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COURT OF APPEALS, DIVISION II
OF THE STATE OF WASHINGTON

SAMANTHA A.,

Respondent,

v.

STATE OF WASHINGTON, DEPARTMENT OF SOCIAL & HEALTH SERVICES,

Appellant.

BRIEF OF APPELLANT

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ORIGINAL

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I. INTRODUCTION

This is an appeal of a superior court order invalidating a Department of Social and Health Services rule, WAC 388-106-0213. The rule governs the level of financial assistance a child may receive under a state and federally funded program administered by DSHS. That program assists disabled individuals with the cost of in-home "personal care services"—services that assist disabled adults and children in performing tasks of daily living, such as bathing, dressing, toileting, food preparation, and house cleaning.

The substantive DSHS rule invalidated by the Superior Court, WAC 388-106-0213 (the children's personal care rule), involves the number of paid personal care hours children in the program may receive. All program participants are assessed individually to determine the number of personal care hours needed per month by the individual. Under the rule at issue here, a child's need for paid personal care assistance is determined after considering two additional factors: (1) the age of the child and (2) whether the child lives with his or her parents. Based on these factors, the number of hours is adjusted downward to reflect the reality that all children below a certain age—regardless of disability—require the same level of assistance, and that parents have a duty to provide basic care to their minor children.

The superior court determined this rule violates federal Medicaid law in two ways: first, because it does not require DSHS to "meaningfully consider and weigh" a physician's recommendations regarding personal care; and second, because it is inconsistent with the federal law's requirement that services to all recipients must be comparable in amount, duration and scope.

The superior court's ruling ignores the fact that it is impossible to tell whether a child's need for assistance with personal care tasks is due to age or disability without reference to normal developmental mileposts. Furthermore, the ruling fails to recognize the parents' basic responsibility to provide for the needs of their children. The children's personal care rule properly adjusts paid personal care service hours based on age and parental responsibility. It does not conflict with federal Medicaid law, and therefore the superior court's order should be reversed.

II. ASSIGNMENTS OF ERROR

1. The superior court erred by entering Finding of Fact 11.[1]
2. The superior court erred by entering Finding of Fact 12.
3. The superior court erred by entering Finding of Fact 13.
4. The superior court erred by entering Finding of Fact 15.

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[1] The Findings of Fact, Conclusions of Law, and Order of Judgment, CP at 250-259, are attached as Appendix A.

5. The superior court erred by entering Finding of Fact 21.

6. The superior court erred by entering Finding of Fact 22.

7. The superior court erred by entering Conclusion of Law 1.

8. The superior court erred by entering Conclusion of Law 2.

9. The superior court erred by entering Conclusion of Law 3.

10. The superior court erred by entering Conclusion of Law 4.

11. The superior court erred by entering Conclusion of Law 6.

12. The superior court erred by entering Conclusion of Law 7.

13. The superior court erred by entering Conclusion of Law 8.

14. The superior court erred by entering Conclusion of Law 10.

15. The superior court erred by entering Conclusion of Law 11.

16. The superior court erred by entering Conclusion of Law 12.

17. The superior court erred by entering Conclusion of Law 13.

18. The superior court erred by entering Conclusion of Law 14.

19. The superior court erred by entering Conclusion of Law 15.

20. The superior court erred by entering Conclusion of Law 16.

21. The superior court erred by entering Conclusion of Law 17.

22. The superior court erred by entering its Order of Judgment.

23. The superior court erred by entering its Order regarding attorney fees.[2]

III. ISSUES PRESENTED

1. Does the children's personal care rule violate the requirements of the EPSDT program under Medicaid by not specifically requiring the Department to "meaningfully consider and weigh physician's recommendations," even though 42 U.S.C. §1396d(a)(24) provides that, at a state's discretion, personal care services may be entirely authorized by the state? Assignments of Error Nos. 2, 3, 5, 6, 10, 11, 12, 13, 14, 17, 18, 19, and 22.

2. Does the children's personal care rule violate federal Medicaid law requiring comparability of amount, duration, and scope of services, even though reductions in personal care service hours are based first on developmental stage, not disability, and second on the normal responsibility of parents? Assignments of Error Nos. 1, 3, 4, 6, 7, 8, 9, 14, 15, 16, 18, 20, and 22.

3. Does the superior court's award of $85,423.35 in attorney fees for the superior court stage of this case, violate the Equal Access to

[2] The trial court's order setting the amount of attorney fees due to Respondent's counsel was set forth in the Judgment and Order Setting Attorney Fees, entered September 11, 2009.

Justice Act which caps attorney fees at $25,000 for each stage of a judicial review of agency action? Assignment of Error No. 17.

IV. STATEMENT OF THE CASE

A. Procedural History

This case began as an administrative appeal of the number of personal care service hours awarded to Respondent Samantha A. by DSHS's Division of Developmental Disabilities (DDD) following a 2006 annual assessment. Administrative Record (AR) at 227. Samantha is a 15-year-old client of DDD who was 12 at the time of the assessment. AR at 229. The administrative law judge who conducted the hearing and the DSHS Board of Appeals review judge who reviewed the case both affirmed DDD's determination as consistent with Department rules. AR at 21-40 and 1-15.

Samantha petitioned for judicial review, seeking reversal of the Department's final order and a declaratory judgment regarding the rule upon which it was based. CP at 41–48. She alleged that the rule violates the federal Medicaid requirements for comparability of services for all Medicaid recipients, and the Medicaid requirement that the Department provide all medically necessary services to children covered by Medicaid's Early and Periodic Screening, Diagnosis and Treatment

(EPSDT) program. *Id.* The superior court reversed the Department's final order and invalidated the challenged rule.[3] CP at 250–259.

