medicaid benefits in July of 2004. She became eligible for those benefits when she turned 18 on July 18, 2004. Although DSHS did not complete its determination until August and did not start payments until September, Faith is entitled to coverage from July 1, 2004, forward.

This is highlighted by WAC 388-106-0225: "If you live in your own home, you do not participate toward the cost of our personal care services." By leaving a two month gap between Ms. Freeman's eligibility for personal care services and DSHS's provision of payment, DSHS required Ms. Freeman to pay for her own services in violation of WAC 388-106-0225.

The ALJ's order of retroactivity of benefits is lawful and should be affirmed.

The second brief filed by the Appellant on September 22, 2008, was in response to the Department's appeal from the Corrected Initial Order dated July 3, 2008, and provided, in part:

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²⁸ See, paragraph 9, on page 19, *supra*.
REVIEW DECISION & FINAL ORDER
Docket No. 09-2004-A-0143 DDD Freeman
Docket No. 11-2005-A-1878 DDD Freeman
Docket No. 12-2006-A-0855 DDD Freeman

I. Introduction

Throughout the term of this litigation, DSHS has sought to impermissibly limit the review of its actions. That strategy ultimately failed, first before the Thurston County Superior Court, and then before the ALJ. DSHS continues its failed strategy in its request for review.

DSHS argues Appellant's entitlement under EPSDT is limited by the terms of the State Medicaid plan, despite the federal statute's clear prohibition of that limitation, 42 U.S.C. 1396d(r)(5). DSHS further argues that the ALJ's review of the CARE assessment be limited to the facts known to the assessor at the time. That is, it argues that the ALJ should be limited to appellate, rather than original, jurisdiction. DSHS is wrong on both counts.

The ALJ correctly applied the law, both state and federal, to the facts properly admitted into evidence before her, with the exceptions noted in Appellant's request for review. DSHS's request for review is without merit and should be rejected.

II. Analysis

A. The ALJ Correctly Applied EPSDT

1. The ALJ Correctly Identified the Analysis Required Under EDSDT

The ALJ painstakingly analyzed the appropriate EPSDT analysis under both federal and state law. She quoted the appropriate statutes and rules, COL 10 - 15. Conclusion of Law nos. 21 and 22, which DSHS acknowledges are correct, succinctly summarize the correct standard of law to be applied in the EPSDT analysis. The ALJ then correctly applied that law:

The court in Rosie D. v. Romney, 410 F.Supp.2d 18, 26 (2006) defines the EPSDT program broadly and stated: "Courts construing EPSDT requirements have ruled that so long as a competent medical provider finds specific care to be "medically necessary" to improve or ameliorate a child's condition, the 1989 amendments to the Medicaid statute require a participating state to cover it. "

Conclusion of Law no. 30

2. The ALJ Correctly Found the Services Prescribed by Appellant's Physician Qualified as Medicaid Personal Care Services.

Conclusion of law no. 16 correctly characterizes the services requested by Appellant as Medicaid Personal Care Services (MPCS). DSHS does not dispute that the supervisory services are within the scope of the federal definition of MPCS. Indeed its rule defining Personal Care Services used to include supervisory services:

(38) "Personal care services" means both physical assistance and/or prompting and supervising the performance of direct

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personal care tasks and household tasks, as listed in subdivisions (a) through (q) of this subsection. Such services may be provided for clients who are functionally unable to perform all or part of such tasks without specific instructions. Personal care services do not include assistance with tasks performed by a licensed health professional.

(m) "Supervision" means being available to:

- (i) Help the client with personal care tasks that cannot be scheduled, such as toileting, ambulation, transfer, positioning, some medication assistance; and
- (ii) Provide protective supervision to a client who cannot be left alone because of impaired judgment.

WAC 388-15-202, Long-term care services definitions, repealed in 2003, exhibit 42. Although DSHS has exercised its discretion not to provide supervisory care to the general Medicaid population, the authorization of the benefit in DSHS's own rule establishes that it is within the scope of the federal definition of personal care services available under Medicaid. Appellant's guardian testified that he accepted the definition in former WAC 388-15-202(38)(m) as defining the scope of supervisory services he sought on behalf of Faith Freeman.

DSHS's refusal to provide benefits that are clearly covered recall the underlying facts in *S.D. v. Hood*, 391 F.3d 581 (5th Cir. 2004). The benefit at issue was incontinence underwear prescribed for a teenage Medicaid beneficiary who was totally incontinent as a result of spina bifida. The State denied coverage, saying that incontinence underwear is not medical in nature or within the scope of the Medicaid program. The diapers were specifically excluded from coverage in State rules.

The Court held that the exclusion of incontinence supplies under EPSDT was improper because they are "unquestionably within the scope of services fundable under § 1396d(a)". The Court noted that the federal Medicaid agency has approved other state plans which included incontinence supplies, thus surmising that the service must be coverable under § 1396d(a). In this case the tribunal need look no further than Washington's own state plan to see that supervisory benefits were included in an approved state plan and thus, are coverable under §1396d(a).

DSHS argues that the language in 42 U.S.C. §1396d(a)(24) defining "personal care services" in part as "authorized for the individual by a physician in accordance with a plan or treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan provided by the State." overturns the EPSDT prohibition on applying limitations in the State Medicaid Plan to EPSDT and instead incorporates those limitations. This argument fails for several reasons.

First, the unambiguous language of the federal definition is inclusive, not exclusive. It provides that qualifying services are those personal care services are either: 1) are authorized by a physician in accordance with a plan or treatment; or 2) authorized under a service plan approved by the State. Either method of authorization qualifies, as long as the services fall within the federal

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definition of "personal care services." For the non-EPSTD Medicaid population, DSHS is not required to provided all personal care services that fall within the federal definition. For the EPSTD population, it must provide all such services.

A state's (Medicaid) plan must provide coverage to seven designated classes of needy individuals, termed "categorically needy," for at least seven specific kinds of medical care or services. See §1396a(a)(10)(A)(I), - (a)(17), 1396d(a). . . . Additionally, the state may choose to expand the care and services available under its plan beyond the seven mandated categories. See § § 1396a(10)(A), 1396d(a) (defining "medical assistance" by enumerating twentyeight types of care and services). For example, a state must provide coverage for inpatient hospital and physicians services, but retains the option of covering private duty nursing or physical therapy services.

As broad as the overall Medicaid umbrella is generally, the initiatives aimed at children are far more expansive.

In other words, while a state may chose which medical services beyond the mandated seven it may offer to eligible adults, states are bound, when it is medically necessary, to make available to Medicaid-eligible children all of the twenty-eight types of care and services included as part of the definition of medical assistance in the Act. See *S.D. v. Hood*, 391 F.3d at 590 ("[E]very Circuit which has examined the scope of the EPSTD program has recognized that states must cover every type of health care or service necessary for EPSTD corrective or ameliorative purposes that is allowable under 1396d(a).")

The breadth of EPSTD requirements is underscored by the statues definition of "medical services." Section 1396d(a)(13) defines as covered medical services any "diagnostic, screening, preventative, and rehabilitative services, including any medical or remedial services ... for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.

Courts construing EPSTD requirements have ruled that so long as a competent medical provider finds specific care to be "medically necessary" to improve or ameliorate a child's condition, the 1989 amendments to the Medicaid statute require a participating state to cover it.

Rosie D. v. Romney, 410 F.Supp2d 18, 24 - 26 (2006) [emphasis in original].

DSHS's argument that supervisory care is not a MPCS service is really an argument that it is not provided within the current parameters of Washington's State Medicaid Plan. That assertion is true. It is also irrelevant.

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By 1989, Congress had become concerned that, because the original EPSDT health care, services and treatment provision was optional and not described in detail in the statute, many states had chosen not to provide EPSDT-eligible children all the care and services allowable under federal law. See Senate Finance Committee Report, 135 Cong. Rec. 24444 (Oct. 12, 1989) ... Congress therefore amended the Act in 1989 to mandate that a state agency must provide EPSDT eligible children "[s]uch other necessary health care described in [the Act's § 1936d(a) definition of medical assistance] to correct or ameliorate defects ... illnesses and conditions discovered by the screening services whether or not such services are covered under the State plan." 42 U.S.C. 1396d(r)(5).

S.D. v. Hood, 391 F.3d 581 at 589 (5th Cir. 2004) (emphasis added by Court). The ALJ correctly found that the services requested by Appellant fit within the allowable federal definition of MPCs services, just as they did prior to 2003.

DSHS's argument that the prescribed services are not MPCs services fails. Accordingly, its argument that Appellant's guardians are not qualified to provide those services fails. DSHS does not dispute that the ALJ's disqualification of Appellant's guardians was also an error. Therefore, the Board should uphold the conclusion that the prescribed services qualify as MPCs services and find that the Freeman's are eligible to provide those services.

3. *The ALJ Correctly Found the Prescribed Services Met the Requirements of 42 USC 1396d(a)(13).*

EPSDT requires that services prescribed by the treating physician be provided by a State if the services are medically necessary and meet the definitions of "medical services" in 42 USC 1396d(a). The ALJ correctly found that the prescribed services meet the definition of 42 USC 1396d(a)(13), COL 21 - 31. DSHS claims that the services prescribed by Dr. Sciaronne and Dr. deGive were not remedial and therefore did not meet those requirements. The ALJ carefully considered this question and, relying upon the expert opinion of Appellant's physician, held that the services were remedial and, therefore required under EPSDT.

4. *The ALJ Correctly Found that the Services Prescribed by Dr. Sciaronne and Dr. deGive were Medically Necessary.*

Appellant's physicians testified, and the ALJ found, that the services prescribed were medically necessary. Both Dr. deGive and the ALJ relied upon and referenced DSHS's rule defining that term, COL #9. DSHS argues that the treatment prescribed by Dr. Degive is not medically necessary. It is telling that, in making that argument, both before the Superior Court and before this Board, DSHS did not cite to its own definition:

"Medically necessary" is a term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that

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endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all.

WAC 388-500-0005. The treatment prescribed by Dr. DeGive is medically necessary under DSHS's own definition, i.e. it is necessary to alleviate conditions in Ms. Freeman that endanger her life, cause suffering or pain, threaten to aggravate a handicap, or cause physical malfunction.

Dr. deGive's testimony focused on the question of whether, in his opinion as an experienced treating physician, supervisory care was medically necessary for Ms. Freeman. Dr. deGive testified that Ms. Freeman has Trisomy 21. This a congenital condition whereby she lacks a chromosome found in persons without that condition. Dr. deGive gave extensive testimony about the physical limitations this condition imposes on Ms. Freeman. He specifically testified that protective supervision is reasonably calculated to correct, cure, alleviate or prevent worsening of conditions in the Ms. Freeman that endanger her life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. That is, the services are medically necessary under WAC 388-500-0005.

a. Medically Necessary Services are not Limited to Services of Medical Professionals.

DSHS correctly notes that EPSDT is limited to medically necessary services. It then argues that the ALJ erred by not limited those services to those provided by a certified medical professional. This argument was inconsistent with DSHS's own use of the term "medically necessary". DSHS employees Debbie Johnson and Chris Imhof identified a number of services that were not provided by a medical professional, yet were deemed medically necessary and compensated under Medicaid. See exhibit 41.

DSHS witness Gail Kreiger admitted under testimony that she limited EPSDT qualification to "skilled services provided by a licensed health care provider." She also admitted that this requirement was not part of the definition of "medically necessary" but was a separate requirement that she applied for reasons that do not appear in the record. Her EPSDT analysis was not a finding that the supervisory services were not medically necessary.

In Burnham v. DSHS, 115 Wn.App. 435, 63 P.3d 816 (2003), the court considered whether providing a trained canine companion to a mentally ill Medicaid patient was a covered service. "DSHS found that Burnham's service dog is 'medically necessary.' AR at 67. DSHS does not challenge that finding." Burnham, supra at 439. If a provider need not be human for his services to be medically necessary, then clearly there is no requirement that the provider be human, possess a medical degree.

b. Supervisory Care for Appellant is Medically Necessary.

WAC 388-500-0005 recognizes that "mere observation" qualifies as a medically necessary course of treatment. This portion of the rule was clearly drafted to enable the Department to provide the required treatment in the least expensive way possible, which belies DSHS's assertion that only the treatment of a licensed health care professional can qualify. Ms. Kreiger's attempts to explain away this portion of the WAC are not probative evidence of the rule's meaning.

"Rules of statutory construction apply to administrative rules and regulations, particularly where ...they are adopted pursuant to express legislative authority." *Cannon v. DOL*, 147 Wn.2d 41, 56, 50 P.3d 627 (2002). (quoting *City of Kent v. Beigh*, 145 Wn.2d 33, 45, 32 P.3d 258 (2001)). Statutory construction requires a two-step process: First an examination of the plain meaning of the statute; Second, if and only if there is a showing of ambiguity, the Court looks to extrinsic materials such as Legislative history.

The Court's fundamental objective is to ascertain and carry out the legislature's intent, and if the statute's meaning is plain on its face, then the Court must give effect to that plain meaning as an expression of legislative intent.

CAT v. Murphy, 151 Wn.2d 226, 242, 88 P.3d 375 (2004).

Moreover, we do not construe unambiguous statutes. *Whatcom County v. City of Bellingham*, 128 Wn.2d 537, 546, 909 P.2d 1303 (1996). "In judicial interpretation of statutes, the first rule is 'the court should assume that the legislature means exactly what it says. Plain words do not require construction.'"

Western Telepage v. City of Tacoma, 140 Wn.2d 599, 608, 609, 998 P.2d 884 (2000).

The plain language of the definition of "medically necessary" states in part: "course of treatment" may include mere observation or, where appropriate, no treatment at all." WAC 388-500-0005 (emphasis added). The language could not be clearer. DSHS has not claimed, let alone demonstrated, an ambiguity. Absent ambiguity, the tribunal need look no further than the plain language of the rule itself. "Course of treatment" includes mere observation. Supervision usually requires more than mere observation, but even if that were all it required, it would qualify as medically necessary. It is the needs of the client, not the scope of the services, that determines medical necessity.

B. The ALJ's CARE Ruling is Correct.

DSHS does not dispute any of the facts found by the ALJ regarding Appellant's CARE assessments. It argues, however, that the ALJ erred in considering facts other than those considered in the original assessment for each year. That is, DSHS argues that the ALJ has only appellate, and not original, jurisdiction.

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1. The ALJ's Review is De Novo.

State v. Breazeale, 99 Wn. App. 400, 408 [Reversed in part on other grounds, *State v. Breazeale* 144 Wn.2d 829, 31 P.3d 1155 (2001). ALJ Habegger correctly found that, Judge Tabor conferred jurisdiction on her to review the entire the 2004 CARE assessment, including application of the CARE rule. Indeed, WAC 388-106-1310 required her to engage in that review.

II. FINDINGS OF FACT

The undersigned has reviewed the verbatim transcript of the hearing, the Amended Initial Order, the Corrected Initial Order, the Appellant's Petitions for Review, the Department's Petitions for Review, as well as all the various motions and responsive pleadings and determines that the Findings of Fact are supported by substantial evidence in the record and are adopted as findings in this decision except as follows:²⁹ (1) where findings were not supported by substantial evidence in the record, they are struck through; and (2) where additional findings were needed, they are indicated by underlining.

1. This matter is before me pursuant to an Order issued by the Thurston County Superior Court on November 3, 2006. ~~The Court remanded the case to the Office of Administrative Hearings for further proceedings "consistent with this order".~~ Six conclusions of law were entered. The first recites the court's jurisdiction. The second states the scope of review. The third through the sixth are as follows:

3. *DSHS erred in failing to consider Ms. Freeman's eligibility for Medicaid benefits under the Early Periodic Screening Diagnosis and Treatment program under 42 USC 1396d(r) and 42 USC 1396a(10)(A).*

4. *DSHS erred in failing to allow Ms. Freeman to present evidence & argument on other federal claims raised in her Petition for Judicial Review.*

5. *DSHS did not err in not providing Ms. Freeman with a hearing on her constitutional claims.*

6. *Remanding this matter for further adjudicative proceedings before an Administrative Law Judge is an appropriate remedy under RCW 34.05.570(3)(f) where the agency has not decided all issues requiring resolution by the agency.*

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²⁹ WAC 388-02-0600(2) and RCW 34.05.464(8).
REVIEW DECISION & FINAL ORDER
Docket No. 09-2004-A-0143 DDD Freeman
Docket No. 11-2005-A-1878 DDD Freeman
Docket No. 12-2006-A-0855 DDD Freeman

The Superior Court entered the following order:

DSHS's Review Decision and Final Order is hereby vacated and this matter is REMANDED for further adjudicative proceedings before an Administrative Law Judge for further proceedings consistent with the Court's order. The Court reserves the issue of attorney's fees for a subsequent proceeding under this cause number.

2. On September 13, 2007, the Appellant filed a Motion for Partial Summary Judgment. The ALJ issued an Amended Initial Order on March 21, 2008, which granted in part and denied in part the Appellant's motion on various points at issue.

3. In the Amended Initial Order on the Motion for Partial Summary Judgment the ALJ ruled in relevant part as follows:

I. *The Appellant's request for summary judgment on the issue of whether the results of the 2007 CARE should be applied retroactively to 2004 is ORDERED DENIED.*

II. *The Appellant's request for summary judgment on the issue of whether the DSHS is bound by the Social Security Administration determination that Faith lives alone is ORDERED DENIED.*

III. *The Appellant's request for summary judgment on the issue of the retroactive application to the invalidation of the shared living rule is ORDERED GRANTED. The department shall recalculate Faith's CARE hours accordingly.*

IV. *The Appellant's motion for summary judgment on the issue of whether her procedural rights were violated due to the lack of adequacy of the notice from the DSHS and the failure to issue a timely order is ORDERED GRANTED. However, there is no remedy which I can order to address these issues.*

V. *The Appellant is eligible for Medical [sic] Personal Care Services commencing July 1, 2004.*

4. Faith Freeman is a 22 year old woman with Downs Syndrome who lives with and is cared for by her loving family. Faith turned 18 years of age on July 18, 2004. She began receiving Supplemental Security Income (SSI) benefits and medical assistance at that time. Faith turned 21 on July 18, 2007.

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5. In July 2004, Faith's parents filed an application for medical assistance with the Department on her behalf. The department determined that she was eligible for categorically needy medical assistance (*i.e.*, Medicaid) beginning September July 1, 2004.

6. A Comprehensive Assessment Reporting Evaluation (CARE) was completed by a department employee for Faith in 2004, 2005, 2006, and 2007, to determine her eligibility for Medicaid Personal Care (MPC). The 2004 CARE resulted in a determination that she qualified for 72 hours in part because of an application of the shared living rule. In the 2005 CARE the department determined that Faith qualified for 74 hours per month of MPC care. In the 2006 CARE the department determined that Faith qualified for 121 hours per month of MPC care. In 2007, another CARE resulted in a determination that Faith qualified for 190 hours per month of MPC. The department determined that this decision would be implemented after Faith's 21st birthday.

7. In determining that Faith qualified for SSI, the Social Security Administration determined that she qualified for a full grant as opposed to one for which she had "supplied shelter". In doing so, they recognized that Faith rented a room from her parents. Faith also began receiving basic food benefits³⁰ under the WASHCAP program after she was found eligible for SSI benefits.

8. The department mailed Ms. Freeman a "Notice of the Authorization, Denial, Termination, or Reduction of Medicaid Personal Care (MPC)" on August 17, 2004. Exhibit 1 from Docket No. 09-2004-A-0134 0143. The notice states in pertinent part as follows:

On 07/09/2004 (date) you were assessed for Medicaid Personal Care (MPC) services to determine:

x your eligibility for MPC services.

As a result, your MPC services have been:

[] denied, [] reduced, [] terminated, because:

[Blank area]

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³⁰ The state regulations call this program Basic Food. The federal statute and regulations still call it Food Stamps.

This decision is based upon Washington Administrative Code (WAC) sections 388-71 and 388-72A. A copy of these regulations is available upon request. ..."

The notice also included a statement of Faith's right to appeal the decision including how to request a hearing and the time limits for doing so.

9. Exhibit BB summarizes the findings of the CAREs completed for Faith between 2004 and 2007. An initial assessment (CARE) was completed on July 9, 2004. The 2005 Annual CARE was completed on October 26, 2005. The 2006 Annual CARE was completed on October 31, 2006. A CARE was completed on July 24, 2007 due to a "significant change. Additionally "Interim Assessments" were completed on October 28, 2004 and August 9, 2007.

10. ~~The following summarizes the changes from 2004 to 2005 on the CARE. In 2005, transfers was upgraded from "independent" to "extensive assistance" and "unmet". Dressing was upgraded from "limited assistance" to "extensive assistance" and "unmet". The total ADL was upgraded from 11 to 14.~~

11. ~~The following summarizes the changes from 2005 to 2006 on the CARE. The task of eating from changed from "unmet" to "partially met 1/4 - 1/2". Also locomotion outside was changed from "partially met less than 1/4" to "partially met 1/2 - 3/4". Her overall ADL score increased from 14 to 15.~~

12. The following summarizes the changes from 2006 to 2007 on the CARE. **Eating** was changed from "partially met 1/4 to 1/2" need to "unmet". **Locomotion outside the room** was upgraded from "partially met 1/2 to 3/4 time" to "partially met less than 1/4 time". **Medication management** was changed from "Assistance required" to "Must be administered". Also, **shopping, housework and meal preparation** went from "met" to "unmet" due to the Supreme Court striking down the "shared living rule". Additionally, for the first time the department found that her condition was clinically complex due to a determination that the Appellant suffered from aphasia. Finally, they found that Faith "must be administered" medication in 2007. Previously her

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worker rated this task as "assistance required". The reason for this change is that in 2007 Faith had carbuncles - open wounds which her parents applied cream to and required antibiotic treatment.

13. Kris Jorgensen-Dobson (Ms. J-D) administered the CARE to Faith in 2004, 2005, 2006 and 2007. Mr. and Ms. Freeman were present at each of these as well and served as Faith's "reporter".

~~14. With regard to eating, Ms. J-D found this task was "partially met 1/4 to 1/2 time in 2006 because she believed that Faith's school was partially meeting this task.~~

~~15. With regard to dressing, Ms. J-D determined that Faith was in need of "extensive assistance" in 2005 because she could put on her bra by herself. In 2004, she rated this as "limited assistance" as she did not know that Faith needed to have her mother actually close her bra for her.~~

~~16. On the task of locomotion outside the room, Ms. J-D rated this as partially met in 2006 and 2007 because she understood that Faith received some assistance with this at school. She could not explain how she determined the need was met specifically 1/2 to 3/4 of the time.~~

17. In 2007 when she determined that Faith had a clinically complex diagnosis, this was based upon her belief that Dr. Sciarrone physician's diagnosis of had diagnosed the Appellant with aphasia. Additionally, the department no longer applied the "shared living rule" because it was stricken by the State Supreme Court, thus **meal preparation, housework and shopping** were no longer considered met. In addition, on this CARE, the department determined that Faith's medications needed to be administered to her. Throughout the entire period at issue, Faith's medications have been administered in the same manner by her family. They have taken her pills and crushed or broken them up and placed them in yogurt for her to consume. ~~The only~~ ^{one} new factor in 2007 is that Faith had a wound, which the department referred to as a carbuncle, to

which they applied an antibiotic cream. Ms. J-D also found that her need for assistance with locomotion outside the room was partially met less than ¼ of the time whereas this was found to be partially met ½ to ¾ of the time in 2006.

18. Mr. Freeman testified credibly that Faith's conditions have remained largely the same throughout the period in question. With regard to toileting, Mr. Freeman testified credibly that when Faith is at school, her urination is handled. However, her bowel movements are handled at home. He and his wife have a regular structured time in the evening with a firm time for Faith to use the commode. Faith is not able to wipe herself or clean up on her own.

19. Mr. Freeman also testified credibly that they never could leave Faith home alone. When Faith was 13 years old, his wife quit her job in order to stay home full time to care for Faith. In the past Faith has flooded their bathroom from multiple flushes of the toilet. She has also hurt herself by shutting her fingers in a door.

20. ~~Faith has been diagnosed with Aphasia and Apraxia. These are both speech disorders. Aphasia is caused by damage to the brain resulting in difficulties formulating speech. Apraxia is related to physical damage in the parts of the body needed to speak orally. Dr. Sciarrone, the Appellant's adult primary care physician, conducted an EPSDT exam on June 15, 2007. The DSHS EPSDT examination form indicates under the heading "abnormal findings and comments" "patient has normal appearance of child with Down's syndrome. See my CP exam details." The attached chart note does not contain a diagnosis of aphasia. It does list acne, carbuncles, Down's syndrome, syncope, and plantar fasciitis as "current problems". diagnosed Ms. Freeman with aphasia in 2007 Exhibit 36. Accompanying Dr. Sciarrone's exam results in this same exhibit is a copy of a letter sent by the Appellant's father to the doctor in which he poses several questions for the doctor. Question #5 asks "How does Faith K. Freeman's cognitive impairment compare/contrast to an elder with a diagnosis of aphasia? Could Faith legitimately be diagnosed with aphasia in addition to Down Syndrome? If Faith were so~~

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diagnosed it would solve a significant problem since the DSHS assessment tool attributes clinical complexity points (and care hours) to a diagnosis of aphasia but the tool contains an irrebuttable presumption that there can be no clinical complexity related to a diagnosis of Down Syndrome."

The doctor responded in her own handwriting, "Patient has Down's syndrome and is unable to vocalize any other words except yes and no. Yes - expressive aphasia." Dr. Sciarrone did not testify at the hearing.

21. Dr. deGive conducted an EPSDT exam on the Appellant on August 27, 2004, and did not diagnose aphasia. He did diagnose her with dysarthria. Dysarthria is a condition where the patient has difficulty in articulating words due to a disease of the central nervous system. However, when Dr. deGive testified at the hearing on May 20, 2008, he did not discuss dysarthria at all. Instead, with respect to the Appellant's apparent communications issues, the doctor discussed the difficulties in determining whether or not a patient with Down Syndrome and mental retardation could be diagnosed with either aphasia or apraxia. Dr. deGive specifically stated that he could not determine whether the Appellant had these conditions, saying that he would "have to defer to a good speech therapist on that." Transcript of the Proceedings, Part III, pages 23 & 24. Later, when asked during cross-examination if the Appellant had aphasia, the doctor responded, "I really don't know." Id., at page 55. Even when the Appellant's attorney attempted to rehabilitate the doctor's testimony regarding aphasia, Dr. deGive continued to express reservations about a medical professional's ability to diagnose the condition of aphasia in the Appellant's case, and stated that the Appellant's condition was only "comparable to aphasia" in that she couldn't talk. Id., at pages 63 & 64.

22. At the time of Dr. Sciarrone's EPSDT examination on June 15, 2007, the Department's regulation regarding clinical complexity was WAC 388-106-0095. The rule describes the condition of aphasia as either expressive or receptive (or both). Aphasia is generally defined in the medical literature as "defect or loss in the power of speech, writing, or

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signs, or of comprehending spoken or written language due to injury or disease of the brain centers." A different source defines it as "loss or impairment of the power to use or comprehend words usually resulting brain damage." Expressive aphasia is "aphasia in which there is impairment of the ability to speak and write, due to a lesion of the cortical center. The patient understands written and spoken words, and knows what he wants to say, but cannot utter the words." Receptive aphasia is also known as sensory aphasia, which is defined as the "inability to understand the meaning of written spoken or tactile speech symbols, due to disease of the auditory and visual word centers." Another source defines sensory aphasia as the "inability to understand spoken, written, or tactile speech symbols that results from damage (as by a brain lesion) to an area of the brain (as Wernicke's area) concerned with language - called also receptive aphasia." See, Dorland's Illustrated Medical Dictionary; the Sloane-Dorland Annotated Medical-Legal Dictionary; and Medline Plus, a service of the National Library of Medicine and the National Institutes of Health, www.nlm.nih.gov/medlineplus. Prior to June 2007 there is no indication in the record that the Appellant was ever diagnosed by any medical professional with any type of aphasia.

23. Mr. Freeman testified credibly that in 2004 when the CARE was new he did not know what the various applicable terms meant. Additionally, Ms. J-D testified that when she administered the CARE she did not give the Freemans a copy of the definitions of the terms she used such as the definition of bathing, eating, and the terms "supervision" and "limited assistance".

24. Additionally Mr. Freeman testified credibly that with regard to the task of transferring Faith, nothing changed between 2004 and 2005 except he thinks that in 2005, Ms. J-D asked more detailed questions which resulted in her determination that Faith needed more assistance.

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25. With regard to the task of eating, Mr. Freeman acknowledged that Faith had her lunch at school 4 days per week when she was in school. Mr. Freeman understood that the department downgraded this task from limited assistance to supervision because they decided that cutting food was part of the task of food preparation, not eating.

26. With regard to the task of dressing, Faith has always needed the same level of assistance throughout the period at issue.

27. With regard to locomotion, Mr. Freeman also testified that Faith needed the same level of assistance with this task throughout the period at issue. Nothing changed at school between 2005 and 2006 with regard to this task.

28. With regard to toileting, Mr. Freeman testified that Faith always needed the same level of assistance, which Mr. Freeman thinks was extensive assistance.

29. In addition to assisting Faith on a daily basis seven days per week with various activities of daily living, the Freemans work with Faith to attempt to train her to be as self-sufficient as possible. For example when assisting her showering, they show her the difference between soap and shampoo and how to clean herself and dry herself off. They show her how to prepare meals. They work with her on habilitation skills such as: how to be appropriate when she is out in the community and working skills and personal care skills. They are constantly working with Faith to try to train her to learn new things to keep her safe and fully develop her potential.

30. On January 30, 2006, Dr. Henry DeGive signed a written declaration stating the following:

1. *I am a Doctor of Pediatrics with over twenty years experience as a Pediatrician. I have been Faith Freeman's treating physician ever since she was two weeks old and am very familiar with her condition.*

2. *As a Pediatrician, I am familiar with the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Medicaid program. Over the years I have performed many EPSDT screenings. I had never been notified by DSHS that EPSDT coverage extended until age 21. I had believed it was limited to young children. I had to be convinced by Faith's father that she still qualified for an EPSDT screening.*

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3. On August 27, 2004, after Faith turned 18, I conducted an EPSDT screening of her condition. My screening is attached to this declaration as exhibit "A". In the screening I concluded, based upon Faith's diagnosis of trisomy 21 and conditions flowing from that diagnosis that she needed constant supervision in order to maintain her health and safety.

4. In my medical opinion, it is medically necessary that Faith continue to receive 24-hour, 7 days a week assistance as a remedial service for the maximum reduction of Faith's physical and mental disability necessary to restore her to the best possible functional level.

5. The level of treatment I prescribed in the EPSDT screening is a health care and treatment measure medically necessary to correct or ameliorate Faith's trisomy 21 and physical illness which I identified and documented in the EPSDT screening.

31. Exhibit A, referenced above is dated August 27, 2004 and was written by Dr. deGive. Therein he noted in pertinent part that "Patient requires 24/7 supervision. She wandered off from school on a couple of occasions when she was not being watched. She has no concept to personal danger and will walk across the street in front a car (sic) or allow herself to be approached by stranger. She is unable to use public transportation without an aide. She has no concept of money, although parents do take patient shopping. She enjoys picking out things that she wants but does not have any concept of paying or of money." Dr. DeGive also testified in this hearing and his testimony largely mirrored his written declaration.

32. Ms. J-D testified that she did not know about the EPSDT program until 2004 when Mr. Freeman asked her about it. There is no evidence in the record that the department informed the Freemans about the EPSDT program. In fact, the evidence is to the contrary, that is that the Freemans informed the department about the EPSDT program.

33. Exhibit 27 was prepared by Mr. Freeman. It shows the "unpaid balance" for hours of care to Faith for which the Freemans have not been compensated. The "unpaid balance" shown is the number of uncompensated hours excluding school and work time and any other "informal support" hours not provided by the Freemans. It does not include the hours for which the Freemans were previously paid under the MPC program. It does include 8 hours of sleep

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time each day. The hourly rate of pay used in this exhibit by Mr. Freeman is the amount paid to the Freemans by the department under the MPC program.

34. ~~Attached to the Department's Closing Brief and referenced therein is a declaration of Joyce Pashley Stockwell.~~

2004 CARE Assessment:

35. The Appellant, Faith Freeman, was born on July 18, 1986, and thus, is 18 years of age. The Appellant is eligible to receive Medicaid Personal Care (MPC) benefits from the Department. A primary purpose of MPC benefits is to enable a client to remain in a community placement, which is both less expensive than an institutional placement, and more accommodating to client choice.

36. The Appellant lives in a home located in Olympia, Washington. She moved to her current residence prior to the dates material to this matter, in part to avoid the stairs in her previous residence.

37. Loren and Jean Freeman (the Freemans) are the Appellant's biological parents, and reside at the same residential address. The Freemans were appointed full guardians of the Appellant's person and estate by order of the Thurston County Superior Court on May 14, 2004. Exhibit 12. The Freemans also serve as the Appellant's paid care providers.

38. On July 14, 2004, a *Month to Month Residential Rental Agreement* (rental agreement) was executed. Exhibit 5, pp.14-18. The rental agreement purports to rent a room and access to common areas of the house to the Appellant on a month to month basis for \$370 per month. Id. Specifically, the rental agreement provides in relevant part:

Clause 1. Identification of Landlord and Tenant.

This Agreement is entered into between Faith Kimberly Freeman ("Tenant") and Loren M. and/or Jean M. Freeman ("Landlord"). Each Tenant is jointly and severally liable for the payment of rent and performance of all other terms of this Agreement. 000059.S

Clause 2. Identification of Premises.

Subject to the terms and conditions in this Agreement, Landlord rents to Tenant, and Tenant rents from Landlord, for residential purposes only, a furnished bedroom and access to all common areas at the premises located at 2323 Woodfield Loop S.E., Olympia, Washington, 98501 ("the Premises"), together with the following furnishings and appliances: all furniture in the furnished bedroom and all television(s), kitchen appliances, laundry appliances, and bathroom facilities within the common areas of the premises. Access is not included in the personal bedrooms of any other tenant(s) of the residential premises.

Rental of the premises also includes: landlord provided maintenance of the premises.

Clause 15. Landlord's Right to Access.

Landlord or Landlord's agents may enter the premises in their landlord capacity in the event of an emergency, to make repairs or improvements or to show the premises in their landlord capacity to conduct an annual inspection to check for safety or maintenance problems. Except in cases of emergency, Tenant's abandonment of the premises, court order or where it is impractical to do so, Landlord will give Tenant ten days notice before entering the premises in the capacity of Landlord. The limitation in this clause shall not affect that access necessary in any capacity or role that is not subject to this Agreement (i.e., access as legal guardian or as contracted personal care provider).

Clause 24. Grounds for Termination of Tenancy.

The failure of Tenant or their guests or invitees to comply with any term of this Agreement is grounds for termination of the tenancy, with appropriate notice to the Tenant and procedures as required by law.

The rental agreement was signed on July 14, 2004, by Loren Freeman as Landlord, the Appellant as Tenant, and both Loren and Jean Freeman as Co-Guardians of the Appellant. Exhibit 5, p.

18. The rental agreement was entered in anticipation of the Appellant's 18th birthday, in order to establish a separate household for her. The agreement was designed to address the requirements of benefit programs such as the requirements of the Social Security Administration in connection with the Appellant's then-pending application for Supplemental Security Income

(SSI).

39. Pursuant to the rental agreement, the Appellant lives in her own room, with access to the common areas of the residence, including the kitchen, bath, and living room. The Freemans have segregated the storage of food, supplies, materials, and linens in an effort to create "a completely separate household for Faith." Testimony of Loren Freeman.

40. The Freemans' attempt to comply strictly with the terms of the rental agreement. On one occasion, Mr. Freeman provided a 10-day notice to the Appellant that he would enter her room to change a burned out light bulb. The Appellant waived the notice requirement in this instance. Mr. Freeman admits that although it is theoretically possible under the contract for the Appellant to be evicted, this would be extremely unlikely.

41. The Department determines the appropriate number of paid hours of personal care through the Comprehensive Assessment Reporting Evaluation (CARE) tool.

42. On July 9, 2004, Case Manager Kris Jorgensen-Dobson conducted an evaluation of the Appellant using the CARE tool (assessment). This was the first assessment of the Appellant, and was scheduled at the request of the Freemans due to the Appellant's impending 18th birthday.

43. The CARE assessment was based on information provided by and interviews with the Appellant, the Freemans, and the Appellant's primary care physician, Dr. Henry DeGive. Ms. Jorgensen-Dobson provided a copy of the assessment to the Freemans for comment and review. Based on the assessment, the Department ultimately awarded the Appellant 72 hours of MPC.

44. On August 17, 2004, the Department drafted a Notice of Authorization, Denial, Termination, or Reduction of Medicaid Personal Care (notice). Exhibit 1, p. 2. The notice provided that the Department's decision regarding eligibility for MPC services would take effect on August 13, 2004. Id. The notice did not specify the exact number of hours of MPC awarded

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to the Appellant. Id.

45. The Freemans were given an opportunity to go through the assessment before the Department "locked in" the final result. The assessment was locked on July 18, 2004, and a copy was sent to the Freemans on the same date. The assessment was signed by the Appellant and the Freemans on August 27, 2004, and returned to the Department. Exhibit C. Ms. Jorgensen-Dobson added her signature on September 10, 2004. Id.

46. The Appellant timely requested an adjudicative proceeding with the Office of Administrative Hearings on August 27, 2004. Exhibit 1.

47. From September 1, 2004, forward, the Department has provided authorization for 70 hours of MPC per month pending the outcome of the Appellant's appeal.

48. On September 7, 2004, the Department approved both Loren and Jean Freeman as the Appellant's paid care providers, effective September 1, 2004. Exhibit 2, p. 2 - 3.

The Appellant's Condition and Circumstances

49. The Appellant is diagnosed with Trisomy 21-type Down Syndrome, mental retardation, hypotonia, flat feet, cataracts, constipation, and eczema. Exhibit 5, p. 5; Exhibit 21. She has an I.Q. of 50, severely impaired cognition and operates at the functional equivalent of a five-to six-year-old child. The Appellant's medical conditions require constant care and supervision on a 24-hour per day, seven day per week basis.

50. The Appellant takes the following supplements and medications: calcium supplement, chewable multivitamin, chewable vitamin C, Children's Benadryl, clindamycin, Differin, and Lortab. Exhibit 21. In addition, the Appellant's conditions require the application of Head and Shoulders shampoo, Jergens Ultra Healing lotion, and Kersal lotion.

51. The Appellant has no problems with recent memory, but she does have long-term memory problems. She is not comatose. She makes poor decisions and is oblivious to the consequences of her actions, so she needs cues, reminders, and supervision in planning and

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organizing her daily routine. She is not capable of supervising her paid care provider. Id.

52. The Appellant has significant speech problems, but adequate hearing. She is rarely understood by others. The Appellant's cataracts and need for glasses result in moderate impairment of her vision.

Mood and Behavior

53. In the seven days immediately prior to the assessment, the Appellant demonstrated crying and tearfulness that was easily altered. It was occurring once every 1-3 days.

54. In the seven days immediately prior to the assessment, the Appellant demonstrated irritability/agitation that was easily altered. It was occurring once every 1-3 days.

55. In the seven days immediately prior to the assessment, the Appellant demonstrated mood swings that were not easily altered. They were occurring once every 1-3 days.

56. In the seven days immediately prior to the assessment, the Appellant demonstrated inappropriate verbal noises that were easily altered. The behavior was occurring once every 1-3 days.

57. In the seven days immediately prior to the assessment, the Appellant demonstrated hoarding and collecting behaviors, including the hoarding of food in her room, that were not easily altered. This was occurring once every 1-3 days.

58. In the past, but not in the seven days immediately prior to the assessment, the Appellant was hiding items while at school. This appears to be resolved through informing her that this behavior is not appropriate.

Activities of Daily Living

59. The Appellant has poor balance, poor hand/eye coordination, an unsteady gait, and limited fine motor control. These limitations negatively impact her functional ability to

complete the activities of daily living.

60. **Personal Hygiene.** The Appellant needs extensive, physical assistance performing her personal hygiene. She cannot comb her own hair, is generally unaware of her grooming needs, and needs reminders to brush her teeth, change her clothes, apply deodorant, trim her fingernails, and wash her face.

61. **Bed Mobility.** The Appellant can independently position herself in bed.

62. **Transfer.** The Appellant requires extensive assistance to get out of bed in the morning and must be helped out of bed by the provider.

63. **Eating.** The Appellant requires limited assistance with eating.³¹ She has a good appetite, but cannot cut her food, and needs reminders throughout the meal.