B. The Medicaid Benefit At Issue

Medicaid is a joint state and federally funded program of medical services for low-income individuals. *See generally* 42 U.S.C. § 1396a – 1396v (the Medicaid Act). In Washington, Medicaid is administered by DSHS. There are 28 categories of medical assistance covered by Medicaid, including such services as inpatient and outpatient hospital services, laboratory and x-ray services, nursing facility services, and personal care services. 42 U.S.C. § 1396d(a).[4] The federal statute defines personal care services broadly, leaving states to specify the exact nature of personal care services the state will cover. Under the federal statute, personal care services are 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

[3] Several months earlier, another Thurston County Superior Court judge declined to invalidate the rules when presented with the same arguments in a case involving another child who received personal care services. *See* Order Denying Petitioner's Motion for Summary Judgment, *Katy L. v. DSHS*, TCSC Cause No. 08-2-01730-1 (Appendix B).

[4] 42 U.S.C. § 1396d is attached in its entirety with relevant sections in bold (Appendix C).

> such services and who is not a member of the individual's family, and (C) furnished in a home or other location[.]

42 U.S.C. § 1396d(a)(24).[5] This definition is the only one of the 28 medical assistance categories which specifically allows states to authorize the service. 42 U.S.C. § 1396d(a).

C. The Children's Personal Care Rule

Washington defines "personal care services" in DSHS rule: they are services which provide "physical or verbal assistance with activities of daily living (ADL) and instrumental activities of daily living (IADL) due to [a client's] functional limitations." WAC 388-106-0010. There are 12 separately defined ADLs (e.g., bathing, dressing, toilet use) and 7 IADLs (e.g., meal preparation, shopping, telephone use). *Id.* DSHS clients are formally assessed annually on their need for assistance with each of these personal care tasks as well as other aspects of their functioning. WAC 388-106-0085. The assessment tool used by the Department, the Comprehensive Assessment and Reporting Evaluation (CARE) tool, calculates the number of paid personal care hours for which a client is eligible. The method of calculation, known as an algorithm, is described in Department rules in chapter 388-106 WAC.

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[5] The associated regulation, 42 C.F.R. § 440.167(b), is virtually identical, the only difference being that the regulation clarifies that the provider cannot be a "legally responsible relative." Thus, for children, parents cannot be the paid personal care providers.

The CARE assessment algorithm is a two-stage process. First, a client is assigned to 1 of 17 classification groups based on a formula that considers the client's cognitive performance, clinical complexity, moods and behaviors, activities of daily living, and need for exceptional care. WAC 388-106-0125. Each of the classification groups has a set number of personal care hours ("base hours") associated with it. WAC 388-106--0125. Next, the number of paid personal care hours a client will receive is determined by reducing the base hours by the amount of informal support available to the client, or in the case of children, by application of the children's personal care rule. WAC 388-106-0130. That rule reduces the base hours when a child's need for assistance is due to his or her age, and/or when a child lives with his or her parent who is legally responsible for meeting the child's basic needs. WAC 388-106-0213.

The rule at issue, WAC 388-106-0213, has three subsections, the latter two of which influence the number of paid personal care hours a child client may receive. Sub-section (2) of the rule is a chart or grid of the age guidelines for each of the ADLs and IADLs that make up the category of personal care.[6] The principle underlying the age guidelines is that *all* children, disabled or not, require complete assistance with all personal care tasks when they are very young, and some assistance with some

[6] A print-out of the grid is attached (Appendix D).

personal care tasks as they get older. The grid sets out the age at which assistance with each personal care task is considered "met" for all children.[7] For example, according to the grid, "medication management" is considered met, and is not an appropriate expense for the state to assume, for all children up to age 18. The rationale for this designation is that the disability of the child is irrelevant to the child's need for caregiver/parent oversight of administering medications. Similarly, a need for total assistance with bathing and dressing is considered met (again by caregivers or parents) for all children under 6 years old; a need for some physical assistance with bathing and dressing is considered met for all children between 6 and 9; and a need for simple supervision with bathing and dressing is considered met for all children between the ages of 9and 13. The assistance needed in bathing, dressing, or taking the right dosage of medication by children at those ages is due to the child's age, not her disability.

Sub-section (3) of the WAC states that when a child lives with a legally responsible parent, the child's status and assistance available to the child will be coded as met or partially met three-quarters or more of the

[7] The designation "met" does not mean that no assistance is required. Rather, it means that no *paid* assistance is required. Thus, a need would be considered met if, for example, a client is able to perform the task independently *or* if there is informal (unpaid) assistance available.

time. In other words, children who live with their parents will be presumed to have their personal care needs met by their parents most or all of the time. Thus, if a child lives with someone other than a parent, such as an aunt or foster parent, the child's needs for assistance will be determined according to the grid in sub-section (2). However, if the child lives with a parent, the grid will be largely inapplicable because the child's needs for assistance will be presumed to be met most or all of the time.[8] The Department staff member who performs the CARE assessment has discretion under sub-section (3) to determine whether the assistance available to the child is either fully met or met three-quarters or more of the time.

If a client's case manager believes that the personal care hours allocated through the CARE assessment are insufficient due to the particular circumstances of the client, or, in the case of children, the circumstances of the client's family, the case manager may request additional hours. WAC 388-440-0001(1). Such requests are granted or denied by a central committee within the Aging and Disabilities Services Administration of DSHS. If the committee does not grant exceptional

[8] The age guidelines and presumption of parental care are not the only factors in determining how many paid hours of personal care services a child will receive. The Department also considers other sources of informal support, such as when the child is at school or daycare, which may reduce a client's base hours of paid care.

service hours, Department rules allows for an internal review procedure for initial denials, and an administrative hearing for termination of exceptional service hours previously granted. WAC 388-440-0001(4); WAC 388-106-1315.