64. **Toilet Use.** The Appellant needs extensive assistance in toileting. She is aware of the need to use the toilet, but is incapable of toileting without significant assistance, especially in the area of perineal care after use of the toilet. The Appellant is continent, but subject to constipation due in part to her lack of muscle tone. She requires reminders to regularly use the toilet to prevent constipation and bowel movements are always managed at home.

65. **Dressing.** The Appellant requires extensive assistance with dressing. She likes to pick out her own clothes, but she does not choose seasonally or weather appropriate clothes without prompting. She is unable to use tie or zip fasteners and hangs up all of her clothes, including dirty clothes, and she cannot fasten her bra without her mother's assistance.

66. **Locomotion.** The Appellant is independent walking in her immediate living environment, including her room and the hallway. Outside of her immediate living environment, the Appellant requires assistance on uneven surfaces, has poor safety awareness, and would need assistance to evacuate in the event of an emergency.

67. **Administration of Medicine.** The Appellant requires daily reminders to self

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³¹ In accordance with the definition of eating in the regulations applicable at that time.

administer her medication. She cannot crush pills or open container, is unable to read labels, and has poor coordination.

68. **Bathing.** The Appellant needs non-weight bearing physical assistance while bathing. She cannot be left unattended, is difficult to transfer into and out of the tub, cannot judge the water temperature, and cannot shampoo her own hair.

Instrumental Activities of Daily Living

69. **Meal preparation.** The Appellant is totally dependent on her providers for meal preparation. She is unable to lift pans, plan meals, reach the stove, reheat items, reach the shelves, cut/peel/chop food, or to cook for herself.

70. **Ordinary Housework.** The Appellant needs extensive assistance with ordinary housework.

71. **Essential Shopping.** The Appellant is totally dependent on others to perform her shopping. She is unable to carry heavy items, read labels, write checks, or reach items in the store. The Freemans attempt to have the Appellant assist with the shopping, but this task takes longer with the Appellant's assistance.

72. **Transportation to Medical Services.** The Appellant requires extensive assistance with transportation to her medical and other appointments. She is unable to arrange transportation, and needs an escort if she utilizes public transportation.

Informal Supports

73. The Freemans are listed as informal supports for the Appellant under the assessment. Loren Freeman is assigned finances, housework, meal preparation, essential shopping, and transportation. Jean Freeman is assigned finances, housework, meal preparation, and essential shopping.

74. Based on the evidence presented at the hearing, the Appellant's July 2004 ~~COARE~~ ⁶⁵ Assessment (Exhibits B, P and V) should have indicated the following summary of her needs:

Ms. Freeman has not been diagnosed with any of the conditions listed in WAC 388-72A-0082, and does not meet the criteria for being clinically complex.

Ms. Freeman's hoarding & collecting behavior has sufficient status, frequency, and alterability to meet the requirements of WAC 388-72A-0083(3). Thus, she is appropriately placed in the mood and behavior classification group.

Ms. Freeman exhibited a Cognitive Performance Score (CPS score) of 4 points:

Comatose = No

Decision Making = Moderately Impaired

Able to make themselves understood = Rarely Understood

Short Term Memory/Delayed Recall = No recent memory problem

Self Performance in Eating = Limited assistance needed.

The Appellant exhibited the following ADL scores:

ADL	Self Performance Needs	Score	Total Score
Personal Hygiene	Extensive Assistance	3	3
Bed Mobility	Independent	0	3
Transfers	Extensive Assistance	3	6
Eating	Limited Assistance	2	8
Toilet Use	Extensive Assistance	3	11
Dressing	Extensive Assistance	3	14
Locomotion in Room	Independent	0	Choose the highest of these three scores
Locomotion Outside Room	Limited Assistance	2	
Walk in Room	Independent	0	
Total ADL Score			16

The Appellant was classified as mood and behavior – yes, CPS = 4, not clinically complex, and with an ADL score between 15 – 28 making her correctly classified as level “B High” and eligible for 155 base hours of in home care.

Under WAC 388-72A-0095, the Department deducts hours from the total number of base hours to reflect available informal supports and to account for shared living arrangements.

IADL	Status	Assistance Available	Value Percentage
Self-Administration Of Medications	Unmet	None	1
Walk in Room	Independent	N/A	-
Bed Mobility	Independent	N/A	-
Transfer	Unmet	N/A	1
Toilet Use	Unmet	None	1
Eating	Unmet	None	1
Bathing	Unmet	None	1
Dressing	Unmet	None	1

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Personal Hygiene	Unmet	None	1
Transportation	Unmet	N/A	1
*Meal Preparation	Met	Shared Living	0
*Shopping	Met	Shared Living	0
*Housework	Met	Shared Living	0
Total			8

$$8/11 = .73(A)$$

$$1 - .73(A) = .27(B)$$

$$.27/3 = .09(C)$$

$$.73 + .09 = .82(D)$$

$$155 \times .82 = 127.$$

**Items indicated with an asterisk are Individual Activities of Daily Living (IADL's) where the status is automatically adjusted to "met" when a client and paid provider live together. This is codified in WAC 388-72A-0095.

75. At all times relevant to this case, the Appellant's community placement in the Freeman home has been appropriate and has been the care alternative preferred by the Appellant. Further, the evidence produced at hearing demonstrates that the Freemans care deeply for their daughter and take every action necessary to provide her the best care available.

2005 CARE Assessment:

76. The Appellant has no problems with recent memory, but she does have long-term memory problems. She is not comatose. She makes poor decisions and is oblivious to the consequences of her actions, so she needs cues, reminders, and supervision in planning and organizing her daily routine. She is not capable of supervising her paid care provider.

77. The Appellant has significant speech problems, but adequate hearing. She is rarely understood by others. The Appellant's cataracts and need for glasses result in moderate impairment of her vision.

Mood and Behavior

78. In the seven days immediately prior to the assessment, the Appellant demonstrated current crying and tearfulness that was occurring four or more days per week.

79. In the seven days immediately prior to the assessment, the Appellant

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demonstrated current repetitive movement and pacing that was occurring daily.

80. In the seven days immediately prior to the assessment, the Appellant would get up at night and require intervention on a current basis.

Activities of Daily Living

81. The Appellant has poor balance, poor hand/eye coordination, an unsteady gait, and limited fine motor control. These limitations negatively impact her functional ability to complete the activities of daily living.

82. **Personal Hygiene.** The Appellant needs extensive, physical assistance performing her personal hygiene. She cannot comb her own hair, is generally unaware of her grooming needs, and needs reminders to brush her teeth, change her clothes, apply deodorant, trim her fingernails, and wash her face.

83. **Bed Mobility.** The Appellant can independently position herself in bed.

84. **Transfer.** The Appellant requires extensive assistance to get out of bed in the morning and must be helped out of bed by the provider.

85. **Eating.** The Appellant requires only supervision eating.³² She has a good appetite, but cannot cut her food, and needs reminders throughout the meal.

86. **Toilet Use.** The Appellant needs extensive assistance in toileting. She is aware of the need to use the toilet, but is incapable of toileting without significant assistance, especially in the area of perineal care after use of the toilet. The Appellant is continent, but subject to constipation due in part to her lack of muscle tone. She requires reminders to regularly use the toilet to prevent constipation and bowel movements are always managed at home.

87. **Dressing.** The Appellant requires extensive assistance with dressing. She likes to pick out her own clothes, but she does not choose seasonally or weather appropriate clothes without prompting. She is unable to use tie or zip fasteners and hangs up all of her clothes. 000068S

³² In accordance with the definition of eating in the regulations applicable at that time.

including dirty clothes, and she cannot fasten her bra without her mother's assistance.

88. **Locomotion.** The Appellant is independent walking in her immediate living environment, including her room and the hallway. Outside of her immediate living environment, the Appellant requires assistance on uneven surfaces, has poor safety awareness, and would need assistance to evacuate in the event of an emergency.

89. **Administration of Medicine.** The Appellant requires daily reminders to self-administer her medication. She cannot crush pills or open container, is unable to read labels, and has poor coordination.

90. **Bathing.** The Appellant needs non-weight bearing physical assistance while bathing. She cannot be left unattended, is difficult to transfer into and out of the tub, cannot judge the water temperature, and cannot shampoo her own hair.

Instrumental Activities of Daily Living

91. **Meal preparation.** The Appellant is totally dependent on her providers for meal preparation. She is unable to lift pans, plan meals, reach the stove, reheat items, reach the shelves, cut/peel/chop food, or to cook for herself.

92. **Ordinary Housework.** The Appellant needs extensive assistance with ordinary housework.

93. **Essential Shopping.** The Appellant is totally dependent on others to perform her shopping. She is unable to carry heavy items, read labels, write checks, or reach items in the store. The Freemans attempt to have the Appellant assist with the shopping, but this task takes longer with the Appellant's assistance.

94. **Transportation to Medical Services.** The Appellant requires extensive assistance with transportation to her medical and other appointments. She is unable to arrange transportation, and needs an escort if she utilizes public transportation.

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Informal Supports

95. The Freemans are listed as the primary informal supports for the Appellant under the assessment. Loren Freeman is assigned finances, housework, meal preparation, essential shopping, and transportation. Jean Freeman is assigned finances, housework, meal preparation, and essential shopping. Also listed as informal supports are a speech therapist and an occupational therapist.

96. Based on the evidence presented at the hearing, the Appellant's CARE Assessment for October 2005 (Exhibits G, R and X) should have indicated the following summary of her needs:

Ms. Freeman has not been diagnosed with any of the conditions listed in WAC 388-106-0095, and does not meet the criteria for being clinically complex.

Ms. Freeman's crying/tearfulness, repetitive movement/pacing, and nighttime wakefulness/requires intervention behaviors have sufficient status, frequency, and alterability to meet the requirements of WAC 388-106-0100. Thus, she is appropriately placed in the mood and behavior classification group.

Ms. Freeman exhibited a Cognitive Performance Score (CPS score) of 4 points:

Comatose = No

Decision Making = Moderately Impaired

Able to make themselves understood = Rarely Understood

Short Term Memory/Delayed Recall = No recent memory problem

Self Performance in Eating = Limited assistance needed.

The Appellant exhibited the following ADL scores:

<u>ADL</u>	<u>Self Performance Needs</u>	<u>Score</u>	<u>Total Score</u>
Personal Hygiene	Extensive Assistance	3	3
Bed Mobility	Independent	0	3
Transfers	Extensive Assistance	3	6
Eating	Supervision	1	7
Toilet Use	Extensive Assistance	3	10
Dressing	Extensive Assistance	3	13
Locomotion in Room	Independent	0	Choose the highest of
Locomotion Outside Room	Limited Assistance	2	these three scores
Walk in Room	Independent	0	15
Total ADL Score			15

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The Appellant was classified as mood and behavior – yes, CPS = 4, not clinically complex, and with an ADL score between 15 – 28, making her correctly classified as level “B High” and eligible for 155 base hours of in home care.

Under WAC 388-106-0130, the Department deducts hours from the total number of base hours to reflect available informal supports and to account for shared living arrangements.

IADL	Status	Assistance Available	Value Percentage
Self-Administration Of Medications	Unmet	None	1
Walk in Room	Independent	N/A	-
Bed Mobility	Independent	N/A	-
Transfers	Unmet	N/A	1
Toilet Use	Partially Met	< ¼ time	.9
Eating	Partially Met	< ¼ time	.9
Bathing	Unmet	None	1
Dressing	Unmet	None	1
Personal Hygiene	Unmet	None	1
Transportation	Unmet	N/A	1
*Meal Preparation	Met	Shared Living	0
*Shopping	Met	Shared Living	0
*Housework	Met	Shared Living	0
	Total		7.8

	$7.8/11 = .71(A)$
	$1 - .71(A) = .29(B)$
	$.29/3 = .10(C)$
	$.71 + .10 = .81(D)$
	$155 \times .82 = 126.$

**Items indicated with an asterisk are Individual Activities of Daily Living (IADL's) where the status is automatically adjusted to "met" when a client and paid provider live together or the client is under the age of 18. This is codified in WAC 388-106-0130 and WAC 388-106-0213.

2006 CARE Assessment:

97. The Appellant has no problems with recent memory, but she does have long-term memory problems. She is not comatose. She makes poor decisions and is oblivious to the consequences of her actions, so she needs cues, reminders, and supervision in planning and organizing her daily routine. She is not capable of supervising her paid care provider.

98. The Appellant has significant speech problems, but adequate hearing. She is rarely understood by others. The Appellant's cataracts and need for glasses result in moderate

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impairment of her vision.

Mood and Behavior

99. In the seven days immediately prior to the assessment, the Appellant demonstrated current crying and tearfulness that was occurring four or more days per week.

100. In the seven days immediately prior to the assessment, the Appellant demonstrated current repetitive movement and pacing that was occurring daily.

101. In the seven days immediately prior to the assessment, the Appellant would get up at night and this behavior would require intervention, all of which was occurring on a current basis.

Activities of Daily Living

102. The Appellant has poor balance, poor hand/eye coordination, an unsteady gait, and limited fine motor control. These limitations negatively impact her functional ability to complete the activities of daily living.

103. **Personal Hygiene.** The Appellant needs extensive, physical assistance performing her personal hygiene. She cannot comb her own hair, is generally unaware of her grooming needs, and needs reminders to brush her teeth, change her clothes, apply deodorant, trim her fingernails, and wash her face.

104. **Bed Mobility.** The Appellant can independently position herself in bed.

105. **Transfer.** The Appellant requires extensive assistance to get out of bed in the morning and must be helped out of bed by the provider.

106. **Eating.** The Appellant requires only supervision in the task of eating.³³ She has a good appetite, but cannot cut her food, and needs reminders throughout the meal.

107. **Toilet Use.** The Appellant needs extensive assistance in toileting. She is aware of the need to use the toilet, but is incapable of toileting without significant assistance, especially

³³ In accordance with the definition of eating in the regulations applicable at that time.
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in the area of perineal care after use of the toilet. The Appellant is continent, but subject to constipation due in part to her lack of muscle tone. She requires reminders to regularly use the toilet to prevent constipation and bowel movements are always managed at home.

108. **Dressing.** The Appellant requires extensive assistance with dressing. She likes to pick out her own clothes, but she does not choose seasonally or weather appropriate clothes without prompting. She is unable to use tie or zip fasteners and hangs up all of her clothes, including dirty clothes, and she cannot fasten her bra without her mother's assistance.

109. **Locomotion.** The Appellant is independent walking in her immediate living environment, including her room and the hallway. Outside of her immediate living environment, the Appellant requires assistance on uneven surfaces, has poor safety awareness, and would need assistance to evacuate in the event of an emergency.

110. **Administration of Medicine.** The Appellant requires daily reminders to self-administer her medication. She cannot crush pills or open container, is unable to read labels, and has poor coordination.

111. **Bathing.** The Appellant needs non-weight bearing physical assistance while bathing. She cannot be left unattended, is difficult to transfer into and out of the tub, cannot judge the water temperature, and cannot shampoo her own hair.

Instrumental Activities of Daily Living

112. **Meal preparation.** The Appellant is totally dependent on her providers for meal preparation. She is unable to lift pans, plan meals, reach the stove, reheat items, reach the shelves, cut/peel/chop food, or to cook for herself.

113. **Ordinary Housework.** The Appellant needs extensive assistance with ordinary housework.

114. **Essential Shopping.** The Appellant is totally dependent on others to perform her shopping. She is unable to carry heavy items, read labels, write checks, or reach items in the

store. The Freemans attempt to have the Appellant assist with the shopping, but this task takes longer with the Appellant's assistance.

115. **Transportation to Medical Services.** The Appellant requires extensive assistance with transportation to her medical and other appointments. She is unable to arrange transportation, and needs an escort if she utilizes public transportation.

Informal Supports

116. The Freemans are listed as the primary informal supports for the Appellant under the assessment. Loren Freeman is assigned finances, housework, meal preparation, essential shopping, and transportation. Jean Freeman is assigned finances, housework, meal preparation, and essential shopping. Also listed as an informal support is Barbara Roder in the area of speech, occupation and employment support.

117. Based on the evidence presented at the hearing, the Appellant's CARE Assessment for October 2006 (Exhibits H, S and Y) should have indicated the following summary of her needs:

Ms. Freeman has not been diagnosed with any of the conditions listed in WAC 388-106-0095, and does not meet the criteria for being clinically complex.

Ms. Freeman's crying/tearfulness, repetitive movement/pacing, and nighttime wakefulness/requires intervention behaviors have sufficient status, frequency, and alterability to meet the requirements of WAC 388-106-0100. Thus, she is appropriately placed in the mood and behavior classification group.

Ms. Freeman exhibited a Cognitive Performance Score (CPS score) of 4 points:

Comatose = No

Decision Making = Moderately Impaired

Able to make themselves understood = Rarely Understood

Short Term Memory/Delayed Recall = No recent memory problem

Self Performance in Eating = Limited assistance needed.

The Appellant exhibited the following ADL scores:

<u>ADL</u>	<u>Self Performance Needs</u>	<u>Score</u>	<u>Total Score</u>
<u>Personal Hygiene</u>	<u>Extensive Assistance</u>	<u>3</u>	<u>3</u>
<u>Bed Mobility</u>	<u>Independent</u>	<u>0</u>	<u>3</u>
<u>Transfers</u>	<u>Extensive Assistance</u>	<u>3</u>	<u>6</u>

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Eating	Supervision	1	7
Toilet Use	Extensive Assistance	3	10
Dressing	Extensive Assistance	3	13
Locomotion in Room	Independent	0	Choose the highest of these three scores
Locomotion Outside Room	Limited Assistance	2	
Walk in Room	Independent	0	15
Total ADL Score			15

The Appellant was classified as mood and behavior – yes, CPS = 4, not clinically complex, and with an ADL score between 15 – 28, making her correctly classified as level **“B High”** and eligible for **155** base hours of in home care.

Under WAC 388-106-0130, the Department deducts hours from the total number of base hours to reflect available informal supports and to account for shared living arrangements.

IADL	Status	Assistance Available	Value Percentage
Self-Administration Of Medications	Unmet	None	1
Walk in Room	Independent	N/A	-
Bed Mobility	Independent	N/A	-
Transfers	Unmet	N/A	1
Toilet Use	Partially Met	< ¼ time	.9
Eating	Partially Met	< ¼ time	.9
Bathing	Unmet	None	1
Dressing	Unmet	None	1
Personal Hygiene	Unmet	None	1
Transportation	Unmet	N/A	1
*Meal Preparation	Met	Shared Living	0
*Shopping	Met	Shared Living	0
*Housework	Met	Shared Living	0
Total			7.8

$$7.8/11 = .71(A)$$

$$1 - .71(A) = .29(B)$$

$$.29/3 = .10(C)$$

$$.71 + .10 = .81(D)$$

$$155 \times .81 = 126.$$

**Items indicated with an asterisk are Individual Activities of Daily Living (IADL's) where the status is automatically adjusted to "met" when a client and paid provider live together or the client is under the age of 18. This is codified in WAC 388-106-0130 and WAC 388-106-0213.

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Shared Living Rule:

118. The outcome of all three CARE assessments was affected by the shared living rule. The Department has stated that those assessments were being reviewed in light of the invalidation by the Supreme Court of the Department's rule. According to Exhibit 27, the Department has made two separate payments (in January and March 2008) to the Freeman's in the aggregate amount of \$6,676.80 for a shared living rule correction payment.

III. CONCLUSIONS OF LAW

1. **Procedural Summary.** This case is a consolidation of three separate Medicaid Personal Care cases for the 2004, 2005, and 2006 annual CARE assessments. The Appellant is Faith Freeman, a 22 year-old woman with Down Syndrome who has the essential functional level of a five year-old child. She receives Medicaid benefits under the Categorically Needy program due to her developmental disability. Her parents, Loren and Jean Freeman, are her guardians and life-long caregivers, and the Appellant continues to live with them in their household, although she is now paying them rent for her room. The Division of Developmental Disabilities, Aging and Disability Services Administration, Department of Social and Health Services is the "Department" in this matter. The Freeman's believe that the Appellant is entitled under the EPSDT program to "24/7" supervisory care hours paid for by the Department. Exhibit 27 in the record contains the Freeman's calculation that they, as the Appellant's caregivers, are owed in the neighborhood of \$200,000.00 in additional hours of care, including interest, from the State of Washington.

The first case to come up was the July 2004 CARE assessment under docket number 09-2004-A-0143. An administrative hearing was held in that case in November 2004 and an Initial Order entered in May 2005. The Initial Order was appealed to the DSHS Board of Appeals by the Appellant and a Review Decision and Final Order was entered by Review Judge Sturges on

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August 31, 2005. The Appellant then pursued judicial review in the Superior Court of Thurston County. On November 3, 2006, Superior Court Judge Gary R. Tabor vacated the Review Decision and Final Order and remanded the case for further proceedings before the ALJ. The court remanded the case so that the Appellant would have the opportunity to present evidence and argument at an administrative hearing on the federal claims raised in her judicial review petition as well as for a consideration of the Appellant's additional claim of eligibility under the EPSDT program.

The clear intent of Judge Tabor's order was to have the ALJ consider all the claims (other than constitutional) raised by the Appellant and then resolve all the issues in a single proceeding in accordance with the Administrative Procedure Act, Chapter 34.05 RCW. After this judicial order on remand, the Appellant's objections to the CARE assessments for 2005 and 2006 were consolidated for resolution under their docket numbers, 11-2005-A-1878 and 12-2006-A-0855, respectively. The Appellant's objection, if any, to the 2007 CARE assessment was not consolidated in this case and the details of that assessment were not reviewed by ALJ Habegger. The 2007 CARE assessment is not properly before the undersigned on appellate review.³⁴

The ALJ to whom the matter was remanded entered an Amended Initial Order on March 21, 2008, and a Corrected Initial Order on July 3, 2008. Both the Appellant and the Department have filed appeals of these orders. This Review Decision and Final Order will resolve the various petitions and responses and enter the final agency order as required by RCW 34.05.464.

2. **Jurisdiction.** The Petitions for Review were timely filed and are otherwise proper.³⁵ Jurisdiction exists to review the Amended Initial Order and the Corrected Initial Order and to enter the final agency order.³⁶

³⁴ There were numerous references to the 2007 CARE assessment and the ALJ made various factual findings and legal conclusions that directly referenced the 2007 assessment.

³⁵ WAC 388-02-0560 through -0585.

³⁶ WAC 388-02-0215, -0530(2), and -0570.

3. **Motion to Dismiss Late Petition for Review.** After the administrative hearing conducted in April and May of 2008 the ALJ issued an initial order on June 27, 2008. However, on July 3, 2008, the ALJ issued a new initial order due to a request for correction of the June 27th order, calling this one the "Corrected Initial Order."³⁷ Subsequently, on July 22, 2008, the Department filed a Petition for Review. The Appellant has moved to dismiss the Department's petition because she believes that the Department's appeal was filed after the deadline for requesting review. The Department's position is that (1) the request for review was timely filed because it was filed within twenty-one days of the July 3rd Corrected Initial Order or, in the alternative, (2) the request for review should be accepted because even though it was filed more than twenty-one days after the ALJ's June 27th initial order, it was filed with thirty days after the deadline and "good reason"³⁸ was shown by the Department for missing the deadline. The parties have offered extensive argument which has been set forth *supra* in paragraphs 9 thru 14 on pages 17 thru 28.

The undersigned has fully considered the facts of the matter, the arguments submitted by counsel, and the law applicable to appellate review. For the reasons set forth immediately following, it is the decision of the undersigned that the Department's Petition for Review be accepted and the Appellant's motion to dismiss is denied.

The simplest answer to this question is that the regulation cited by the Appellant, WAC 388-02-0555, should not be interpreted in the manner suggested by the counsel for the Appellant. The rule is set forth in full as follows:

What happens when a party requests a corrected ALJ decision?

- (1) When a party requests a corrected initial or final order, the ALJ must either:*
 - (a) Send all parties a corrected order; or*
 - (b) Deny the request within three business days of receiving it.*

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³⁷ The Department requested the correction pursuant to the authority in WAC 388-02-0540 thru -0555.

³⁸ See, e.g., WAC 388-02-0580(3).

(2) If the ALJ corrects an initial order and a party does not request review, the corrected initial order becomes final twenty-one calendar days after the original initial order was mailed.

(3) If the ALJ denies a request for a corrected initial order for a case listed in WAC 388-02-0215(4) and the party still wants the hearing decision changed, the party must request review from BOA.

(4) Requesting a corrected initial order for a case listed in WAC 388-02-0215(4) does not automatically extend the deadline to request review of the initial order by BOA. A party may ask for more time to request review when needed.

(5) If the ALJ denies a request for a corrected final order and you still want the hearing decision changed, you must request judicial review.

[Statutory Authority: RCW 34.05.020, chapter 34.05 RCW, Parts IV and V, 2002 c 371 § 211, 02-21-061, § 388-02-0555, filed 10/15/02, effective 11/15/02. Statutory Authority: RCW 34.05.020, 00-18-059, § 388-02-0555, filed 9/1/00, effective 10/2/00.]

The rule makes it very clear that the act of *requesting* a correction does not extend the deadline within which to file a subsequent request for review. The rule also makes it clear that if the order is corrected pursuant to the request and no party files a request for review, then the corrected order becomes final twenty-one days after the *original* order was mailed. Subsection (3) of the rule addresses the situation where a party has requested a correction and the ALJ denies the request - in that case the party is warned that the only remaining avenue to change the order is to file a request for review. Then subsection (4) advises the party requesting review that there is no automatic extension of the deadline. However it is clear here that the rule is referring to the deadline as measured from the entry of the initial order *which will clearly not be changed*. In this situation, the original initial order provides the only date from which the deadline can be measured.

But what is not addressed in the rule is the effect on the deadline in the situation where the ALJ actually does issue a corrected initial order *and* one of the parties thereafter files a request for review. A party receiving a corrected initial order has received a new initial order.

An examination of the Corrected Initial Order issued by ALJ Habegger on July 3, 2008, 000079 S
reveals that the order is date-stamped, contains findings of fact, conclusions of law, and an order.

Moreover, the following language is found on the last page of the Corrected Initial Order just beneath the distribution list:

NOTICE TO PARTIES: THIS ORDER BECOMES FINAL ON THE DATE OF MAILING UNLESS WITHIN 21 DAYS OF MAILING OF THIS ORDER A PETITION FOR REVIEW IS RECEIVED BY THE DSHS BOARD OF APPEALS, PO BOX 45803, OLYMPIA, WA 98504-5803. A PETITION FORM AND INSTRUCTIONS ARE ENCLOSED.

WAC 388-02-0580 is the rule governing the timeliness of requests for review filed with the Board and it provides:

- (1) Board of Appeals (BOA) must receive the written review request on or before the twenty-first calendar day after the initial order was mailed.
- (2) A review judge may extend the deadline if a party:
 - (a) Asks for more time before the deadline expires; and
 - (b) Gives a good reason for more time.
- (3) A review judge may accept a review request after the twenty-one calendar day deadline only if:
 - (a) The BOA receives the review request on or before the thirtieth calendar day after the deadline; and
 - (b) A party shows good reason for missing the deadline.

Given the importance of appellate review in administrative hearings, it only makes sense to construe the language of the rules in such a way as to maximize the ability of the parties to file appeals and otherwise exercise appellate procedures. For example, in determining how to compute the thirty days allowed to file a petition for judicial review of a final agency order, the rules contemplate that parties might wish to request reconsideration of a final agency order and therefore the rules provide for a delay in the running of the thirty-day period for judicial review as the reconsideration request is considered.³⁹ Moreover, even in cases where the Board of Appeals denies reconsideration, the Board notifies the parties that the thirty-day period begins to run from the date of the decision on reconsideration.⁴⁰ In this case, the ALJ issued a new order in response to the request for correction. Because a new order was in fact entered, the

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³⁹ Even though it is not necessary to request reconsideration in order to "exhaust" administrative remedies.

⁴⁰ See WAC 388-02-0605 thru -0635 and RCW 34.05.470.

twenty-one day deadline for both parties began to run from the date of the entry of the Corrected Initial Order.

The parties each addressed the concept of "good reason" in their briefs on this issue. And, although it is not necessary to find good reason for a late filing in this case (in order to preserve one of the party's right to request review), the undersigned wishes to address the concept, at least in the form of an alternative reason for accepting the Department's request for review.

Good reason is not defined in Chapter 388-02 WAC. Both parties in this case have equated it to "good cause." No such literal equation exists in administrative law under the Administrative Procedure Act. Attorneys may feel more comfortable in discussing the matter in good cause terms and the law is replete with instances of the use the term "good reason" in their definitions of good cause.⁴¹ Suffice it to say that what a presiding or reviewing officer in the exercise of their discretion has found to be a *good cause* would probably also always be a *good reason*. Another reasonable (and not contradictory of the immediately previous sentence) reading of the regulations is that good reason is "less" than good cause.

In this case the Assistant Attorney General representing the Department requested correction of the original order. The ALJ granted this request and in fact issued a new order with a new entry date stamped in the customary place on the first page of the order. The order itself contained a bold-face, all-caps notice that advised all the parties that they had twenty-one days from the date "of mailing of this order" to file any request for review. Neither WAC 388-02-0555 nor WAC 388-02-0580 contradicts this prominent notification beneath the ALJ's

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⁴¹ Even the APA and DSHS hearing rules use both terms. See, e.g., WAC 388-02-0020: (1) *Good cause is a substantial reason for legal justification for failing to appear, to act, or respond to an action. To show good cause, the ALJ must find that a party had a good reason for what they did or did not do, using the provisions of Superior Court Civil Rule 60 as a guideline.* (emphasis added) See, also, RCW 34.05.449(5)

signature. By any standard, this is a sufficiently "good reason" for not filing a request for review with twenty-one days after the issuance of the *original* initial order.⁴²

4. **Standard of Review.** In a case such as this, the authority of the undersigned to review a case has been modified by Department rule. A Review Judge may change an Initial Order in a case such as this only if one or more of the following defects is present: (1) irregularity affecting the fairness of the hearing; (2) findings of fact that are unsupported by substantial evidence in the record; (3) a need for additional findings of fact based upon substantial evidence in the record;⁴³ (4) an error of law; or (5) a need for clarification in order to implement the decision.⁴⁴

In this case, having fully reviewed the record and the pleadings, the undersigned finds (1) that certain of the ALJ's factual findings are not supported by substantial evidence in the record, (2) that additional factual findings are necessary, (3) that certain of the ALJ's legal conclusions are erroneous, and (5) that clarification of the order is necessary in order to implement the decision.

5. **Applicable Law.** ALJs and Review Judges must first apply the Department of Social and Health Services (DSHS) rules adopted in the Washington Administrative Code (WAC). If no DSHS rule applies, the ALJ or Review Judge must decide the issue according to the best legal authority and reasoning available, including federal and Washington State constitutions, statutes, regulations, and court decisions.⁴⁵

In this case the Superior Court judge remanded the matter for "further adjudicative proceedings before an Administrative Law Judge for further proceedings consistent with the

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⁴² This of course assumes, as is the case here, that the request for review is received at the Board in no less than thirty days *after* the filing deadline in accordance with WAC 388-02-0580(3)(a).

⁴³ See, *Kabbae v. DSHS*, 144 Wn.App. 432, 192 P.2d 903 (2008).

⁴⁴ WAC 388-02-0600(2). See the foregoing footnote for the judicial modification of subsection (2)(e) of this rule.

⁴⁵ WAC 388-02-0220.

Court's order."⁴⁶ The judge in the superior court determined that the agency should determine whether or not the Appellant was eligible for Medicaid benefits under the Early Periodic Screening Diagnosis and Treatment program (EPSDT) and that the Appellant should be given an opportunity to present evidence and make argument on other federal claims.

This language instructs the administrative tribunal to consider the Appellant's eligibility for the requested services (i.e., the 24/7 supervisory care) not only under the Medicaid Personal Care rules, but also under the rules pertaining to EPSDT. Judge Tabor was careful to point out that he had made no factual findings at that time and that the case was being returned to the ALJ for additional development of the record. What the superior court did not do was enlarge the jurisdiction of the administrative hearing process. Before either an ALJ or a Review Judge can look to federal law, they must first be guided by applicable DSHS regulations published in the Washington Administrative Code. In this case the state administrative regulations clearly incorporate the requirements of the federal regulations, which themselves clearly incorporate the federal statutes referenced in the judicial remand order.⁴⁷ Both the ALJ and the undersigned have reviewed and considered the federal statutes and regulations.

6. **Burden of Proof.** The party seeking relief in the administrative hearing process bears the burden of proof at the hearing unless a rule or statute directs otherwise. This is also known as the *burden of persuasion* and may be defined as the requirement to provide convincing evidence that will satisfy the persuasion standard; i.e., the preponderance of evidence.⁴⁸

7. **EPSDT.** The first matter that should be decided in this case is whether or not the Appellant has proven that she is eligible under the provisions of the EPSDT program for either supervisory assistance or personal care services benefits without the limitations imposed by the Medicaid Personal Care (MPC) program regulations. As noted earlier, the essence of this case is

⁴⁶ Order on Review of Administrative Decision, Thurston County Superior Court, Docket No. 05-2-01958-01 filed November 3, 2006. 000083 S

⁴⁷ In this case, 42 CFR, Part 441, Subpart B. See, WAC 388-534-0100.

⁴⁸ WAC 388-02-0480 through -0490. See, also, *Schaffer v. Weast*, 546 U.S. 49 (2005) and *Director, OWCP, Dept. of Labor v. Greenwich Collieries*, 512 U.S. 267 (1994).

that the Freeman's believe that they ought to be compensated monetarily by state and/or federal government medical programs for the 24-hour care that they have provided their daughter since she became an adult under the law in July 2004 when she became 18 years of age. Since the MPC regulations obviously operate to limit the amount of paid hours that can be provided to a Department client, the Freeman's look to the provisions of the EPSDT program in the belief that this program would eliminate any care restrictions or limitations imposed by the MPC program rules, either by characterizing the services as medically necessary supervisory assistance or as Medicaid Personal Care services.

With respect to the ALJ's legal conclusions regarding EPSDT, the ALJ ruled that (1) the Freeman's would not be allowed under federal law⁴⁹ to provide personal care services, but that (2) the Appellant was entitled to receive "24 hour - 7 days per week assistance" as because it was authorized under 42 USC 1396d(a)(13) and 42 USC 1396d(r)(5). The ALJ called this entitlement "remedial services for the maximum reduction of physical or mental disability and the restoration of an individual to the best possible functional level,"⁵⁰ and the ALJ cited the medical opinion of Dr. deGive as the persuasive authority for the proposition that these terms described the 24/7 services to be provided by the Appellant's parents. However, after having exhaustively reviewed the evidence and the law applicable to this case, the undersigned finds that the ALJ's legal conclusions on both counts are in error.

⁴⁹ 42 USC 1396d(a)(24). *But see*, 42 CFR 440.167 which provides as follows:

(a) *Personal care services means services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are--*

(1) *Authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State;*

(2) *Provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and*

(3) *Furnished in a home, and at the State's option, in another location.*

(b) *For purposes of this section, family member means a legally responsible relative.*

Under the laws applicable in this state, the Freeman's ceased being legally responsible for the Appellant in July 2004 when she attained the age of eighteen. See also, Exhibit 11, page 4.

⁵⁰ The actual language of subsection 13 of 42 USC 1396d(a) is set forth *infra*.

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The acronym EPSDT refers to the early and periodic screening, diagnosis and treatment services authorized under the 1989 amendments to the Medicaid Act. The scope of these services is set forth in 42 USC 1396d(r) as follows:

The term "early and periodic screening, diagnostic, and treatment services" means the following items and services:

(1) Screening services—

(A) which are provided—

- (i) at intervals which meet reasonable standards of medical and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care and, with respect to immunizations under subparagraph (B)(iii), in accordance with the schedule referred to in section 1396s (c)(2)(B)(i) of this title for pediatric vaccines, and*
- (ii) at such other intervals, indicated as medically necessary, to determine the existence of certain physical or mental illnesses or conditions; and*

(B) which shall at a minimum include—

- (i) a comprehensive health and developmental history (including assessment of both physical and mental health development),*
- (ii) a comprehensive unclothed physical exam,*
- (iii) appropriate immunizations (according to the schedule referred to in section 1396s (c)(2)(B)(i) of this title for pediatric vaccines) according to age and health history,*
- (iv) laboratory tests (including lead blood level assessment appropriate for age and risk factors), and*
- (v) health education (including anticipatory guidance).*

(2) Vision services—

(A) which are provided—

- (i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and*
- (ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and*

(B) which shall at a minimum include diagnosis and treatment for defects in vision, including eyeglasses.

(3) Dental services—

(A) which are provided—

- (i) at intervals which meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care, and*
- (ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and*

(B) which shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health.

(4) Hearing services—

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- (A) which are provided—
- (i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and
 - (ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and
- (B) which shall at a minimum include diagnosis and treatment for defects in hearing, including hearing aids.

(5) Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.

Nothing in this subchapter shall be construed as limiting providers of early and periodic screening, diagnostic, and treatment services to providers who are qualified to provide all of the items and services described in the previous sentence or as preventing a provider that is qualified under the plan to furnish one or more (but not all) of such items or services from being qualified to provide such items and services as part of early and periodic screening, diagnostic, and treatment services. The Secretary shall, not later than July 1, 1990, and every 12 months thereafter, develop and set annual participation goals for each State for participation of individuals who are covered under the State plan under this subchapter in early and periodic screening, diagnostic, and treatment services.

(Emphasis added.)

The State of Washington does acknowledge the duty imposed by federal law and the Department, as the single state agency responsible for implementation of the state Medicaid plan, has published administrative regulations in Chapter 388-534 WAC. These regulations reference and incorporate the federal rules with respect to EPSDT. 42 USC 1396d(r)(5) above refers back to "other measures described in subsection (a) of this section." This is a reference to the list of 28 types of care and services specifically delineated to be provided under a state's medical assistance plan that are listed in subsection (a), which provides, in pertinent part:

(a) Medical assistance

The term "medical assistance" means payment of part or all of the cost of the following care and services . . .

(1) inpatient hospital services (other than services in an institution for mental diseases);

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(2)

(A) outpatient hospital services,

(B) consistent with State law permitting such services, rural health clinic services (as defined in subsection (l)(1) of this section) and any other ambulatory services which are offered by a rural health clinic (as defined in subsection (l)(1) of this section) and which are otherwise included in the plan, and

(C) Federally-qualified health center services (as defined in subsection (l)(2) of this section) and any other ambulatory services offered by a Federally-qualified health center and which are otherwise included in the plan;

(3) other laboratory and X-ray services;

(4)

(A) nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older;

(B) early and periodic screening, diagnostic, and treatment services (as defined in subsection (r) of this section) for individuals who are eligible under the plan and are under the age of 21; and

(C) family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies;

(5)

(A) physicians' services furnished by a physician (as defined in section 1395x (r)(1) of this title), whether furnished in the office, the patient's home, a hospital, or a nursing facility, or elsewhere, and

(B) medical and surgical services furnished by a dentist (described in section 1395x (r)(2) of this title) to the extent such services may be performed under State law either by a doctor of medicine or by a doctor of dental surgery or dental medicine and would be described in clause (A) if furnished by a physician (as defined in section 1395x (r)(1) of this title);

(6) medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law;

(7) home health care services;

(8) private duty nursing services;

(9) clinic services furnished by or under the direction of a physician, without regard to whether the clinic itself is administered by a physician, including such services furnished outside the clinic by clinic personnel to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address;

(10) dental services;

(11) physical therapy and related services;

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(12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

(13) other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level;

(14) inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases;

(15) services in an intermediate care facility for the mentally retarded (other than in an institution for mental diseases) for individuals who are determined, in accordance with section 1396a (a)(31) of this title, to be in need of such care;

(16) effective January 1, 1973, inpatient psychiatric hospital services for individuals under age 21, as defined in subsection (h) of this section;

(17) services furnished by a nurse-midwife (as defined in section 1395x (gg) of this title) which the nurse-midwife is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider, and without regard to whether or not the services are performed in the area of management of the care of mothers and babies throughout the maternity cycle;

(18) hospice care (as defined in subsection (o) of this section);

(19) case management services (as defined in section 1396n (g)(2) of this title) and TB-related services described in section 1396a (z)(2)(F) of this title;

(20) respiratory care services (as defined in section 1396a (e)(9)(C) of this title);

(21) services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner (as defined by the Secretary) which the certified pediatric nurse practitioner or certified family nurse practitioner is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the certified pediatric nurse practitioner or certified family nurse practitioner is under the supervision of, or associated with, a physician or other health care provider;

(22) home and community care (to the extent allowed and as defined in section 1396t of this title) for functionally disabled elderly individuals;

(23) community supported living arrangements services (to the extent allowed and as defined in section 1396u of this title);

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(24) *personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are*

(A) authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State,

(B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and

(C) furnished in a home or other location;

(25) *primary care case management services (as defined in subsection (t) of this section);*

(26) *services furnished under a PACE program under section 1396u-4 of this title to PACE program eligible individuals enrolled under the program under such section;*

(27) *subject to subsection (x) of this section, primary and secondary medical strategies and treatment and services for individuals who have Sickle Cell Disease; and*

(28) *any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary,*

...

In order for a service or treatment to be provided under the auspices of the EPSDT program the item or service must be a medical screening service, vision service, dental service or hearing service. If the service cannot be characterized in one of those four categories, then there is a residual (or catch-all) category that might allow the requested service. In the Appellant's case, this residual category is the only one where the requested supervisory service might be found, and in that respect at least the undersigned concurs with ALJ Habegger's legal conclusion. As set forth above in bold face (on pages 72 & 73), this category encompasses those "health care, diagnostic services, treatment, *and other measures* described in subsection (a) to *correct or ameliorate* defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan."⁵¹

The ALJ concluded as a matter of law that the supervisory service provided by the Freeman's

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⁵¹ 42 USC 1396d(r).

(an extension of the parental supervision that Jean and Loren Freeman had always exercised for their daughter) was an "other measure" that could be found in the statute at subsection (a)(13).

However, as noted above, (a)(13) is for "other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services recommended by a physician . . . for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level." The ALJ concluded that the Freeman's supervision was "remedial" primarily because Dr. deGive used the term in his testimony.⁵² The problem is that the supervision being provided by the Freeman's is largely undefined and the most medically-related definition of it (as supplied by both Dr. deGive and Dr. Sciarrone) is that it is the type of supervision that a parent provides to a toddler to ensure that no harm comes to the child based on their lack of judgment and lack of experience in the ways of the world.

This type of supervision, at its very core, is directly related to the quintessential protective and educational role of the parent. It is neither remedial nor ameliorative. It is not remedial because it doesn't cure any medical condition and it isn't ameliorative because it doesn't improve any medical condition. Keeping track of a child and ensuring that the child comes to no harm is not "remedial" in nature. It is therefore not medical. And, if it is not related to the medical treatment for an underlying condition, then it is simply not a covered service under the EPSDT program.⁵³

Since the supervisory services being provided by the Freeman's are not remedial in the medical sense of the term, then they cannot be authorized under the 42 USC 1396d((a)(13).

⁵² See ALJ's Conclusions of Law 23 and 24 in the Corrected Initial Order.

⁵³ The Appellant refers in the Response to the term "mere observation" in WAC 388-500-0005's definition of medical necessity, indicating that this equates to the supervision exercised by the Freeman's. The undersigned disagrees and finds that the use of this term in the medical necessity definition means that the person treating the underlying medical condition may appropriately choose to simply monitor the patient's condition before determining the necessity of further treatment.

The implementing rules for the EPSDT program found in the Code of Federal Regulations provide in 42 CFS 440.40(b) that:

- (b) *EPSDT. "Early and periodic screening and diagnosis and treatment" means*
- (1) *Screening and diagnostic services to determine physical or mental defects in recipients under age 21; and*
 - (2) *Health care, treatment, and other measures to **correct or ameliorate any defects and chronic conditions discovered.***

(Emphasis added.) While it is true that the Appellant requires supervision, much as a child would, that supervisory care will neither improve nor cure her condition. Since that is true, that care is not a service or treatment that can be provided under the EPSDT program.

On the appeal the Department has stated that the supervisory care services being requested are not "personal care services," at least in the sense that the term is used in 42 USC 1396d(a)(24). The ALJ decided that the services at issue were more properly characterized as personal care services as opposed to supervision. The undersigned is in essential agreement with ALJ Habegger in this regard, but it doesn't really matter. In order for a service or treatment to be ordered under the EPSDT it must meet the criteria referred to above with respect to the Appellant's condition: neither "personal care services" under 1396d(a)(24) nor "other remedial services" under 1396d(a)(13) meet the federal statutory and regulatory requirements for the EPSDT program that they cure or improve the Appellant's condition. Therefore, based on all the evidence presented and after consideration of the applicable federal statutes and regulations, the Appellant is *not eligible under the EPSDT program* for supervisory or personal care services. That does not mean, however, that the Appellant is not eligible for some personal care services under another program.

General supervision in and of itself is not medical treatment. On the other hand, personal care services that may contain a supervisory component might very well be considered appropriate after a considered assessment. 42 USC 1396d(a)(24) refers to this subsection (A) where it provides that the services could be "authorized for the individual by a

physician in accordance with a plan of treatment or *(at the option of the state) otherwise authorized for the individual in accordance with a service plan approved by the state.*" The State of Washington has clearly opted to provide personal care services in the context of the CARE assessment process and, in the case of the Appellant, to provide them under the Medicaid Personal Care program. In other words; an assessment under the state plan determines the nature and extent of the personal care services that may be appropriate in a given case, and not the patient's health care provider. Persons may disagree with this scheme, but it is the law both of the state and the federal government.

8. **Findings of Fact.** The undersigned has changed some of the ALJ's factual findings in the Corrected Initial Order and has added some additional factual findings to the record. The authority for these changes is found in WAC 388-02-0600(2)(b), *Tapper v Employment Security Dept.*, 122 Wn.2d 397, 858 P.2d 494 (1993), and *Kabbae v DSHS*.⁵⁴ As the Division One Court of Appeals said recently:

In Tapper [citation omitted] the court held that RCW 34.05.464(4) authorizes the agency to substitute its own findings of fact for those made by the ALJ. The court looked to federal cases interpreting a virtually identical provision and concluded that under the statutory language, administrative review is different from appellate review. [Citation omitted] The court held that in enacting RCW 34.05.464(4), the legislature made the judgment that "the final authority for agency decision-making should rest with the agency head rather than with his or her subordinates, and that such final authority includes 'all the decision-making power' of the hearing officer." Tapper, 122 Wn.2d at 405.

Kabbae at 441.

The changes made to Finding of Fact (FOF) 1 simply states more accurately the contents of Thurston County Superior Court Judge Tabor's November 2006 remand order.

The Department asked the undersigned to change FOF 3 to reflect that the Appellant's eligibility for MPC benefits begins September 1, 2004, and not July 1, 2004, as the ALJ found in Amended Initial Order. The undersigned has declined to change FOF 3 as it appears in the
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⁵⁴ See, fn. 43 *supra* for the full citation for *Kabbae*.
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Review Decision and Final Order because it is simply a restatement of what the ALJ found had "found" in the Amended Initial Order, and so it is not inaccurate in that regard.⁵⁵

The Appellant asked the undersigned to change FOF 5 to reflect that the Appellant's eligibility for MPC benefits begins July 1, 2004, and not September 1, 2004. The undersigned has changed FOF 5 to more correctly reflect the evidence. However, the evidence does not support a finding that MPC benefits were awarded as of July 1; only that categorically needy medical assistance was approved for the Appellant on that date. Footnote #55 contained in the previous paragraph relative to FOF 3 is also germane to this paragraph.

In FOF 8 the undersigned has corrected a transposition error in line 3.

FOF 10, 11, 14, 15 and 16 have not been adopted because the undersigned has added at a later point in the findings the necessary findings of fact to support the analyses of the 2004, 2005 and 2006 CARE assessments.⁵⁶

In FOF 12 the undersigned added language to the finding that makes it clear why the Department found "clinical complexity."

FOF 17 was changed to make it clear which of the Appellant's physicians had referred to the condition of aphasia.

In FOF 20 the ALJ had found that the Appellant had been diagnosed with aphasia and apraxia. This finding is not supported by any (let alone substantial) evidence in the record. First of all, the condition known as apraxia is, with respect to the salient issue of clinical complexity, simply not relevant. Second, there *no evidence* of a diagnosed condition of aphasia prior to June 2007. Moreover, there is only scant evidence of a qualified diagnosis in June 2007, given the lack of reference to the condition in Dr. Sciarrone's chart notes and the fact that the doctor was "led" by the letter from Loren Freeman to express an opinion on a complex

⁵⁵ The issue of *when* the Appellant is eligible for MPC in 2004 is a matter of law and will be addressed appropriately by the undersigned in Conclusion of Law 9 *infra*, which addresses this issue in the context of the Department's appeal from the Amended Initial Order.

⁵⁶ The ALJ had failed to provide an analysis of any of the three CARE assessments at issue in the case.

diagnosis that the doctor may not have been qualified to make.⁵⁷ The undersigned changed the finding by fully illuminating the evidence in the record and entering the only finding possible in this case, to wit: for the period July 2004 through June 2007 there is no evidence that the Appellant had been diagnosed with the condition of either expressive or receptive aphasia.

FOF 34, a reference by the ALJ to a declaration from an employee of the Department, was not adopted since it simply refers to a document that was not admitted into evidence by the ALJ, nor has it been admitted into evidence or considered by the undersigned on review.

FOF 35 through 118 have been added by the undersigned because of the necessity that the CARE assessments for 2004, 2005 and 2006 all be reviewed. The ALJ did not review those assessments because she erroneously concluded that the 2007 CARE assessment should control the Appellant's entitlement to MPC benefits for each of the three previous years.

9. **Amended Initial Order - Department's Appeal.** The ALJ ruled in the Amended Initial Order of March 21, 2008, that the Appellant was eligible for MPC benefits on July 1, 2004. The Department has appealed this determination. The ALJ did not make any specific legal conclusion in the Corrected Initial Order of July 3, 2008, relative to the "start" date for the Appellant's eligibility for MPC, but the ALJ at least tacitly confirmed her March 21st ruling by referring to the month of August 2004 in that order's conclusion of law #31.

The Department's appeal is well-taken: under the rule applicable at the time of the Department's determination in September 2004,⁵⁸ clients were informed:

Am I eligible for one of the HCP programs? You are eligible to receive HCP services if you meet the functional and financial eligibility requirements in WAC 388-72A-0055 for COPES, WAC 388-72A-0057 for Medically Needy Residential Waiver, WAC 388-72A-0058 for Medically Needy In-home Waiver, WAC 388-72A-0060 for MPC, or WAC 388-72A-0065 for Chore. Functional eligibility for all HCP programs is determined through an assessment as provided under WAC

⁵⁷ But the 2007 CARE assessment is not being reviewed in this hearing - it is apparently the subject of a separate case that is presently in another Superior Court review of an Office of Administrative Hearings administrative order. It is fair to say, as did Dr. deGive, that the Appellant suffers from an "aphasia-like" condition - but that is not the same as a diagnosis of expressive or receptive aphasia.

⁵⁸ WAC 388-72A-0053.

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388-72A-0025. *Your eligibility begins upon the date of the department's service authorization.*

(Emphasis added.) This rule is clear and unequivocal, assuming that the meaning of the term “service authorization” can be determined. However, the evidence available in the record upon which the determination must be made is not quite as clear. Moreover, the question that needs to be resolved isn’t really when the Appellant became eligible for MPC services, but rather when her provider may be paid for MPC services.

Page 2 of Exhibit 1 is the notice to the Freeman’s from the Department advising them that their daughter’s MPC benefits were authorized effective August 13, 2004. This notice was obviously drafted in the expectation that it would ordinarily be used to convey “bad news” to Department clients; e.g., reductions or terminations of service. However, the purpose of this particular notice is obviously to inform the Freeman’s that their daughter had just been determined to be eligible for MPC benefits with an effective date of August 13, 2004. The case manager has annotated the title of the document with the word “authorization” to signify that this is a notice of eligibility.

Pages 2 and 3 of Exhibit 2 on the other hand are also service authorization notifications. And in this case they provide the more relevant information: Ms. Jean Freeman was approved to be a parent care provider as of September 1, 2004. Mr. Loren Freeman was also approved to be a parent care provider effective September 1, 2004. There is no evidence in the record that indicates that either of them were approved to provide care prior to that time.

So what the evidence shows is that the Appellant became eligible for medical assistance in July and for MPC benefits on August 13, 2004, but did not have an eligible care provider approved until September 1, 2004. Based on the evidence taken at the hearing, since there wasn’t an approved care provider until September 1, 2004, that is the date that the Department must begin paying for service care hours invoiced by the Appellant’s parents. To find any date

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earlier than this (or at the very worst any date prior to August 13, 2004) would be to ignore the clear requirement of WAC 388-71A-0053. And the rules applicable to administrative hearings clearly prohibit both the ALJ and the undersigned from failing to enforce the applicable departmental regulations. Therefore the ALJ's ruling in the Amended Initial Order granting summary judgment on the issue of the date that the Appellant may begin receiving MPC benefits is reversed.

10. **Amended Initial Order - Appellant's Appeal.** The Amended Initial Order contained the orders detailed in FOF 3 *supra*. In November 2007 the Appellant filed an Interlocutory Appeal relating to three elements of ALJ Habegger's original Initial Order, which carried forward into the subsequently issued amended order. The appeal⁵⁹ disputed (1) the ALJ's denial of summary judgment on whether the 2007 CARE assessment should be applied retroactively to the entire period spanned by the case; (2) the ALJ's denial of summary judgment on the issue of whether DSHS is bound by the determination of the Social Security Administration that the Appellant resided "alone;" and the last issue raised by the Appellant: (3) the ALJ's alleged failure to rule on the Appellant's claim that DSHS had violated federal regulations with respect to notice about the EPSDT program.

With respect to (1) above, although the ALJ denied summary judgment on the issue, she later found on the merits in the Corrected Initial Order that the 2007 CARE assessment should be applied retroactively to determine the Appellant's MPC care needs for 2004, 2005, and 2006; thus rendering moot the earlier ruling in the Amended Initial Order. A case is moot if the issues it presents are "purely academic."⁶⁰ It is not moot, however, if a court can still provide effective relief.⁶¹ The court in *Pentagram* explained that a case is considered moot if there is no longer a controversy between the parties; if the question is merely academic; or if a substantial question

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⁵⁹ Which may be found in its entirety in paragraph 2, pages 1 & 2 of this Review Decision.

⁶⁰ *State v. Turner*, 98 Wn. 2d 731, 733, 658 P. 658 2d (1983), citing *Grays Harbor Paper Co. v. Grays Harbor Cy.*, 74 Wn.2d 70, 73, 442 P.2d 967 (1968).

⁶¹ *Turner, id.*, citing *Pentagram Corp. v. Seattle*, 28 Wn. App. 219, 223, 622, P.2d 892 (1981).

no longer exists. *Pentagram*, 28 Wn. App. At 223. In this case, the undersigned concludes that there is no real controversy between the parties and the issue presented is purely academic. The undersigned will not address further this aspect of the Appellant's appeal from the ALJ's rulings on the summary judgment motions.

As far as the matter raised by the Appellant in (2) above is concerned, the undersigned is unable to determine from the record why this issue was even raised. The Appellant's living arrangements are clearly a matter of record and neither party has indicated any dispute with the facts as found. The Appellant's Interlocutory Appeal filed on November 26, 2007, does not indicate the importance of this issue and provides no legal argument or authority that would provide any guidance. Moreover, the Appellant's Petition for Review filed on July 16, 2008, simply "incorporates her earlier interlocutory appeal within this appeal by reference" and does not provide any further legal argument or authority to support the claim that the ALJ legally erred in failing to grant summary judgment on the issue.

WAC 388-02-0575 is the Department rule relating to the filing of appeals with the Board of Appeals. It provides:

A party must make the review request in writing, send it to BOA, and clearly identify the:

- (1) Parts of the initial order with which the party disagrees; and*
- (2) Evidence supporting the party's position.⁶²*

Given that the undersigned can find no argument or evidence to decide the issue one way or the other, and since there does not appear to be any purpose in overturning the ALJ's ruling that only denied summary judgment, the undersigned denies this portion of the Appellant's appeal.

The last portion of the Appellant's appeal actually **only** relates to the "original" Initial Order (which was dated November 5, 2007). As noted before, the Appellant's interlocutory appeal was filed on November 26, 2007, and this is the document which raises the issue.

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⁶² This citation is from the version of the regulation that was effective November 21, 2008. However the rule that was in effect at the relevant time was virtually identical.

However, the ALJ has already addressed this interlocutory matter: in the Amended Initial Order dated March 21, 2008, ALJ Habegger corrected her November 2007 ruling to include a reference to the EPSDT notice issue and ruled that, pursuant to the Superior Court order, the issue of the adequacy of the Department's "notice and outreach" with respect to the EPSDT program as well as the Appellant's eligibility for the program would be determined on the merits. Inasmuch as an administrative hearing was subsequently held and the matters addressed, any appeal relating to the issue would be necessarily be from the Corrected Initial Order. Those matters raised in the parties' appeals from the Corrected Initial Order will be addressed in the next section of these Conclusions.⁶³

11. **Corrected Initial Order - Department's Appeal.** In addition to the objection to FOF 3 as found by the ALJ (which has already been addressed previously in this Review Decision), the Department has also objected to the legal conclusions entered by the ALJ as numbers 16, 18, 23, 31 and 32. The undersigned has not adopted any of these conclusions in this Review Decision and Final Order because they are based on an erroneous interpretation or application of the relevant law. As noted in Conclusion of Law 7 *supra*, the Appellant was not eligible for any EPSDT services, so any of the conclusions relating to that program are either erroneous or irrelevant.⁶⁴

With respect to the Department's two objections to ALJ Habegger's legal conclusion numbered 32, the undersigned agrees in part and disagrees in part. The Department's first contention was that the ALJ did not need to review the 2004 CARE assessment because the

⁶³ It is also not clear what the Appellant's attorney is asking for. It would appear that he is asserting that the ALJ should have granted him summary judgment on the ESPDT notice issue, yet that position seems tenuous at best. After all, if anything at all is clear in this case, it is that there are many disputed factual issues relating to the Appellant's eligibility for EPSDT as well as what notices were or were not given. The ALJ was entirely correct to have deferred further consideration of the issue until it could be developed in the record (assuming that the parties chose to pursue the matter). Furthermore, summary judgment is not provided for under either the APA or the Department's hearing rules. See, e.g. *Verizon NW Inc. v Employment Security Department*, 194 P.3d 255 (2008). And although the DAD 00985 adopted a rule (WAC 10-08-135) in 1999 which allows an ALJ to render summary judgment, there are no established review procedures with respect to such determinations. However, the aforementioned *Verizon* case provides excellent guidance for reviewing authorities in the matter.

⁶⁴ This refers specifically to the ALJ's numbered legal conclusions 16, 18, 23 and 31 in the Corrected Initial Order.

terms of the Thurston County Superior Court remand did not require a redetermination. The undersigned does not concur with this position and concludes that the 2004 CARE assessment must be reviewed (along with the 2005 and 2006 assessments). Superior Court Judge Tabor's November 3, 2006, order vacated the Review Decision and Final Order entered at the Board of Appeals by Review Judge Sturges on August 21, 2005. To vacate an order or judgment is to annul it or set it aside, thus rendering it void. It was the agency's final order which was vacated, therefore any new hearing on the matter would need to enter factual findings and legal conclusions with respect to the matters asserted in the request for hearing. A *de novo* hearing was required with respect to all three of the CARE assessments consolidated for hearing under these three docket numbers.⁶⁵

The Department's second contention with respect to legal conclusion 32 is that the ALJ erred legally in concluding that the provisions of the 2007 CARE assessment must be used to determine the outcome of the 2004, 2005 and 2006 assessments. The undersigned concurs and, as is obvious from the factual findings previously entered, has undertaken to correctly analyze each year's CARE assessments in light of the available evidence.⁶⁶

This particular legal conclusion is troubling for more than one reason. For one thing, the ALJ states, "In the alternative, *had I not decided this case under the EPSDT program*, a review of the 2004, 2005 and 2006 CAREs would be necessary." And then the ALJ proceeds to determine a radically different remedy based on an erroneous factual determination that the condition of aphasia actually existed prior to 2007 and therefore should have been applied to the assessments conducted in 2004, 2005 and 2006. Since the undersigned has found that the substantial weight of the evidence does not support any such finding, and in fact that the weight of the evidence is that it is far more likely that the Appellant does not suffer from a *diagnosed*

⁶⁵ See, Conclusion of Law 1, pages 63 & 64, *supra*.

⁶⁶ The undersigned disagrees with the Department's specific contention with respect to the meaning of *de novo* review, but an examination of that issue is unnecessary in this case due to the undersigned's resolution of the assessments themselves.

condition of aphasia at all, the ALJ's legal conclusion cannot be supported and is therefore not adopted.

12. **Corrected Initial Order - Appellant's Appeal.** Aside from her objection to FOF 5,⁶⁷ the Appellant also objects to portions of the ALJ's legal conclusions numbered 18 and 31. The Appellant's attorney is certainly correct with respect to the personal care disqualification issue in #18, and the undersigned has previously addressed the matter in Conclusion of Law 7, page 71, *supra*. With respect to the Appellant's objection to a portion of the contents of #31, the undersigned has not adopted any of the ALJ's EPSDT legal conclusions, and therefore the issue of whether or not the Freeman's should be paid for supervisory services provided while they may have been sleeping is irrelevant.

13. **The CARE Assessments.** Since the Appellant is not eligible for the requested EPSDT services, the CARE assessments conducted by the Department must be reviewed under the applicable Department rules. Since each assessment was separately appealed and the subject of a specific docket number, each year's assessment will be separately considered and an order entered that will establish the Appellant's MPC entitlement for 2004, 2005 and 2006. The undersigned has considered all of the testimony given at the hearing as well as all of the documents admitted into evidence throughout the proceedings. Having entered the necessary findings of fact with respect to the three different CARE assessments considered at the hearing and having considered the appropriate Department regulations, the following legal conclusions are entered.⁶⁸

14. **2004 CARE Assessment.** Medicaid Personal Services are included with MPC funded residential services under the title of Home and Community Programs (HCP).⁶⁹ By Department rule, beginning March 22, 2003, the CARE tool replaced all other assessment

⁶⁷ The undersigned largely concurs with this assignment of error and has corrected the finding accordingly.

⁶⁸ There were some rule changes between the 2004 and 2006 assessments, so the legal conclusions have to be tailored a little differently and the rules citations are different as well. That having been said, there will still be a certain amount of repetition in the legal conclusions rendered for the three CARE assessments.

⁶⁹ WAC 388-71-0405(2).

methods previously used by the Department to determine clients' eligibility for HCP services.⁷⁰ This rule required that the CARE tool be used when the Department: (a) initially assessed an applicant for HCP services; (b) completed an annual reassessment for services; or (c) completed an assessment based on a significant change in condition.⁷¹ Based on a separate Department rule effective August 3, 2003, the Department also discontinued payment for shopping, housework, laundry, meal preparation, or wood supply services to HCP clients when they and their individual provider resided in the same household.⁷² The CARE tool was updated to automatically incorporate this limitation within its algorithm and, *at the time of the assessments in this case*, did not authorize any MPC service hours for shopping, housework, laundry, meal preparation, or wood supply services when an individual provider resides in the same household as the MPC client. Finally, the Department's rules specifically prohibit payment for services already available to the client on a paid or unpaid basis.⁷³

The CARE tool processes the information gathered by the assessor through an algorithm. An algorithm is "a numerical formula utilized by the CARE assessment software that determines a classification group, payment level and referral needs based upon information documented in the CARE assessment."⁷⁴

The number of in-home hours an individual is determined eligible to receive is based upon fourteen (14) care groups. Each classification group is assigned a base number of care hours.⁷⁵ CARE is used to assess client characteristics and place an individual in a classification group based upon the assessment.

The CARE tool evaluates an individual's cognitive performance, clinical complexity, mood/behaviors and activities of daily living (ADLs) in order to place an individual into a

⁷⁰ WAC 388-72A-0015.

⁷¹ WAC 388-72A-0005.

⁷² WAC 388-71-0460(3), and later WAC 388-72A-0095.

⁷³ WAC 388-71-0460(1).

⁷⁴ WAC 388-72A-0069.

⁷⁵ WAC 388-72A-0070.

classification group. Only the amount of assistance required to perform the ADL in the seven days prior to the assessment is considered.⁷⁶

The substantial weight of the evidence of record is that the Department used the CARE algorithm on July 9, 2004, in order to evaluate the Appellant's eligibility for MPC benefits. Additionally, the hearing evidence, with the exceptions noted below, supported the conclusions that the Appellant was properly and correctly evaluated by her case manager with respect to: (a) her cognitive performance; (b) the clinical complexity of her medical conditions; (c) any mood/behaviors that would require additional hours of care; and (d) the amount of assistance she needed to perform her Activities of Daily Living (ADLs).⁷⁷ Finally, this evidence also demonstrated that, again with the exceptions noted below, the case manager entered the above assessments correctly into the CARE algorithm.

The exceptions to the foregoing conclusions, as supported by the factual findings adopted by the undersigned (especially Finding of Fact 74), are: the Appellant's hoarding & collecting behaviors provide the foundation for placement into the mood and behavior classification group, the Appellant requires extensive assistance in making transfers out of bed in the morning and must be helped by the providers on a daily basis, the Appellant requires extensive assistance with toileting in order to ensure proper hygiene, and the Appellant also requires extensive assistance in dressing on a daily basis.

Based on the foregoing changes to the 2004 CARE assessment, the Appellant should have been classified as mood and behavior - yes, cognitive performance score = 4, not clinically complex, and with an ADL score between 15 and 28. This classifies the Appellant as **Level B High** and therefore eligible for 155 base hours of in home care.

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⁷⁶ WAC 388-72A-0080.
⁷⁷ WAC 388-72A-0075.
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As noted in Finding of Fact 74, after the deductions for informal supports and application of the shared living rule, the Appellant is entitled to **127 hours** of in home care beginning September 1, 2004.

15. **2005 CARE Assessment.** Medicaid Personal Services are included with MPC funded residential services under the title of Home and Community Programs (HCP).⁷⁸ By Department rule, beginning March 22, 2003, the CARE tool replaced all other assessment methods previously used by the Department to determine clients' eligibility for HCP services.⁷⁹ This rule required that the CARE tool be used when the Department: (a) initially assessed an applicant for HCP services, (b) completed an annual reassessment for services, or (c) completed an assessment based on a significant change in condition. Based on a separate Department rule effective August 3, 2003, the Department also discontinued payment for shopping, housework, laundry, meal preparation, or wood supply services to HCP clients when they and their individual provider resided in the same household.⁸⁰ The CARE tool was updated to automatically incorporate this limitation within its algorithm and, *at the time of the assessments in this case*, did not authorize any MPC service hours for shopping, housework, laundry, meal preparation, or wood supply services when an individual provider resides in the same household as the MPC recipient.

The CARE tool processes the information gathered by the assessor through an algorithm. An algorithm is "a numerical formula utilized by the CARE assessment software that determines a classification group, payment level, and referral needs based upon information documented in the CARE assessment."

The number of in-home hours an individual is determined eligible to receive is based upon fourteen (14) care groups. Each classification group is assigned a base number of care

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⁷⁸ WAC 388-106-0015.

⁷⁹ WAC 388-72A-0015.

⁸⁰ WAC 388-71-0460(3), later WAC 388-72A-0095, and still later WAC 388-106-0130.

hours.⁸¹ CARE is used to assess client characteristics and place an individual in a classification group based upon the assessment.

The CARE tool evaluates an individual's cognitive performance, clinical complexity, mood/behaviors, and ADLs in order to place an individual into a classification group.⁸² Only the amount of assistance required to perform the ADL in the seven days prior to the assessment is considered.⁸³

The weight of the evidence taken at the hearing clearly shows that the Department used the CARE algorithm on October 26, 2005, in order to evaluate the Appellant's continued eligibility for MPC benefits. Additionally, the evidence, with the exception noted below, demonstrated that the Appellant was properly and correctly evaluated by her case manager with respect to: (a) her cognitive performance, (b) the clinical complexity of her medical conditions, (c) any mood/behaviors that would require additional hours of care, and (d) the amount of assistance she needed to perform her ADLs. Finally, the hearing evidence also demonstrated, again with the exception noted below, that the case manager entered the above assessments correctly into the CARE algorithm.

The single exception to the foregoing conclusions, as supported by the factual findings adopted by the undersigned (especially Finding of Fact 96), is: the Appellant requires extensive assistance with toileting in order to ensure proper hygiene.

Based on the foregoing change to the 2005 CARE assessment, the Appellant should have been classified as mood and behavior - yes, cognitive performance score = 4, not clinically complex, and with an ADL score between 15 and 28. This classifies the Appellant as **Level B High** and eligible for 155 base hours of in home care.

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⁸¹ WAC 388-106-0080.

⁸² WAC 388-106-0085.

⁸³ WAC 388-106-0105 and -0010 "Self performance for ADLs."

As noted in Finding of Fact 96, after the adjustments for informal supports and application of the shared living rule, the Appellant is entitled to **126 hours** of in home care beginning November 1, 2005.⁸⁴

16. **2006 CARE Assessment.** Medicaid Personal Services are included with MPC funded residential services under the title of Home and Community Programs (HCP).⁸⁵ By Department rule, beginning March 22, 2003, the CARE tool replaced all other assessment methods previously used by the Department to determine clients' eligibility for HCP services.⁸⁶ This rule required that the CARE tool be used when the Department: (a) initially assessed an applicant for HCP services, (b) completed an annual reassessment for services, or (c) completed an assessment based on a significant change in condition. Based on a separate Department rule effective August 3, 2003, the Department also discontinued payment for shopping, housework, laundry, meal preparation, or wood supply services to HCP clients when they and their individual provider resided in the same household.⁸⁷ The CARE tool was updated to automatically incorporate this limitation within its algorithm and, *at the time of the assessments in this case*, did not authorize any MPC service hours for shopping, housework, laundry, meal preparation, or wood supply services when an individual provider resides in the same household as the MPC recipient.

The CARE tool processes the information gathered by the assessor through an algorithm. An algorithm is "a numerical formula utilized by the CARE assessment software that determines a classification group, payment level, and referral needs based upon information documented in the CARE assessment."

The number of in-home hours an individual is determined eligible to receive is based upon fourteen (14) care groups. Each classification group is assigned a base number of care

⁸⁴ The reason for the one hour reduction from 2004 to 2005 is due to the determination that the Appellant has some of her toileting and eating needs met while out of her parents' immediate care during the day.

⁸⁵ WAC 388-106-0015.

⁸⁶ WAC 388-72A-0015.

⁸⁷ WAC 388-71-0460(3), later WAC 388-72A-0095, and still later WAC 388-106-0130.

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hours.⁸⁸ CARE is used to assess client characteristics and place an individual in a classification group based upon the assessment.

The CARE tool evaluates an individual's cognitive performance, clinical complexity, mood/behaviors, and ADLs in order to place an individual into a classification group.⁸⁹ Only the amount of assistance required to perform the ADL in the seven days prior to the assessment is considered.⁹⁰

The factual findings adopted by the undersigned (especially Finding of Fact 117) clearly demonstrate that the Department used the CARE algorithm on October 31, 2006, in order to evaluate the Appellant's continued eligibility for MPC benefits. Additionally, that evidence also demonstrated that the Appellant was properly and correctly evaluated by her case manager with respect to: (a) her cognitive performance, (b) the clinical complexity of her medical conditions, (c) any mood/behaviors that would require additional hours of care, and (d) the amount of assistance she needed to perform her ADLs. Finally, the hearing evidence also established that the case manager entered the above assessments correctly into the CARE algorithm.

Based on the 2006 CARE assessment, the Appellant should have been classified as mood and behavior - yes, cognitive performance score = 4, not clinically complex, and with an ADL score between 15 and 28. This classifies the Appellant as **Level B High** and eligible for 155 base hours of in home care.

Finally, as noted in Finding of Fact 117, after the adjustments for informal supports and application of the shared living rule, the Appellant is entitled to **126 hours** of in home care beginning November 1, 2006.

17. **Shared Living Rule.** The Department does not pay for "informal support" already provided to the client. An informal support is a person or resource that is available to provide

⁸⁸ WAC 388-106-0080.

⁸⁹ WAC 388-106-0085.

⁹⁰ WAC 388-106-0105 and -0010 "Self performance for ADLs."

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assistance without MPC program funding. The rules applicable at the time of each of these CARE assessments required the evaluator to determine the level of informal support available to assist the client in the completion of each ADL, and each instrumental activity of daily living (IADL). At the time of these assessments, the Department was required to use the CARE tool as outlined in WAC 388-71-0460(3), WAC 388-72A-0095 or WAC 388-106-0130 (depending upon the particular rule in effect when the assessment was accomplished) when evaluating the amount of informal support available to the Appellant, thereby determining her eligibility for personal care hours. Pursuant to this rule, the case worker was required to automatically use a "met" informal support designation for the IADL's of shopping, housework, laundry and meal preparation because the Appellant resided with her care providers.

Neither the ALJ nor the undersigned has the authority to decide that a DSHS rule is invalid or unenforceable. Only a court may decide this issue.⁹¹ However, since the initial hearing, the Washington Supreme Court invalidated WAC 388-106-0130(b), thereby requiring the Department to specifically determine the level of informal support available to a client for each of these IADLs.⁹² For those cases where a hearing was held that considered the issue prior to the invalidation of the shared living rule, the Department has adopted a process of internally reviewing the files and determining the amount that each party should receive as a form of "back payment."

According to the evidence in the record of this case, the Freeman's have received in 2008 payments totaling \$6676.80 based on the Department's calculation of the shared living rule adjustment. However, based on the outcome of this Review Decision and Final Order increasing the number of hours of MPC in home care due to the Appellant in each of the three years covered by the Order, the Department may have to recalculate the amount due the Freeman's. There is insufficient information before the undersigned to be able to determine

⁹¹ WAC 388-02-0225(1).

⁹² See, *Jenkins, et. al., v. Dep't of Soc. & Health Servs. (DSHS)*, 160 Wn.2d 287, 157 P.3d 388 (2007).

0001075

what, if any, additional funds might be necessary to comply with the invalidation of the shared living rule, but the Department appears to have an internal process in place to administratively accomplish these adjustments.

18. The undersigned has considered the Amended Initial Order, the Corrected Initial Order, both the Appellant's and the Department's Petitions for Review, all of the numerous additional appellate pleadings filed by each of the parties, as well as the entire hearing record. The factual findings have been modified and supplemented as necessary. All of the conclusions of law necessary for the resolution of both the Appellant's and the Department's appeals have been entered herein by the undersigned as Conclusions of Law 1 through 17, and this Review Decision and Final Order constitutes the final agency order under the Washington Administrative Procedure Act, RCW 34.05.464. Any arguments in the Petitions for Review and any other appellate pleadings that are not specifically addressed have been duly considered but are found to have no merit or to not substantially affect a party's rights. The procedures and time limits for seeking reconsideration or judicial review of this decision are in the attached statement.

DECISION AND ORDER

1. The Amended Initial Order is **affirmed in part and reversed in part**:

a. Sections I, II, III, IV and VI are affirmed (to the extent that they were not necessarily subsumed in the Corrected Initial Order).

b. Section V is reversed - the correct beginning date for MPC services is September 1, 2004.

2. The Corrected Initial Order is **reversed**.

3. The Appellant is not entitled to any services under the EPSDT program for the period July 18, 2004, through July 17, 2007.

000108 S

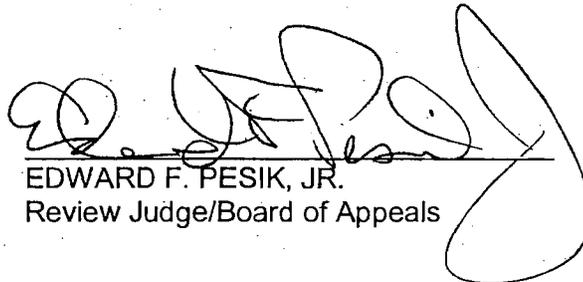
4. The Appellant is entitled to 127 hours of in home care for the period September 1, 2004, through October 31, 2005.

5. The Appellant is entitled to 126 hours of in home care for the period November 1, 2005, through October 31, 2006.

6. The Appellant is entitled to 126 hours of in home care beginning November 1, 2006, and continuing until the day prior to her twenty-first birthday on July 18, 2007. It appears from the record that it was the Department's intention that a new CARE plan would be implemented when the Appellant became twenty-one years old.

7. The Department shall review these three newly-established MPC entitlements and determine whether any further retroactive adjustments may be owed to the Appellant based on the invalidation of the shared living rule.

Mailed on the 8th day of December, 2008.



EDWARD F. PESIK, JR.
Review Judge/Board of Appeals

Attached: Reconsideration/Judicial Review Information

Copies have been sent to: Faith Freeman, Appellant
Loren Freeman, Other
Paul Neal, Appellant's Representative
Bruce Work, Department Representative, MS: 40124
Mark Ebbeson, Program Administrator, MS: 45504
Sharon Mannion, Program Administrator, MS: 45310
Jane L. Habegger, ALJ, Olympia OAH

000109.5

Attachment B

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**IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON
IN AND FOR THE COUNTY OF THURSTON**

FAITH FREEMAN

No. 05-2-01953-8

v.

**STATE OF WASHINGTON,
DEPARTMENT OF SOCIAL AND HEALTH
SERVICES**

**DECLARATION OF DR. HENRY
DeGIVE**

I, Dr. Henry DeGive, declare:

1. I am a Doctor of Pediatrics with over twenty years experience as a Pediatrician. I have been Faith Freeman's treating physician ever since she was two weeks old and am very familiar with her condition.
2. As a Pediatrician, I am familiar with the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Medicaid program. Over the years I have performed many EPSDT screenings. I had never been notified by DSHS that EPSDT coverage extended until age 21. I had believed it was limited to young children. I had to be convinced by Faith's father that she still qualified for an EPSDT screening.

DECLARATION OF DR. HENRY DEGIVE
Page 1 of 2

001175

NEAL & NEAL LLC
Attorneys at Law
112 E Fourth Avenue, Suite 200
Olympia, Washington 98501
(360) 352-1907
Fax: (360) 754-1465

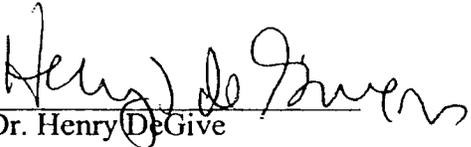
Attachment B Exhibit 21

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3. On August 27, 2004, after Faith turned 18, I conducted an EPSDT screening of her condition. My screening is attached to this declaration as exhibit "A". In the screening I concluded, based upon Faith's diagnosis of trisomy 21 and conditions flowing from that diagnosis that she needed constant supervision in order to maintain her health and safety.
4. In my medical opinion, it is medically necessary that Faith continue to receive 24-hour, 7-days-a-week assistance as a remedial service for the maximum reduction of Faith's physical and mental disability necessary to restore her to the best possible functional level.
5. The level of treatment I prescribed in the EPSDT screening is a health care and treatment measure medically necessary to correct or ameliorate Faith's trisomy 21 and physical illness which I identified and documented in the EPSDT screening.

I declare under penalty of perjury of the laws of the State of Washington that the foregoing is true and correct.

Signed this 30 day of January, 2006.


Dr. Henry DeGive

MO: _____

NAME

Faith Freeman

FA: _____

DOB

7.18.86

11.04

Mailed genetics lab results to
Jan Carrington - Attorney at Law
4160 6th Ave. S.E. Suite 202
Facey, WA. 98503
Kinsey KPA

.27.04

EPDST exam for DSHS.

\$.120

\$.55

P $\frac{100}{60}$

Vision - yearly - Peter Shelley

Hearing - yearly

Yearly Physical exams

Exhibit A

FREEMAN, Faith

S: This is an 18-year-old young woman who recently was placed on SSI because of disabilities related to her trisomy 21. Patient comes in today for an EPDST exam at her father's request.

Patient has a confirmed diagnosis of trisomy 21 (or Down syndrome). As a result of this, she suffers from mental retardation, hypotonia, and a variety of other medical conditions related to these primary problems.

Patient does have documented mental retardation. She is verbal only in that she can make her needs known to people who are familiar with her but she has significant dysarthria which interferes with her communicating effectively to people that do not know her well. She does receive speech therapy services. She has been involved with sports and particularly with track and field activities and parents have made an effort to keep her physically active but she does struggle with her weight because of difficulties maintaining a high enough activity level. This problem is compounded by her low muscle tone and ligamentous laxity, which make it hard for her to exercise vigorously.

She has significant orthodontic needs. She has a high arch palate and a very narrow jaw and is missing some of her teeth and has been receiving ongoing orthodontic work for many years; unfortunately, she still has much work that needs to be done. This work is really functional rather than a cosmetic nature and for the most part related to her underlying Down syndrome.