D. The Administrative Record

The relevant record in this case consists of the stipulated facts agreed to by the Department and Samantha before the administrative hearing, AR at 41–44, the parties' exhibits, AR at 79–35, including two declarations submitted by Samantha, AR at 141–142, AR at 234-35, and the initial and final decisions. No testimony was taken at the administrative hearing.

Like all clients of DDD, Samantha suffers from serious functional impairments. She has a diagnosis of Down syndrome, and has significant communication and behavioral problems. Ex. 1 (AR at 79–101). At the time of the assessment at issue in this case, she was 12 years old and living with her mother and sister. AR at 41. She had significant needs for assistance with her activities of daily living and with management of her behavior. *Id.* at 41–43. She was assessed in 2006 using the CARE assessment tool. Ex. 1 (AR at 79–101). The assessment algorithm determined that Samantha required 90 hours of assistance with personal care needs, of which 39 hours could be approved for payment by a formal,

paid caregiver. Ex. 3 (AR at 102–114); Ex, 6 (AR at 123–136). This was a decrease from 96 paid personal care hours authorized in 2005.[9] Samantha appealed the determination.

After the 2006 assessment, Samantha's mother took her to her physician, Jill Miller, M.D. Samantha then submitted a declaration from Dr. Miller recommending that Samantha receive 96 hours of personal care services. AR at 234–235. The only explanation given by Dr. Miller for her recommendation was that Samantha had done well on this amount previously. There was no indication in Dr. Miller's declaration that she considered how many of the recommended 96 hours could be provided by Samantha's mother. The Department did not change its personal care authorization as a consequence of the doctor's recommendation, but the record is silent on how the Department processed the physician's recommendations.

Samantha also submitted into evidence a document titled "Physician Evaluation Form." Ex. A (AR at 137–140).[10] On the second page of this form, Dr. Miller addressed four "activities of daily living,"

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[9] The record does not indicate why Samantha was authorized for 96 hours of paid personal care services in 2005.

[10] In Respondent's briefing to the superior court, this document is described as an "EPSDT evaluation," CP at 172, but nothing in the administrative record provides support for that description. Because there was no testimony at the administrative hearing, the exhibits in the case were admitted without any sponsorship or discussion. It is therefore impossible to determine the actual purpose of this document.

one of which, decision making, is not an "activity of daily living" (ADL) or "instrumental activity of daily living" (IADL) in Department's rules.[11] *Id.* at 138. Of the three activities of daily living considered by Dr. Miller that are also activities of daily living or instrumental activities of daily living in Department rules (use of the telephone, eating needs, and toilet use), Dr. Miller provided a numeric score (from 1 to 5) indicating the level of self-sufficiency or need for assistance with that task, but provided no indication of the time required to assist Samantha. *Id.* In response to a compound question on the form regarding whether assistance with the "above activities" would result in the maximum reduction of disabilities and restoration of the patient to the best possible functional level, Dr. Miller wrote "Yes." Thus, even including the "Physician Evaluation Form" as evidence of Dr. Miller's recommendation, Dr. Miller only addressed Samantha's needs in 3 of the 19 activities of daily living which the Department considers in its assessments, and provided no guidance on how many hours of assistance (paid or unpaid) Samantha required.

Although Samantha claimed that her condition deteriorated as a result of the reduction in personal care hours, the declaration from Dr. Miller, dated August 14, 2007, indicates otherwise. Dr. Miller states:

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[11] A client's abilities in decision-making are separately considered in the CARE assessment.

> Samantha is unable to perform the majority of activities of daily living. *While she continues to improve*, she will never be to do (sic) all these activities without limited assistance or supervision.

AR at 234 (emphasis added). Nothing else in the declaration suggests that Dr. Miller had seen a decline in Samantha's condition. In the document titled "Physician Evaluation Form," Dr. Miller notes that Samantha has had "[n]o recent medical changes, but her progress with the above has plateaued and in some cases gone backward [with] the decrease in home support."[12] Ex. A (AR at 138). However, this statement contradicts her declaration, which was signed four days later.

As of the date of the administrative hearing, Samantha did not have a paid care provider. AR at 44; AR at 142. Samantha's mother was providing *all* of Samantha's personal care services, and had been doing so for an indeterminate length of time. AR at 44; AR at 142.[13] The record is silent on the duration of time Samantha had been without a paid care provider, as well as the reason for that absence, but the reason was clearly *not* that the Department refused to authorize any services—there is no dispute that the Department authorized 39 hours of paid personal care

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[12] It is unclear what "the above" refers to in this sentence; presumably, it is activities of daily living. AR at 138.

[13] In her declaration, Samantha's mother stated that her "availability to provide informal support is limited given my status as a divorcing mother of two children and a full-time employee." AR at 142.

services. There is no evidence in the record linking any deterioration in Samantha's condition to the reduction in authorized personal care services.

E. Attorney Fees

The superior court awarded Samantha A.'s counsel $85,423.35 in attorney fees for prevailing at the judicial review stage of this case. CP at 443-45. This was the full amount requested by counsel: $34,370.00 for attorney Hamburger, and $51,053.35 for attorneys Bailey and Kas. *Id.*; CP at 324–76. These fees related only to the work involved at the judicial review stage, which consisted of briefing for a partial summary judgment motion, briefing for the hearing on the petition, oral argument for the motion and the hearing, and ancillary activities. In support of their fee request, counsel submitted logs indicating that they had collectively spent 284.9 hours working on the case. CP at 317–23, 377-83, and 384–88.

V. ARGUMENT

The superior court invalidated the Department children's personal care rule based on its conclusions that the rule violated (1) Medicaid's EPSDT requirements and (2) Medicaid's comparability requirements. Because the rule is entirely consistent with Medicaid requirements, this Court should reverse the superior court's ruling.