001177

Patient requires 24/7 supervision. She has wandered off from school on a couple of occasions when she was not being watched. She has no concept to personal danger and will walk across the street in front a car or allow herself to be approached by stranger. She is unable to use public transportation without an aide. She has no concept of money, although parents do take patient shopping. She enjoys picking out things that she wants but does not have any concept of paying or of money.

rn. no. _____
MO: _____ NAME FAITH Freeman
FA: _____ DOB 7.18.86

She is able to feed and clothe herself but does need help taking care of her bowel movements and her menses. She is unable to effectively wipe herself due to limitations imposed by shortness of her limbs as well as difficulties with maintaining attention long enough to take care of this problem. Generally, her mother helps her with her menses. She does need help in cleaning herself and maintaining hygiene during her menstrual cycles. She is able to feed herself, dress herself.

Patient has several other problems, which require ongoing attention. She has had multiple skin problems including recurring bouts of eczema and seborrhea; she also has some mild acne. She currently is on Cleocin T in the morning and has been on different peeling agents in the evening for her acne.

Because of patient's trisomy 21, she has had ongoing surveillance for thyroid disease and for celiac disease. So far, these tests have been unremarkable. Patient is seen regularly by ophthalmologist, most recently she has been under the care of Peter Shelley.

PMH: NKDA. Immunizations are up to date. No recent hospitalizations or surgeries. Currently on no medications other than her acne medications.

ROS: Patient has generally been reasonably healthy and "well" other than problems mentioned above, She has had intermittent difficulties with congestion and sinusitis. Family is concerned about possibility of allergies, as they both have significant allergic rhinitis.

She has not had any problems with food intolerances, vomiting, diarrhea. She does tend to put on weight fairly easily. She has had no unexplained fevers, night sweats, weight loss. She has a good appetite. Skin problems have been outlined above. No joint problems.

O: GENERAL: This is an alert young lady, who is nonverbal throughout my exam here. She has typical stigmata of trisomy 21 as previously described. HEENT: PERRLA. EOMI. Facies symmetric. TMs are benign. Oropharynx: She does have a very high arched palate, with very narrow jaw. She has somewhat chaotic dentition. TMs are benign. NECK: Supple. CHEST: RR is 12 and regular. She has wide spaced nipples. She does have some webbing of her neck. Chest is otherwise clear to P&A. Heart without murmurs. Heart rate is 80 and regular. ABDOMEN: Soft, without tenderness, masses or organomegaly. SKIN: With typical lesions of acne around the face. GU: External genitalia—normal female. Tanner Stage III. BACK/EXTREMITIES: Symmetric, without deformities. She does have pes planus with obvious low muscle tone. NEUROLOGICAL: She is alert, oriented but nonverbal during the course of the exam. Cranial nerves: see above. Motor Exam: She has diminished strength proximally, reasonably good strength distally with good heel walk, toe walk. Some difficulties with squatting. She does have some pronation of both her feet. DTRs are preserved. Station and gait: She has a fairly wide-based gait and is a little awkward.

001178

PH. NO. _____ PAGE _____
MO: _____ NAME Faith Freeman
FA: _____ DOB 7-18-86

08 27-04 (cont)

- A: (1) Trisomy 21. (2) Mental retardation. (3) Hypotonia. (4) Dysarthria. (5) Multiple orthodontic problems, in need of remediation. (6) Acne. (7) Possible allergic rhinitis. (8) "Well-child" care, EPSDT.
- P: Patient's main medical need at this point appears to be to finish her orthodontic work and to continue with speech therapy in order to remediate her dysarthria. Patient will continue to need supervision on a 24-hour-a-day, seven-day-a-week basis. Patient will continue to need encouragement in supervision in order to ensure that she has adequate level of physical activity. Recommended that parents investigate swimming as another possible outlet. Patient will be started on a regimen of Benzamycin for her skin, to be used nightly; if this is not working, parents will return for further evaluation. Patient will continue to need yearly PE with screens for thyroid and celiac disease. She will continue to need to be seen at least yearly by Dr. Peter Shelley or a qualified ophthalmologist for eye exams. Recommend that she have hearing exams done periodically as well. An Immuno-Cap screening is ordered today to exclude possibility of allergies. She is to be given a Pneumovax vaccine. Further treatment to be determined by clinical course.

HLD:cj
D: 08/27/2004 T: 08/30/2004

FREEMAN, Faith

Child does have pronation of both feet with pes planus due to her low muscle tone. This is not of the degree to warrant orthotics at the present time; although if her feet should become painful or she should develop symptomatology from her pes planus, then this would certainly be a consideration.

HLD:cj
D: 09/02/2004 T: 09/03/2004

9/9/04
Immucap rd. no sig allergies.
AP

001179

Attachment C

Loren M. and Jean M. Freeman

*1324 Woodfield Loop S.E.
Olympia, Washington 98501*

June 12, 2007

To: *Daria Sciarrone, M.D. – Primary Care Physician for Faith K. Freeman*

*RE: EPSDT appointment for Faith
K. Freeman – 6/15/2007*

Dear Dr. Sciarrone:

This is a letter of clarification regarding the appointment for an EPSDT screening for Faith K. Freeman for this coming Friday. Please be advised that this EPSDT screening is in response to a specific request by DSHS for an exit screening for Faith (i.e., prior to her 21st birthday). Since it is the direct result of a DSHS request, there should be no issue from DSHS in regard to the billing for this screening.

Please be aware that DSHS has some questions that need to be answered before they can resolve issues that remain from the 2004 EPSDT screening. There may be a need to consult with Dr. deGive or you may be able to rely upon the documentation Dr. deGive left in the medical record.

There are certain required elements to an EPSDT screening and we would expect that each of those required elements will need to be completed within the current screening. In addition, DSHS has provided us with a letter and questionnaire that they indicated was a required element of an EPSDT screening (copy enclosed). In the letter, the department representative invites you to contact her if you have any questions. Please be advised that it is our experience that the department uses such oral contacts as an opportunity to inject policy standards that are not consistent with the law. Should you have any questions about the EPSDT program, we would invite you to contact Mr. Paul Neal, Attorney at Law who represents Faith in this matter.

In addition to the enclosed letter from the department, DSHS staff have posed certain questions directly to us in an effort to clarify the findings of Dr. deGive in his 2004 screening. We believe that Dr. deGive's findings were both clear and obvious, but DSHS has asked, belatedly (i.e., in January of 2007), for clarifications. We ask that, at this time, you provide your professional assessment in the following matters (please feel free to consult with Dr. deGive if you believe that it is necessary):

001257

Attachment C Exhibit 36

1. In your professional opinion, has Faith K. Freeman's diagnosis and/or her underlying condition changed significantly since the 2004 EPSDT screening (i.e., is Down Syndrome subject to improvement, on its own, over time)?

Yes No

2. Does Faith K. Freeman have a cognitive impairment that significantly restricts her judgment and/or self-care in regard to her health and safety?

Yes No

3. If Faith Freeman were left unattended inappropriately, would her disabling condition and/or medical condition likely be detrimentally impacted through judgment limitations contributing to self-neglect or injury?

Yes No

4. Dr. deGive indicated that Faith's condition could be ameliorated over time, to some degree, by keeping her safe and healthy through supervision and through providing her with training during those supervisory hours. Do you concur?

Yes No

5. How does Faith K. Freeman's cognitive impairment compare/contrast to an elder with a diagnosis of aphasia? Could Faith legitimately be diagnosed with aphasia in addition to Down Syndrome? If Faith were so diagnosed it would solve a significant problem since the DSHS assessment tool attributes clinical complexity points (and care hours) to a diagnosis of aphasia but the tool contains an irrebuttable presumption that there can be no clinical complexity related to a diagnosis of Down Syndrome.

patient has Down's syndrome and is unable to vocalize any other words except yes + no. Yes - expressive aphasia

6. It appears that, in 2004, Dr. deGive had formed an EPSDT finding of need that Faith required 24 hour a day / 7 day a week supervision to provide for the amelioration of her disabling condition. Do you concur that he did so find and that the need continues?

Yes No

(continued on page 3)

001258

EXHIBIT 4.1

7. As a result of Faith Freeman's diagnosis and an individualized assessment performed by DSHS in 2004, Faith Freeman qualifies for (and is deemed to require) 24/7 supervision in a state institution like Rainier School (or an equivalent community based level of care). Do you concur?

(Yes) No _____

8. In your professional opinion, out of a 24-hour day, how many hours per day is it safe to leave Faith K. Freeman completely alone and unattended: None

9. Per the above, in your professional opinion, how many days per week/ per month is it safe to leave Faith K. Freeman completely alone and unattended: 0

10. For the hours that Faith K. Freeman requires health and safety supervision/attending (i.e., for the amelioration of her disabling condition), what is the level of credentials necessary for the attending staff:

- a. licensed medical staff, or
- b. the same level as that used by the department for institutional care under the Medicaid program, or
- (c) the same level as that used by the department for community-based personal care under the Medicaid program, or
- d. other: _____

I want to thank you for responding to the need for this EPSDT screening.

Sincerely,

[Handwritten signature]

6/15/07
at 15:30

[Handwritten signature]
360-459-1354

cc: PAUL NEAL

001259

EXHIBIT 4-2



**WELL CHILD EXAM -
ADOLESCENCE: 18 YEARS**
(Meets EPSDT Guidelines)

DATE 6/15/07

ADOLESCENCE: 18 YEARS

ADOLESCENT TO COMPLETE ABOUT SELF	CHILD'S NAME <u>Faith</u>		DATE OF BIRTH <u>7/18/1986</u>
	ALLERGIES <u>Ceclor</u>		CURRENT MEDICATIONS <u>J. Fanning Bactroban</u>
	ILLNESSES/ACCIDENTS/PROBLEMS/CONCERNS SINCE LAST VISIT <u>1) abscess 2) syncope 20 for dehydration</u>		TODAY I HAVE A QUESTION ABOUT:
	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> I eat breakfast every day.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> I get some physical activity every day.	
<input checked="" type="checkbox"/> <input type="checkbox"/> I have someone I can talk to.	<input type="checkbox"/> <input type="checkbox"/> I get enough sleep; <u>6</u> hours per night.		
<input checked="" type="checkbox"/> <input type="checkbox"/> I am happy with how I am doing in school and/or at work.			

WEIGHT KG/OZ PERCENTILE <u>137</u>	HEIGHT CM/IN PERCENTILE <u>56.25</u>	BLOOD PRESSURE <u>116/68</u>
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Review of systems Review of family history

Screening:

	MHZ	R	L
Hearing Screen	4000	_____	_____
<u>Not done due to</u>	2000	_____	_____
<u>no immunizations</u>	1000	_____	_____
	500	_____	_____

Vision Screen R 20/ _____ L 20/ _____ Dr's helper in Federal Way

Development for age

Behavior happy, calm

Social Emotional limited

Mental Health appropriate

Physical:

	N	A		N	A
General appearance	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Chest	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Skin	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Lungs	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Head	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Cardiovascular/Pulses	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>
Ears	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Genitalia	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Nose	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Spine	<input type="checkbox"/>	<input type="checkbox"/>
Oropharynx/Teeth	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Extremities	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Neck	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Neurologic	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Nodes	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Gait	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Describe abnormal findings and comments:
pt has normal appearance of child w/ down's syndrome. See my CPE details.

Diet normal

Sleep has sleep apnea

Review Immunization Record

Hgb/Hct _____ TB Dental Referral

Cholesterol

Health Education: (Check all discussed/handouts given)

Nutrition/weight control Regular physical activity

Driving & Alcohol Injury prevention/safety

Tobacco Use Drugs/Alcohol STD/HIV/AIDS

Sex education/birth control Suicide/Depression

Dental Care Self-Exam Future Plans

School Plans

Assessment/Plan: Work s/p school termination. Will do industrial assembly work in group setting.

IMMUNIZATIONS GIVEN: Polio done current; Pneumococ

REFERRALS: None now 001260

NEXT VISIT:

HEALTH PROVIDER SIGNATURE: [Signature]

HEALTH PROVIDER NAME: Dalie Swanson

HEALTH PROVIDER ADDRESS: 5622 Oregon Rd

FREEMAN, FAITH K. 07/18/1986

1 of 3

Office/Outpatient Visit

Date: Fri, Jun 15, 2007 03:18 pm

Provider: Daria Sciarrone, MD (Assistant: JULIE BENNETT, MA)

Location: Olympia Family Medicine, Inc.

This note has not been signed and may be incomplete. Printed on 06/15/2007 at 3:43 pm.

SUBJECTIVE:

CC:
Ms. FREEMAN is a 20-year-old female. She is here for an annual exam.

HPI:
Ms. FREEMAN presents with well Woman Exam. She cannot recall when she last had a physical exam. Her last menstrual period was 6-07.

ROS:
CONSTITUTIONAL: Negative for chills, fatigue, fever, and weight change.
EYES: Negative for blurred vision, eye pain, and photophobia.
E/N/T: Negative for hearing problems, E/N/T pain, congestion, rhinorrhea, epistaxis, hoarseness, and dental problems.
CARDIOVASCULAR: Negative for chest pain, palpitations, tachycardia, orthopnea, and edema.
RESPIRATORY: Negative for cough, dyspnea, and hemoptysis.
GASTROINTESTINAL: Negative for abdominal pain, heartburn, constipation, diarrhea, and stool changes.
MUSCULOSKELETAL: See HPI
NEUROLOGICAL: Negative for dizziness, headaches, paresthesias, and weakness.
HEMATOLOGIC/LYMPHATIC: Negative for easy bruising, bleeding, and lymphadenopathy.
ENDOCRINE: Negative for hair loss, heat/cold intolerance, polydipsia, and polyphagia.

Past Medical History / Family History / Social History:

Past Medical History:

Obesity
broken R foot 2005
Td 8/06

CURRENT MEDICAL PROVIDERS:
Ophthalmologist: Shelly

Surgical History:

Tonsillectomy/Adenoidectomy; 1995;

Family History:

Mother: Hypertension

Social History:

Household: Lives with her parents.
Marital Status: Single

Substance Abuse History:

NEGATIVE

001261

Current Problems:

Acne vulgaris
Carbuncle of leg
Down's syndrome
Foot pain
Near-syncope

EXHIBIT 4-4

FREEMAN, FAITH K. 07/18/1986

2 of 3

Office/Outpatient Visit

Date: Fri, Jun 15, 2007 03:18 pm

Provider: Daria Sciarrone, MD (Assistant: JULIE BENNETT, MA)

Location: Olympia Family Medicine, Inc.

This note has not been signed and may be incomplete. Printed on 06/15/2007 at 3:43 pm.

Plantar fasciitis

Well Woman Exam

Immunizations:

Td (Tetanus-Diphtheria toxoids) 8/23/2006

Pneumococcal, 23-valent (adult dose) 6/15/2007

Allergies:

Ceclor:

Current Medications:

Bactroban 2% Cream Apply small amount to affected area bid

Clindamycin HCl 150mg Capsules Take 1 capsule(s) by mouth qid x 10 days. Take with a full glass of water or with food

OBJECTIVE:

Vitals:

Current: 6/15/2007 3:23:57 PM

Ht: 56.25 inch(es) (.00%); Wt: 137 lbs (.00%); BMI 30.4

BP: 116/68 mm Hg (right arm, sitting);

Exams:

GENERAL: **moderately obese**

EYES: lids and conjunctiva are normal; pupils and irises are normal; fundoscopic exam reveals sharp disc margins; normal vessels bilateral;

E/N/T: normal external ears and nose;; normal external auditory canals and tympanic membranes; Hearing: grossly normal Nasal Septum/Mucosa: typical Down's syndrome high palate and hyperglossia with receding chin; Lips, Teeth and Gums: normal; Oropharynx: normal mucosa, palate, and posterior pharynx;

NECK: Neck is supple with full range of motion; thyroid is normal to palpation;

RESPIRATORY: normal respiratory rate and pattern with no distress; percussion is normal without hyperresonance or dullness; lung fields normal to palpation; normal breath sounds with no rales, rhonchi, wheezes or rubs;

CARDIOVASCULAR: normal PMI placement; no thrills, heaves, or lifts; normal rate and rhythm without murmurs; normal S1 and S2 heart sounds with no S3, S4, rubs, or clicks;; carotids: 2+ amplitude, no bruits; femoral pulses: 2+ amplitude, no bruits; 2+ pedal pulses; no edema or significant varicosities;

BREASTS: symmetric; no overlying skin changes; no tenderness, nodularity, or masses;

GASTROINTESTINAL: normal bowel sounds; no masses or tenderness; no organomegaly no abdominal or inguinal hernia;

GENITOURINARY: external genitalia and vagina: normal vaginal mucosa; normal hair distribution; no discharge; urethra: normal; bladder: normal;

LYMPHATIC: no enlargement of cervical nodes; no axillary adenopathy; no inguinal adenopathy; no supraclavicular, suboccipital, periauricular or other nodes;

MUSCULOSKELETAL: gait: **slowed**; tone and strength: normal overall tone; 5/5 strength in all major muscle groups; stability: laxity of all joints due to generalized decreased tone; pes planus

SKIN: no ulcerations, lesions or rashes no skin thickening, induration, or subcutaneous nodules;

NEUROLOGIC: cranial nerves II-XII grossly intact; reflexes: biceps: 2+; triceps: 2+; knee jerks: 2+; ankle jerks: 2+;

PSYCHIATRIC: Orientation: alert; responsive to vocal stimuli; appropriate affect and demeanor;

001262

Procedures:

Well Woman Exam

MEDICATION/VACCINATION ADMINISTRATION:

1. DT: 0.5 ml unit dose given IM; (manufacturer: MERCK; lot #0200U; exp. 3-14-09); administered by: JB

EXHIBIT 4-5

FREEMAN, JOHN K. 07/18/1966

3 of 3

Office/Outpatient

Visit Date: 06/15/2007 03:18 pm

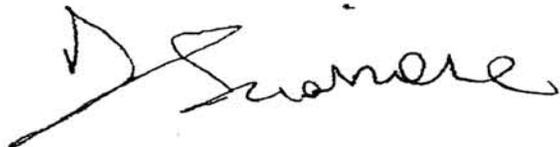
Provider: E. Swane, MD (Assistant) E. BENNETT, MA

Location: Family Medicine

This document has been signed and may be incomplete. Printed on 06/15/2007 at 3:43 pm.

ASSESSMENT:

7700 Well Woman Exam



PLAN:

Well Woman Exam

LABORATORY: All tests ordered today include, CBC, and comprehensive metabolic panel.

MEDICATIONS: (see today's med list)

COUNSEL: Advice provided today regarding the following topics: healthy eating habits, weight loss program, and vitamin and mineral supplementation (calcium and D).

IMMUNIZATIONS: given today: and Pneumovax.

Orders:

36415 Collection of venous blood by venipuncture

85025 CBC, complete with automated differential

80053 Comprehensive metabolic panel

90471 Immunization administration (includes percutaneous, intradermal, subcutaneous or intramuscular injec

G0009 Administration of pneumococcal vaccine when no physician fee schedule service on the same day (x1)

70732 Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for use in

G0009 Administration of pneumococcal vaccine when no physician fee schedule service on the same day (x1)

90702 DT toxoids, IM for pediatric

001263

EXHIBIT 4-6

Attachment D

3/17/08 JMT

Account Receivable from Faith Freeman for unpaid MPCs/EPsDT hours beginning 07/18/2004 and ending 07/17/2007 (3 years from age 18 to age 21)

JMT

~~July 02, 2007~~ – Accounting is by calendar year

2004

<i>Service Period</i>	<i>Total hours</i>	<i>informal*</i>	<i>balance</i>	<i>MPCS Pd</i>	<i>EPsDT pd</i>	<i>Unpaid Bal.</i>
<i>Of need</i>						
<i>July 18-31, 2004</i>	<i>336 hours</i>	<i>53</i>	<i>283</i>	<i>0</i>	<i>0</i>	<i>283</i>
<i>August 2004</i>	<i>744 hours</i>	<i>26.5</i>	<i>717.5</i>	<i>0</i>	<i>0</i>	<i>717.5</i>
<i>September 2004</i>	<i>720 hours</i>	<i>119</i>	<i>601</i>	<i>72</i>	<i>0</i>	<i>529</i>
<i>October 2004</i>	<i>744 hours</i>	<i>145</i>	<i>599</i>	<i>72</i>	<i>0</i>	<i>527</i>
<i>November 2004</i>	<i>720 hours</i>	<i>133</i>	<i>587</i>	<i>72</i>	<i>0</i>	<i>515</i>
<i>December 2004</i>	<i>744 hours</i>	<i>85.5</i>	<i>658.5</i>	<i>72</i>	<i>0</i>	<i>586.5</i>
<i>2004 Totals:</i>	<i>4008 hours</i>	<i>562</i>	<i>3446</i>	<i>288</i>	<i>0</i>	<i>3158</i>

Calculated at a payment rate of \$8.43 per hour until 09/30/04 and \$8.93 thereafter

Verified Balance for 2004: *\$27,436.19*

Simple interest @ 9% per annum from 12/31/04 to 6/30/07 *\$6,173.14*

2005

<i>Service Period</i>	<i>Total hours</i>	<i>informal*</i>	<i>balance</i>	<i>MPCS Pd</i>	<i>EPsDT pd</i>	<i>Unpaid Bal.</i>
<i>Of need</i>						
<i>January 2005</i>	<i>744 hours</i>	<i>121</i>	<i>623</i>	<i>72</i>	<i>0</i>	<i>551</i>
<i>February 2005</i>	<i>672 hours</i>	<i>105</i>	<i>567</i>	<i>72</i>	<i>0</i>	<i>495</i>
<i>March 2005</i>	<i>744 hours</i>	<i>141</i>	<i>603</i>	<i>72</i>	<i>0</i>	<i>531</i>
<i>April 2005</i>	<i>720 hours</i>	<i>102.5</i>	<i>617.5</i>	<i>72</i>	<i>0</i>	<i>545.5</i>
<i>May 2005</i>	<i>744 hours</i>	<i>146.0</i>	<i>598</i>	<i>72</i>	<i>0</i>	<i>526</i>
<i>June 2005</i>	<i>720 hours</i>	<i>115</i>	<i>605</i>	<i>72</i>	<i>0</i>	<i>533</i>
<i>July 2005</i>	<i>744 hours</i>	<i>97.5</i>	<i>646.5</i>	<i>72</i>	<i>0</i>	<i>574.5</i>
<i>August 2005</i>	<i>744 hours</i>	<i>32.5</i>	<i>711.5</i>	<i>72</i>	<i>0</i>	<i>639.5</i>
<i>September 2005</i>	<i>720 hours</i>	<i>126</i>	<i>594</i>	<i>72</i>	<i>0</i>	<i>522</i>
<i>October 2005</i>	<i>744 hours</i>	<i>146.5</i>	<i>597.5</i>	<i>72</i>	<i>0</i>	<i>525.5</i>
<i>November 2005</i>	<i>720 hours</i>	<i>131.5</i>	<i>588.5</i>	<i>74</i>	<i>0</i>	<i>514.5</i>
<i>December 2005</i>	<i>744 hours</i>	<i>79.5</i>	<i>664.5</i>	<i>74</i>	<i>0</i>	<i>590.5</i>
<i>Totals in hours</i>	<i>8760 hours</i>	<i>1344</i>	<i>7416</i>	<i>868</i>	<i>0</i>	<i>6548</i>

Calculated at a payment rate of \$8.93 per hour until 06/30/05 and \$9.20 thereafter

Verified Balance for 2005: *\$59,382.60*

001230

3/17/08 LMT
6/22/002

Simple interest on 2005 charges from 12/31/05 to 6/30/07: \$8,016.65

Grand Total of principle to 12/31/05: \$86,818.79

2006

Service Period	Total hours	informal*	balance	MPCS Pd	EPSDT Pd	Unpaid Bal.
Of need						
January 2006	744 hours	131.5	612.5	74	0	538.5
February 2006	672 hours	91	581	74	0	507
March 2006	744 hours	156.5	587.5	74	0	513.5
April 2006	720 hours	105	615	74	0	541
May 2006	744 hours	136.3	607.7	74	0	533.7
June 2006	720 hours	103	617	74	0	543
July 2006	744 hours	48	696	74	0	622
August 2006	744 hours	18	726	74	0	652
September 2006	720 hours	135	585	74	0	511
October 2006	744 hours	162.5	581.5	74	0	507.5
November 2006	720 hours	157	563	121	0	442
December 2006	744 hours	84	660	121	0	539
Totals in hours	8760 hours	1327.8	7432.2	982	0	6450.2

Calculated at a payment rate of \$9.20 per hour until 06/30/06 and \$9.43 thereafter

Verified Balance for 2006: \$60,094.75

Simple interest @ 9% from 12/31/06 to 6/30/07: \$2,704.26

Grand Total of principle to 12/31/06: \$146,913.53

2007

Service Period	Total hours	informal*	balance	MPCS Pd	EPSDT Pd	Unpaid Bal.
Of need						
January 2007	744 hours	112.5	631.5	121	0	510.5
February 2007	672 hours	109.75	562.25	121	0	441.25
March 2007	744 hours	122.75	621.25	121	0	500.25

001231

3/17/08 ZMT
~~July 2, 2007~~

April 2007	720 hours	114	606	121	0	485
May 2007	744 hours	139	605	121	0	484

(at end of Guardianship year, 2007 balance was \$22,830.03 for a grand total of \$169.... + i

June 2007	720 hours	115.5	604.5	121	0	483.5
July 2007 (thru 17 th)	408 hrs.	44	364	66.4	0	297.6

End of final EPSDT

Period totals:	4752 hrs	813.5	3938.5	792.4	0	3149.5
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Calculated at a payment rate of \$9.43 per hour until 06/30/07 for a subtotal of \$27,389.44 and \$9.73 per hour for the partial month of July for an additional \$2,895.65.

Verified Balance for January 1 through July 17, 2007: \$30,285.09

Grand Total of principle to 7/17/07: \$177,198.62

Grand Total of interest to 6/30/07: \$16,894.05

Grand Total of principle and interest charges to 7/17/07: \$194,092.67

It should be noted that the above cost (for three years of care) is comparable to about what it costs the state for one year of institutionalization. Of course, this figure does not include actual and other damages resulting from the state's refusal to provide prompt provision of Medicaid services.

Monthly interest charge beginning 8/1/07: \$1,455.74

From this point on, interest will be compounded at 9% (0.0075 multiplier)

Monthly interest charge for September (based on \$195,548.41) \$1,466.61

Monthly interest charge for October (based on \$197,015.02) \$1,477.61

Monthly interest charge for November (based on a new total of \$198,492.63) \$1,488.69

Monthly interest charge for December (based on \$199,981.32) \$1,499.86

Monthly interest charge for January 2008 (based on \$201,481.17) \$1,511.11

(there was a payment for back hours at this time: (\$2,436.43)

Monthly interest charge for February 2008 (based on \$199,044.74) \$1,492.84

Total account is \$200,537.58 as of 2/29/08

Last portion of shared living correction payment:

(\$4,240.37) ← 3/17/08 ZMT

Monthly interest charge for March 2008 (based on \$196,297.21) \$1,472.23

Monthly interest charge for April 2008 (based on \$197,769.44) \$1,483.27

Monthly interest charge for May 2008 (based on \$199,252.71) \$1,494.40

001232



Attachment E

1 Neal?

2 MR. NEAL: I do.

3 THE COURT: Okay.

4 MR. NEAL: Um, okay. Um, let-- let's start here at
5 the top of my list. Um, uh, when did you first begin
6 administering CARE assessments?

7 MS. JORGENSEN-DOBSON: CARE (Inaudible) and entered
8 would be (Inaudible) of March of 2004.

9 MR. NEAL: And prior to that time how did you, uh, did
10 you assess people for their needs?

11 MS. JORGENSEN-DOBSON: I did, it was (Inaudible) the
12 assessments.

13 MR. NEAL: Okay. And, um, is there a different
14 process for that or was it still kind of this process used?

15 MS. JORGENSEN-DOBSON: It was not on the computer.

16 MR. NEAL: Um hum.

17 MS. JORGENSEN-DOBSON: It was a handwritten
18 questionnaire.

19 MR. NEAL: And as part of the Legacy process was there
20 a, um, was there a ability to provide, um, support for
21 cognitive supervision?

22 MS. JORGENSEN-DOBSON: Yes there was.

23 MR. NEAL: Can you describe what that-- tell what
24 cognitive supervision means?

25 MS. JORGENSEN-DOBSON: For the clients that could not

1 be left alone that needed 24/7 assistance. We were able to
2 add those hours in.

3 MR. NEAL: And-- and how many hours would you add in?

4 MS. JORGENSEN-DOBSON: I think the total was 96.

5 MR. NEAL: So that would be 96 hours in--

6 MS. JORGENSEN-DOBSON: Maximum, in a month.

7 MR. NEAL: Ninety-six in addition to what the Legacy
8 tool was telling you or?

9 MS. JORGENSEN-DOBSON: No, 96 total including what the
10 Legacy was, it's what we would do is we would just add the-
11 - the hours to get the max.

12 MR. NEAL: Okay. So what was the, um, criteria for
13 awarding, um, cognitive supervision hours?

14 MS. JORGENSEN-DOBSON: Whether someone was able to be
15 left alone. Did the parents go to work and leave the
16 client home alone for six hours. If they were not able to
17 do that then we would add in those hours.

18 MR. NEAL: And what would make someone not be able to
19 be left alone?

20 MS. JORGENSEN-DOBSON: Whether they would not be able
21 to handle an emergency, if they were unsafe in any way. If
22 they had medical needs. They had wandering behaviors,
23 depending on behaviors, cognitive needs to address
24 decisions.

25 MR. NEAL: Now, and I think you answered this question

1 back in 2004 (Inaudible) don't remember your-- your
2 specific answer, um, in your opinion of Faith Freeman could
3 she be left alone?

4 MS. JORGENSEN-DOBSON: (Inaudible) well I (Inaudible)
5 not, I really don't know if she could be left for 20
6 minutes, some clients can. Um, I know the family doesn't.

7 MR. NEAL: Well you-- do you think she could be left
8 alone for more than 20 minutes?

9 MS. JORGENSEN-DOBSON: I really can't answer that.

10 MR. NEAL: Um, if I were to tell you that your answer
11 in 2004 was that the supervision was to be--

12 MS. JORGENSEN-DOBSON: Supervision--

13 MR. NEAL: --(Inaudible).

14 MS. JORGENSEN-DOBSON: --(Inaudible).

15 MR. NEAL: Okay.

16 MS. JORGENSEN-DOBSON: I was (Inaudible).

17 MR. NEAL: And the 96 hour limit in Legacy where was
18 that wh-- where did that come from?

19 MS. JORGENSEN-DOBSON: I believe it was (Inaudible) at
20 the time.

21 MR. NEAL: And-- and just so I'm understanding, to
22 understand that usually this tool the maximum was
23 (Inaudible) what-- let me be a little more (Inaudible) than
24 that.

25 Um, what, uh, what program did the Legacy provide

1 benefits under? Or (Inaudible)?

2 MS. JORGENSEN-DOBSON: I think it was Medicaid
3 personal care.

4 MR. NEAL: MPC. And so, at that point there was a-- a
5 96 hour limitation on MPC?

6 MS. JORGENSEN-DOBSON: Um hum.

7 MR. NEAL: And (Inaudible) that was-- that was a
8 (Inaudible) from the WAC?

9 MS. JORGENSEN-DOBSON: Um hum.

10 MR. NEAL: Um, let's see, I wanted to (Inaudible) I'm
11 going to wait for these-- these things to be, you know,
12 copied and looked at. Uh, Exhibit 30.

13 MR. WORK: (Inaudible).

14 THE COURT: Whoops.

15 MR. NEAL: Uh, now I wouldn't-- actually, if I could
16 just have you turn to the-- to the last page, the third
17 page in that exhibit. The first two pages are a letter
18 from Mr. Freeman, which I-- I won't-- I don't need you to
19 (Inaudible) for.

20 Um, my questions have to do with this third page. Um,
21 can you identify for the record what the-- what that
22 document is?

23 MS. JORGENSEN-DOBSON: This is an assistance available
24 total.

25 MR. NEAL: And who, um, who produces that?

Attachment F

1 in their own home under supported living and qualify for
2 that level four of, um, 24 hour availability and
3 instruction and support?

4 MR. HAKIM: Yes.

5 MR. NEAL: An--

6 MR. HAKIM: That's true.

7 MR. NEAL: So-- so in-- in that situation how many
8 hours would DSHS be paying for?

9 MR. HAKIM: If-- see that-- that's the piece is that
10 if you break it down into an individual level it's
11 different of the way we do rate in supported living
12 services is at a household level.

13 So individually when you look at that document the--
14 the person qualifies for, uh, you know, 24 hours of
15 staffing. But the Department may only purchase eight hours
16 for that person because they are sharing the hours and
17 everybody is bringing eight hours so there is 24 hours
18 there.

19 MR. NEAL: Okay. I guess what I'm asking about, uh, as
20 I understand your testimony so far but usually you're in a
21 group home situation like the one you just referred but it
22 is possible for an individual to be living in their own
23 home just-- just them and to be receiving the 24 hour, um,
24 supported living, is that true? That-- that is true?

25 MR. HAKIM: That is true.

1 you. Um, and again when-- when you said paying for 20
2 hours that would be at that \$15.49 an hour rate?

3 MR. HAKIM: Yeah, right.

4 MR. NEAL: Okay. Um, okay. That's-- that's all the
5 questions I have.

6 MR. WORK: I have a follow up.

7 THE COURT: Okay. Go ahead.

8 MR. WORK: Um, Seif, are staff paid for, uh, let-- let
9 me put this differently. Does the Department pay an hourly
10 rate for supervision, uh, plain availability an hourly
11 rate?

12 MR. HAKIM: Hourly rate for supervision.

13 MR. WORK: Um hum.

14 MR. HAKIM: Yes. The Department does for supported
15 living, yes.

16 MR. WORK: What does that mean?

17 MR. HAKIM: Uh, it's protected supervision which is
18 that, you know, uh, a person has a need of support all the
19 time but there are as, you know, any normal person you do
20 work at sometimes and that-- then there are other times
21 when you are sitting back-- back relaxing or you are
22 sleeping.

23 If you have a need even while you are sleeping, so for
24 instance a client is sleeping but has the seizure disorder,
25 uh, that is so intense that the staff needs to be there

1 because the seizures are frequent so there are parts of the
2 time--

3 THE COURT: We're back on record on side two of tape
4 number one in the May 21, 2008, uh, hearing in the matter
5 of Faith Freeman. Um, excuse me, Mr. Hakim, that did cut
6 you off. Can you back up in your testimony a little bit
7 please?

8 MR. HAKIM: Okay.

9 THE COURT: Thank you.

10 MR. HAKIM: So, uh-- uh, I was-- I was explaining the
11 supervision part. So there are parts of time when the
12 person would need assistance and parts of the same, you
13 know, the parts of the time when they are, um, either
14 sleeping or involved in an activity that they like to do.

15 But staff needs to be there to assist them. And, uh,
16 so in between, um, you know, structured activities the time
17 where they need their asso-- where they may need assistance
18 is the supervision time.

19 MR. WORK: Um hum.

20 MR. HAKIM: Um, let's say we have a client who comes
21 back from work and they are sitting there and maybe
22 watching a show on TV. So for that hour it's supervision
23 time but we-- we pay for it because staff needs to be there
24 because, uh, let's say for community protection time they
25 may not watch an appropriate show that is approved by the

1 therapist. So staff needs to be there to, uh, turn off
2 the-- queue the client to stay away from certain shows.

3 Or the client may not have the dexterity to ch-- uh,
4 tu-- to change channel so the staff is there. But it's
5 supervision because the client is involved in watching a
6 show on TV.

7 So, uh, that-- that-- that's what it essentially is
8 the supervision is the time when the person is involved in
9 their own, uh, in-- in a relaxing activity or something
10 that they would like to do but the staff needs to be there
11 to help them with those activities.

12 MR. WORK: So is that--

13 MR. HAKIM: Does that answer your question--

14 MR. WORK: --is--

15 MR. HAKIM: --Bruce?

16 MR. WORK: I think so. Are you paying an hourly rate
17 for that?

18 MR. HAKIM: Yes.

19 MR. WORK: Okay. That's all.

20 MR. HAKIM: Um, Bruce in terms of the document, the
21 Unscheduled Protective Supervision is only authorized for
22 clients who ha-- who's assessment shows that they have a 24
23 hour support need.

24 MR. WORK: So you're talking about protected
25 supervision?

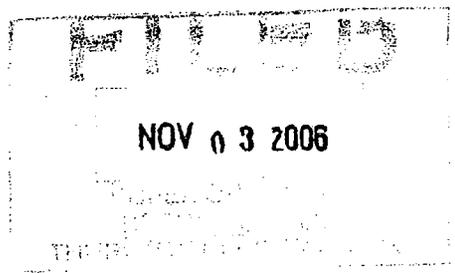
Attachment G

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HEADQUARTERS OFFICE OF
ADMINISTRATIVE HEARINGS



**IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON
IN AND FOR THE COUNTY OF THURSTON**

FAITH FREEMAN

No. 05-2-01953-8

v.

**STATE OF WASHINGTON,
DEPARTMENT OF SOCIAL AND HEALTH
SERVICES**

**ORDER ON REVIEW OF
ADMINISTRATIVE DECISION
(PROPOSED)**

THIS MATTER came before the Court on petitioner Faith Freeman's petition for Judicial Review of an agency order under RCW 34.05.570(3) and review of rules under RCW 34.05.570(2). The agency order at issue was the Final Order and Review Decision of the Department of Social and Health Services (DSHS) limiting the grant of Medicaid benefits to Faith Freeman to those determined under application of the CARE tool. The Court has considered the briefs of the parties, the records and files herein, and has heard oral argument. The Court hereby makes the following findings of fact and conclusions of law.

000386

ORDER ON REVIEW OF
ADMINISTRATIVE DECISION

Page 1 of 3

NEAL & NEAL LLC
Attorneys at Law
112 E Fourth Avenue, Suite 200
Olympia, Washington 98501
(360) 352-1907
Fax: (360) 754-1465

Attachment 2

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FINDINGS OF FACT

- 1. The DSHS Review Decision and Final Order under petition was issued on August 31st, 2005, and a petition for judicial review was filed with this Court within 30 days thereof.
- 2. The entire agency record of the administrative proceedings under review, consisting of the Agency Record and the transcript of the proceedings, is before the Court.
- 3. The Court has made no other findings of fact apart from the findings contained or incorporated in the DSHS Review Decision and Final Order.

From the foregoing findings and the record herein, the Court makes the following:

CONCLUSIONS OF LAW

- 1. The Court has jurisdiction of the petition under chapter 34.05 RCW.
- 2. The Court reviews the agency's Review Decision and Final Order within the scope of review set forth in RCW 34.05.570(3), and reviews agency rules within the scope of review set forth in RCW 34.05.570(2).
- 3. DSHS erred in failing to consider Ms. Freeman's eligibility for Medicaid benefits under the Early Periodic Screening Diagnosis and Treatment program under 42 U.S.C. 1396d(r) and 42 U.S.C 1396a(10)(A).
- 4. DSHS erred in failing to ^{allow} provide Ms. Freeman ^{to present evidence & arguments} with a full hearing on the other federal claims raised in her Petition for Judicial Review.
- 5. DSHS did not err in not providing Ms. Freeman with a hearing on her constitutional claims.
- 6. Remanding this matter for further adjudicative proceedings before an Administrative Law

1 Judge is an appropriate remedy under RCW 34.05.570(3)(f) where the agency has not
2 decided all issues requiring resolution by the agency.

3 Based on the foregoing findings and conclusions, the Court enters the following:

4

5

ORDER

vacated *per BW* *[Signature]*

6

7

8

9

DSHS's Review Decision and Final Order is hereby REVERSED, and this matter is
REMANDED for further adjudicative proceedings before an Administrative Law Judge
for further proceedings consistent with the Court's order. The Court reserves the issue of
attorney's fees for a subsequent proceeding under this cause number.

10

SO ORDERED this 3rd day of November, 2006.

11

12

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14

[Signature]
GARY R. TABOR, Judge
Thurston County Superior Court

15

16

Presented by:

Approved as to form,

17

Notice of presentation waived

18

19

[Signature]
PAUL NEAL, WSBA #16822
Attorney for Petitioner

[Signature]
BRUCE WORK, WSBA #33824
Assistant Attorney General
Attorney for Respondent

20

21

22

23 ORDER ON REVIEW OF
ADMINISTRATIVE DECISION

24 Page 3 of 3

25

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NEAL & NEAL LLC **000388**
Attorneys at Law
112 E Fourth Avenue, Suite 200
Olympia, Washington 98501
(360) 352-1907
Fax: (360) 754-1465

Attachment H

MAILED
JUL 03 2008
OLYMPIA OAH

BEFORE THE WASHINGTON STATE OFFICE OF ADMINISTRATIVE HEARINGS
FOR THE DEPARTMENT OF SOCIAL AND HEALTH SERVICES

In Re:

FAITH K FREEMAN
APPELLANT

Docket No. 09-2004-A-0143
11-2005-A-1878
12-2006-A-0855

DSHS#: 731698
CORRECTED
INITIAL ORDER

Jane L. Habegger, Administrative Law Judge, conducted an administrative hearing on this matter on April 16 and 17, 2008 and May 20 and 21, 2008. The record was kept open until June 16, 2008 for the filing of closing briefs. The Appellant appeared and was represented by Paul Neal, attorney at law. Bruce Work, an assistant attorney general, represented the Department of Social and Health Services (department).

ISSUES

- (1) Did the Appellant qualify for the Early Periodic Screening Diagnosis and Treatment Program prior to the age of 21?
- (2) Is the Appellant eligible to receive more than 72 hours under a Comprehensive Assessment Reporting Evaluation (CARE) dated July 9, 2004?
- (3) Is the Appellant eligible to receive more than 74 hours under a CARE dated October 26, 2005?
- (4) Is the Appellant eligible to receive more than 121 hours under a CARE dated October 31, 2006?

000001

Attachment D

RESULTS

The Appellant is entitled to services under the EPSDT as set forth below. Alternatively, she is eligible for 190 hours under the 2007 CARE retroactive to 2004, minus any hours in which her needs were met with "informal supports" in school or work.

FINDINGS OF FACT

1. This matter is before me pursuant to an Order issued by the Thurston County Superior Court on November 3, 2006. The Court remanded the case to the Office of Administrative Hearings for further proceeding "consistent with this order". Six conclusions of law were entered. The first recites the court's jurisdiction. The second states the scope of review. The third through the sixth are as follows:

3. DSHS erred in failing to consider Ms. Freeman's eligibility for Medicaid benefits under the Early Periodic Screening Diagnosis and Treatment program under 42 USC 1396(r) and 42 USC 1396a(10)(A).
4. DSHS erred in failing to allow Ms. Freeman to present evidence & argument on claims raised in her Petition for Judicial Review.
5. DSHS did not err in not providing Ms. Freeman with a hearing on her constitutional claims.
6. Remanding this matter for further adjudicative proceedings before an Administrative Law Judge is an appropriate remedy under RCW 34.05.570(3)(f) where the agency has not decided all issues requiring resolution by the agency.

2. On September 13, 2007, the Appellant filed a *Motion for Partial Summary Judgment*. I issued an *Amended Initial Order* on March 21, 2008 granting in part and denying in part the Appellant's motion on various points at issue.

3. In my *Amended Initial Order on the Motion for Partial Summary Judgment* 000002

I ruled in relevant part as follows:

I. The Appellant's request for summary judgment on the issue of whether the results of the 2007 CARE should be applied retroactively to 2004 is ORDERED DENIED.

II. The Appellant's request for summary judgment on the issue of whether the DSHS is bound by the Social Security Administration determination that Faith lives alone is ORDERED DENIED.

III. The Appellant's request for summary judgment on the issue of the retroactive application to the invalidation of the shared living rule is ORDERED GRANTED. The department shall recalculate Faith's CARE hours accordingly.

IV. The Appellant's motion for summary judgment on the issue of whether her procedural rights were violated due to the lack of adequacy of the notice from the DSHS and the failure to issue a timely order is ORDERED GRANTED. However, there is no remedy which I can order to address these issues.

V. The Appellant is eligible for Medical Personal Care Services commencing July 1, 2004.

4. Faith Freeman is a 21 year old woman with Downs Syndrome who lives with and is cared for by her loving family. Faith turned 18 years of age on July 18, 2004. She began receiving Supplemental Security Income (SSI) benefits and medical assistance at that time. Faith turned 21 on July 18, 2007.

5. In July 2004, Faith's parents filed an application for medical assistance with the Department on her behalf. The department determined that she was eligible for medical assistance beginning September 1, 2004.

6. A Comprehensive Assessment Reporting Evaluation (CARE) was completed by a department employee for Faith in 2004, 2005, 2006, and 2007, to determine

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her eligibility for Medicaid Personal Care (MPC). The 2004 CARE resulted in a determination that she qualified for 72 hours in part because of an application of the shared living rule. In the 2005 CARE the department determined that Faith qualified for 74 hours per month of MPC care. In the 2006 CARE the department determined that Faith qualified for 121 hours per month of MPC care. In 2007, another CARE resulted in a determination that Faith qualified for 190 hours per month of MPC. The department determined that this decision would be implemented after Faith's 21st birthday.

7. In determining that Faith qualified for SSI, the Social Security Administration determined that she qualified for a full grant as opposed to one for which she had "supplied shelter". In doing so, they recognized that Faith rented a room from her parents. Faith also began receiving basic food benefits¹ under the WASHCAP program after she was found eligible for SSI benefits.

8. The department mailed Ms. Freeman a "Notice of the Authorization, Denial, Termination, or Reduction of Medicaid Personal Care (MPC)" on August 17, 2004.

Exhibit 1 from Docket No. 09-2004-A-0134.

The notice states in pertinent part as follows:

On 07/09/2004 (date) you were assessed for Medicaid Personal Care (MPC) services to determine:

x your eligibility for MPC services.

As a result, your MPC services have been:

denied, reduced, terminated, because:

Blank area.

This decision is based upon Washington Administrative Code (WAC) sections 388-71 and 388-72A. A copy of these regulations is available upon request. ..."

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The state regulations call this program Basic Food. The federal statute and regulations still call it Food Stamps.

The notice also included a statement of Faith's right to appeal the decision including how to request a hearing and the time limits for doing so.

9. Exhibit BB summarizes the findings of the CAREs completed for Faith between 2004 and 2007. An initial assessment (CARE) was completed on July 9, 2004. The 2005 Annual CARE was completed on October 26, 2005. The 2006 Annual CARE was completed on October 31, 2006. A CARE was completed on July 24, 2007 due to a "significant change. Additionally "Interim Assessments" were completed on October 28, 2004 and August 9, 2007.

10. The following summarizes the changes from 2004 to 2005 on the CARE. In 2005, **transfers** was upgraded from "independent" to "extensive assistance" and "unmet". **Dressing** was upgraded from "limited assistance" to "extensive assistance" and "unmet". The total ADL was upgraded from 11 to 14.

11. The following summarizes the changes from 2005 to 2006 on the CARE. The task of **eating** from changed from "unmet" to "partially met 1/4-1/2". Also "locomotion outside" was changed from "partially met less than 1/4" to "partially met 1/2-3/4". Her overall ADL score increased from 14 to 15.

12. The following summarizes the changes from 2006 to 2007 on the CARE. **Eating** was changed from "partially met 1/4 to 1/2" need to "unmet". **Locomotion outside the room** was upgraded from "partially met 1/2 to 3/4 time" to "partially met less than 1/4 time". **Medication management** was changed from "Assistance required" to "Must be administered". Also, **shopping, housework** and **meal preparation** went from "met" to "unmet" due to the Supreme Court striking down the "shared living rule". Additionally, for the first time the department found that her conditions were clinically complex. Finally, they

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found that Faith "must be administered" medication in 2007. Previously her worker rated this task as "assistance required". The reason for this change, is that in 2007, Faith had carbaunkels-open wounds which her parents applied cream to and required antibiotic treatment.

13. Kris Jørgensen-Dobson (Ms. J-D) administered the CARE to Faith in 2004, 2005, 2006 and 2007. Mr. and Ms. Freeman were present at each of these as well and served as Faith's "reporter".

14. With regard to **eating**, Ms. J-D found this task was "partially met 1/4 to 1/2 time in 2006 because she believed that Faith's school was partially meeting this task.

15. With regard to **dressing**, Ms. J-D determined that Faith was in need of "extensive assistance" in 2005 because she cannot put on her bra by herself. In 2004, she rated this as "limited assistance" as she did not know that Faith needed to have her mother actually close her bra for her.

16. On the task of **locomotion outside the room**, Ms. J-D rated this as partially met in 2006 and 2007 because she understood that Faith received some assistance with this at school. She could not explain how she determined the need was met specifically 1/2 to 3/4 of the time.

17. In 2007 when she determined that Faith had a clinically complex diagnosis, this was based upon her Physician's diagnosis of Aphasia. Additionally, the department no longer applied the "shared living rule" because it was stricken by the State Supreme Court, thus **meal preparation, housework and shopping** were no longer considered met. In addition, on this CARE, the department determined that Faith's medications needed to be administered to her. Throughout the entire period at issue, Faith's medications have been

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administered in the same manner by her family. They have taken her pills and crushed or broken them up and placed them in yogurt for her to consume. The only new factor in 2007 is that Faith had a wound, which the department referred to as a carbunkle, to which they applied an antibiotic cream. Ms. J-D also found that her need for assistance with locomotion outside the room was partially met less than 1/4 of the time whereas this was found to be partially met 1/2 to 3/4 of the time in 2006.

18. Mr. Freeman testified credibly that Faith's conditions have remained largely the same throughout the period in question. With regard to toileting, Mr. Freeman testified credibly that when Faith is at school, her urination is handled. However, her bowel movements are handled at home. He and his wife have a regular structured time in the evening with a firm time for Faith to use the commode. Faith is not able to wipe herself or clean up on her own.

19. Mr. Freeman also testified credibly that they never could leave Faith home alone. When Faith was 13 years old, his wife quit her job in order to stay home full time to care for Faith. In the past Faith has flooded their bathroom from multiple flushes of the toilet. She has also hurt herself by shutting her fingers in a door.

20. Faith has been diagnosed with Aphasia and Apraxia. These are both speech disorders. Aphasia is caused by damage to the brain resulting in difficulties formulating speech. Apraxia is related to physical damage in the parts of the body needed to speak orally. Dr. Sciarrone diagnosed Ms. Freeman with aphasia in 2007. Exhibit 36.

21. Mr. Freeman testified credibly that in 2004 when the CARE was new he did not know what the various applicable terms meant. Additionally, Ms. J-D testified that when she administered the CARE she did not give the Freemans a copy of the definitions

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of the terms she used such as the definition of bathing, eating, and the terms "supervision" and "limited assistance".

22. Additionally Mr. Freeman testified credibly that with regard to the task of transferring Faith, nothing changed between 2004 and 2005 except he thinks that in 2005, Ms. J-D asked more detailed questions which resulted in her determination that Faith needed more assistance.

23. With regard to the task of **eating**, Mr. Freeman acknowledged that Faith had her lunch at school 4 days per week when she was in school. Mr. Freeman understood that the department downgraded this task from limited assistance to supervision because they decided that cutting food was part of the task of food preparation, not eating.

24. With regard to the task of **dress**ing, Faith has always needed the same level of assistance throughout the period at issue.

25. With regard to **locomotion**, Mr. Freeman also testified that Faith needed the same level of assistance with this task throughout the period at issue. Nothing changed at school between 2005 and 2006 with regard to this task.

26. With regard to **toileting**, Mr. Freeman testified that Faith always needed the same level of assistance, which Mr. Freeman thinks was extensive assistance.

27. In addition to assisting Faith on a daily basis seven days per week with various activities of daily living, the Freemans work with Faith to attempt to train her to be as self-sufficient as possible. For example when assisting her showering, they show her the difference between soap and shampoo and how to clean herself and dry herself off. They show her how to prepare meals. They work with her on habilitation skills such as:
how to be appropriate when she is out in the community and working skills and personal

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care skills. They are constantly working with Faith to try to train her to learn new things to keep her safe and fully develop her potential.

28. On January 30, 2006, Dr. Henry DeGive signed a written declaration stating the following:

1. I am a Doctor of Pediatrics with over twenty years experience as a Pediatrician. I have been Faith Freeman's treating physician ever since she was two weeks old and am very familiar with her condition.
2. As a Pediatrician, I am familiar with the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Medicaid program. Over the years I have performed many EPSDT screenings. I had never been notified by DSHS that EPSDT coverage extended until age 21. I had believed it was limited to young children. I had to be convinced by Faith's father that she still qualified for an EPSDT screening.
3. On August 27, 2004, after Faith turned 18, I conducted an EPSDT screening of her condition. My screening is attached to this declaration as exhibit "A". In the screening I concluded, based upon Faith's diagnosis of trisomy 21 and conditions flowing from that diagnosis that she needed constant supervision in order to maintain her health and safety.
4. In my medical opinion, it is medically necessary that Faith continue to receive 24-hour, 7 days a week assistance as a remedial service for the maximum reduction of Faith's physical and mental disability necessary to restore her to the best possible functional level.
5. The level of treatment I prescribed in the EPSDT screening is a health care and treatment measure medically necessary to correct or ameliorate Faith's trisomy 21 and physical illness which I identified and documented in the EPSDT screening."

29. Exhibit A, referenced above is dated August 27, 2004 and was written by Dr. DeGive. Therein he noted in pertinent part that *"Patient requires 24/7 supervision. She wandered off from school on a couple of occasions when she was not being watched. She has no concept to personal danger and will walk across the street in front a car (sic) or allow herself to be approached by stranger. She is unable to use public transportation without an aide. She has no concept of money, although parents do take patient shopping. She enjoys picking out things that she wants but does not have any concept of paying or of money."* Dr. DeGive also testified in this hearing and his

testimony largely mirrored his written declaration.

30. Ms. J-D testified that she did not know about the EPSDT program until 2004 when Mr. Freeman asked her about it. There is no evidence in the record that the department informed the Freemans about the EPSDT program. In fact, the evidence is to the contrary, that is that the Freemans informed the department about the EPSDT program.
31. Exhibit 27 was prepared by Mr Freeman. It shows the "unpaid balance" for hours of care to Faith for which the Freemans have not been compensated. The "unpaid balance" shown is the number of uncompensated hours excluding school and work time and any other "informal support" hours not provided by the Freemans. It does not include the hours for which the Freemans were previously paid under the MPC program. It does include 8 hours of sleep time each day. The hourly rate of pay used in this exhibit by Mr. Freeman is the amount paid to the Freemans by the department under the MPC program.
32. Attached to the Department's Closing Brief and referenced therein is a declaration of Joyce Pashley Stockwell.

CONCLUSIONS OF LAW

1. The undersigned has jurisdiction over the persons and subject matter herein pursuant to RCW 74.08.080, WAC 388-106-1305 and chapter 34.12 RCW.

I. DECLARATION OF JOYCE PASHLEY STOCKWELL

2. The declaration of Joyce Pashley Stockwell will not be admitted into the

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record. I kept the record open beyond the end of this hearing for the sole and exclusive purpose of allowing the parties to file Closing Briefs. WAC 388-02-0505(1) states that the record closes at the end of the hearing unless the ALJ permits the parties to "send in evidence or argument." Subsection (2) provides that otherwise the record closes after the time to submit the evidence or argument is over. Neither party asked for permission to submit any further *evidence* after May 21, 2008. Thus the factual hearing record closed on May 21, 2008, the last day of the hearing. WAC 388-02-0505(1).

II. BECAUSE OF THE INVALIDATION OF THE SHARED LIVING RULE BY THE STATE SUPREME COURT, IS FAITH ENTITLED TO BENEFITS WITHOUT THE APPLICATION OF THE SHARED LIVING RULE *RETROACTIVE* TO JULY 1, 2004?

3. On May 3, 2007, the Washington State Supreme Court issued the *Jenkins v. DSHS* opinion. 160 Wn. 2d 287, 157 P. 3d 388 (2007). Therein the court affirmed an earlier Court of Appeals opinion which struck down WAC 388-106-0130(3)(b), commonly referred to as the shared living rule, as violating the federal comparability requirement for the medicaid program. The Appellant argues that the *Jenkins* ruling should be applied retroactively. The department disagreed with her at this hearing. I asked the parties to brief this issue.

4. In their Post Hearing Brief in Response to the Appellant's Closing Brief, the department agrees with the Appellant, that having preserved her challenge to the shared living rule, under Docket Number 09-2004-A-0143, Ms. Freeman is entitled to a recalculation of her MPC hours without the shared living rule, back to her 2004 CARE. The department therefore argues that this point is moot because the department has agreed

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to this occurring. However, the department did not take this position at this hearing. The first time the Appellant and this tribunal heard that this is the department's position was in their closing brief. I conclude that since the parties have now stipulated that Ms. Freeman is entitled to a retroactive recalculation of her MPC benefits without the application of the shared living rule, back to her 2004 CARE, that it shall be so ordered.

5. In so ruling, I am mindful of the department's position that this is a moot point. A moot case is defined as one which seeks to determine an abstract question which does not rest upon existing facts or rights. *State v. International Typographical Union*, 57 Wn. 2d 151, 356 P. 2d 6, (1960). The general rule is that if a question is moot or presents abstract propositions, the appeal should be dismissed. *Sorenson v. Bellingham*, 80 Wn. 2d 547, 558, 496 P. 2d 512 (1972). However, even if a case is moot, the Washington Supreme Court recognized an exception to this rule when "matters of continuing and substantial public interest are involved." *Sorenson*, at 558.

III. THE EARLY PERIODIC SCREENING DIAGNOSIS AND TREATMENT PROGRAM

6. The superior court ruled that DSHS and the previous ALJ who conducted the original hearing in this case erred in not considering the Appellant for possible eligibility for the Early Periodic Screening Diagnosis and Treatment program (EPSDT). This issue is now before me.

7. Under a 1989 amendment to the federal medicaid law, all states must provide EPSDT services. Omnibus Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2261-2265, 2268, 2269 (codified as amended at 42 U.S.C. § 1396(r)(2005)).

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8. **WAC 388-534-0100, a DSHS regulation, provides:**

EPSDT.

(1) Persons who are eligible for Medicaid are eligible for coverage through the early and periodic screening, diagnosis, and treatment (EPSDT) program up through the day before their twenty-first birthday.

(2) Access and services for EPSDT are governed by federal rules at 42 CFR, Part 441, Subpart B which were in effect as of January 1, 1998.

(a) The standard for coverage for EPSDT is that the services, treatment or other measures are:

(i) Medically necessary;

(ii) Safe and effective; and

(iii) Not experimental.

(b) EPSDT services are exempt from specific coverage or service limitations which are imposed on the rest of the CN and MN program. Examples of service limits which do not apply to the EPSDT program are the specific numerical limits in WAC 388-545-300, 388-545-500, and 388-545-700.

(c) Services not otherwise covered under the Medicaid program are available to children under EPSDT. The services, treatments and other measures which are available include but are not limited to:

(i) Nutritional counseling;

(ii) Chiropractic care;

(iii) Orthodontics; and

(iv) Occupational therapy (not otherwise covered under the MN program).

(d) Prior authorization and referral requirements are imposed on medical service providers under EPSDT. Such requirements are designed as tools for determining that a service, treatment or other measure meets the standards in subsection (2)(a) of this section.

(3) Transportation requirements of 42 CFR 441, Subpart B are met through a contract with transportation brokers throughout the state.

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9. **The term "Medically necessary" is defined in WAC 388-500-0005 as**

follows:

"Medically necessary" is a term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all.

10. 42 USC § 1396d(r) defines EPSDT services as follows:

(r) Early and periodic screening, diagnostic, and treatment services.

The term "early and periodic screening, diagnostic, and treatment services" means the following items and services:

(1) Screening services--

(A) which are provided--

- (i) at intervals which meet reasonable standards of medical and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care and, with respect to immunizations under subparagraph (B)(iii), in accordance with the schedule referred to in section 1928(c)(2)(B)(i) [42 USCS § 1396s(c)(2)(B)(i)] for pediatric vaccines, and
- (ii) at such other intervals, indicated as medically necessary, to determine the existence of certain physical or mental illnesses or conditions; and

(B) which shall at a minimum include--

- (i) a comprehensive health and developmental history (including assessment of both physical and mental health development),
- (ii) a comprehensive unclothed physical exam,
- (iii) appropriate immunizations (according to the schedule referred to in section 1928(c)(2)(B)(i) [42 USCS § 1396s(c)(2)(B)(i)] for pediatric vaccines) according to age and health history,
- (iv) laboratory tests (including lead blood level assessment appropriate for age and risk factors), and
- (v) health education (including anticipatory guidance).

(2) Vision services--

(A) which are provided--

- (i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and
- (ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

(B) which shall at a minimum include diagnosis and treatment for defects in vision including eyeglasses.

(3) Dental services--

(A) which are provided--

(i) at intervals which meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

(B) which shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health.

(4) **Hearing services--**

(A) which are provided--

(i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

(B) which shall at a minimum include diagnosis and treatment for defects in hearing, including hearing aids.

(5) **Such other necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) [subsec. (a) of this section] to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.**

Nothing in this title [42 USCS §§ 1396 et seq.] shall be construed as limiting providers of early and periodic screening, diagnostic, and treatment services to providers who are qualified to provide all of the items and services described in the previous sentence or as preventing a provider that is qualified under the plan to furnish one or more (but not all) of such items or services from being qualified to provide such items and services as part of early and periodic screening, diagnostic, and treatment services. The Secretary shall, not later than July 1, 1990, and every 12 months thereafter, develop and set annual participation goals for each State for participation of individuals who are covered under the State plan under this title [42 USCS §§ 1396 et seq.] in early and periodic screening, diagnostic, and treatment services.

11. **42 USC 1396d(a), referenced in 42 USC 1396d(r)(5) above (“subsec.(a) of this section”), under “such other services...” and provides with emphasis as follows:**

(a) **Medical assistance.** The term "medical assistance" means payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance or, in the case of medicare cost-sharing with respect to a qualified medicare beneficiary described in subsection (p)(1), if provided after the month in which the individual becomes such a beneficiary) for individuals, and, with respect to physicians' or dentists' services, at the option of the State,

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to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A) [42 USCS § 1396a(a)(10)(A)]) not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV [42 USCS §§ 301 et seq., 1201 et seq., 1351 et seq., or 1381 et seq., or 601 et seq.], and with respect to whom supplemental security income benefits are not being paid under title XVI [42 USCS §§ 1381 et seq.], who are--

(i) under the age of 21, or, at the option of the State, under the age of 20, 19, or 18 as the State may choose,

(ii) relatives specified in section 406(b)(1) with whom a child is living if such child is (or would, if needy, be) a dependent child under part A of title IV [42 USCS §§ 601 et seq.],

(iii) 65 years of age or older,

(iv) blind, with respect to States eligible to participate in the State plan program established under title XVI [42 USCS §§ 1381 et seq.],

(v) 18 years of age or older and permanently and totally disabled, with respect to States eligible to participate in the State plan program established under title XVI [42 USCS §§ 1381 et seq.],

(vi) persons essential (as described in the second sentence of this subsection) to individuals receiving aid or assistance under State plans approved under title I, X, XIV, or XVI [42 USCS §§ 301 et seq., 1201 et seq., 1351 et seq., or 1381 et seq.],

(vii) blind or disabled as defined in section 1614 [42 USCS § 1382c], with respect to States not eligible to participate in the State plan program established under title XVI [42 USCS §§ 1381 et seq.],

(viii) pregnant women,

(ix) individuals provided extended benefits under section 1925 [42 USCS § 1396r-6],

(x) individuals described in section 1902(u)(1) [42 USCS § 1396a(u)(1)],

(xi) individuals described in section 1902(z)(1) [42 USCS § 1396a(z)(1)],

(xii) employed individuals with a medically improved disability (as defined in subsection (v)), or

(xiii) individuals described in section 1902(aa) [42 USCS § 1396a(aa)],

but whose income and resources are insufficient to meet all of such cost--

(1) inpatient hospital services (other than services in an institution for mental diseases);

(2) (A) outpatient hospital services, (B) consistent with State law permitting such services, rural health clinic services (as defined in subsection (l)(1)) and any other ambulatory services which are offered by a rural health clinic (as defined in subsection (l)(1)) and which are otherwise included in the plan, and (C) Federally-qualified health center services (as defined in subsection (l)(2)) and any other ambulatory services offered by a Federally-qualified health center and which are otherwise included in the plan;

(3) other laboratory and X-ray services;

(4) (A) nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older; (B) early and periodic screening, diagnostic, and treatment services (as defined in subsection (r)) for individuals who are eligible under the plan and are under the age of 21; and (C) family planning services and supplies furnished (directly or under arrangements with others) to individuals of childbearing age (including

minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies;

(5) (A) physicians' services furnished by a physician (as defined in section 1861(r)(1) [42 USCS § 1395x(r)(1)]), whether furnished in the office, the patient's home, a hospital, or a nursing facility, or elsewhere, and (B) medical and surgical services furnished by a dentist (described in section 1861(r)(2) [42 USCS § 1395x(r)(2)]) to the extent such services may be performed under State law either by a doctor of medicine or by a doctor of dental surgery or dental medicine and would be described in clause (A) if furnished by a physician (as defined in section 1861(r)(1) [42 USCS § 1395x(r)(1)]);

(6) medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law;

(7) home health care services;

(8) private duty nursing services;

(9) clinic services furnished by or under the direction of a physician, without regard to whether the clinic itself is administered by a physician, including such services furnished outside the clinic by clinic personnel to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address;

(10) dental services;

(11) physical therapy and related services;

(12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

(13) other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level;

(14) inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases;

(15) services in an intermediate care facility for the mentally retarded (other than in an institution for mental diseases) for individuals who are determined, in accordance with section 1902(a)(31) [42 USCS § 1396a(a)(31)], to be in need of such care;

(16) effective January 1, 1973, inpatient psychiatric hospital services for individuals under age 21, as defined in subsection (h);

(17) services furnished by a nurse-midwife (as defined in section 1861(gg) [42 USCS § 1395x(gg)]) which the nurse-midwife is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider, and without regard to whether or not the services are performed in the area of management of the care of mothers and babies throughout the maternity cycle;

(18) hospice care (as defined in subsection (o));

(19) case management services (as defined in section 1915(g)(2) [42 USCS § 1396n(g)(2)]) and TB-related services described in section 1902(z)(2)(F) [42 USCS § 1396a(z)(2)(F)];

(20) respiratory care services (as defined in section 1902(e)(9)(C) [42 USCS §

1396a(e)(9)(C));

(21) services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner (as defined by the Secretary) which the certified pediatric nurse practitioner or certified family nurse practitioner is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), whether or not the certified pediatric nurse practitioner or certified family nurse practitioner is under the supervision of, or associated with, a physician or other health care provider;

(22) home and community care (to the extent allowed and as defined in section 1929 [42 USCS § 1396t]) for functionally disabled elderly individuals;

(23) community supported living arrangements services (to the extent allowed and as defined in section 1930;

(24) **personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home or other location;**

(25) primary care case management services (as defined in subsection (t));

(26) services furnished under a PACE program under section 1934 [42 USCS § 1396u-4] to PACE program eligible individuals enrolled under the program under such section;

(27) subject to subsection (x), primary and secondary medical strategies and treatment and services for individuals who have Sickle Cell Disease; and

(28) any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary, except as otherwise provided in paragraph (16), such term does not include--

(A) any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution); or

(B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases.

For purposes of clause (vi) of the preceding sentence, a person shall be considered essential to another individual if such person is the spouse of and is living with such individual, the needs of such person are taken into account in determining the amount of aid or assistance furnished to such individual (under a State Plan approved under title I, X, XIV, or XVI [42 USCS §§ 301 et seq., 1201 et seq., 1351 et seq., or 1381 et seq.]), and such person is determined, under such a State plan, to be essential to the well-being of such individual. The payment described in the first sentence may include expenditures for medicare cost-sharing and for premiums under part B of title XVIII [42 USCS §§ 1395j et seq.] for individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV [42 USCS §§ 301 et seq., 1201 et seq., 1351 et seq., or 1381 et seq., or 601 et seq.], or with respect to whom supplemental security income benefits are being paid under title XVI [42 USCS §§ 1381 et seq.], or (B) with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal

in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A) [42 USCS § 1396a(a)(10)(A)], and, except in the case of individuals 65 years of age or older and disabled individuals entitled to health insurance benefits under title XVIII [42 USCS §§ 1395 et seq.] who are not enrolled under part B of title XVIII [42 USCS §§ 1395j et seq.], other insurance premiums for medical or any other type of remedial care or the cost thereof. No service (including counseling) shall be excluded from the definition of "medical assistance" solely because it is provided as a treatment service for alcoholism or drug dependency.

12. There are five broad categories of assistance available under the EPSDT program. They are:

- (1) Screening services,
- (2) Vision services,
- (3) Dental Services,
- (4) Hearing Services, and
- (5) Such other necessary health care services, treatment, and other measures described in section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.

13. 42 CFR § 440.40(b) defines the EPSDT program as follows:

"(b) EPSDT. "Early and periodic screening and diagnosis and treatment" means --

- (1) Screening and diagnostic services to determine physical or mental defects in recipients under age 21; and
- (2) Health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered. (See subpart B of part 441 of this chapter.)"

14. Additionally, 42 CFR § 441.56 provides:

"EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) OF INDIVIDUALS UNDER AGE 21

§ 441.56 Required activities.

(a) Informing. The agency must--

- (1) Provide for a combination of written and oral methods designed to inform effectively all EPSDT eligible individuals (or their families) about the EPSDT program.
- (2) Using clear and nontechnical language, provide information about the following--
 - (i) The benefits of preventive health care;

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(ii) The services available under the EPSDT program and where and how to obtain those services;

(iii) That the services provided under the EPSDT program are without cost to eligible individuals under 18 years of age, and if the agency chooses, to those 18 or older, up to age 21, except for any enrollment fee, premium, or similar charge that may be imposed on medically needy recipients; and

(iv) That necessary transportation and scheduling assistance described in § 441.62 of this subpart is available to the EPSDT eligible individual upon request.

(3) Effectively inform those individuals who are blind or deaf, or who cannot read or understand the English language.

(4) Provide assurance to CMS that processes are in place to effectively inform individuals as required under this paragraph, generally, within 60 days of the individual's initial Medicaid eligibility determination and in the case of families which have not utilized EPSDT services, annually thereafter.

(b) **Screening.** (1) The agency must provide to eligible EPSDT recipients who request it, screening (periodic comprehensive child health assessments); that is, regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. (See paragraph (c)(3) of this section for requirements relating to provision of immunization at the time of screening.) As a minimum, these screenings must include, but are not limited to:

(i) Comprehensive health and developmental history.

(ii) Comprehensive unclothed physical examination.

(iii) Appropriate vision testing.

(iv) Appropriate hearing testing.

(v) Appropriate laboratory tests.

(vi) Dental screening services furnished by direct referral to a dentist for children beginning at 3 years of age. An agency may request from CMS an exception from this age requirement (within an outer limit of age 5) for a two year period and may request additional two year exceptions. If an agency requests an exception, it must demonstrate to CMS's satisfaction that there is a shortage of dentists that prevents the agency from meeting the age 3 requirement.

(2) Screening services in paragraph (b)(1) of this section must be provided in accordance with reasonable standards of medical and dental practice determined by the agency after consultation with recognized medical and dental organizations involved in child health care. 000020

(c) **Diagnosis and treatment.** In addition to any diagnostic and treatment services included in the plan, the agency must provide to eligible EPSDT recipients, the following services, the need for which is indicated by screening, even if the services are not included in the plan--

(1) Diagnosis of and treatment for defects in vision and hearing, including eyeglasses and hearing aids;

(2) Dental care, at as early an age as necessary, needed for relief of pain and infections, restoration of teeth and maintenance of dental health; and

(3) Appropriate immunizations. (If it is determined at the time of screening that immunization is needed and appropriate to provide at the time of screening, then immunization treatment must be provided at that time.)

(d) **Accountability.** The agency must maintain as required by §§ 431.17 and 431.18--

(1) Records and program manuals;

(2) A description of its screening package under paragraph (b) of this section; and

(3) Copies of rules and policies describing the methods used to assure that the informing requirement of paragraph (a)(1) of this section is met.

(e) **Timeliness.** With the exception of the informing requirements specified in paragraph (a) of this section, the agency must set standards for the timely provision of EPSDT services which meet reasonable standards of medical and dental practice, as determined by the agency after consultation with recognized medical and dental organizations involved in child health care, and must employ processes to ensure timely initiation of treatment, if required, generally within an outer limit of 6 months after the request for screening services.

15. A primary issue in this hearing is did Faith qualify for EPSDT services under the category:

"Such other necessary health care services, treatment, and other measures described in section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan."? 42 USC 1396d(r).

16. The department characterizes the care provided by the Freemans to Faith as "supervision" and argues that supervision is not covered by the EPSDT program. The care which the Freemans provide as Faith's caregivers is more properly characterized as

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personal care services, which are provided under Medicaid and the EPSDT program.

17. 42 USC § 1396d(a)(24) provides that personal care services covers:

*“personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State, (B) provided by an individual who is qualified to provide such services and **who is not a member of the individual's family**, and (C) furnished in a home or other location;” (emphasis added).*

18. Faith's parents are her care providers. They are members *“of the individual's family”*. Thus under 42 USC §1396d(a)(24), the services are not covered under the definition of medical assistance. I therefore cannot conclude that Faith qualifies for personal care services under the EPSDT program. The fact that Faith is past the age of majority and her father is her legal guardian does not negate the fact that he and her mother are still her family and were so when she was between the ages of 18 and 21. Under this provision of the federal statute, Faith therefore cannot receive personal care services provided by them.

19. Although she previously received orthodontic services under the EPSDT program, the Appellant is not currently seeking assistance for the period at issue under the categories of screening services, vision services, dental services or hearing services. 42 USC 1396d(r)(5) provides that *“such other necessary health care..”* is covered even if it is not covered by the State plan, this does not provide legal authority to disregard the plain and clear language of the federal statute.

20. I recognize that Faith began receiving Medicaid *Personal Care* benefits when she turned 18. However, I cannot disregard the plain words of the above federal statute precluding coverage of *personal care services* provided by a family member.

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21. Broken down into its essential elements relevant to this case, 42 USC 1396d(a)(13) provides for coverage **in addition to** personal care services under the EPSDT program for the following:

- (1) **remedial services**
- (2) **provided in a home**
- (3) **recommended by a physician within the scope of their practice under State law**
- (4) **for the maximum reduction of physical or mental disability and**
- (5) **restoration of an individual to the best possible functional level.**

22. 42 USC 1396d(r)(5) additionally provides that in order to qualify for EPSDT coverage, it must be:

- (1) **a "measure" which**
- (2) **corrects or ameliorates defects and physical and mental illnesses and conditions discovered during screening,**
- (3) **whether or not covered by the State plan.**

23. I conclude that the care provided by the Freemans to Faith was not diagnostic, screening or preventative care. The question remains, did they provide remedial services which were:

- (1) recommended by a physician and
- (2) "for the maximum reduction of physical or mental disability and restoration of Faith to and restoration of Faith to the best possible functional level"?

The answer to #1 is yes. Dr. DeGive prescribed 24 hour -7 days per week assistance for Faith. Dr. DeGive stated that the 24 hour a day 7 days per week of assistance provided by her parents is a remedial service for the maximum reduction of Faith's physical and mental disability and to restore her to her best possible functional level. The answer to #2 is also yes, according to the opinion of Dr. DeGive, Faith's Pediatrician since shortly after the time of her birth.

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24. Dr. Henry DeGive, Faith's pediatrician, signed a written declaration stating

that on August 27, 2004 he conducted an EPSDT screening exam of Faith. Dr. DeGive diagnosed Trisomy 21 and conditions which flow from that diagnosis and he indicated that Faith needs constant supervision in order to maintain her health and safety. He also stated that in his "medical opinion, it is necessary that Faith continue to receive 24-hour, 7 days a week assistance as a remedial service for the maximum reduction of Faith's physical and mental disability necessary to restore her to the best possible functional level. The level of treatment I prescribed in the EPSDT screening is a health care and treatment measure medically necessary to correct or ameliorate Faith's trisomy 21 and physical illness which I identified and documented in the EPSDT screening."

25. Likewise Dr. Sciarrone reached largely the same conclusion. Also, the department stipulated that Faith needs 24 hour per day care 7 days per week. Exhibit 28.

26. In attempting to ascertain the meaning of the applicable statutes and regulations, I have reviewed the case law cited by the parties. *Punikaia v. Clark*, involves the issue of hospital care coverage by medicaid. *Punikaia v. Clark*, 720 F. 2d 564 (9th Cir. 1983). *Atkins v. Rivera* involves medically needy medical assistance eligibility. *Atkins v. Rivera*, 477 U.S. 154, 106 S. Ct. 2456 (1986). *Collins v. Hamilton* involves long term residential care for psychiatric residents. *Collins v. Hamilton*, 349 F 3d 370 (7th Cir.2003). *Pediatric Specialty Care v. Arkansas* involves health management services for children. *Pediatric Specialty Care v. Arkansas*, 293 F. 3d 472 (8th Cir. 2002). All of these cases involve services provided by various health care professionals.

27. *Rosie v. Romney* involves services under the EPSDT to children who are emotionally disturbed. *Rosie v. Romney*, 410 F. Supp 2d 18 (2006). This case specifically involves services, including in-home behavioral supports and crisis services, provided by

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various health care and related professionals, not by lay caregivers such as the Freemans.

28. The case of *S.D. v. Hood*, on the other hand involves an analysis of the EPSDT program coverage and did not involve a service. At issue is a medical supply: disposable incontinent underwear. *S.D. v. Hood* 391 F. 3d 581 (5th Cir. 2004).

29. None of the cases cited by the Appellant involve non-health care providers of in-home care to a recipient of EPSDT services. However, I agree with the Appellant that all services which are covered by medicaid are not legally required to be provided by a licensed health care professional. One example of this is transportation services provides under chapter 388-546 WAC. Additionally, the department's own regulation, WAC 388-534-0100 does not require that the care be provided by a health care professional. Both the *Hood* and *Rosie* opinions contain language which recognizes the broad mandate of EPSDT to cover children, even when the services at issue are not part of a state plan.

30. The court in *Rosie D. v. Romney*, 410 F. Supp. 2d 18, 26 (2006) defines the EPSDT program broadly and stated: "*Courts construing EPSDT requirements have ruled that so long as a competent medical provider finds specific care to be "medically necessary" to improve or ameliorate a child's condition, the 1989 amendments to the Medicaid statute require a participating state to cover it.*"

31. Having considered all of the above, I conclude that Faith was entitled to care from her parents during the period at issue under the EPSDT program. However, I do not conclude that she was entitled to care during 8 hours per day when I presume she was sleeping. I recognize that the Freemans have an auditory monitor in Faith's bedroom and that Mr. Freeman testified credibly that they often get only 5 hours of uninterrupted sleep per night, but he did not testify that they only get 5 hours of sleep on average per night.

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also recognize that within a week of this hearing, Ms. Freeman got up to attend to Faith in the middle of the night and repositioned her. I assume however, that when they are awakened by Faith and check on her, they normally go back to sleep themselves. Thus the care for which they should be compensated is for 16 hours per day minus any time Faith was out of her home in school or working and thus not under the care of her parents. Exhibit 27 was prepared by Mr Freeman. It shows the "unpaid balance" for hours of care to Faith for which the Freemans have not been compensated. The "unpaid balance" shown is the number of uncompensated hours excluding school and work time and any other "informal support" hours not provided by the Freemans. It also does not include the hours for which the Freemans were previously paid under the MPC program. It does, however, include 8 hours of sleep time each day. The balance owed under this order is the figure in the "unpaid balance" column minus 8 hours per day, which I conclude is not covered by the EPSDT program. Thus for example in August 2004 since there were 31 days, 248 hours (8 hours times 31days) are subtracted from 717.5, leaving a balance of 469.50 hours. The net figure must then be multiplied times the hourly rate of pay used by the department for the appropriate period.

32. In the alternative, had I not decided this case under the EPSDT program, a review of the 2004, 2005 and 2006 CAREs would be necessary. Had I not decided the case under the EPSDT program above, I would have ruled that Faith is entitled to the number of hours determined in the 2007 CARE minus the hours of care provided by informal supports such as when she was in school or working. Those hours are shown on Exhibit 27. The reason for this conclusion is that Faith's condition was the same throughout this period. She suffers from a permanent disability. The fact that she was not diagnosed with aphasia until 2007 and therefore not found to meet the criteria for clinical complexity

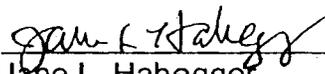
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until then is not because the condition did not exist. Rather it is because a Physician simply had not stated that it existed. In fact her Pediatrician, Dr. DeGive, testified that her disabilities and conditions largely stem from her condition of Trisomy 21, which was diagnosed shortly after her birth. There is no evidence of record that the condition of aphasia did not exist throughout the period. I am reaching this conclusion because this is a de novo hearing. I now have the benefit of all of the evidence considered by the department in each of the years of 2004, 2005 and 2006 when the CARE was previously administered.