A. Standard Of Review

The Administrative Procedure Act governs this Court's review of the superior court's ruling invalidating the children's personal care rule and WAC 388-02-0225. *See generally* RCW 34.05.570; *Jenkins v. Dep't of Soc. & Health Servs.*, 160 Wn.2d 287, 295, 157 P.3d 388 (2007).

The APA provides that a rule may be found invalid if it: (1) violates constitutional provisions; (2) exceeds the agency's statutory authority; (3) was adopted without compliance to statutory rule-making procedures; or (4) is arbitrary and capricious. RCW 34.05.570(2)(c); *Jenkins,* 160 Wn.2d at 295. The party challenging the validity of the rule has the initial burden of proving the rule invalid. RCW 34.05.570(1)(a); *Wash. Indep. Tele. Ass'n. v. Utils. & Transp. Comm'n*, 148 Wn.2d 887, 903, 64 P.3d 606 (2003). A party challenging a rule must also show she has been "substantially prejudiced" by the rule. RCW 34.05.570(1)(d); *Ass'n of Wash. Bus*, 121 Wn. App. 766, 770, 90 P.3d. 1128 (2004).

An agency's interpretation of federal law is reviewed de novo under an "error of law" standard. *Jenkins,* 160 Wn.2d at 296. Under the "error of law" standard, substantial weight is given to the agency's interpretation of the law, though the Court is not bound by the agency's interpretation. *Haley v. Medical Disciplinary Bd.,* 117 Wn.2d 720, 728, 818 P.2d 1062 (1991).

B. The Children's Personal Care Rule Complies With EPSDT Requirements

Under the terms of a 1989 amendment to the Medicaid Act, any "medically necessary service" must be provided to Medicaid eligible children age 20 and younger, regardless of whether the service is covered under the state plan for adults. *Ekloff v. Rogers*, 443 F. Supp. 2d 1173, 1173, 1178 (D. Ariz. 2006) (citing H.R. 3299, 101st Cong. § 4213 (1989)). This requirement is the essential feature of 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);[14] *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 WAC chapter 388-534, which references the

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[14] This sub-section describes the scope of EPSDT coverage. In addition to the four general categories of services—medical screening services, vision services, dental services, and hearing services—EPSDT includes a fifth catch-all category:

> (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.

42 U.S.C. § 1396d(r).

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.") "Personal care services" is one of the 28 types of medical assistance under 42 U.S.C. § 1396d(a), and the Department agrees that personal care services for children must be provided in accordance with EPSDT requirements. The question presented here is whether EPSDT requires the Department to provide paid personal care services at whatever level a physician recommends.

Respondent initially claimed that the state must provide—that is, pay for—*all* personal care services recommended by a physician. CP at 68. This claim was denied on summary judgment, though the superior court held that there was a material fact at issue regarding the degree of deference the state accords to a physician's recommendation. CP at 150. Respondent later modified her claim to assert that the state must give "considerable and substantial weight" to a physician's recommendations regarding personal care. CP at 177. The superior court agreed, holding that the state must "meaningfully consider and weigh the EPSDT recommendations of medical providers into the MPC assessment," and that the children's personal care rule "automatically overrides, without any consideration, the recommendations of a child's medical provider." CP at 256 - 257. However, both conclusions are inaccurate: Medicaid law does

not require consideration of medical providers' recommendations regarding the amount of paid personal care services the state must provide, and the rule does not override such recommendations.

42 U.S.C. § 1396d(a)(24) defines personal care services as 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;

42 U.S.C. § 1396d(a)(24). (Emphasis added.) The category of "personal care services" is unique among the 28 medical assistance categories in specifically providing states the option to either allow a physician to authorize the service or to authorize the service itself.

Nothing in the federal statute or the regulations regarding EPSDT requires or even suggests that a state needs to give considerable or substantial weight to a physician's recommendation regarding the *number of hours* of personal care services. In fact, nothing in the federal law suggests that a state needs to give such recommendations any weight at all, so long as the state is providing such services. Nor is there any federal judicial decision to support the proposition that a physician's

recommendation may define or significantly affect the determination of the number of personal care service hours for children. Respondent's argument in the superior court relied entirely on federal case law regarding *other* medical services, and one Florida state case whose primary holding was unrelated to EPSDT or Medicaid law.

The Florida case, *C.F. v. Dep't of Children & Families*, 934 So. 2d 1 (Fla. Dist. Ct. App. 2005), does involve both EPSDT and personal care services, but does not support Respondent's claim or the superior court's position. In *C.F.*, the state Medicaid agency had reduced a child's personal care hours on the basis of a paper review of the child's file conducted by a private contractor.[15] *Id.* at 7. The private contractor recommended a reduction in hours on the basis of agency definitions of "medical necessity" and "personal care" that, the court held, were impermissibly narrow under the requirements of EPSDT. *Id.* at 5.

However, in a point of law unrelated to federal Medicaid requirements, in *C.F.* the court then held that the treating physician's opinion regarding the child's personal care needs should have been given "considerable and substantial weight." *Id.* at 7. In so holding, the court

[15] The kind of assessment used by Florida—a paper file review by a contractor who never met with the child or his family—is markedly different than the intensive in-person assessment used by DSHS. Furthermore, the physician in that case was the child's life-long pediatrician who knew the child well. Thus, the court was presented with a factual situation categorically different than what occurs in Washington.

did not discuss or rely upon EPSDT or other Medicaid rules, but relied instead upon a line of cases requiring that an administrative law judge always show good cause for failure to credit a treating physician's opinion. *Id.*, (citing *Synder v. Dep't of Children & Families*, 705 So. 2d 1067, 1068-69 (Fla. Dist. Ct. App. 1998) (adult Medicaid eligibility), and *Broughton v. Heckler*, 776 F.2d 960, 961-62 (11th Cir. 1985) (Social Security disability benefit eligibility)).