ORDER

The Appellant is entitled to services under the EPSDT as set forth above. Alternatively, she is she is eligible for 190 hours under the 2007 CARE retroactive to 2004 minus any hours in which her needs were met with "informal supports" in school or work.

SERVED on the date of mailing.



Jane L. Habegger
Administrative Law Judge
Office of Administrative Hearings

A copy was sent to:

Faith K Freeman, Appellant
Loren And Jean Freeman, Appellant Rep
Shannon Manion, Program Admin
Paul Neal, Appellant Rep

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Bruce Work A A G, Department Rep

NOTICE TO PARTIES: THIS ORDER BECOMES FINAL ON THE DATE OF MAILING UNLESS WITHIN 21 DAYS OF MAILING OF THIS ORDER A PETITION FOR REVIEW IS RECEIVED BY THE DSHS BOARD OF APPEALS, PO BOX 45803, OLYMPIA, WA 98504-5803. A PETITION FORM AND INSTRUCTIONS ARE ENCLOSED.

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Attachment I

MAILED
JUN 27 2008
OLYMPIA OAH

BEFORE THE WASHINGTON STATE OFFICE OF ADMINISTRATIVE HEARINGS
FOR THE DEPARTMENT OF SOCIAL AND HEALTH SERVICES

In Re:

FAITH K FREEMAN
APPELLANT

Docket No. 09-2004-A-0143
11-2005-A-1878
12-2006-A-0855
DSHS#: 731698

INITIAL ORDER

Jane L. Habegger, Administrative Law Judge, conducted an administrative hearing on this matter on April 16 and 17, 2008 and May 20 and 21, 2008. The record was kept open until June 16, 2008 for the filing of closing briefs. The Appellant appeared and was represented by Paul Neal, attorney at law. Bruce Work, an assistant attorney general, represented the Department of Social and Health Services (department).

ISSUES

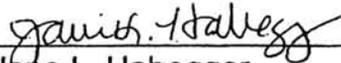
- (1) Did the Appellant qualify for the Early Periodic Screening Diagnosis and Treatment Program prior to the age of 21?
- (2) Is the Appellant eligible to receive more than 72 hours under a Comprehensive Assessment Reporting Evaluation (CARE) dated July 9, 2004?
- (3) Is the Appellant eligible to receive more than 74 hours under a CARE dated October 26, 2005?
- (4) Is the Appellant eligible to receive more than 121 hours under a CARE dated October 31, 2006?

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ORDER

The Appellant is entitled to services under the EPSDT as set forth above. Alternatively, she is she is eligible for 190 hours under the 2007 CARE retroactive to 2004 minus any hours in which her needs were met with "informal supports" in school or work.

SERVED on the date of mailing.



Jane L. Habegger
Administrative Law Judge
Office of Administrative Hearings

A copy was sent to:

Faith K Freeman, Appellant
Loren And Jean Freeman, Appellant Rep
Shannon Manion, Program Admin
Paul Neal, Appellant Rep
Bruce Work A A G, Department Rep

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Attachment J



Rob McKenna

ATTORNEY GENERAL OF WASHINGTON

7141 Cleanwater Dr SW • PO Box 40124 • Olympia WA 98504-0124

RECEIVED

JUL 02 2008

OAH - Olympia

July 2, 2008

ALJ Jane Habegger
Office of Administrative Hearings
2420 Bristol Court SW, 3rd Floor
Olympia, WA 98504-2489

Re: *In Re Faith Freeman,*
Docket Nos. 09-2004-A-0143, 11-2005-A-1878, and 11-2006-A-0855

Dear Judge Habegger,

I am writing to let you know that there appears to be a clerical error in the Initial Order in the above-named case. On pages 26 and 27 there are two Conclusions of Law No. 32. Both of them begin with the same four sentences, but the second appears to be the full paragraph. The continuation of the first Conclusion of Law No. 32 on the top of page 27 appears to be a repetition of the last five lines of Conclusion of Law No. 31. I assume there is no Conclusion of Law No. 33.

Could you please send a corrected version of the order? Thank you for your attention to this matter.

Sincerely,

BRUCE WORK
Assistant Attorney General

cc. Paul Neal

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Attachment 5



Attachment K

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RECEIVED
AUG 01 2008
DSHS
BOARD OF APPEALS

**STATE OF WASHINGTON, DEPARTMENT OF SOCIAL AND HEALTH SERVICES
BOARD OF APPEALS**

In Re:

FAITH FREEMAN,

Appellant.

NOs. 09-2004-A-0143
11-2005-A-1878
12-2006-A-0855

DECLARATION OF BRUCE WORK

I, BRUCE WORK, state and declare as follows:

1. I am a citizen of the United States and of the State of Washington, over 18 years of age and competent to testify to the matters set forth below, based on my own personal knowledge.

2. I am an Assistant Attorney General with the Washington State Attorney General's Office and I represent the Department in this appeal.

3. On or about July 11, 2008, I telephoned the DSHS Board of Appeals regarding the deadline for submission of a request for review of the initial order in this case. I did this because I had received a corrected initial order after I had notified the ALJ in this case of a significant clerical error in the original initial order. The corrected initial order notified parties that the deadline to request review of the order was 21 days from the date it was issued, which would be after the deadline noted on the original initial order.

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Attachment 14

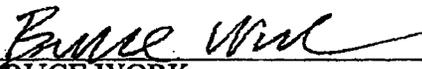
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4. When I called the BOA, I spoke with Shelly Tencza, Legal Secretary 3. She confirmed that the correct deadline was the deadline noted on the corrected initial order. I repeated her statement to ensure that I understood it correctly, and she again confirmed that my understanding was correct.

5. On or about July 17, 2008 Ms. Tencza telephoned me to reiterate the same message regarding the deadline. She said she was calling because the BOA had received a request for review from counsel for the Appellant in this case, and she wanted to reassure me that I had more time to file my own request for review.

I declare under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

Signed at Tumwater, Washington on August 1, 2008.



BRUCE WORK

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Attachment L

RECEIVED

MAY 14 2010

OFFICE OF THE ATTORNEY GENERAL
SOCIAL & HEALTH SERVICES DIV.

**SUPERIOR COURT OF WASHINGTON
IN AND FOR THURSTON COUNTY
FAMILY & JUVENILE COURT**

FAITH FREEMAN,

Petitioner,

vs.

STATE OF WASHINGTON,
DEPARTMENT OF SOCIAL AND
HEALTH SERVICES,

Respondent.

CAUSE NO. 08-2-02909-1

ORDER ON JUDICIAL REVIEW

Clerk's Action Required

THIS MATTER came before the Court on petitioner Faith Freeman's petition for judicial review of an agency order under RCW 34.05.570(3) and review of rules under RCW 34.05.570(2). The agency order at issue was the Department of Social and Health Services (DSHS) Board of Appeals December 8, 2008 Review Decision and Final Order. HR 14S-109S. The Court has considered the briefs of the parties, the records and files herein, and has heard oral argument. The Court hereby makes the following findings of fact and conclusions of law.

I. FINDINGS OF FACT

1. The decision under petition was issued on December 8, 2008. A petition for review was filed with this Court and served on opposing parties within 30 days of the issuance of the decision of the DSHS Board of Appeals.
2. The entire record of the contested proceedings under review is in the possession of the Court.
3. Ms. Freeman turned 18 on July 18, 2004. She turned 21 on July 18, 2007.
4. Ms. Freeman's medical conditions have been essentially the same since birth. This includes Ms. Freeman's diagnosed condition of Aphasia. The Administrative Law Judges' (ALJ) finding that Ms. Freeman has suffered from Aphasia essentially since birth was supported by substantial evidence.

ORDER ON JUDICIAL REVIEW - 1

COPY

ATTACHMENT 1

THURSTON COUNTY SUPERIOR COURT
FAMILY & JUVENILE COURT
MAIL: 2000 Lakeridge Dr. SW, Olympia, WA 98502
LOCATION: 2801 - 32nd Avenue SW, Tumwater
(360) 709-3201 - Fax: (360) 709-3256
CLERK: (360)709-3260

1 5. The \$200 per hour charged by Ms. Freeman's counsel for the appeal of the DSHS action is
2 reasonable. The documentation of the time expended by Ms. Freeman's counsel does not indicate the
3 time dedicated to each of the claims in this appeal. A reasonable estimate of the time spent by Ms.
4 Freeman's counsel on successful claims is 70% of the total time spent on the case.

5 6. Ms. Freeman succeeded in obtaining the reversal of DSHS's final order. This Court did not
6 provide her relief under EPSDT because it found that cognitive supervision services were not provided
7 by Medicaid, an issue not reached by DSHS in its final order. It is reasonable for Ms. Freeman to
8 receive an award of 70% of the fees she incurred in bringing this action to Superior Court. The 70%
9 calculation will be applied after subtraction of all fees and costs associated with Ms. Freeman's
10 unsuccessful motion on summary judgment.

11 II. CONCLUSIONS OF LAW

12 1. Petitioner has properly invoked the jurisdiction of this Court to review DSHS's final order
13 dated December 8, 2008.

14 2. Ms. Freeman qualified for the benefits provided by the Early Periodic Screening, Diagnosis
15 and Treatment law (EPSDT), 42 U.S.C. § 1396d(r), until she turned 21.

16 3. The DSHS review judge incorrectly found that EPSDT coverage was limited to medical
17 services. While services need not be medical to be covered under EPSDT, the services must fall under
18 one of the definitions of medical assistance in 42 U.S.C. § 1396d(a).

19 4. The supervisory services provided to Ms. Freeman do not qualify as medical assistance
20 under 42 U.S.C. § 1396d(a)(13) because the services are not remedial.

21 5. The services provided to Ms. Freeman are more properly characterized as personal care
22 services. To the extent those services are to provide assistance with the activities of daily living, they
23 are covered under the Medicaid Personal Care definition in 42 U.S.C. § 1396d(a)(24). To the extent
24 those services are for supervision, they are not covered under the Medicaid Personal Care definition in
25 42 U.S.C. § 1396d(a)(24).

26 6. The ALJ's finding that Ms. Freeman had been diagnosed with Aphasia and that she has
27 suffered from that condition essentially since birth was supported by substantial evidence. The
28 Review Judge erred in reversing an ALJ finding of fact that was supported by substantial evidence,
WAC 388-02-0600(2). The ALJ's finding is reinstated. The Review Judge's findings and

1 conclusions on that issue are reversed.

2 7. Pursuant to the diagnosis of Aphasia, Ms. Freeman qualifies for 190 hours per month of
3 Medicaid Personal Care services for assistance with activities of daily living throughout the period
4 covered by this appeal, as awarded by the ALJ in her opinion dated June 27, 2008.

5 8. DSHS must pay for Medicaid services retroactively up to three months prior to the date of
6 application. 42 U.S.C. § 1396a(a)34. Further, that eligibility extends to the first of the month if the
7 individual was eligible at any time during the month. 42 C.F.R. § 914(2)(b). Ms. Freeman applied
8 for Medicaid benefits in July of 2004. She became eligible for those benefits when she turned 18 on
9 July 18, 2004. Accordingly, Ms. Freeman is entitled to Medicaid Personal Care Benefits beginning on
10 July 1, 2004.

11 9. Ms. Freeman's petition for review has been granted in part and denied in part. Ms.
12 Freeman prevailed on significant issues. She is entitled to reasonable attorney's fees and costs under
13 RCW 74.08.080(3) and RCW 4.84.350 for a portion of fees incurred pursuing review on the issues.
14 Ms. Freeman obtained relief on the state law issue, i.e. her eligibility for coverage under the state
15 Medicaid Personal Care Services program. Ms. Freeman obtained relief on her claim that she was
16 entitled to additional personal care hours due to her diagnosis of Aphasia. She also obtained relief on
17 the issue of retroactivity. She obtained relief in overturning the Review Judge's finding that EPSDT
18 was limited to medical benefits, although ultimately her claim for additional services under EPSDT
19 was denied. This Court awards Ms. Freeman 70% of the attorney fees bringing this claim to Superior
20 Court, including 70% of the fees deferred by Judge Tabor in his December 15, 2006 order.

21 III. ORDER

22 1. Ms. Freeman's petition for reversal of DSHS 's holding that EPSDT only covers medical
23 services in GRANTED.

24 2. Ms. Freeman's petition for Medicaid coverage under EPSDT for supervisory services is
25 DENIED.

26 3. Ms. Freeman's petition for Medicaid Personal Care Services for 190 hours per month
27 pursuant to her diagnosis of Aphasia is GRANTED.

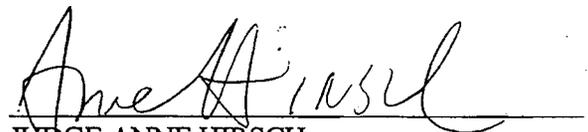
28 4. Ms. Freeman's petition for retroactive benefits back to July 1, 2004, is GRANTED.

5. DSHS is ordered to calculate the number of hours of service Ms. Freeman is entitled to by

1 applying 190 hours of service to each month beginning July 1, 2004. DSHS will multiply this by the
2 appropriate hourly rate applicable during the time period in question. DSHS will deduct from this the
3 hours of Medicaid Personal Care Services already compensated during this period. The difference
4 shall be paid to Petitioner.

5 6. Ms. Freeman is entitled to an award of reasonable attorney fees and costs incurred in
6 appealing DSHS's final orders in this matter to Superior Court. Having fully reviewed the record, the
7 Court awards Ms. Freeman 70% of the fees incurred for a total award of \$14,243.24. This amount will
8 be payable immediately if this matter is not further appealed, or, if the matter is appealed, at such time
9 as the appeal is resolved in Ms. Freeman's favor. Provided: that the stay on liability for payment of
10 attorney fees will apply only to those portions of the attorney fees award associated with the issues
11 appealed.

12 DATED this 11th day of May 2010.

13 
14 JUDGE ANNE HIRSCH
15 Thurston County Superior Court
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1 EXPEDITE
2 No Hearing Set
3 Hearing is Set
4 Date:
5 Time:
6 Judge Hirsch

7 STATE OF WASHINGTON
8 THURSTON COUNTY SUPERIOR COURT

9 FAITH FREEMAN,
10 Petitioner/Appellant,
11 v.
12 STATE OF WASHINGTON,
13 DEPARTMENT OF SOCIAL &
14 HEALTH SERVICES,
15 Respondent/Cross-Appellant.

NO. 08-2-02909-1

COA No.

DECLARATION OF SERVICE

16 I declare and state as follows:

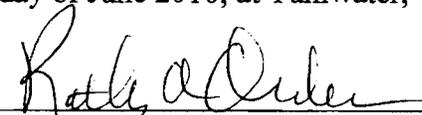
17 I served a true and correct copy of this document and the following document by ABC
18 Legal Messenger to Paul Neal: NOTICE OF CROSS APPEAL TO COURT OF APPEALS
19 DIVISION II on the date below as shown.

20 Attorney for Petitioner/Appellant

21 Paul Neal
22 Neal & Neal, LLC
23 112 East Fourth Avenue, Suite 200
24 Olympia, WA 98501

25 I declare under penalty of perjury under the laws of the state of Washington that the
26 forgoing is true and correct.

RESPECTFULLY SUBMITTED this 22nd day of June 2010, at Tumwater, WA.


KATHY ANDERSON, Legal Assistant

DECLARATION OF SERVICE

COPY

ATTORNEY GENERAL OF WASHINGTON
7141 Cleanwater Dr SW
PO Box 40124
Olympia, WA 98504-0124
(360) 586-6565

Attachment M

FILED

7

2007 MAY 18 PM 12:11

CLERK OF SUPERIOR COURT
YAKIMA COUNTY, WASHINGTON

IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON
IN AND FOR THE COUNTY OF YAKIMA

JOSHUA RULAND and JANET RULAND,

Husband and Wife,

Petitioners,

vs.

STATE OF WASHINGTON DEPARTMENT
OF SOCIAL AND HEALTH SERVICES,

Respondent.

ORIGINAL

NO. 06-2-03813-3

COURT'S DECISION

The Rulands petition the superior court for judicial review of a final administrative order revoking their foster family home license. It was revoked after CPS investigated and found Ms. Ruland abused and/or neglected a foster child in her care. It was assigned referral number 1642848. The referral was received by DSHS on August 10, 2005.

On October 13, 2005 a letter was sent to Ms. Ruland informing her of the founded finding. The letter provided information about how to seek review and of a 20-day time limit.

In a December 29, 2005 letter Deputy Administrator Smith informed Ms. Ruland that the finding was correct and being upheld. The letter included instructions for review by the Office of Administrative Hearings, including a 30-day time limit from date of receipt of the letter. Ms. Ruland received it on January 13, 2006.

Concurrently with the above referral the Office of Foster Care Licensing investigated Ms. Ruland to determine if she had violated any licensing requirements. By letter dated October 28, 2005 the Rulands were informed that their application for a foster care license was being denied. (They had moved to a new home and were required to

apply for a new license.) The Rulands properly appealed the denial of their application. An administrative hearing was scheduled.

During a December 13, 2005 pre-hearing conference (16 days before the founded finding was upheld) there were discussions concerning consolidation of the founded finding and the denial of the license. Judge Davenport (ALJ) noted that not only was a foster care license involved, but it also appeared that there was a CAPTA matter. The Ruland's attorney responded affirmatively. He also indicated that the finding was contested. A hearing was set for February 14, 2006.

On February 14, 2006, the first day of hearing, the department moved for dismissal of review of the founded finding of abuse and neglect because Ms. Ruland had not petitioned for administrative review within the 30-day appeals period. It was determined that the 30th day was February 13, 2006.

Counsel for the Rulands indicated that he had earlier, after getting the review back, talked to a Mr. Marchilar in Olympia about doing both at once and Mr. Marchilar had responded: "(W)ell you can." (RP page 10, line 6) Judge Davenport consolidated both claims and proceeded with the hearing indicating: "We can conjoin them and we'll hear evidence on both matters, and then we'll make a decision whether or not the CAPTA matter should be dismissed." (RP Page 16, lines 11-14)

On May 5, 2006, Judge Davenport denied respondent's motion to dismiss, found neither abuse nor neglect and reversed the denial of the foster care license. He found that Ms. Ruland objected to the founded report, and her attorney had requested a review in a November 2, 2005 letter.

He also found:

(A)t the pre-hearing conference (i)t was then acknowledged that the license and abuse allegations would be joined for hearing, assuming the finding was not reversed, and a hearing date of February 14, 200(6) was set. On December 29, 2005 a letter was sent to Mrs. Ruland advising her of the department's decision not to change the founded finding. This letter was received January 13, 2006. A written objection to the final finding was filed on the date of hearing, February 14, 2006. Although the department was aware of the Appellant's previous oral and written objections to the license denial and founded finding, and that a hearing was scheduled, the department moved for dismissal, indicating lack of jurisdiction for failure to timely request review. (Initial Order, pages 2-3)

He concluded that the November 2, 2005 objection was a request for review of the founded finding even though it was received prior to the final finding. He concluded:

It is noted that this matter was set for hearing on the licensing matter prior to issuance of the final founded finding. The parties had agreed to consolidation and the department was aware of the Appellant's objection to the license denial and founded finding. (Initial Order, pages 6-7)

Respondent petitioned for review by the Board of Appeals. Concluding that Judge Davenport had no jurisdiction to hear the founded finding because of the failure to properly appeal, Judge Stalnaker reversed the Initial Order and denied the application for a Foster Family Home license.

Judge Stalnaker entered new findings of fact because "several of the Initial Order's findings were not supported by substantial evidence, several were actually conclusions of law . . . , and several were ambiguously written in the passive voice(.)" (Page 13 of Review Decision and Final Order and page 26 of the Record). The Rulands timely filed this appeal to Superior Court.

The first issue is whether a notice of appeal must be in writing. If so, is the November 2, 2005 letter a proper notice of appeal to the Office of Administrative Hearings on the neglect case. If it is, the next issue is whether the facts support a founded finding of abuse and neglect and whether appellants violated certain WAC provisions as alleged in the licensure denial notice. If the facts support violations of the WACs and/or abuse and neglect, the issue is whether the license renewal should have been denied.

If the November 2 letter is not a proper notice of appeal, the next issue is whether the department should be estopped from pursuing its motion to dismiss. If it should be estopped, the same issues arise if the November 2 letter is a proper appeal.

Must an appeal be in writing?

Yes.

WAC 388-15-105(2) provides:

The request for a hearing must be in writing and sent to the Office of Administrative Hearings.

RCW 26.44.125 grants review rights to "alleged perpetrators" by allowing them to seek review of a founded finding within 20 days of receipt of the notice. This review is by a management level person with the department. Section 4, subsection (2) provides that the "request must be made in writing."

If management upholds the founded finding, the "alleged perpetrator" can request an adjudicative hearing which is governed by RCW 34.05 and Chapter 26.44 RCW. Although there is no language in subsections (3), (4) or (5) that the request be in writing,

subsection (4) requires that the request "be filed within thirty calendar days after receiving notice of the agency review determination." (My emphasis). Filing is accomplished by filing a written document.

Can a letter be a request for review?

Yes.

Neither the WAC nor the RCW requires anything other than a written request. There is no form designated. A correctly phrased letter can be a written request for review by OAH.

Is a request for review of the initial founded finding sufficient to accomplish appeal to the OAH when there has been no written request for review of the management founded finding?

There were two November 2, 2005 letters sent on behalf of the Rulands. One was sent to Mr. Donicio Marichalar referencing #164248. The first two paragraphs provide:

On behalf of my clients, the Rulands, we deny any and all allegations of Negligent treatment or maltreatment of the foster children that were in their care under your program

We feel that the founded findings are not based upon anything the Rulands did that was negligent or indicative of maltreatment. We seek a review.

The second letter was sent to the "Program Manager of the Division of Licensed Resources, Child Abuse and Neglect Section" and also references #1642848. It provides:

Enclosed please find our Notice of Appearance and Request for Review. Under separate cover we have already sent your "form" to you. I am also including the information I have sent to Donicio Marichalar in your Yakima office.

The Rulands argue that they did appeal both the CPS and licensing actions. It was not necessary that they seek review of both the initial founded finding and its affirmance.

The department acknowledges that the Rulands properly appealed the licensing action but argues they only satisfied internal agency appeal requirements in the CPS action. By failing to follow all regulatory and statutory procedural requirements they failed to perfect their appeal of the CPS action.

Under RCW 26.44.125(2) department review must be requested within 20 days of receipt of the department decision. In part that subsection provides:

If a request for review is not made as provided in this subsection, the alleged perpetrator may not further challenge the finding and shall have no right to agency review or to an adjudicative hearing or judicial review of the finding.

Under RCW 26.44.125(4) if the report remains founded the aggrieved person can seek adjudicative review, but

The request for adjudicative review must be filed within thirty days after receiving notice of the agency review determination. If a request for an adjudicative proceeding is not made as provided in this subsection, the alleged perpetrator may not further challenge the finding and shall have no right to agency review or to an adjudicative hearing or judicial review of the finding.

WAC 388-15-105 also provides for challenge to a founded finding by management staff by request for an administrative hearing. It "must be in writing and sent to the Office of Administrative Hearings and must be received within thirty days from the date that the person requesting the hearing receives the CPS management review decision."

The legislature has established a procedure by which aggrieved persons can seek review of founded findings. The language of the statute is clear and unambiguous. Upon receiving notice of a founded finding the aggrieved party must petition for review within the time limits set in the statute. Failure to do so results in the founded finding becoming final.

If that person does seek review to management staff, he or she must follow the statutory mandates for review. This language is also clear and unambiguous. Failure to do so results in loss of the right to review both administratively and judicially.

The intent of the legislature is to make the statutory requirements jurisdictional. It has done so both clearly and unambiguously. Administrative and/or judicial review require following the statutory mandates.

The Rulands properly requested review of the licensure issues. They properly requested departmental review of the CPS issues, but failed to request administrative review of the CPS issues. They were required to do so. The ALJ lacked jurisdiction to decide that issue as a matter of law.

The 30-day review request time limitation is also jurisdictional requiring strict compliance. Failure to request review on or before the thirtieth day results in loss of the right to seek review. The Rulands did not file within the required time period. The founded finding became final when they failed to properly request administrative review within the 30-day period unless they had a legal reason for not doing so.

Estoppel and agreement to jurisdiction.

The Rulands argue and the ALJ concluded that the department agreed with consolidation and knew of their objections to the founded finding. Their attorney had spoken to Mr. Marichalar who agreed that the actions should be consolidated. He also spoke to "Ms. Smith reiterating our position that both issues would be heard in the February 14 hearing." (Ruland's Reply to Memorandum of Department of Social and Health Services, page 2)

The department argues that where there is no jurisdiction the parties cannot agree to create jurisdiction. Not only did Judge Stalnaker conclude that there was no such agreement, she also concluded that jurisdiction cannot be created by parties where there is none to begin with.

Decision Equitable Estoppel and Agreement.

It is unnecessary to consider equitable estoppel, and whether there was an agreement to consolidate the CPS and licensure cases. This case is being decided on the narrow issue of whether the Rulands were required to seek review from the management decision upholding the founded finding and whether they had to do so within 30 days.

The statute requires appeal within the 30 days from the management staff founded finding. That requirement is jurisdictional. It is a legislative mandate. The parties cannot agree to change it. Failure to seek review within the time limits results in loss of jurisdiction. It is the similar to a civil case in which judgment is entered following trial, and the losing party fails to appeal within the 30-day time limit. The parties, for whatever reason, cannot agree that it should be extended.

The founded finding is final and the law of the case. It cannot be challenged on appeal.

Is the founded finding a sufficient basis for denial of relicensure?

Under WAC 388-148-0095(2)(b) "The department must . . . disqualify (an applicant if): (b) You have been found to have committed child abuse or neglect." The founded finding is final. It requires denial of relicensure.

Findings and Conclusions of Judge Stalnaker.

I adopt Judge Stalkaker's findings 1 through 13. To the extent that this opinion above makes additional findings they are incorporated as further findings.

I adopt Judge Stalnaker's Conclusions of Law 1 through 9 except the following language in conclusion 4 because whether they agreed is irrelevant:

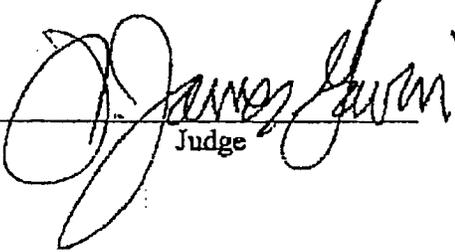
The Department never agreed that the CPS action and the licensing action were both before the ALJ to adjudicate at the time of the December 13, 2005, pre-hearing conference. . . And the ALJ never consolidated the CPS action and the

licensing action, according to both the December 16, 2005, Prehearing Order and the verbal exchanges that were made at this conference.

Disposition.

The founded finding is final. Relicensure was properly denied.

Dated this 17 day of May, 2007.


Judge

Attachment N

STATE OF WASHINGTON, DEPARTMENT OF SOCIAL AND HEALTH SERVICES

BOARD OF APPEALS

In Re:	)	Docket No. 11-2005-L-0998	MAILED
)		
JOSHUA and JANET RULAND	)	REVIEW DECISION AND	SEP 21 2006
	)	FINAL AGENCY ORDER	
	)		DSHS
Appellants	)	Child Care Agencies – Foster Care	BOARD OF APPEALS

I. NATURE OF ACTION

1. Joshua and Janet Ruland (the Appellants) were licensed by the Department of Social and Health Services (the Department) as foster parents. The Appellants moved to a new address and submitted a new application for licensure on August 23, 2005, in order to continue as licensed foster parents at their new location. During the pendency of their reapplication, the Department's Child Protective Services (CPS) entered a founded finding of child neglect against Janet Ruland. The Department subsequently denied the Appellants' application for relicensure. The Appellants requested an administrative hearing to challenge the Department's decision to deny their license application.

2. At the beginning of the merits hearing on the relicensure denial, the Department orally moved for an order dismissing any challenge the Appellants might make to the child neglect finding based on the Appellants' failure to timely request a hearing on this matter pursuant to RCW 26.44.125(4). Administrative Law Judge (ALJ) Craig Davenport denied the Department's motion, conducted a hearing, and issued an Initial Order on May 5, 2006. The Initial Order determined that the CPS incident in question did not constitute child neglect. The Initial Order also reversed the Department's decision to deny relicensure.

3. On May 26, 2006, the Department filed a Petition for Review of the Initial Order with the Board of Appeals. The Department argued in its petition as follows:

The Department of Social and Health Services (herein, the Department), by and through Rob McKenna, Attorney General, and Alicia Kinney, Assistant Attorney General, petitions the Board of Appeals for review of the Initial Order entered in the above-referenced action on

May 5, 2006, and requests that the Initial Order be reversed on two main errors: (1) denial of the Department's motion to dismiss for lack of jurisdiction as to the founded finding of child abuse or neglect and (2) based on Ms. Ruland's failure to properly supervise the foster children in her care, the founded finding of child abuse or neglect and subsequent denial of the Rulands' re-application for a foster home license were supported by sufficient evidence.

I. THE INITIAL ORDER SHOULD BE REVERSED BECAUSE THE ALJ'S FINDING THAT THE APPELLANT HAD TIMELY FILED A HEARING REQUEST AS TO THE FOUNDED FINDING OF CHILD ABUSE AND NEGLECT IS LEGALLY INCORRECT AND THE DEPARTMENT'S MOTION TO DISMISS FOR LACK OF JURISDICITON SHOULD HAVE BEEN GRANTED.

A. BACKGROUND

On or about August 10, 2005, the Department of Social and Health Services, Division of Licensing Resources/Child Protective Services (hereinafter DLR/CPS) received a referral tagged as #1642848 regarding alleged child abuse or neglect by Ms. Ruland. On or about October 13, 2005, DLR/CPS sent a letter to Ms. Ruland informing her that, as a result of the investigation into this referral, the allegation of abuse and neglect is founded as negligent treatment or maltreatment. (Dept. Exhibit 2) This letter informed Ms. Ruland that she may request a review of the founded report of child abuse and neglect pursuant to RCW 26.44.125 and such review would be conducted by a DLR/CPS Director or designee according to WAC 388-15-093 and gave Ms. Ruland directions on where to mail her review request and informed her of the 20-calendar day time limit for making such a request.

The original DLR/CPS finding was reviewed by Kyle Smith, Deputy Administrator, Licensed Resources. Ms. Smith issued a letter to Ms. Ruland dated December 29, 2005, informing her that the finding of negligent treatment or maltreatment in referral #1642848 was correct and that no changes to the finding would be made. (See attached Appendix 1.) This letter clearly indicated the steps Ms. Ruland would need to take under law to contest Ms. Smith's review finding. The one-page letter included the following information in regular typeface (emphasis in original):

Based on RCW 26.44.125, you have the right to challenge my determination by requesting an administrative hearing. You must send a written request for a hearing along with a copy of this letter to the following address:

**Office of Administrative Hearings
P.O. Box 42488
Olympia, Washington 98504**

Your written request for a hearing must be received by the Office of Administrative Hearings **within 30 days** from the date that you receive this letter. If you do not request an administrative hearing **within 30 days**, you will have no further right to challenge the CPS finding.

This letter was sent to Ms. Ruland by certified mail and received, as indicated by Ms. Ruland's signature on the certified mail return receipt, on January 13, 2006. (See attached Appendix 1) A written request for a hearing to challenge this CPS finding was never received by the Office of Administrative Hearings.

Since referral #1642848 alleged child abuse and neglect by a licensed foster parent, the referral was also investigated concurrently by the Division of Licensed Resources/Office of Foster Care Licensing (DLR/OFCL) for possible violations to the minimum licensing requirements that govern licensed foster homes. Following this investigation, a letter was issued to Joshua and Janet Reed dated October 28, 2005, informing them that because of the founded finding of child abuse and neglect against Ms. Ruland and violations to the governing portions of the Washington Administrative Code for foster homes, their application for a foster home license was denied. (See Department Exhibit 4.) The Rulands had been licensed at their prior residence but had submitted a new application following a move to a new home. This letter indicated numerous violations to the WAC, including WAC 388-148-0095(2)(b), which states that the Department must disqualify the Rulands if they have been found to have committed child abuse or neglect. This letter, signed by Brian Hynden, Division of Licensing Resources Area Administrator, indicated how the Rulands must proceed if they wished to contest the denial of their foster home license application. The Rulands properly appealed this issue, and an administrative hearing (Docket #11-2005-L-0998) as to the licensing denial was scheduled.

The Rulands were represented by their attorney George Wynn Colby at the telephonic pre-hearing conference and the administrative hearing. During the pre-hearing conference on December 13, 2005, consolidation of the separate matters of the founded finding of abuse or neglect and the foster home license denial was discussed in the event the founded finding was upheld by Ms. Smith and properly appealed by Ms. Ruland. However, since at the time of the pre-hearing conference, Ms. Smith had not yet completed her review of the founded finding, discussions of future consolidations were only speculative and not substantively before the Administrative Law Judge (ALJ) to consolidate at that time. The administrative hearing on the foster home licensing denial was scheduled for February 14, 2006.

At the start of the administrative hearing on February 14, 2006, the Department made a verbal motion to dismiss as there had been no request for an administrative hearing to challenge the founded finding of abuse and neglect following receipt of Ms. Smith's letter by Ms. Ruland on January 13, 2006. Because the founded finding was now final, WAC 388-148-0095 requires an application for a foster home license to be denied. The ALJ withheld ruling on the motion and the hearing proceeded as to both the founded finding and the denial of the foster home license. The ALJ requested a written motion be filed by the Department. This motion was filed in advance of the second day of the hearing. (See attached Appendix 1). This motion is supported by RCW 26.44.125(4) and argument that a request for an administrative hearing on the founded finding of child abuse and neglect was not timely made and therefore the ALJ had no jurisdiction to make any rulings as to the founded finding. As part of the Interim Order dated May 5, 2006, by ALJ Craig Davenport, the Department's motion to dismiss was denied.

B. ISSUES REGARDING JURISDICTION ON REVIEW

The Department asserts that the Initial Order is in error in regarding the jurisdictional matter in the following respects:

(1) Finding of Fact (FoF) No. 2, which finds in part that:

... The Rulands objected to the license denial by a letter dated November 2, 2005 sent by their attorney and requested a hearing. The letter stated: "... we deny any and all allegations of negligent treatment or maltreatment of the foster children that were in their care under your program. We feel that the founded findings are not

based upon anything the Rulands did that was negligent or indicative of maltreatment. We seek a review."

The Department contests this finding of fact as the quoted portion is taken from the Rulands' letter dated November 2, 2005, asking for Department review of the founded finding of abuse or neglect, which was the basis for Kyle Smith conducting the review that upheld the founded finding. (See Appellant's Exhibit 13). Even if this letter had been received by the Office of Administrative Hearings it would not have been able to trigger any jurisdiction as to the founded finding. Any request for an adjudication to challenge a founded finding that was upheld following Department review can only be requested following receipt of the letter upholding the finding and pursuant to the requirements in RCW 26.44.1256 outlined in Ms. Smith's letter to Janet Ruland. Those legal requirements were not met by the Rulands.

(2) Finding of Fact No. 3, which finds that:

License denial was based upon a finding of neglect which resulted from the incident on August 8, 2005. A founded finding of neglect was mailed to Janet Ruland on October 13, 2005. On October 27, 2005, Janet Ruland objected to the founded report. By a letter from her Attorney George Colby, Mrs. Ruland requested a review of the founded findings on November 2, 2005. A pre-hearing conference was conducted on December 13, 2005. It was then acknowledged that the license and abuse allegations would be joined for hearing, assuming the finding was not reversed, and a hearing date of February 14, 2006 [sic] was set. On December 29, 2005 a letter was sent to Mrs. Ruland advising of the department's decision not to change the founded finding. This letter was received January 13, 2006. A written objection to the final finding was filed on the date of hearing, February 14, 2006. Although the department was aware of the Appellant's previous oral and written objections to the license denial and founded finding, and that a hearing was scheduled, the department moved for dismissal, indicating lack of jurisdiction for failure to request timely review.

The Department contests this finding of fact as the pre-hearing conference and hearing scheduled for the date indicated was set to contest the DLR/OFCL suspension and revocation of the Appellant's foster home license. This finding of fact fails to acknowledge that the license was required to be denied upon a finding of abuse or neglect, but additional violations to WAC 388-148 were also alleged in Brian Hynden's letter. It is not clear how "[o]n October 27, 2005 Janet Ruland objected to the founded report." The first documentation received was Mr. Colby's November 2, 2005, letter requesting Department review of the founded finding. (See Appellant's Exhibit 13). During the pre-hearing conference, the Department did not agree - nor does the Department have the ability to agree to waive jurisdiction - to hearing any matters not properly before the court by the time the February 14, 2006, hearing began. At the time of the pre-hearing conference, the Department review of the founded finding had not been completed. While judicial economy warrants consolidation of cases where similar parties and facts are involved, because Ms. Ruland never properly sought a hearing to contest the founded finding, the ALJ had no jurisdiction to rule on the founded finding, either at the time of the pre-hearing conference or during the licensing hearing that began on February 14, 2006. Consolidation of cases requires there to be two or more cases before the court; here, only the licensing denial was before the court. In addition, a written request for adjudication to challenge the upheld founded finding was not filed on February 14, 2006, by the Rulands or their counsel. Even if a written request had been filed on February 14, 2006, it would not have been timely as RCW 26.44.125 requires such requests to be received by the Office of Administrative Hearings within thirty days of receipt of the

letter upholding the founded finding. Thirty days from Ms. Ruland's receipt of Ms. Smith's letter ended on February 13, 2006.

(3) Conclusion of Law (COL) No. 4, which finds that:

RCW 34.05.419 indicates the requirements for all agencies upon their receipt of a request for adjudicative proceeding. Subsection three states: If the application seeks relief *that is not available when the application is filed by may be available in the future*, the agency may proceed to make a determination of eligibility within the time limits provided in subsection one. (Ninety days)

The Department contends that the Conclusion is erroneous, not in its recitation of RCW 34.05.419(3), but in its applicability to the jurisdictional matter as later applied in COL No. 5. This RCW is titled, "Agency action on applications for adjudication" and addresses how an agency shall proceed following receipt of an application for an adjudicative proceeding. The Department contends that this RCW is not applicable to Department action as it appears to apply to the procedures of the Office of Administrative Hearings and not to applications which the DLR/CPS or DLR/OFCL had control over. Neither the Department nor the proper recipient of the Office of Administrative Hearings received a request for an adjudicative proceeding as to the upheld founded finding of abuse or neglect.

(4) Conclusion of Law No. 5, which finds that:

The undersigned accepts the objection filed on November 2, 2005 as a request for hearing with respect to the department's final founded finding of neglect after review. It is technically correct to observe that the request preceded the final finding. As provided in RCW 34.05 the initial request was requesting a current review and also hearing which would become available in the future. The unusual circumstances created by a simultaneous license revocation and child abuse allegation of neglect was not meant by the legislature or agency to create a trap for the unwary to enable the department to avoid a fair adjudication on the merits. Due process requires a fair opportunity to be heard on the merits and administrative matters must be conducted with the greatest degree of informality consistent with fairness. *Jacquins v. DSHS*, 69 Wn. App. 21 (993). [sic] The department's motion to dismiss is denied. It is noted that this matter was set for hearing on the licensing matter prior to issuance of the final founded finding. The parties had agreed to consolidation and the department was aware of the Appellant's objection to the license denial and founded finding.

The Department contends that the Conclusion is erroneous in interpreting the Rulands' November 2, 2005, letter requesting Department review of the initial DLR/CPS founded finding as a request for an administrative hearing on the issue. RCW 26.44.125(4) very clearly states that the request for an adjudicative proceeding must be filed within thirty calendar days after receiving notice of the agency review determination and that failure to make such a request in the manner required leaves the alleged perpetrator of child abuse or neglect with "no right to agency review of to an adjudicative hearing or judicial review of the finding." Ms. Smith's letter to Ms. Ruland outlined very clearly the procedure Ms. Ruland must follow to request an adjudicative proceeding to contest the founded finding. This COL fails to differentiate between the request made to the Office of Administrative Hearings for an adjudicative proceeding on the licensing denial and the request referred to in this COL, which in fact was a letter requesting Department review of the initial finding as provided by RCW 26.44.125. The COL also fails to differentiate between the fact

that two separate actions had been taken by the Department following the August 8, 2005, incident, and those actions and any timely adjudication actions are separately unless and until they are consolidated.