The court in *C.F.* did *not* address the express language of 42 U.S.C. 1396d(a)(24) that gives states the option to authorize personal care services themselves—indeed, no court in the country seems to have done so. And even if Washington law had a similar line of precedent regarding the weight given to a treating physician's opinion—which it does not—the express language of 42 U.S.C. 1396d(a)(24) makes clear that any general standard for considering and incorporating physician's recommendations is not applicable to personal care services: at the option of the state, either the physician or the state can authorize personal care services.

Other cases in which the state has been required to provide medical services under EPSDT relate solely to the provision of medical services *other* than personal care. *See, e.g.*, *Rosie D. v. Romney*, 410 F. Supp. 2d 18 (D. Mass., 2006) (intensive psychiatric interventions); *Pinneke v. Priesser*, 623 F.2d 546, 550 (8th Cir. 1980) (sex change surgery);

Pediatric Specialty Care, Inc. v. Ark. Dep't of Human Services, 293 F.3d 472, 480 (8th Cir. 2002) (early intervention day treatment); *Pittman ex rel. Pope v. Sec'y, Fla. Dep't of Health & Rehab. Servs.*, 998 F.2d 887 (11th Cir. 1993) (organ transplants). All of these and other related cases primarily emphasize the EPSDT requirement that all 28 listed Medicaid services be provided to eligible children, whether or not the state plan authorizes those services for adults. However, that requirement is irrelevant here, since personal care services *are* being provided.

By singling out personal care services as the one type of medical assistance in 42 U.S.C. § 1396d(a) that specifically allows the state to opt for self authorization of the service, Congress clearly intended that personal care services be treated differently than other services. That distinction is appropriate. Physicians are not in the habit of determining the level of assistance their patients need in dressing, bathing, or toileting, much less evaluating who may be available or have a duty to perform such tasks on behalf of their patients. Physicians rarely address personal care services at all, and are not expert in determining personal care needs. Even when they recognize that a patient needs assistance with activities of daily living, physicians have no way to translate that recognition into the number of hours required to provide that assistance. In contrast, the Department regularly assesses the need for personal care services for all of

the in-home clients served through the Aging and Disabilities Services Administration within DSHS, and it does so using a sophisticated assessment instrument. In regards to personal care services, the Department is the expert, not the physician.

The physician's recommendation for an increase in the number of personal care services authorized by the Department in this case provides a salutary example of the difficulty in giving "considerable and substantial weight" to such recommendations. Here, Dr. Miller filled in a "Physician's Evaluation Form" that gave her assessment of Samantha's abilities on two activities of daily living (ADLs), eating and toileting, and one instrumental activity of daily living (IADL), use of the telephone. AR at 138. Dr. Miller then wrote "yes" in response to a compound question regarding whether assistance in those areas (as well as in decision making) would be beneficial for Samantha. *Id.* Clearly, this provides no helpful information in determining the amount of paid personal care services Samantha should receive. The fact that Dr. Miller also submitted a declaration for the administrative hearing indicating that Samantha should receive 96 hours of personal care services because she had previously done well on this amount, AR at 234–235, also adds no information of

substance about her present need, or the availability of informal care provided by others.[16]

In contrast, the Department spent extensive time with Samantha and her mother reviewing Samantha's specific care needs related to 19 ADLs and IADLs, and produced a detailed analysis of her situation. *See* Ex. 1 (the CARE assessment print out), AR at 79–101. There is no basis for concluding that a "considerable and substantial" consideration of Dr. Miller's recommendation should have altered the Department's far more thorough assessment of Samantha's needs.

Finally, under state law, the Department is not only authorized to administer the assessments of functional disability, it is *required* to do so. RCW 74.09.520(4) ("The department shall design and implement a means to assess the level of functional disability of persons eligible for personal care services under this section."); RCW 74.39.005(2) (The purpose of the long-term care service options chapter is to "[e]nsure that functional ability . . . will be determined by a uniform system for comprehensively assessing functional disability."). The determination of the number of paid in-home personal care hours per month to which an individual is

[16] Samantha did not seek (and the superior court did not order) *96* hours of personal care services per month. Rather, Samantha only sought *90* hours, the number of hours she would receive without the operation of the rule at issue. Thus, it appears, even she and the trial court did not believe that the physician's recommendation was accurate.

entitled must be based on a standardized and uniform assessment of the individual's functional disabilities, so it would be a violation of state statutes for DSHS to accept a doctor's recommendation on personal care services.

WAC 388-106-0213 does not conflict with Medicaid's EPSDT requirements. The superior court erred in invalidating the rule on this basis.

C. WAC 388-106-0213(2) and WAC 388-106-0213(3) Do Not Violate Medicaid Comparability Requirements

The superior court also invalidated WAC 388-106-0213 on the basis of Medicaid's "comparability requirement." 42 U.S.C. § 1396a(a)(10)(B) and 42 C.F.R. § 440.240. That statute and regulation require a state to ensure

> that the medical assistance made available to any [Medicaid eligible] individual . . . shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual.[17]

The Department agrees that its children's personal care services rule treats medically eligible children differently than medically eligible adults. The rule results in fewer paid personal care hours for children who

[17] The statute and regulation actually require that services available to categorically needy recipients not be less in amount, duration, and scope than services available to medically needy recipients, and that services available within those groups be comparable for all recipients. 42 U.S.C. § 1396a(a)(10)(B) and 42 C.F.R. § 440.240. However, those distinctions are unnecessary to the issue presented here.

live with their parents, and for younger children with the same level of disability as older children. The Department does not agree that this distinction between children and adults violates the so-called comparability rule.