The Appellant's request for an administrative hearing to appeal the denial of their foster home license does not alleviate the legal requirements under RCW 26.44.125 that she properly appeal the finding of child abuse and neglect. The ALJ's use of Jaquins v. DSHS is misplaced in that the way in which DSHS administrative hearings are held applies only to hearings that are properly before the ALJ. The level of informality during an administrative hearing does not extend to allow an ALJ to invalidate portions of the RCW or WAC that limit the time in which an individual may appeal an adverse finding or decision by an agency. The Department's objection to the assertion that the Department agreed to consolidation during the pre-hearing conference is discussed above, and the Department did not and may not agree to the Office of Administrative Hearings hearing a matter for which the OAH has no jurisdiction.

C. ARGUMENT REGARDING JURISDICTION

1. Standard of Review

A Review Judge decides a hearing *de novo*. WAC 388-02-0600. Furthermore, a Review Judge may change the hearing decision if the decision includes an error of law. Id. The ALJ's finding that the Appellant timely filed a request for a hearing to contest the founded finding of abuse or neglect is legally incorrect and the Department's motion to dismiss the Appellant's oral challenge to the finding for lack of jurisdiction should have been granted. The ALJ contends that Ms. Ruland timely appealed the founded finding of child abuse and neglect and therefore had a right to adjudication of that finding. The Department maintains that, under the law, this position is incorrect.

a. The language of the RCW and WAC supports the Department's position.

Chapter 26.44 of the Revised Code of Washington is dedicated to Abuse of Children. RCW 26.44.125 outlines the right of alleged perpetrators of child abuse and neglect to review and amendment of findings. This RCW clearly outlines the manner in which an alleged perpetrator must proceed if that individual wishes to contest a finding of abuse or neglect. RCW 26.44.125(1) states that an alleged perpetrator of abuse or neglect has the right to seek review and amendment of the finding as provided in this section. (Emphasis added.)

First, under RCW 26.44.125(2), the alleged perpetrator has twenty days from receipt of written notice that they have been named an alleged perpetrator in a founded report of abuse or neglect to request that the Department review the finding. RCW 26.44.125(3) indicates that upon receipt of a written request for review, the Department shall review, and if appropriate, amend the finding. This review is done by management level staff within the Children's Administration, and the Department will notify the alleged perpetrator in writing by certified mail of the agency's determination. RCW 26.44.125(4) states that:

If, following agency review, the report remains founded, the person named as the alleged perpetrator in the report may request an adjudicative hearing to contest the finding.... **The request for an adjudicative proceeding must be filed within thirty calendar days after receiving notice of the agency review determination. If a request for an adjudicative proceeding is not made as**

provided in this subsection, the alleged perpetrator may not further challenge the finding and shall have no right to agency review or to an adjudicative hearing or judicial review of the finding. (Emphasis added.)

In addition, Washington Administrative Code chapter 388-15 addresses Child Protective Services. WAC 388-15-105(3) also requires that "the office of administrative hearings must receive the written request for a hearing within thirty days from the date that the person requesting the hearing receives the CPS management review decision.

b. The Appellant did not timely appeal the agency review determination and therefore has no right to an adjudicative hearing or judicial review of the finding.

Under the RCW and WAC applicable to findings of child abuse and neglect, an alleged perpetrator must file a request for an adjudicative proceeding on the child abuse and neglect finding within thirty calendar days after receiving the notice of the agency review determination.

Here, the agency review was completed by Ms. Kyle Smith and the finding of child abuse and neglect was not changed. Ms. Smith's letter indicating the unchanged finding was sent to the Appellant on December 29, 2005, and received by the Appellant on January 13, 2006, according to the certified mail return receipt received by the Department.

The Office of Administrative Hearings received no written request for a hearing on the founded finding after Ms. Smith's letter was received by Ms. Ruland. Beginning counting with the day following the actual date the Appellant received Ms. Smith's letter, for the Appellant's request for a hearing on the child abuse and neglect finding to be timely, it would have had to have been received by the Office of Administrative Hearings by February 13, 2006. It was not.

The Appellant failed to follow the mandatory procedures in RCW 26.44.125 and therefore she has no right to an adjudicative hearing or judicial review of the finding. The ALJ's finding in the Initial Order that the Appellant had timely appealed the finding of abuse or neglect is not supported by law. Therefore, the ALJ had no jurisdiction to make any rulings as to the founded finding.

c. The Department's motion to dismiss for lack of jurisdiction should have been granted.

WAC 388-02-0220 identifies what rules and laws an ALJ or review judge must apply when making decisions:

(1) ALJs and review judges must first apply the DSHS rules adopted in the Washington Administrative Code. (2) If no DSHS rule applies, the ALJ or review Judge must decide the issue according to the best legal authority and reasoning available, including federal and Washington state constitution, statutes, regulations, and court decisions.

Here, WAC 388-15-105(3) explicitly requires requests for adjudicative hearings as to child abuse and neglect findings to be received within thirty days. Therefore, that WAC controls the ALJ's decision-making on that issue. With RCW 26.44.125(4) making similar unambiguous requirements, there should be no question that when the Appellant's request for an administrative hearing on the child abuse issue and neglect finding was not received within thirty days, the ALJ should have found that the Office of Administrative Hearings lacked the jurisdiction to hear

argument as to that finding. Because WAC 388-148-0095 requires DLR/OFCL to deny or revoke a foster home license if an applicant is found to have committed child abuse or neglect, at the time the Department's oral motion to dismiss was made on February 14, 2006, and the written motion was filed and the motion renewed at the second trial date of March 21, 2006, the founded finding had become final and therefore the ALJ did not have authority under WAC 388-02-0020 and WAC 388-148-0095 to make any decision other than affirm the license denial.

II. IF THE DEPARTMENT'S MOTION TO DISMISS IS NOT GRANTED ON REVIEW, THE DEPARTMENT'S FOUNDED FINDING OF ABUSE OR NEGLECT AND THE DENIAL OF THE RULAND'S FOSTER HOME LICENSE SHOULD BE UPHELD.

By filing this petition for review in part regarding the Initial Order's determinations that overturned the founded finding of neglect, the Department does not concede that the ALJ had jurisdiction to make any determinations as to the founded finding. As discussed above, it is the Department's position that based on the Rulands' failure to request an adjudicative proceeding within thirty days following receipt of Ms. Smith's letter upholding the founded finding, at the time of the February 14, 2006, hearing date the founded finding had become final and Ms. Ruland had no right to further challenge the finding or to an adjudicative hearing or judicial review of the finding per RCW 26.44.125. Therefore, under WAC 388-148-0095, DLR/OFCL was required to deny the Ruland's application based on the founded finding.

A. ISSUES REGARDING THE FOUNDED FINDING AND LICENSING DENIAL ON REVIEW

The Department asserts that the Initial Order is in error regarding the founded finding and licensing denial matters in the following respects:

Finding of Fact No. 3 which is excerpted above with identification of the portions with which the Department disagrees.

Finding of Fact No. 5, which states in part that:

In the evening of August 8, 2005, Janet Ruland went outside to mow her lawn. ... Mrs. Ruland was outside for approximately fifteen minutes to one-half hour. While outside, Mrs. Ruland heard the infant crying and then went back inside to investigate.

The Department contests this finding of fact because it inaccurately indicates the incident of abuse or neglect occurred on August 8, 2005, when in fact it occurred on August 9, 2005. (See Department Exhibit 1.) In addition, this FoF does not accurately reflect the evidence presented regarding the amount of time Ms. Ruland acknowledged being outside mowing her lawn. In the written Incident Report Ms. Ruland filled out on the evening of August 9, 2005, she indicates that the foster infant was injured between "8/8:30 pm" and 9:00 pm." (See Department Exhibit 1.) Ms. Ruland acknowledged at the hearing that she had filled out the Incident Report on the evening of the incident and could have been outside mowing the lawn between half an hour to an hour as the Incident Report indicates. In addition, both the Incident Report and Ms. Ruland's testimony indicate that she heard the infant screaming as she went into the house after mowing the lawn, while this FoF implies that she heard the infant crying while mowing the lawn. Ms. Ruland testified that their lawn mower is gas-powered and makes noise while in use.

Finding of Fact No. 9, which finds in part that:

Licensing authorities reviewed the incident with the Appellants. They were concerned that the infant had been left alone too long without supervision. They chose not to remove the children from the home. ...

The Department contests this finding of fact because it improperly characterizes the evidence regarding the foster home licensors in this case. Testimony was provided by licensors Elisa Powell and Brian Hynden that licensors do not have authority to remove children from a home but instead address licensing requirements and compliance. Pending the completion of the DLR/CPS investigation into the allegation of abuse or neglect, the children remained in the foster home under a safety plan. However, upon completion of the investigation DLR/CPS determined that abuse or neglect had occurred and notified Ms. Ruland by letter dated October 13, 2005. (See Department Exhibit 2.) On or about October 24, 2005, Brian Hynden sent the Rulands a letter indicating that due to the DLR/CPS investigation and founded finding, DLR/OFCL was placing a "stop placement" on the Rulands' foster home and that a revocation letter would be sent shortly. (See Department Exhibit 3.) As is required under WAC 388-148-0095, the Rulands' licensing application was denied by DLR/OFCL's letter dated October 28, 2005. (See Department's Exhibit 4.)

Finding of Fact No. 10, which finds in part that:

The Rulands' minister reports no complaints concerning the manner in which they have cared for children and has received complimentary reports.

The Department contests this finding of fact because the Department does not believe this evidence was properly before the court. The Rulands' minister never appeared as a witness. On the first day of trial, the Rulands presented several letters from various character references including their minister. However, the Department does not believe that this information was entered into evidence.

Conclusion of Law No. 8, which finds in part that:

... The undersigned does not find that Mrs. Ruland's actions on August 8, 2005, rise to the level of neglect. ... She was not aware of a clear and present danger. While one might argue that Mrs. Ruland did not exercise ordinary care when she went outside to take care of chores while the children slept, even if this were true, ordinary negligence does not rise to the level of neglect. Until she was informed of the children's background, she was not aware of a clear and present danger. The incident which occurred was unforeseen. ... The allegation of neglect is not founded.

The Department contests this conclusion of law because Mrs. Ruland's actions on August 9, 2005, were neglectful for failure to properly supervise the foster children in her care such that there was a danger to the child's health, welfare and safety, and indeed, the infant did suffer physical harm that proper supervision could have prevented. Ms. Ruland failed to provide the minimum level of supervision necessary to protect the well-being of the foster children in her care. The allegation of abuse or neglect was properly determined by DLR/CPS to be founded.

Conclusion of Law 9, which finds in part that:

As the incident is not founded for neglect, the Appellant's license is not revoked as a matter of law, based upon the founded finding. Likewise, the undersigned does not find that the evidence establishes reasonable cause to believe the Rulands lack character, suitability, or competence to care for children or that the Rulands have failed or refused to comply with RCW 74.15 or 74.13 or the applicable regulations. ... The evidence as produced at the hearing establishes the Rulands as good foster parents who reacted well in a crisis situation, doing all that was expected of them. ... The license is not denied.

The Department contests this conclusion of law because the finding of abuse or neglect was properly made based on Ms. Ruland's failure to supervise the foster children in her care. In the DLR/OFCL letter informing the Rulands that their license had been denied, several valid violations of the Minimum Licensing Requirement WACs are listed in support of the Department's decision: 388-148-0095 (discussed above), 388-148-0035 (personal characteristics necessary), 388-148-0095 (other reasons as basis to lose a license), 388-148-0505 (services foster parents must provide), and 388-148-0460 (requirements for supervising children). Testimony was provided by licensors Ellsa Powell and Area Administrator Brian Hynden how Ms. Ruland's decision on August 9, 2005, to leave the children unattended in the house while she mowed the lawn caused Ms. Ruland to fail to provide the level of supervision required under the governing WACs. In addition to the matter of the founded finding as a basis for the licensing denial, the valid failures to follow the licensing requirements were also part of DLR/OFCL's decision to deny the license.

B. ARGUMENT REGARDING THE FOUNDED FINDING AND LICENSING DENIAL

1. Standard of Review

A Review Judge decides a hearing *de novo*. WAC 388-02-0600. Furthermore, a Review Judge may change the hearing decision if the decision includes an error of law. *Id.* Under WAC 388-15-129, an ALJ must uphold the CPS founded finding if a preponderance of the evidence supports the CPS finding. RCW 74.15.130 requires the ALJ to uphold the Department's denial of the Rulands' foster home license if there is reasonable cause to believe that the applicant lacks the character, suitability, or competence to care for children placed in out-of-home care or the applicant has failed to comply with any provisions of chapter 74.15 RCW, RCW 74.13.031, or the requirements adopted pursuant to such provisions.

2. The language of the RCW and WAC along with the evidence presented at the hearing support the Department's founded finding and license denial.

When investigating allegations that a foster parent has abused or neglected a child, DLR/CPS weighs the information received during the investigation with the standards outlined in WAC 388-15-009. This legal standard is included in the letter sent by DLR/CPS Supervisor Donicio Marichalar to Ms. Ruland. (See Department Exhibit 2). This WAC provides in part:

Negligent treatment or maltreatment means an act or a failure to act on the part of a child's ... caregiver that shows a serious disregard of the consequences to the child of such magnitude that it creates a clear and present danger to the child's health, welfare, and safety. A child does not have to suffer actual damage or

physical or emotional harm to be in circumstances which create a clear and present danger to the child's health, welfare, and safety. Negligent treatment or maltreatment includes, but is not limited to: (a) Failure to provide adequate ... supervision ... necessary for a child's health, welfare, and safety ... (b) Actions, failures to act, or omissions that result in injury to or which create a substantial risk of injury to the physical, emotional, and/or cognitive development of a child

The Incident Report Ms. Ruland filled out on the evening of the incident clearly indicates that she left the children unattended for between half an hour to an hour. Her testimony months later at the hearing asserted that it could have been less than half an hour but acknowledges that she was unaware that the newborn infant was being scratched and bitten inside the house. Testimony of DLR/CPS Investigator Greg Robbins and DLR/CPS Supervisor Donicio Marichalar both indicate that they have experience and training in investigating allegations of abuse or neglect and making decisions on whether abuse or neglect occurred. Upon completion of the investigation, both Mr. Robbins and Mr. Marichalar agreed that Ms. Ruland's failure to provide adequate supervision to the children violated WAC 388-15-009. The children had been unsupervised to an extent that there was both a risk of injury and actual injuries suffered and that Ms. Ruland could have prevented the injuries with proper supervision. As noted by Ms. Ruland in the Incident Report and affirmed in Ms. Ruland's testimony, when Ms. Ruland returned to the house and found the infant, she discovered that the baby's diaper had been removed, the child was screaming, and she noticed "scratches on right top of head and red marks all along her back," "bruise under her right eye with more red marks on face & front side," "another bruise on her left nipple," "scratches like on the head on her left hand," and a "round spot on the top left of her head" that appeared to be a bite mark. The injuries sustained by the infant placed with the Rulands could have and should have been prevented by Ms. Ruland adequately supervising the children. The evidence presented did support by a preponderance of the evidence that DLR/CPS had an adequate basis for the founded finding of abuse or neglect by Ms. Ruland.

Under the authority of RCW 74.15 and WAC 388-148, DLR/OFCL has the responsibility to grant, deny, suspend or revoke foster home licenses and to ensure that licensed homes meet the Minimum Licensing Requirements as outlined within WAC 388-148. By letter sent on October 28, 2005, DLR Area Administrator Brian Hynden notified the Rulands that their application for a foster home license at their new address was denied. After receiving information about the DLR/CPS referral alleging abuse or neglect, the Rulands were also investigated by DLR/OFCL licensors to determine if the Rulands had violated any licensing requirements. The letter cites WAC 388-148-0095(b) which requires a license to be denied if the applicant has been found to have committed child abuse or neglect. In addition, the investigation into the August 9, 2005, incident resulted in several "valid" findings where there was reasonable cause to believe that licensing requirements under WAC 388-148 had been violated.

The DLR/OFCL letter summarizes the information gathered as part of the investigation of the supervision provided by Ms. Ruland on August 9, 2005, and the injuries suffered by the infant during the period Ms. Ruland was out of sight and hearing of the children while outside mowing her lawn. The valid findings in the DLR/OFCL letter were supported by testimony of Brian Hynden during the administrative hearing. It was determined by Mr. Hynden that Ms. Ruland did not exercise the level of supervision necessary under WAC 388-148-0095(1) to "care for children in a way that ensures their safety, health and well-being." DLR/OFCL also determined that the Rulands failed to "provide a safe, healthy and nurturing environment for children under your care" under WAC 388-148-0100, did not "meet the child's basic needs and have the knowledge and skills to ... protect and nurture children in a safe, healthy environment..." as required by WAC 388-148-0505, and did not fulfill the requirements of WAC 388-148-04600 by "provid[ing] or

arrang[ing] for care and supervision that is appropriate for the child's age, developmental skill level, and condition" which requires "appropriate adult supervision." The evidence presented at the hearing support the determination by DLR/OFCL that the Rulands had not demonstrated the necessary decision-making skills or supervision required by the Minimum Licensing Requirements under WAC 388-148.

III. CONCLUSION

For the foregoing reasons, the Department of Social and Health Services respectfully requests that the Initial Order mailed on May 5, 2006, be reversed and that the Department's motion to dismiss be granted. If the motion to dismiss is granted, the foster home license must be denied. Should the Department's motion to dismiss not be granted, the Department requests that the founded finding and foster home license denial be upheld.

4. On June 29, 2006, the Appellants filed a response to the Department's petition for review and argued as follows:

We, Joshua and Janet Ruland, the Appellants, are hereby responding to the request for review made by the Department of Social and Health Services (hereinafter, the Department), by and through Rob McKenna, Attorney General, and Alicia Kinney, Assistant Attorney General, on May 26, 2006.

A. We, the Appellants, support the conclusion of law as determined by the Administrative Law Judge, Craig Davenport, that he did indeed have jurisdiction to rule on the matter of the founded finding of negligent treatment or maltreatment in referral #1642848. In that, the Appellants provided appropriate requests for hearings on this matter in conjunction with the Department's denial of foster care license, as evidenced via letters by our attorney, George Colby, dated November 2, 2005.

On December 13 in a pre-hearing conference, both parties agreed to the consolidation of both matters and scheduled a hearing for February 14, 2006, provided the Department failed to reverse its earlier finding. In a letter dated December 29 sent to Mrs. Ruland, consolidation was reinforced as the Department failed to reverse the founded finding. Our lawyer also spoke to Ms. Smith reiterating our understanding that both issues would be heard in the February 14 hearing. The judge was correct to reinforce the intent of the law to provide a fair and just environment for adjudication of the merits of this case. As stated in Judge Davenport's final ruling, Conclusion of Law, paragraph 5,

The Undersigned accepts the objection filed on November 2, 2005, as a request for hearing with respect to the department's final founded finding of neglect after review. It is technically correct to observe that the request preceded the final finding. As provide in RCW 34.05 the initial request was requesting a current review and also hearing which would be available in the future.

Precedence supports Judge Davenport's jurisdiction to make such ruling as to the founded finding of neglect, in keeping with the mandate that due process requires a fair opportunity for administrative matters be heard on the merits and this to be conducted with the greatest degree of fairness available.

B. The Department's second point of appeal states no "error of law." On the contrary, the Department repeatedly contests the decision of the Administrative Law Judge solely on the basis of prejudice, in that such decisions do not agree with the stated decision of the Department. In addition the Department cites a typographical error in the Judge's Initial Order. This technical error does not rise to the level of "Error of Law" nor does it change the substance of neither the findings nor the facts supporting Judge Davenport's decisions. Item (2) should routinely be declared without merit.

CONCLUSION

The undersigned respectfully request that the Initial Order mailed on May 5, 2006, be upheld and remain in force.

5. On June 30, 2006, the Department filed a document entitled, "Supplement to the Department's Petition for Review." In this document the Department supplemented its original petition for review with specific citations to the hearing transcript.

6. On July 17, 2006, the Appellants filed a document entitled, "Appellant's Response to Supplemental Request for Review. In this document the Appellants cited to the transcript to support their argument that they had initiated the process for appealing the CPS finding in advance of the RCW 26.44.125(4) filing deadline.

II. FINDINGS OF FACT

The undersigned has reviewed the audio record of the December 13, 2005, prehearing conference; the documents in the Appellants' hearing file relevant to jurisdiction to hear the child neglect issue; the May 5, 2006, Initial Order; parts of the hearing transcript; the Department's petition for review; and the Appellants' response. RCW 34.05.464(5). The undersigned has evaluated the adequacy and appropriateness of the Findings of Fact entered by the ALJ in the Initial Order. As several of the Initial Order's findings were not supported by substantial evidence, several were actually conclusions of law rather than findings of fact, and several were ambiguously written in the passive voice, the undersigned has entered new Findings of Fact pursuant to RCW 34.05.464(8).

1. Joshua and Janet Ruland have been licensed by the Department as a Foster Family Home since September 28, 2004. Their original license was valid through September 27, 2007. However, the Appellants moved to a new address and therefore submitted a new application for licensure on August 23, 2005, in order to continue as licensed foster parents at their new location.

2. The Department's Child Protective Services (CPS) mailed Janet Ruland a letter¹ dated October 13, 2005, informing her that CPS had received a report alleging that she had neglected a child, that CPS had investigated this report, and that CPS had determined that it was more likely than not that neglect had occurred. This letter informed Ms. Ruland that the allegation was founded as to her for negligent treatment or maltreatment of a child. The letter also advised Ms. Ruland that if she disagreed with the founded report of child neglect, she had several options. One of her options was to:

...submit a written response regarding the CPS finding. This written response will be placed in the CPS file. You may send this response to:

Donicio Marichalar
1002 North 16th Avenue P.O. Box 12500
Yakima, WA 98909

Another one of Ms. Ruland's options was to:

...request a review of the founded report of child abuse and neglect pursuant to RCW 26.44.125. A DLR/CPS Director or designee will conduct this review according to WAC 388-15-093. To request review, you must sign the attached form and mail to:

Program Manager
Division of Licensed Resources
Child Abuse and Neglect Section
P.O. Box 45700
Olympia, WA 98504-5700

3. In a letter² dated October 24, 2005, the Department's Division of Licensed Resources (DLR) notified the Appellants as follows:

¹ Exhibit 2.

² Exhibit 3.

Due to the "Founded" finding resulting from the DLR/CPS investigation on referral #1642848, your foster home license has been put on a "Stop Placement" status. Consequently, the Department is in the process of revoking your foster home license and you will receive a revocation letter in the near future that explains this licensing action in detail. "Stop Placement" means that no placements will occur in your home....

4. In a letter³ dated October 28, 2005, DLR denied the Appellants' application for a Foster Family Home license because they had "... failed to meet Minimum Licensing Requirements." DLR alleged that the Appellants had violated: WAC 388-148-0095(2)(b); WAC 388-148-0035(1), (4) and (5); WAC 388-148-0505(1)(a); WAC 388-148-0100(1)(c) and (d); and WAC 388-148-0460(1), (3), (6), and (7). DLR also stated in its denial letter that:

...the Department received a CPS referral regarding your home. This referral alleges negligent treatment or maltreatment of a child and was determined to be **FOUNDED**. This referral was investigated for alleged licensing issues and concerns involving character concerns and lack of supervision. The above licensing complaint was found **VALID** for violations of the Minimum Licensing Requirements (MLR).

5. On November 9, 2005, the Appellants filed a written request⁴ with the Office of Administrative Hearings (OAH) for a hearing to challenge the Department's decision to deny them relicensure. In their hearing request the Appellants stated: "We request an appeal on the Department's decision to deny renewal of the Ruland's foster care home license application. To that end we assume that an administrative hearing will be set up within the near future...." OAH scheduled an administrative hearing as to the licensing denial. OAH also scheduled a prehearing conference for December 13, 2005.

6. The CPS Review Request Form that was attached to CPS' letter (described above in Finding of Fact 2) states, "I request Children's Administration to conduct a review of the founded report of abuse or neglect in which I am named as an alleged perpetrator." Janet and Joshua Ruland signed this form, dated it October 27, 2005, and submitted it to the Department.

³ Exhibit 4.

⁴ Exhibit 12.

7. Through their attorney, the Appellants sent a letter⁵ dated November 2, 2005, to "Mr. Donicio Marichalar, CPS/DSHS, 1002 North 16th Avenue, PO Box 12500." In this letter the Appellants stated:

On behalf of my clients, the Rulands, we deny any and all allegations of negligent treatment or maltreatment of the foster children that were in their care under your program.

We feel that the founded findings are not based upon anything the Rulands did that was negligent or indicative of maltreatment. We seek a review.

To that end let me assure that we can meet with your or whom ever as soon as is possible. I am inclosing [sic] a copy of their review request form that I hope you have already received. I am also including a copy of the DLR/CPS Family Safety Assessment which, even though signed by the Rulands in August of 2005 was never received by them until after this incident, --even though I believe the record will show that the Rulands asked for it numerous times.

I look forward to working with you. I know there is a solution to these issues.

8. Through their attorney, the Appellants sent a letter dated November 2, 2005, to "Program Manager, Division of Licensed Resources, Child Abuse and Neglect Section, PO Box 45700, Olympia WA 98504-5700." In this letter the Appellants stated:

Dear Sir or Madam:

Enclosed please find our Notice of Appearance and Request for Review. Under separate cover we have already sent your "form" to you. I am also including the information I have sent to Donicio Marichalar in your Yakima Office.

9. At the prehearing conference conducted on December 13, 2005, the following exchange transpired between the ALJ, the Department, and the Appellants through their attorney:

ALJ: Is this a licensing matter, a CAPTA [Child Abuse Prevention and Treatment Act] matter, or both?

Department: I understand it's a licensing matter. I'm not sure where the CAPTA matter is in the process.

Appellants: From our perspective, it's a licensing matter and in regard to your other comment, where's the beef, we agree with that.

⁵ Exhibit 13.

ALJ: A foster care license is involved. Is the CAPTA finding contested?

Appellants: Yes.

ALJ: Where are you in that process? Have you requested a review?

Appellants: We've got two reviews going. The only one we've got going right now is with you, judge. We did three separate responses in regards to the different matters that are involved in this issue. ...

ALJ: I'm looking at the October 13 letter. Has an appeal been filed with respect to that letter?

Department: That's my understanding.

ALJ: And has a review been completed?

Department: I've not heard that it has been...

Appellants: Nor have I, judge.

Department: ...which leads me to believe that it has not been.

ALJ: So obviously that's going to have to be joined with this matter unless the Department changes its position?

Department: I would assume that would be the case

ALJ: But that as of yet hasn't been decided?

Appellants: This is the first opportunity we've had to talk to anybody, judge....
ALJ: And of course when you have some results on the other [CAPTA] matter, then we'll know whether or not that will be separate or will need to be joined here.

Appellants: That's right, judge.

10. OAH issued a Prehearing Order on December 16, 2005, that summarized the agreements made at the December 13, 2005, prehearing conference. The CPS finding is not mentioned in this order. Nor is any agreement to consolidate the CPS and licensing actions.

11. On December 29, 2005, the Department sent Janet Ruland a letter wherein it affirmed CPS' founded finding of child neglect following agency management review. This letter informed her of her right to an administrative appeal. Ms. Ruland received this letter on January 13, 2006.

12. At the beginning of the licensure denial hearing on February 14, 2006, the Department orally moved for an order dismissing any challenge the Appellants might make to the founded child abuse and neglect finding based on the Appellant's failure to timely request a hearing on this matter as required by RCW 26.44.125. The Department argued that the ALJ did not have jurisdiction to hear or decide any dispute over the finding of abuse and neglect. The Appellants argued in response that from the beginning they had told everyone from the Department they had talked to that they were challenging the finding. The ALJ mentioned that "Now I understand oftentimes these matters [licensing and CAPTA issues] are conjoined from the beginning." The ALJ withheld his ruling on the Department's motion and suggested to the Appellants that they file a written request for hearing at that time to challenge the child neglect finding. However, there is no written request for hearing in the Appellants' hearing file.

13. The ALJ subsequently denied the Department's motion and conducted a hearing on the merits of the CPS founded finding of child neglect.

III. CONCLUSIONS OF LAW

1. The Department's Petition for Review of the Initial Order was timely filed and is otherwise proper.⁶ Jurisdiction exists for the undersigned to review the Initial Order and to enter the final agency order in this matter.⁷

2. In Foster Family Home licensing cases, the undersigned has the same authority as the ALJ to enter findings of fact, conclusions of law, and orders.⁸

3. WAC 388-15-105, "What happens if CPS management staff does not change the founded CPS finding" states as follows:

(1) If CPS management staff does not change the founded CPS finding, the alleged perpetrator has the right to further challenge that finding by requesting an administrative hearing.

⁶ WAC 388-02-0580.

⁷ WAC 388-02-0560 to -0600.

⁸ RCW 34.05.464(4) and WAC 388-02-0600(1).

(2) The request for a hearing must be in writing and sent to the Office of Administrative Hearings. WAC 388-02-0025 lists the current address.

(3) The office of administrative hearings must receive the written request for a hearing within thirty days from the date that the person requesting the hearing receives the CPS management review decision.

WAC 388-15-105 (emphasis added).

4. RCW 26.44.125, "Alleged perpetrators – Right to review and amendment of finding – Hearing" states as follows:

(1) A person who is named as an alleged perpetrator after October 1, 1998, in a founded report of child abuse or neglect has the right to seek review and amendment of the finding as provided in this section.

(2) Within twenty calendar days after receiving written notice from the department under RCW 26.44.100 that a person is named as an alleged perpetrator in a founded report of child abuse or neglect, he or she may request that the department review the finding. The request must be made in writing. If a request for review is not made as provided in this subsection, the alleged perpetrator may not further challenge the finding and shall have no right to agency review or to an adjudicative hearing or judicial review of the finding.

(3) Upon receipt of a written request for review, the department shall review and, if appropriate, may amend the finding. Management level staff within the children's administration designated by the secretary shall be responsible for the review. The review must be conducted in accordance with procedures the department establishes by rule. Upon completion of the review, the department shall notify the alleged perpetrator in writing of the agency's determination. The notification must be sent by certified mail, return receipt requested, to the person's last known address.

(4) If, following agency review, the report remains founded, the person named as the alleged perpetrator in the report may request an adjudicative hearing to contest the finding. The adjudicative proceeding is governed by chapter 34.05 RCW and this section. **The request for an adjudicative proceeding must be filed within thirty calendar days after receiving notice of the agency review determination. If a request for an adjudicative proceeding is not made as provided in this subsection, the alleged perpetrator may not further challenge the finding and shall have no right to agency review or to an adjudicative hearing or judicial review of the finding.**

(5) Reviews and hearings conducted under this section are confidential and shall not be open to the public. Information about reports, reviews, and hearings may be disclosed only in accordance with federal and state laws pertaining to child welfare records and child protective services reports.

RCW 26.44.125 (emphasis added).

3. WAC 388-15-105(3) and RCW 26.44.125(4) both require that a person wishing an administrative hearing to challenge a CPS finding file a written request with OAH within thirty days after receiving notice of the Department's internal agency review determination. This regulation and this statute are both clear and unambiguous. The ALJ's conclusion that a person only need satisfy the internal agency appeal requirements of WAC 388-15-085⁹ and RCW 26.44.125(2) in order to perfect her right to an administrative hearing is wrong as a matter of law. Jurisdiction to hear Ms. Ruland's appeal of the CPS finding is properly found only after all regulatory and statutory procedural requirements are satisfied.¹⁰ The time frames for submitting (perfecting) a hearing request are jurisdictional, and a presiding officer in the administrative hearing process only has authority to conduct a full hearing and render a decision on the merits of a case when a timely request has been submitted to the OAH.¹¹ Ms. Ruland's failure to file a written appeal of the CPS finding that was received by OAH within the proscribed 30-day period is a failure to timely appeal the CPS finding. Any other ruling, such as that made by the ALJ in this case, compromises, invalidates, or abrogates both a state statute and a Department rule.

4. Ms. Ruland successfully asked for internal Department review of the CPS finding within the timelines established by WAC 388-15-085(2) and RCW 26.44.125(2)¹² However, satisfying the regulatory and statutory requirements for requesting internal agency review do

⁹ WAC 388-15-085 provides:(1) In order to challenge a founded CPS finding, the alleged perpetrator must make a written request for CPS to review the founded CPS finding of child abuse or neglect. The CPS finding notice must provide the information regarding all steps necessary to request a review. (2) The request must be provided to the same CPS office that sent the CPS finding notice within twenty calendar days from the date the alleged perpetrator receives the CPS finding notice (RCW 26.44.125).

¹⁰ Analogous to *Seattle v. Public Employment Rel. Comm'n*, 116 Wn.2d 923, 926, 809 P.2d 1377 (1991) (Appellant jurisdiction is properly exercised only after all statutory procedural requirements are satisfied for judicial review).

¹¹ RCW 34.05.413(2). See also *Rust v. Western Washington State College*, 11 Wn. App. 410, 415, 523 P.2d 204 (1974) and *Clark v. Selah School District No.119*, 53 Wn. App. 832, 837, 770 P.2d 1062 (1989).

¹² RCW 26.44.125(2): Within twenty calendar days after receiving written notice from the department under RCW 26.44.100 that a person is named as an alleged perpetrator in a founded report of child abuse or neglect, he or she may request that the department review the finding. The request must be made in writing. If a request for review is not made as provided in this subsection, the alleged perpetrator may not further challenge the finding and shall have no right to agency review or to an adjudicative hearing or judicial review of the finding.

not also satisfy the regulatory and statutory requirements for requesting an administrative hearing. OAH never received any written request for a hearing from Ms. Ruland. The Department never agreed that the CPS action and the licensing action were both before the ALJ to adjudicate at the time of the December 13, 2005, pre-hearing conference. Nor could the Department have agreed that jurisdiction existed to conduct a hearing on the CPS finding where none otherwise existed at law. And the ALJ never consolidated the CPS action and the licensing action, according to both the December 16, 2005, Prehearing Order and the verbal exchanges that were made at this conference.

5. The ALJ noted in Conclusion of Law 5 of the Initial Order that the Department was aware of Ms. Ruland's objection to the CPS finding. Apparently this is an implication that the Department was not prejudiced by the fact that Ms. Ruland never submitted a request for hearing. However, the legislature determines what a claimant must do to comply with statutory requirements, and prejudice to either party is not a factor.¹³

6. The ALJ wrote in Conclusion of Law 5 of the Initial Order that, "The unusual circumstances created by a simultaneous license violation and child abuse allegation of neglect was not meant by the legislature to create a trap for the unwary to enable the Department to avoid a fair adjudication of the merits." However, the fact that the Department and a client may be simultaneously involved in both a licensing action and a CPS action does not create "unusual circumstances" within the Department's administrative hearing practice. As the ALJ's own comments at the prehearing conference and at the hearing reveal, simultaneous licensing and CPS actions regularly occur, and when a client properly makes a hearing request on each action, these two actions are routinely combined into one hearing. The ALJ may personally feel that requiring clients to file two hearing requests on two different causes of action creates a trap

¹³ *Nelson v. Dunkin*, 69 Wn.2d 726, 730-32, 419 P.2d 984 (1966); See also *Hintz v. Kitsap County*, 92 Wn. App. 10,14-15,960 P.2d 946 (1998) ("prejudice is immaterial to whether a claim should be dismissed when a party fails to

for the unwary. However, the legislature that created the procedure a client must follow to request an administrative hearing to challenge a licensing action is the same legislature that created the procedure a client must follow to request a hearing to challenge a CPS action. Ms. Ruland was not overly burdened or treated fundamentally differently than other persons challenging CPS findings who have strictly complied with the procedure set out in the regulation and the statute. Review of statutory filing procedure claims have traditionally be treated with minimal scrutiny under the standard of review in Washington courts.¹⁴ Allowing for consistent and uniform procedures protects the governmental entity's interest as any slight procedural requirement does not create a substantial burden on the plaintiff.¹⁵

7. The court in *Jacquins v. DSHS*¹⁶ has indeed directed that administrative hearings be conducted with the greatest degree of informality consistent with fairness. However, this is a directive aimed at administrative hearing processes in general; it is not a directive to ALJs to liberally interpret jurisdictional statutes. Washington courts have broadly interpreted the language of chapter 26.44 RCW and its predecessor and the strong public policy statements contained therein to broadly interpret other rules and statutes in order to protect children.¹⁷ Moreover, as "[t]he basic goal of all statutory construction is to carry out the intent of the legislature,"¹⁸ and as

comply with claim filing procedures.")

¹⁴ *Schoonover v. State*, 116 Wn. App. 171, 64 P.3d 677 (2003) (claim filing requires personal verification and rational basis test used).

¹⁵ Resulting in the failure of an equal protection argument.

¹⁶ *Jacquins v. DSHS*, 69 Wn. App. 21 (1999).

¹⁷ For example, in *State of Washington v. Frank Lawrence Waleczek*, 90 Wn.2d 746, 749-750, 585 P.2d 797 (1978), the court held that the exception to the husband-wife testimonial privilege whereby one spouse may testify against the other regarding a crime against a child of whom the other spouse is the parent or guardian, reflects a legislative intent and a public policy to protect children from physical and sexual abuse, and should be liberally construed in favor of admitting such testimony. The court also held that "[b]oth RCW 26.44.010 and its predecessor, Laws of 1965, ch. 13, 1, make it abundantly clear that the legislature, as well as the public generally, is greatly concerned with incidents of physical and sexual child abuse. Further, these declarations imply that the legislature is not concerned with child abuse only in certain situations, but that it is concerned with all incidents of child abuse." See *State of Washington v. Wayne L. Clevenger*, 69 Wn.2d 136. In *State v. Fagalde*, 85 Wn.2d 730 (1975), the court held that confidential communications between doctor and patient are not protected where they relate to child abuse. In *State v. Lounsberry*, 74 Wn.2d 659, 445 P.2d 1017 (1968), the court held that the word "parent" as used in RCW 5.60.060(1), which provides that communications made during marriage are not privileged in a criminal action against a husband for a crime committed against "any child of whom said husband . . . is the parent," includes a stepparent standing in loco parentis to the child. And in *State of Washington v. Whitney Norlin*, 134 Wn.2d 570, 951 P.2d 1131 (1998), the court ruled that the trial court had not abused its discretion in admitting, pursuant to ER 404(b), testimony of an expert that the child victim's prior injuries were caused by an intentional act.

¹⁸ *State of Washington v. Frank Lawrence Waleczek*, 90 Wn.2d 746, 749-750, 585 P.2d 797 (1078).

the rules of statutory construction apply to the interpretation of administrative rules and regulations,¹⁹ the ALJ's interpretation of WAC 388-15-105(3) and RCW 25.44.125(4) fails to carry out the legislature's intent to make the protection of children paramount over the right of any person to provide foster care.²⁰

8. The undersigned concludes that Ms. Ruland has not perfected her request for a CPS hearing and that jurisdiction does not exist to conduct a hearing on the merits of her challenge to CPS' finding of child neglect. The ALJ, in reaching the opposite legal conclusion, has committed an error of law. The ALJ lacked jurisdiction to hear the CPS case on its merits and only had the authority to dismiss the CPS matter due to lack of subject matter jurisdiction. *Inland Foundry Co. v. Spokane County Air Pollution Control Auth.*, 98 Wn. App 121, 124, 989 P.2d 102 (1999). The Initial Order shall be reversed.

9. CPS has entered a founded finding of child neglect against Ms. Ruland, and inasmuch as Ms. Ruland has not appealed this finding through the administrative hearing process, it has become final by operation of law. Because Ms. Ruland has had a founded finding of child neglect entered against her, the Department had no choice but to deny her application for a Foster Family Home license. WAC 388-148-0095(2)(b).²¹ As this resolves the licensure issue, the undersigned has not reviewed whether the Appellants have also violated WAC 388-148-0035(1), (4) and (5); WAC 388-148-0505(1)(a); WAC 388-148-0100(1)(c) and (d);

¹⁹ *Multicare Medical Center v. Department of Social and Health Services*, 114 Wn.2d 572, 591, 790 P.2d 124 (1990).