At the superior court Respondent did not discuss, and the court did not address, the legal duty a parent has to care for her own child. Nor did they consider the fact that all children below a certain age require the same sort of assistance regardless of whether they have a disability. The state does not and should not pay for personal care services that parents are expected to provide for their own children, or that care providers would be providing to every child, disabled or not. The Medicaid comparability requirement is not compromised by this rule.

1. WAC 388-106-0213(2) Properly Withholds Payment For Assistance With Needs That Are A Function Of Age, Not Disability

Unlike other kinds of Medicaid services, personal care services are the very kind of services parents or parent surrogates normally provide to children under their care. Informal (unpaid) caregivers provide *all* personal care services for infants: they feed them, change them, bathe them, and help them walk. They provide *some* personal care services for older children: for example, they manage their medications, shop for their groceries, prepare their meals, and monitor their phone use. Below a

certain age, children with disabilities have the same need for assistance with these activities of daily living as their non-disabled peers. Therefore, it would be inappropriate—and federal law does not require—that in-home care providers for children with disabilities be paid for providing the same services they would provide if the children were not disabled.

WAC 388-106-0213(2) codifies the age below which all children are presumed to have the same personal care needs. In order for this sub-section to be invalidated on comparability grounds, a court would have to find that a need for assistance with personal care tasks *per se* requires paid assistance, regardless of whether the need is normal for a child of that age. But the state should not pay for normal tasks of caregiving that all children require. Because the CARE assessment considers only how much assistance a client requires for daily living tasks, and how much that client can do for herself in performing those tasks, the assessment would inevitably indicate that *all* young children require a large amount of personal care assistance, even if they had no disability.

The state is required to provide comparable services to all Medicaid recipients with similar *medical* needs. Adult caregivers must help children with many needs, but not all of those needs are medical. For a child of six, a need for total assistance with bathing reflects a disability, such that the need for bathing is medical in nature. But below that age, the

need for assistance is not a *medical* need—it is a *developmental* need. It is no more "medical" than a roof over the child's head, or warm clothes. Where the need bears no relation to the recipient's disability, Medicaid services are not appropriate. Because the state does not and should not pay for services that an informal (i.e., unpaid and non-contracted) caregiver must provide, the age guidelines in WAC 388-106-0213(2) prevent just such an inappropriate use of state and federal funds.

In her argument below, respondent, and the superior court cited *Jenkins v. Dep't of Soc. & Health Servs.*, 160 Wn.2d 287, 157 P.3d 388 (2007) for the proposition that the children's personal care rule creates an "irrebuttable presumption" unattached to an individualized assessment, much like the rule invalidated in that case.[18] However, the children's personal care rule is categorically different than the "shared living" rule examined in *Jenkins*. Rather than creating an irrebuttable presumption, the children's personal care rule simply provides the necessary boundaries for individualized assessment. In order to determine whether a child with a disability requires more assistance with a personal care task than a non-disabled child of the same age, one must first know what needs are normal

[18] In *Jenkins*, the Court invalidated a rule requiring an automatic 15 percent reduction in personal care service hours based on whether a client lived with his or her caregiver. The Court held that the state may not reduce a recipient's benefits "based on a consideration other than actual need." *Jenkins,* 160 Wn.2d at 299.

for a child of that age. The determination that a five year old needs extensive assistance with bathing should be made on the basis of an individualized assessment—as indeed it is in the CARE tool. WAC 388-106-0105. But the state also requires a global benchmark—the bathing needs of all five year olds—against which that assistance is compared in order to avoid paying for a service that is unrelated to the child's disability. No individualized assessment of the recipient can establish the degree to which the child is disabled without a reference to what a fully abled child can do. WAC 388-106-0213(2) provides that reference.

2. WAC 388-106-0213(3) Properly Incorporates Parental Responsibility

It is the explicit law of Washington that parents bear primary responsibility for their children. "Parents have the responsibility to make decisions and perform other parental functions necessary for the care and growth of their minor children." RCW 26.09.002. This essential mandate is not weakened because a child is disabled: "It is the intent of the legislature that parents are responsible for the care and support of children with developmental disabilities." RCW 74.13.350. Courts have interpreted federal Medicaid law to have a similar emphasis. *See, e.g.*, *Poindexter v. Dep't of Human Servs.*, 372 Ill. App. 3d 1021, 1031, 869 N.E. 2d 139, 311 Ill. Dec. 465 (2006) ("Medicaid is not designed to

supplant the traditional notions, enshrined in law and custom, that family members, particularly spouses and parents, have the responsibility to support spouses and children."); *Germosen v. Gupta*, 237 A.D.2d 121, 654 N.Y.S.2d 746 (1997) ("The care and support of a child remains the responsibility of the parent. Medicaid is merely a secondary means of providing necessary medical care, which is furnished by the State in loco parentis.").

The Medicaid program is the payor of last resort. *Caremark, Inc. v. Goetz*, 480 F.3d 779, 785 (6th Cir. 2007); *Cordall v. State*, 96 Wn. App. 415, 424, 980 P.2d 253 (1999). "This means that all other available resources must be used before Medicaid pays for the medical care of an individual enrolled in a Medicaid program." *Caremark,* 480 F. 3d at 785. The Department is required to identify any possible third parties that may be responsible for a portion of the services otherwise provided by Medicaid. 42 U.S.C. 1396a(a)(25); *Cordall* at 424. Medicaid regulations provide that Medicaid will not pay for services if probable liability of a third party is established. 42 C.F.R. § 433.139(c). Medicaid regulations also recognize that family is a potential alternative source for assistance. *See* 42 C.F.R. § 433.147 (recipients required to cooperate with the establishment of child support orders to help defray Medicaid expenses).

WAC 388-106-0213 is not concerned with the number of hours of personal care services a child needs for her assistance with daily tasks, but the number of hours of *paid* personal care services. The state properly expects that a percentage of the parenting care a child receives should come from the parent rather than the state. The parent's duty to provide for her children is at least as binding as an insurer's duty to its customers, and therefore as appropriate for the state to rely upon. Once DSHS makes an individualized determination that a child lives with her parent, it is allowed to rely upon the legal effects of that finding.

This does not mean, of course, that parents are responsible for providing skilled medical care to their Medicaid eligible children. Such services are not a reasonable expectation of parents. However, personal care services are services any able bodied person can provide. They require no training or special expertise. This is evident in this case: Samantha's mother provided all of Samantha's personal care needs at the time of the assessment at issue.

Personal care services clearly fall into the category of "parenting functions" as defined in RCW 26.09.004. "Parenting functions" are "those aspects of the parent-child relationship in which the parent makes decisions and performs functions necessary for the care and growth of the child," including:

> [a]ttending to the daily needs of the child, such as *feeding, clothing, physical care and grooming*, supervision, health care, and day care, and engaging in other activities which are appropriate to the developmental level of the child and that are within the social and economic circumstances of the particular family.

RCW 26.09.004(2)(b) (emphasis added). In the context of termination of parental rights, Washington courts have held that

> [t]he commonly understood general obligations of parenthood entail these minimum attributes: (1) express love and affection for the child; (2) express personal concern over the health, education and general well-being of the child; (3) *the duty to supply the necessary food, clothing, and medical care*; (4) the duty to provide an adequate domicile; and (5) the duty to furnish social and religious guidance.

In re Adoption of Lybbert, 75 Wn.2d 671, 674, 453 P.2d 650 (1969) (emphasis added). Thus, the requirement that most or all personal care needs of children living with their parents be considered "met" derives naturally from law and custom.

Since no parent's legal obligation is greater or less than any other's, all children who live with their parents are identically situated in that regard. If any "presumption" is made by the state, it is one of law, not of fact. The concern pronounced in *Jenkins*—that a rule would make a determination based on theory when the circumstances require an individual determination of the empirical facts—is not implicated here. The child's needs receive an individualized assessment through

application of the CARE tool. What is not individually assessed by the CARE tool or Department rules are the abilities and obligations of the parents.

If WAC 388-106-0213(3) were invalidated and there were no presumption of parental responsibility in rule, parents could turn over all their child's assistance with activities of daily living to the state and federal government. Invalidation of the rule would effectively negate any parental responsibility regarding the personal care needs of their disabled children.[19] Because parents are responsible for providing all the care of their children that they are capable of providing, it is reasonable and appropriate that authorization for others to take on part of that responsibility should be the exception, not the rule. WAC 388-106-0213(3) is therefore valid, and the superior court should be reversed.

D. The Amount Of Attorney Fees Authorized By The Trial Court Is Unreasonable

Under RCW 74.08.080(3), a client of DSHS who seeks judicial review of an agency action related to public assistance is entitled to *reasonable* attorney fees and costs for a successful appeal:

> When a person files a petition for judicial review as provided in RCW 34.05.514 of an adjudicative order

[19] As stated above, if the child's case manager believes the family's circumstances are not reflected in the CARE tool or in the rule, the number of hours may be adjusted.

> entered in a public assistance program, no filing fee shall be collected from the person and no bond shall be required on any appeal. In the event that the superior court, the court of appeals, or the supreme court renders a decision in favor of the appellant, said appellant shall be entitled to reasonable attorneys' fees and costs.

The statute does not further define what may be considered *reasonable* fees and costs. Nor do any state cases provide guidance on what reasonable fees may be under this statute. The trial court found that Respondent's counsel's request for nearly $85,000 just for pursuing judicial review in the superior court was reasonable. That finding is unreasonable.

Counsel for Respondent argued, and the superior court agreed, that the "lodestar" method is the appropriate means for determining reasonable fees in a case such as this. The lodestar method involves multiplying the number of hours reasonably expended in the litigation by a reasonable hourly rate. *Mahler v. Szucs*, 135 Wn.2d 398, 434, 957 P.2d 632 (1998). Consequently, in their request for fees, Respondent's counsel submitted a number of affidavits attesting to the time they spent on the case as well as the propriety of that amount of time and the hourly rates each attorney deserved. *See* Declarations of Eleanor Hamburger, CP at 317–23, Regan Bailey, CP at 377–83, Susan Kas, CP at 384–88, Mark Stroh, CP at 423–25, Michael Madden, CP at 426–34, and Andrea Benneke, CP at 435–41.

With that documentation, the court found the rates and hours reasonable (despite the fact that the three attorneys involved collectively spent more than seven 40-hour workweeks preparing and presenting a standard judicial review case).

The lodestar method is unquestionably the proper means of determining attorney fees in a non-administrative civil case. However, no case law addresses whether it is the appropriate method in a case such as this. Because its application here creates an anomaly in relation to other appeals against Department actions, it should be modified by the standard set in the Equal Access to Justice Act (EAJA), RCW 4.84.340 through 4.84.360. The EAJA is the basis for attorney fees for judicial reviews of agency actions that are not otherwise provided for by statute.

Respondent is a client of DDD. If this case had been about her basic *eligibility* for any services through DDD—if she had been denied eligibility or her eligibility had been terminated—the EAJA only would have applied and RCW 74.08.080 would not. *Johnstun v. Dep't of Soc. & Health Servs.*, 53 Wn. App. 140, 143, 766 P.2d 1104 (1988) ("We conclude that RCW 74.08.070 and 74.08.080 were not intended to provide fair hearings for review of eligibility decisions outside of [RCW] Title 74."). It simply does not make sense that attorney fees should be higher for representing clients' interests in the level of services they receive than

for representing their interests in receiving services at all. Furthermore, the legislature clearly did not intend that outcome. In its uncodified statement of intent in enacting the EAJA, the legislature particularly noted that the act was adopted in order to give individuals and other parties with few resources the "opportunity to defend themselves from inappropriate state agency actions and to protect their rights." Laws of 1995, ch. 403 § 901.