²⁰ RCW 74.15.010(1) and the note to this statute, which provides: "The legislature declares that the state of Washington has a compelling interest in protecting and promoting the health, welfare, and safety of children, including those who receive care away from their own homes. The legislature further declares that no person or agency has a right to be licensed under this chapter to provide care for children. The health, safety, and well-being of children must be the paramount concern in determining whether to issue a license to an applicant, whether to suspend or revoke a license, and whether to take other licensing action. ... Children placed in foster care are particularly vulnerable and have a special need for placement in an environment that is stable, safe, and nurturing. For this reason, foster homes should be held to a high standard of care, and department decisions regarding denial, suspension, or revocation of foster care licenses should be upheld on review if there are reasonable grounds for such action."

²¹ WAC 388-148-0095(2)(b), When are licenses denied, suspended or revoked, states: (2) The department must, also, disqualify you for any of the following reasons: (b) You have been found to have committed child abuse or neglect or you treat, permit or assist in treating children in your care with cruelty, indifference, abuse, neglect, or exploitation, unless the department determines that you do not pose a risk to a child's safety, well-being, and long-term stability.

and WAC 388-148-0460(1), (3), (6), and (7) as alleged by the Department in its licensure denial notice.

10. The procedures and time limits for seeking reconsideration of this decision with the Board of Appeals or judicial review with the superior court are in the attached statement.

IV. DECISION AND ORDER

The Initial Order is reversed. The Appellants' application for a Foster Family Home license is denied.

Mailed on September 21, 2006.


CHRISTINE STALNAKER
Review Judge

Attached: Reconsideration/Judicial Review Information

Copies have been sent to: Joshua and Janet Ruland, Appellants
George Colby, Appellants' Representative
Alicia Kinney, AAG, Department's Representative
Assistant Secretary, Children's Administration MS 45040
Craig Davenport, ALJ, Yakima OAH

Attachment O

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Judge Anne Hirsch

<input type="checkbox"/> EXPEDITE
<input checked="" type="checkbox"/> Hearing is set:
Date: <u>Friday, June 19, 2009</u>
Time: <u>9.00 a.m.</u>
Judge/Calendar: <u>Hon. Anne Hirsch</u>

IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON
IN AND FOR THE COUNTY OF THURSTON

SAMANTHA A.,

Petitioner,

v.

DEPARTMENT OF SOCIAL AND HEALTH
SERVICES,

Respondent.

Docket No. 07-2-02555-1

EX PARTE

~~[PROPOSED]~~ FINDINGS OF FACT,
CONCLUSIONS OF LAW AND ORDER
OF JUDGMENT



The following findings are based on a trial held June 5, 2009 as well as the administrative and rulemaking records and briefing submitted prior to trial.

FINDINGS OF FACT

Upon the basis of the court record, the Court FINDS:

1. Petitioner, Samantha A., has Down's Syndrome, Obesity, Vision Issues/Cataracts, hearing loss, speech and communication problems, developmental delay, and behavior problems. Samantha is now fourteen years old.

2. Samantha requires personal assistance on a daily basis, as she is not able to perform the majority of her activities of daily living independently. Samantha has difficulty speaking and being understood. She is assaultive at times. She disrobes in

[PROPOSED] FINDINGS OF FACT, CONCLUSIONS
OF LAW AND ORDER OF JUDGMENT - 1

Disability Rights Washington
315 5TH Avenue South, Suite 850
Seattle, Washington 98104
(206) 324-1521 · Fax: (206) 957-0729

1 public. She is frequently easily agitated and resistive to care. She wanders away and is
2 not safe when unsupervised in public. She needs help cutting food into pieces and needs
3 to be cued to eat. She requires assistance with using the bathroom, getting dressed,
4 brushing her teeth and her hair. Samantha also has other medical and physical needs
5 related to her disabilities.

6 3. Respondent, the Washington State Department of Social and Health
7 Services ("DSHS" or "the Department") has determined that Samantha is eligible for 24-
8 hour institutional care because of the extreme level of her needs.

9 4. Samantha's parent is a single working mother who is committed to meeting
10 Samantha's needs and trying to prevent her from being institutionalized.

11 5. The Department has enrolled Samantha on the Medicaid Home and
12 Community Based Waiver program for persons with developmental disabilities so she can
13 receive Medicaid and other benefits at home, outside of an institution. As part of her
14 Medicaid benefits, Samantha receives Medicaid Personal Care (MPC).

15 6. The Department assesses a child's need for MPC services using an
16 assessment process known as the "Comprehensive Assessment Reporting Evaluation"
17 (CARE) tool assessment.

18 7. On May 17, 2005, Respondent adopted changes to its CARE assessment.
19 See WSR 05-11-082. Included in the rule changes was a new rule, WAC 388-106-0213,
20 which establishes special automatic reductions to MPC services to be applied only to
21 children. The new rule took effect on June 17, 2005. The rule at issue in this case,
22 referred to here as the Children's Assessment rule, is attached as *Exh. A* to these
23 Findings of Fact, Conclusions of Law and Order of Judgment.

1 8. The Children's Assessment rule reduces the amount of MPC services
2 provided to children in two ways. *First*, the rule reduces the amount of MPC services to
3 children based upon their age. See WAC 388-106-0213(2). *Second*, the rule reduces
4 the amount of MPC services to children if they lived with their legally responsible natural,
5 step or adoptive parents.

6 9. The first reduction treats similarly disabled children differently based upon
7 their age.

8 10. The second reduction treats similarly disabled children differently because
9 they live with caregivers other than their legally responsible parents.

10 11. Both reductions occur automatically, without any inquiry as to whether the
11 recipient child's assessed needs would actually be met after the reductions were taken.

12 12. The Department's regulations do not permit consideration of evidence
13 from children's medical providers regarding the amount of MPC services that are
14 medically necessary to correct or ameliorate the child's condition. There was no
15 evidence of consideration of the medical provider's recommendations for medically
16 necessary services in the instant case.

17 13. The Department's regulations do not allow recipient children to challenge
18 the implementation of the automatic reductions in an administrative hearing by
19 demonstrating that their needs are still unmet after the reductions are taken. The
20 Department does have a process for seeking an Exception to Rule (ETR), but this
21 process does not ensure the due process rights of applicants because it does not grant
22 administrative hearing rights to denials of initial requests for ETRs.

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1 14. The rulemaking file and administrative record do not contain any time-
2 study, evaluation, or any other evidence to support the Department's assumptions
3 regarding the automatic reductions in Children's Assessment rule, WAC 388-106-0213.

4 15. Prior to the implementation of WAC 388-106-0213, the Department
5 assessed Samantha as needing 90 hours of personal care services per month, so that a
6 paid care provider could assist her with bathing, dressing, eating, locomotion, personal
7 hygiene, toilet use, and transfers. Samantha's care provider also addressed her
8 significant behavioral support needs, including responding appropriately and safely to
9 Samantha's aggression, sexual expression, and resistance to care.

10 16. On December 12, 2006, Samantha's needs for MPC services were
11 reassessed and WAC 388-106-0213 was applied to her assessment.

12 17. The new assessment showed that Samantha was exhibiting increased
13 behavioral problems that affected her ability to complete personal care tasks. The
14 assessment determined that Samantha's "base hours" were 90 hours per month.

15 18. 90 and 39 hours are significantly lower than what she actually would need
16 if she were to have all of her needs, in addition to personal care, fully paid for by the
17 state.

18 19. The assessment's "base hours" were automatically reduced to 39 hours
19 because Samantha lives with her mother and because of her age, pursuant to WAC
20 388-106-0213.

21 20. Samantha's mother requested an administrative hearing to appeal the
22 reduction of her care hours.

1 presumptions to reduce certain disabled children's MPC services based upon their age
2 and whether they live with their parents. These presumptions are imposed without any
3 consideration of each child's individualized circumstances nor whether each child's
4 needs will be met after the reduction is imposed. Such irrebuttable presumptions treat
5 similarly disabled children differently, in violation of the Medicaid comparability
6 requirements.

7 3. The irrebuttable presumptions in WAC 388-106-0213 are also arbitrary
8 and capricious because they create an irrebuttable presumption that does not permit
9 any consideration of a participant's individual circumstances and include no basis for
10 any consideration of a treating physician's opinion as to medical necessity of services.

11 4. WAC 388-106-0213 also violates federal Medical laws requiring Early and
12 Periodic Screening Diagnosis and Treatment (EPSDT) for all children under the age of
13 21. EPSDT provisions are codified at 42 U.S.C. § 1396d(a)(4)(B); (13); 42 U.S.C. §
14 1396d(r)(5).

15 5. EPSDT is a broad legislative mandate requiring the Department to
16 provide:

17 ...necessary health care, diagnostic services, treatment, and
18 other measures described in subsection (a) of this section to
19 correct or ameliorate defects and physical and mental illnesses
and conditions discovered by the screening services, whether
or not such services are covered under the State plan.

20 42 U.S.C. § 1396d(r)(5).

21 6. EPSDT requires the Department to meaningfully consider and weigh
22 recommendations from a child's medical providers into the MPC assessment process in
23 determining medical necessity.

1 7. WAC 388-106-0213 violates EPSDT because the rule automatically
2 overrides, without any consideration, the recommendations of a child's medical
3 provider. The rule also violates EPSDT because it allows MPC services to be
4 determined based upon overly restrictive criteria other than medical necessity.

5 8. WAC 388-106-0130 (3)(b) also violates federal Medicaid laws requiring
6 comparability and EPSDT services, insofar as the rule authorizes the Department to
7 reduce children's MPC services based upon WAC 388-106-0213.

8 9. A rule is invalid to the extent it is in conflict with or otherwise exceeds
9 statutory authority and/or is arbitrary and capricious.

10 10. Petitioner has met her burden to show that WAC 388-106-0213 and WAC
11 388-106-0130(3)(b) are invalid because the rules are arbitrary and capricious and
12 exceed the statutory authority of the agency by violating federal laws regarding EPSDT
13 and comparability requirements.

14 11. The Department uses a set formula to assess the needs of children for
15 MPC. That application results in an automatic determination that reduces assessed
16 need based on the age of the child and the fact that the child resides at home with his or
17 her natural, step, or adoptive parent or parents.

18 12. Here, as in *Jenkins*, there was a categorical reduction without any
19 consideration of individual circumstances. Disabled children, such as Samantha, have
20 greater needs, and the Department's rules do not take individual needs or
21 circumstances into account. The Department performs no individualized assessments
22 to determine whether the number of hours allowed bear any resemblance to the needs

1 that were assessed. For this reason, the Department's rules violate comparability and
2 EPSDT. Respondent must assess each child's individual needs.

3 13. In addition to assessing each child's individual needs, Respondent must
4 meaningfully consider and weigh the EPSDT recommendations of medical providers
5 into the MPC assessment process for children.

6 14. The administrative order applying the Children's Assessment rule to the
7 Petitioner's case should be set aside because the rule is outside the statutory authority
8 of the agency and is arbitrary and capricious.

9 15. Petitioner should receive MPC services, consistent with the Department's
10 assessment of her unmet need for personal care assistance and after giving proper
11 consideration to the recommendations of her treating physician.

12 16. Samantha was eligible for MPC services at 90 hours per month effective
13 December 12, 2006. The Department is required to retroactively reimburse Samantha
14 for ^{properly documented} any out of pocket expenses incurred in order to secure personal care services in
15 addition to the 39 hours per month. To the extent that Samantha's current CARE
16 assessment has determined her "base hours" to be a different number of hours per
17 month, the Department shall immediately provide Samantha with those hours, without
18 applying WAC 388-106-0213 or WAC 388-106-0130(3)(b).

19 17. Petitioner should be awarded reasonable attorneys' fees for services
20 received from Disability Rights Washington and Sirianni Youtz Meier and Spoonemore.

21 **ORDER OF JUDGMENT**

22 Based on the above Findings and Conclusions, the court enters the following
23 DECLARATORY JUDGMENT AND ORDER as follows:

24 [PROPOSED] FINDINGS OF FACT, CONCLUSIONS
OF LAW AND ORDER OF JUDGMENT - 8

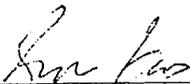
Disability Rights Washington
315 5TH Avenue South, Suite 850
Seattle, Washington 98104
(206) 324-1521 · Fax: (206) 957-0729

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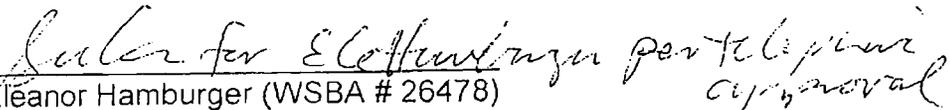
1 Presented by:

2 Attorneys for Petitioners:

3 DISABILITY RIGHTS WASHINGTON

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5 _____
6 Regan Bailey (WSBA # 39142)
6 Susan Kas (WSBA # 36592)

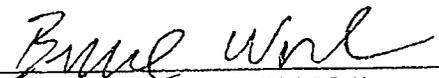
7 SIRIANNI YOUTZ
8 MEIER & SPOONEMORE

9 
10 Eleanor Hamburger (WSBA # 26478) *per telephone*
10 Attorneys for Petitioner *approval*

11
12 Approved as to form and notice of presentation waived by:

13 Attorney for Respondent:

14 OFFICE OF THE ATTORNEY GENERAL

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16 Bruce Work (WSBA #33824)

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Attachment P

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.

Provided: No limitations With limitations*

2.a. Outpatient hospital services.

Provided: No limitations With limitations*

b. Rural health clinic services and other ambulatory services furnished.

Provided: No limitations With limitations*

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

Provided: No limitations With limitations*

3. Other laboratory and x-ray services.

Provided: No limitations With limitations*

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Provided: No limitations With limitations*

b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

c. Family planning services and supplies for individuals of child-bearing age.

Provided: No limitations With limitations*

Attachment I Exhibit 19

001171

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4. b. Early and periodic screening, diagnosis, and treatment

Early Periodic Screening, Diagnosis and Treatment (EPSDT) is a program providing EPSDT to persons under 21 years of age who are eligible for Medicaid or the Children's Health Program. In conformance with 1905(r) of the Act, all medically necessary diagnosis and treatment services are provided regardless of whether the service is included in the plan. Limitations do not apply other than based on medical necessity.

001172

Attachment Q

(6) The registered nurse must document the result of the nursing service provided on a department-approved form. The registered nurse provides a copy to the staff who has case management responsibility.

[Statutory Authority: RCW 74.09.520 and 74.08.090. 98-20-022, § 388-15-194, filed 9/25/98, effective 10/26/98. Statutory Authority: RCW 74.08.090, 74.09.520 and 1995 1st sp.s. c. 18. 95-20-041 (Order 3904), § 388-15-194, filed 9/28/95, effective 10/29/95.]

WAC 388-15-202 Long-term care services—Definitions. The department shall use the definition in subsections (1) through (50) of this section for long-term care services. "Long-term care services" means the services administered directly or through contract by the aging and adult services administration of the department, including but not limited to nursing facility care and home and community services.

(1) "Aged person" means a person sixty-five years of age or older.

(2) "Agency provider" means a licensed home care agency or a licensed home health agency having a contract to provide long-term care personal care services to a client in the client's own home.

(3) "Application" means a written request for medical assistance or long-term care services submitted to the department by the applicant, the applicant's authorized representative, or, if the applicant is incompetent or incapacitated, someone acting responsibly for the applicant. The applicant shall submit the request on a form prescribed by the department.

(4) "Assessment" means an inventory and evaluation of abilities and needs.

(5) "Attendant care" means the chore personal care service provided to a grandfathered client needing full-time care due to the client's need for:

(a) Assistance with personal care; or

(b) Protective supervision due to confusion, forgetfulness, or lack of judgment. Protective supervision does not include responsibilities a legal guardian should assume such as management of property and financial affairs.

(6) "Authorization" means an official approval of a departmental action, for example, a determination of client eligibility for service or payment for a client's long-term care services.

(7) "Available resources" is a term to describe a chore personal care client's assets accessible for use and conversion into money or its equivalent without significant depreciation in the property value.

(8) "Blind person" means a person determined blind as described under WAC 388-511-1105 by the division of disability determination services of the medical assistance administration.

(9) "Categorically needy" means the financial status of a person as defined under WAC 388-503-0310.

(10) "Client" means an applicant for service or a person currently receiving services.

(11) "Community residence" means:

(a) The client's "own home" as defined in this section;

(b) Licensed adult family home under department contract;

(c) Licensed boarding home under department contract;

(d) Licensed children's foster home;

(e) Licensed group care facility, as defined in WAC 388-73-014(8); or

(f) Shared living arrangement as defined in this section.

(12) "Community spouse" means a person as described under WAC 388-513-1365 (1)(b).

(13) "Companionship" means the activity of a person in a client's own home to prevent the client's loneliness or to accompany the client outside the home for other than personal care services.

(14) "Contracted program" means services provided by a licensed and contracted home care agency or home health agency.

(15) "COPEs" means community options program entry system.

(16) "Department" means the state department of social and health services.

(17) "Direct personal care services" means verbal or physical assistance with tasks involving direct client care which are directly related to the client's handicapping condition. Such assistance is limited to allowable help with the tasks of ambulation, bathing, body care, dressing, eating, personal hygiene, positioning, self-medication, toileting, transfer, as defined under WAC 388-15-202 (38)(a) through (e), (j) through (l), (n), and (o).

(18) "Disabled" means a person determined disabled as described under WAC 388-511-1105 by the division of disability determination services of the medical assistance administration.

(19) "Disabling condition" means a condition which prevents a person from self-performance of personal care tasks without assistance.

(20) "Estate recovery" means the department's activity in recouping funds after the client's death which were expended for long-term care services provided to the client during the client's lifetime per WAC 388-15-192.

(21) "Grandfathered client" means a chore personal care services client approved for either:

(a) Attendant care services provided under the chore personal care program when these services began before April 1, 1988; and

(b) Family care services provided under the chore personal care program when these services began before December 14, 1987; and

(c) The client was receiving the same services as of June 30, 1989.

(22) "Home health agency" means a licensed:

(a) Agency or organization certified under Medicare to provide comprehensive health care on a part-time or intermittent basis to a patient in the patient's place of residence and reimbursed through the use of the client's medical identification card; or

(b) Home health agency, certified or not certified under Medicare, contracted and authorized to provide:

(i) Private duty nursing; or

(ii) Skilled nursing services under an approved Medicaid waiver program.

(23) "Household assistance" means assistance with incidental household tasks provided as an integral, but subordinate part of the personal care furnished directly to a client by

and through the long-term care programs as described in this chapter. Household assistance is considered an integral part of personal care when such assistance is directly related to the client's medical or mental health condition, is reflected in the client's service plan, and is provided only when a client is assessed as needing personal care assistance with one or more direct personal care tasks. Household assistance tasks include travel to medical services, essential shopping, meal preparation, laundry, housework, and wood supply.

(24) "Income" means "income" as defined under WAC 388-500-0005.

(25) "Individual provider" means a person employed by a community options program entry system (COPES) or Medicaid personal care client when the person:

(a) Meets or exceeds the qualifications as defined under WAC 388-15-196;

(b) Has signed an agreement to provide personal care services to a client; and

(c) Has been authorized payment for the services provided in accordance with the client's service plan.

(26) "Individual provider program (IPP)" means a method of chore personal care service delivery where the client employs and supervises the chore personal care service provider.

(27) "Institution" means an establishment which furnishes food, shelter, medically-related services, and medical care to four or more persons unrelated to the proprietor. "Institution" includes medical facilities, nursing facilities, and institutions for the mentally retarded, but does not include correctional institutions.

(28) "Institutional eligible client" means a person whose eligibility is determined under WAC 388-513-1315. "Institutionalized client" means the same as defined in WAC 388-513-1365(f).

(29) "Institutional spouse" means a person described under WAC 388-513-1365 (1)(e).

(30) "Medicaid" means the federal aid Title XIX program under which medical care is provided to:

(a) Categorically needy as defined under WAC 388-503-0310; and

(b) Medically needy as defined under WAC 388-503-0320.

(31) "Medical assistance" means the federal aid Title XIX program under which medical care is provided to the categorically needy as defined under WAC 388-503-0310 and 388-503-1105.

(32) "Medical institution" means an institution defined under WAC 388-500-0005.

(33) "Medically necessary" and "medical necessity" mean the same as defined under WAC 388-500-0005.

(34) "Medically oriented tasks" means direct personal care services and household assistance provided as an integral but subordinate part of the personal care and supervision furnished directly to a client.

(35) "Mental health professional" means a person defined under WAC 275-57-020(25).

(36) "Own home" means the client's present or intended place of residence:

(a) In a building the client rents and the rental is not contingent upon the purchase of personal care services as defined in this section; or

(b) In a building the client owns; or

(c) In a relative's established residence; or

(d) In the home of another where rent is not charged and residence is not contingent upon the purchase of personal care services as defined in this section.

(37) "Personal care aide" means a person meeting the department's qualification and training requirements and providing direct Medicaid personal care services to a client. The personal care aide may be an employee of a contracted agency provider or may be an individual provider employed by the Medicaid personal care client.

(38) "Personal care services" means both physical assistance and/or prompting and supervising the performance of direct personal care tasks and household tasks, as listed in subdivisions (a) through (q) of this subsection. Such services may be provided for clients who are functionally unable to perform all or part of such tasks or who are incapable of performing the tasks without specific instructions. Personal care services do not include assistance with tasks performed by a licensed health professional.

(a) "Ambulation" means assisting the client to move around. Ambulation includes supervising the client when walking alone or with the help of a mechanical device such as a walker if guided, assisting with difficult parts of walking such as climbing stairs, supervising the client if client is able to propel a wheelchair if guided, pushing of the wheelchair, and providing constant or standby physical assistance to the client if totally unable to walk alone or with a mechanical device.

(b) "Bathing" means assisting a client to wash. Bathing includes supervising the client able to bathe when guided, assisting the client with difficult tasks such as getting in or out of the tub or washing back, and completely bathing the client if totally unable to wash self.

(c) "Body care" means assisting the client with exercises, skin care including the application of nonprescribed ointments or lotions, changing dry bandages or dressings when professional judgment is not required and pedicure to trim toenails and apply lotion to feet. In adult family homes or in licensed boarding homes contracting with DSHS to provide assisted living services, dressing changes using clean technique and topical ointments must be delegated by a registered nurse in accordance with chapter 246-840 WAC. "Body care" excludes:

(i) Foot care for clients who are diabetic or have poor circulation; or

(ii) Changing bandages or dressings when sterile procedures are required.

(d) "Dressing" means assistance with dressing and undressing. Dressing includes supervising and guiding client when client is dressing and undressing, assisting with difficult tasks such as tying shoes and buttoning, and completely dressing or undressing client when unable to participate in dressing or undressing self.

(e) "Eating" means assistance with eating. Eating includes supervising client when able to feed self if guided,

assisting with difficult tasks such as cutting food or buttering bread, and feeding the client when unable to feed self.

(f) "Essential shopping" means assistance with shopping to meet the client's health care or nutritional needs. Limited to brief, occasional trips in the local area to shop for food, medical necessities, and household items required specifically for the health, maintenance, and well-being of the client. Essential shopping includes assisting when the client can participate in shopping and doing the shopping when the client is unable to participate.

(g) "Housework" means performing or helping the client perform those periodic tasks required to maintain the client in a safe and healthy environment. Activities performed include such things as cleaning the kitchen and bathroom, sweeping, vacuuming, mopping, cleaning the oven, and defrosting the freezer, shoveling snow. Washing inside windows and walls is allowed, but is limited to twice a year. Assistance with housework is limited to those areas of the home which are actually used by the client. This task is not a maid service and does not include yard care.

(h) "Laundry" means washing, drying, ironing, and mending clothes and linens used by the client or helping the client perform these tasks.

(i) "Meal preparation" means assistance with preparing meals. Meal preparation includes planning meals including special diets, assisting clients able to participate in meal preparation, preparing meals for clients unable to participate, and cleaning up after meals. This task may not be authorized to just plan meals or clean up after meals. The client must need assistance with actual meal preparation.

(j) "Personal hygiene" means assistance with care of hair; teeth, dentures, shaving, filing of nails, and other basic personal hygiene and grooming needs. Personal hygiene includes supervising the client when performing the tasks, assisting the client to care for the client's own appearance, and performing grooming tasks for the client when the client is unable to care for own appearance.

(k) "Positioning" means assisting the client to assume a desired position, assistance in turning and positioning to prevent secondary disabilities, such as contractures and balance deficits or exercises to maintain the highest level of functioning which has already been attained and/or to prevent the decline in physical functional level. (Range of motion ordered as part of a physical therapy treatment is not included.)

(l) "Self-medication" means assisting the client to self-administer medications prescribed by attending physician. Self-medication includes reminding the client of when it is time to take prescribed medication, handing the medication container to the client, and opening a container.

(m) "Supervision" means being available to:

(i) Help the client with personal care tasks that cannot be scheduled, such as toileting, ambulation, transfer, positioning, some medication assistance; and

(ii) Provide protective supervision to a client who cannot be left alone because of impaired judgment.

(n) "Toileting" means assistance with bladder or bowel functions. Toileting includes guidance when the client is able to care for own toileting needs, helping client to and from the bathroom, assisting with bedpan routines, using incontinent

briefs on client, and lifting client on and off the toilet. Toileting may include performing routine perineal care, colostomy care, or catheter care for the client when client is able to supervise the activities. In adult family homes or in licensed boarding homes contracting with DSHS to provide assisted living services colostomy care and catheterization using clean technique must be delegated by a registered nurse in accordance with chapter 246-840 WAC.

(o) "Transfer" means assistance with getting in and out of a bed or wheelchair or on and off the toilet or in and out of the bathtub. Transfer includes supervising the client when able to transfer if guided, providing steadying, and helping the client when client assists in own transfer. Lifting the client when client is unable to assist in their own transfer requires specialized training.

(p) "Travel to medical services" means accompanying or transporting the client to a physician's office or clinic in the local area to obtain medical diagnosis or treatment.

(q) "Wood supply" means splitting, stacking, or carrying wood for the client when the client uses wood as the sole source of fuel for heating and/or cooking. This task is limited to splitting, stacking, or carrying wood the client has at own home. The department shall not allow payment for a provider to use a chain saw or to fell trees.

(39) "Physician" means a doctor of medicine, osteopathy, or podiatry, as defined under WAC 388-500-0005.

(40) "Plan of care" means a "service plan" as described under WAC 388-15-205.

(41) "Property owned" means any real and personal property and other assets over which the client has any legal title or interest.

(42) "Provider" or "provider of service" means an institution, agency, or person:

(a) Having a signed department agreement to furnish long-term care client services; and

(b) Qualified and eligible to receive department payment.

(43) "Relative" means:

(a) For chore personal care service, a client's spouse, father, mother, son, or daughter;

(b) For Medicaid personal care service:

(i) "Legally responsible relative" means a spouse caring for a spouse or a biological, adoptive, or stepparent caring for a minor child.

(ii) "Nonresponsible relative" means a parent caring for an adult child and an adult child caring for a parent.

(44) "Service plan" means a plan for long-term care service delivery as described under WAC 388-15-205.

(45) "Shared living arrangement" for purposes of Medicaid personal care means an arrangement where:

(a) A nonresponsible relative as defined in (43)(b)(ii) above is the personal care provider and resides in the same residence with common facilities, such as living, cooking, and eating areas; or

(b) A minor child age seventeen or younger lives in the home of a legally responsible relative as defined in (43)(b)(i) above.

(46) "SSI-related" means a person who is aged, blind, or disabled.

(47) "Supervision" means a person available to a long-term care client as defined under WAC 388-15-202 (36)(m).

(48) "Supplemental Security Income (SSI)" means the federal program as described under WAC 388-500-0005.

(49) "Title XIX" is the portion of the federal Social Security Act which authorizes federal funding for medical assistance programs, e.g., nursing facility care, COPES, and Medicaid personal care home and community-based services.

(50) "Transfer of resources" means the same as defined under WAC 388-513-1365 (1)(g).

(51) "Unscheduled tasks" means ambulation, toileting, transfer, positioning, and unscheduled medication assistance as described in this chapter.

[Statutory Authority: RCW 74.09.520, 97-20-066, § 388-15-202, filed 9/25/97, effective 10/1/97. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.100, 74.39.010, 74.39.030 and 1996 c 302 § 5, 96-20-093, § 388-15-202, filed 10/1/96, effective 11/1/96. Statutory Authority: RCW 74.08.090, 74.09.520 and 1995 1st sp.s. c 18, 95-20-041 (Order 3904), § 388-15-202, filed 9/28/95, effective 10/29/95. Statutory Authority: RCW 74.09.520, 74.39.005, 74.08.043 and 74.08.545, 93-06-042 (Order 3501), § 388-15-202, filed 2/24/93, effective 3/27/93.]

WAC 388-15-203 Long-term care services—Assessment of task self-performance and determination of required assistance. (1) Purpose. The assessor as identified in subsection (2)(a) of this section shall:

(a) Identify client strengths to maximize current strengths and promote client independence;

(b) Evaluate physical health, functional and cognitive abilities, social resources and emotional and social functioning for service planning for long-term care;

(c) Identify client values and preferences for effective service planning based on the person's values and lifestyles; and

(d) Determine client's need for informal support, community support and services, and department paid services.

(2) Assessment responsibility.

(a) Department staff or designee while assessing need for case management shall perform the assessment.

(b) Except for adult protective service, the assessors shall perform a separate assessment for each client.

(c) The assessors shall document the assessment on a prescribed form.

(d) The assessors shall perform the assessment based on an in-person interview with the client.

(e) When performing the assessment, the assessors shall take into account the client's:

(i) Risk of and eligibility for nursing facility placement;

(ii) Health status, psychological/social/cognitive functioning, income and resources, and functional abilities;

(iii) Living situation; and

(iv) Availability of alternative resources providing needed assistance, including family, neighbors, friends, community programs, and volunteers.

(3) The adult client's functional ability to self-perform each personal care task and household task shall be determined using the following definitions of the assistance required:

(a) Ambulation:

(i) Independent. The client is mobile, with or without an assistive device, both inside and outside the household without the assistance of another person.

(ii) Minimal. The client is mobile inside without assistance but needs the assistance of another person outside; or the client needs occasional assistance of another person inside, and usually needs assistance of another person outside.

(iii) Substantial. The client is only mobile with regular assistance of another person both inside and outside.

(iv) Total. The client is not mobile.

(b) Bathing:

(i) Independent. The client can bathe self.

(ii) Minimal. The client requires oversight help or reminding only. The client can bathe without assistance or supervision, but must be reminded some of the time; or the client cannot get into the tub alone and physical help is limited to stand-by assist only.

(iii) Substantial. The client requires physical help in a large part of the bathing activity, for example, to lather, wash, and/or rinse own body or hair.

(iv) Total. The client is dependent on others to provide a complete bath.

(c) Body care:

(i) Independent. The client can apply ointment, lotion, change bandages or dressings, and perform exercises without assistance.

(ii) Minimal. The client requires oversight help or reminding only, or requires occasional assistance.

(iii) Substantial. The client requires limited physical help to apply ointment, lotion, or to perform dry bandage or dressing change.

(iv) Total. The client is dependent on others to perform all required body care.

(d) Dressing:

(i) Independent. The client can dress and undress without assistance or supervision.

(ii) Minimal. The client can dress and undress, but may need to be reminded or supervised to do so on some days; the client can assist dressing and undressing, but frequently or most of the time needs some physical assistance.

(iii) Substantial. The client always needs assistance to do parts of dressing and undressing.

(iv) Total. The client is dependent on others to do all dressing and undressing.

(e) Eating:

(i) Independent. The client can feed self, chew and swallow solid foods without difficulty, or can feed self by stomach tube or catheter.

(ii) Minimal. The client:

(A) Can feed self, chew and swallow foods, but needs reminding to maintain adequate intake;

(B) May need food cut up;

(C) Can feed self only if food is brought to the client.

(iii) Substantial. The client:

(A) Can feed self but needs standby assistance for occasional gagging, choking, or swallowing difficulty; or

(B) Needs reminders/assistance with adaptive feeding equipment; or

Attachment R

1 individual provider in home.

2 MS. JOHNSON: Yes.

3 MR. NEAL: Can you, uh, describe for the record, uh,
4 what that is?

5 MS. JOHNSON: Individual providers are contracted with
6 ADSA to provide, um, services either personal care services
7 or respite services in the client's home. And the
8 qualification for those providers are listed in Washington
9 Administrative Code 388-71, specific section--

10 MR. NEAL: Um hum.

11 MS. JOHNSON: --0500 through 0556.

12 MR. NEAL: And are those-- those qualifications
13 require any kind of, uh, formal education?

14 MS. JOHNSON: No.

15 MR. NEAL: What do those qualifications require?

16 MS. JOHNSON: They require that, um, a Medicaid
17 Personal Care provider has, um, orientation and safety
18 training and revised fundamentals of caregiving and 10
19 hours of continuing education.

20 MR. NEAL: Okay.

Attachment M

21 MS. JOHNSON: Has the skills and abilities to deliver
22 the services outlined in the client service plan.

23 MR. NEAL: And where is the-- where is the-- how is
24 that service funded, is it-- is that a Medicaid service?

25 MS. JOHNSON: Um, Medicaid Personal Care is.

1 MR. NEAL: Um hum. And would you consider those
2 services to be, um, medical services?

3 MS. JOHNSON: In order to qualify for Medicaid
4 Personal you have to have medically necessary, um, needs,
5 correct, for functional disability.

6 MR. NEAL: So these services would be-- would be
7 medically necessary if they're-- if they're funded by
8 Medicaid?

9 MS. JOHNSON: Yeah.

10 MR. NEAL: A slightly different question is, um, if
11 there is a medical nec-- necessary issue, um, are these
12 services considered medical services?

13 MS. JOHNSON: Medicaid Personal Care does not deliver
14 medical ex-- and if you're talking about skilled nursing,
15 skill task cannot be provided by an individual provider.

16 MR. NEAL: Okay. So they're medically necessary but--
17 but not necessarily provided by a skilled--

18 MS. JOHNSON: Medical task.

19 MR. NEAL: Okay.

20 MS. JOHNSON: Correct.

21 MR. NEAL: Thank you. Um, yeah, I think that's the
22 only question I have on-- on interrogatory number two.

23 THE COURT: Okay. Um, Mr. Work, do you have any
24 questions for that-- this witness?

25 MR. WORK: Uh, do you-- uh, were you finished with the

Attachment S



Refer to DMD:SOB:5

JUN 3 1991

Region II
Federal Building
26 Federal Plaza
New York NY 10278

MEDICAID STATE OPERATIONS LETTER #91-44

From: Associate Regional Administrator
Division of Medicaid

To: State Agencies Administering the Medicaid Program

Subject: Clarification of Early and Periodic Screening,
Diagnostic, and Treatment (EPSDT) Provisions.

Section 6403 of Omnibus Budget Reconciliation Act of 1989
(OBRA '89)

A question was raised concerning the phrase "conditions discovered by the screening services" in Section 6403 of OBRA '89 in regards to EPSDT, and its application in determining whether States are permitted to exclude preexisting chronic conditions, which have or have not increased in severity, from necessary follow-up services. Does "discovered during a screen" mean that a condition was first found to exist during the screen?

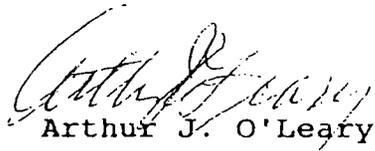
OBRA '89, in addition to requiring all diagnostic and treatment services as a required component of EPSDT, also requires that screening services be provided on both a periodic and interperiodic basis. The nature of the interperiodic services is discussed in the report of the House Committee on Budget. In its deliberations on interperiodic screens, that Committee indicates:

The Committee bill also requires States to provide screening services at intervals other than those identified in their basic periodicity schedule, when there are indications that it is medically necessary to determine whether a child has a physical or mental illness or condition that may require further assessment, diagnosis, or treatment. These interperiodic screening examinations may occur in children whose physical, mental or developmental illnesses or conditions have already been diagnosed, if there are indications that the illness or condition may have become more severe or has changed sufficiently, so that further examination is medically necessary. (Emphasis added.)

Both sentences describing congressional intent about interperiodic screens discuss the need to provide further services or services for conditions already existing. Clearly Congress anticipated that children with already existing health problems would have available diagnostic and treatment services appropriate to their needs. To view this legislation otherwise, is contrary to the preventive thrust of the program and the concept historically embodied in the EPSDT program to diagnose and treat health problems early before they worsen and become more costly. 173

In addition, in order for a child's health problems to be known, the child had to have received screening services at some point in time. For example, a child is seen by a physician and is diagnosed as having some condition. Two months later, the mother takes the child for the scheduled "EPSDT screen" and tells the screener the child was already diagnosed as having a specific health problem. In this example, we interpret the initial encounter with the physician to be an interperiodic screening service in which the health problem was discovered. Furthermore, we consider any encounter with a health care professional practicing within the scope of practice as an interperiodic screen. As such, it does not matter whether the child receives the screening services while Medicaid eligible, nor whether the provider is participating in the Medicaid program at the time those screening services are furnished. Any necessary health care required to treat conditions detected as a result of a screen, must be provided.

If you have any questions, please contact Jane Salchli or your State Representative at (212) 264-2775.


Arthur J. O'Leary

001174

Attachment T



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

JUL 29 2009

Region 10
2201 Sixth Avenue, MS/RX 43
Seattle, Washington 98121

Kathy Leitch, Assistant Secretary
Aging and Disability Services Administration
Department of Social and Health Services
P.O. Box 45015
Olympia, WA 98504-5010

Dear Ms. Leitch:

I am writing in response to your letter dated July 9, 2009, regarding the delivery of personal care services and the pending court order in the *Koshelnik-Turner v. Dreyfus* case. The question you asked the Centers for Medicare & Medicaid Services (CMS) to respond to in your letter is as follows:

Do States have flexibility under Medicaid to make adjustments to benefit levels for in-home personal care services because of budget constraints, so long as the client health and safety and opportunity to live in the community are not compromised?

Background

Medicaid is a jointly funded Federal-State program that provides medical assistance benefits to needy individuals in accordance with an approved State plan. Within a broad Federal framework under title XIX of the Social Security Act (the Act), 42 U.S.C. 1396 et seq., each State has considerable flexibility in administering State Medicaid programs.

Under section 1905(a)(24) of the Act, 42 U.S.C. 1396d(a)(24), a State may elect to provide a benefit under its approved State Medicaid plan for personal care services (PCS), including "in home personal care services." The requirements set forth at 42 CFR 440.167 allow for delivery of PCS as an optional service to individuals who are not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease.

In addition to this optional benefit, medically necessary PCS are also part of a mandatory benefit for individuals under age 21. Section 1905(r) of the Act, 42 USC 1396d(r)(5) defines "early and periodic screening, diagnostic, and treatment services" (EPSDT) which must be provided to eligible individuals under the age of 21. Section 1905(r)(5) specifies that coverage of EPSDT must include "such other necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan."

Attachment H

Page 2 - Kathy Leitch, Assistant Secretary

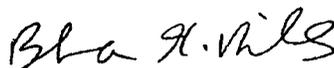
Medicaid benefits must be provided in accordance with an approved Medicaid State plan, as well as all relevant federal and state statute and regulations. Under Federal regulations at 42 CFR 430.10, the Medicaid State plan is required to be "a comprehensive written statement...describing the nature and scope of [the State] Medicaid program." In addition, 42 CFR 430.12(c) specifies that a formal State Plan amendment is required to be submitted for review and approval by CMS whenever necessary to reflect change in Federal law, regulations, policy interpretations, or court decisions; or material changes in State law, organization, or policy, or in the State's operation of the Medicaid program.

Response

A State may limit the amount, duration, or scope of an optional service as long as the limitations are consistent with the requirements of 42 CFR 440.230 and are specified in the approved State plan. Since PCS for children is a component of the mandatory EPSDT benefit, as discussed above, States generally cannot impose limitations on medically necessary services for individuals under age 21, because such limitation would be inconsistent with the EPSDT statutory benefit. Appropriate limitations consistent with 42 CFR 440.230(d), based on such criteria as "medical necessity or on utilization control procedures" are permissible. For example, a requirement for prior authorization for additional services is permitted. For children, however, the final coverage decision must be based on an individualized determination of medical necessity, made on a case-by-case basis. An across-the-board reduction in services that caps the services provided to a child regardless of medical necessity does not meet this standard.

Thank you for contacting me with regard to this matter. Should additional information be required please feel free to contact me at (206) 615-2267 or barbara.richards@cms.hhs.gov.

Sincerely,



Barbara K. Richards
Associate Regional Administrator
Division of Medicaid and Children's
Health Operations

cc:

Cindy Mann, Director, CMSO
Jackie Garner, Consortium Administrator, CMCHO
Terry Pratt, Acting Group Director, DEHPG
Dianne Heffron, Acting Group Director, FCHPG