This legislative purpose is not promoted by an interpretation that provides individuals different remedies in separate cases involving the same type of claims. The allegation in this case was that the state failed to properly apply Medicaid law, thereby denying services to which Samantha and other disabled children were entitled. Because that is the very type of claim for which the EAJA was enacted and the very type of party the EAJA was intended to protect, the limitation on attorney fees in the EAJA provides an appropriate standard for "reasonableness" in RCW 74.08.080(3), since the latter statute does not define the term.

Under the EAJA, attorney fees should not normally exceed $150 per hour, RCW 4.84.340(3), and should never exceed $25,000 for each level of review. RCW 4.84.350(2); *Costanich v. Dep't of Soc. & Health Servs.*, 164 Wn.2d 925, 933, 194 P.3d 988 (2008). Thus, the lodestar method is still applicable in public assistance cases, but the cap on an

award of fees is $25,000. If counsel here had indicated that their hours worked times their hourly rates were $25,000 or less, the lodestar method would be appropriate to determining their fees. Their supporting documentation would be the means by which to determine whether their fee request was reasonable. Because they requested fees well in excess of $25,000, the fee limitation under the EAJA must be the upper limit of what is reasonable.

In the event Respondent prevails on appeal, this case should be remanded to the trial court to determine whether the fee request is reasonable under the EAJA standards. The court should consider the hours spent on the claims that were successful, multiplied by no more than $150 per hour, and limited to a maximum of $25,000 for work performed at the superior court stage of the case.

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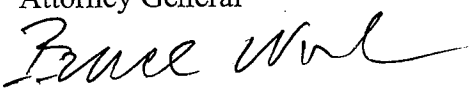
VI. CONCLUSION

For the reasons set forth above, this Court should reverse the decision below, and remand the matter to the superior court with instructions to affirm the Department's administrative decision.

RESPECTFULLY SUBMITTED this 20 day of November 2009.

ROBERT M. MCKENNA
Attorney General



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PROOF OF SERVICE

I certify that I served a copy of this document, Brief of Appellant, on all parties or their counsel of record on the date below as follows:

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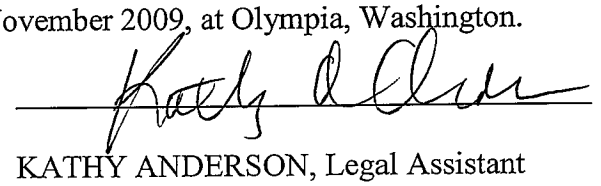
I certify under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

DATED this 20th day of November 2009, at Olympia, Washington.



KATHY ANDERSON, Legal Assistant

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APPENDICES

APPENDIX A

☐ EXPEDITE
☒ Hearing is set:
Date: Friday, June 19, 2009
Time: 9:00 a.m.
Judge/Calendar: Hon. Anne Hirsch

Judge Anne Hirsch

FILED
JUN 19 2009
SUPERIOR COURT
BETTY GOULD
THURSTON COUNTY CLERK

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

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OFFICE OF THE ATTORNEY GENERAL
SOCIAL & HEALTH SERVICES

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

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public. She is frequently easily agitated and resistive to care. She wanders away and is not safe when unsupervised in public. She needs help cutting food into pieces and needs to be cued to eat. She requires assistance with using the bathroom, getting dressed, brushing her teeth and her hair. Samantha also has other medical and physical needs related to her disabilities.

3. Respondent, the Washington State Department of Social and Health Services ("DSHS" or "the Department") has determined that Samantha is eligible for 24-hour institutional care because of the extreme level of her needs.

4. Samantha's parent is a single working mother who is committed to meeting Samantha's needs and trying to prevent her from being institutionalized.

5. The Department has enrolled Samantha on the Medicaid Home and Community Based Waiver program for persons with developmental disabilities so she can receive Medicaid and other benefits at home, outside of an institution. As part of her Medicaid benefits, Samantha receives Medicaid Personal Care (MPC).

6. The Department assesses a child's need for MPC services using an assessment process known as the "Comprehensive Assessment Reporting Evaluation" (CARE) tool assessment.

7. On May 17, 2005, Respondent adopted changes to its CARE assessment. *See* WSR 05-11-082. Included in the rule changes was a new rule, WAC 388-106-0213, which establishes special automatic reductions to MPC services to be applied only to children. The new rule took effect on June 17, 2005. The rule at issue in this case, referred to here as the Children's Assessment rule, is attached as *Exh. A* to these Findings of Fact, Conclusions of Law and Order of Judgment.

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8. The Children's Assessment rule reduces the amount of MPC services provided to children in two ways. ***First,*** the rule reduces the amount of MPC services to children based upon their age. *See* WAC 388-106-0213(2). ***Second,*** the rule reduces the amount of MPC services to children if they lived with their legally responsible natural, step or adoptive parents.

9. The first reduction treats similarly disabled children differently based upon their age.

10. The second reduction treats similarly disabled children differently because they live with caregivers other than their legally responsible parents.

11. Both reductions occur automatically, without any inquiry as to whether the recipient child's assessed needs would actually be met after the reductions were taken.

12. The Department's regulations do not permit consideration of evidence from children's medical providers regarding the amount of MPC services that are medically necessary to correct or ameliorate the child's condition. There was no evidence of consideration of the medical provider's recommendations for medically necessary services in the instant case.

13. The Department's regulations do not allow recipient children to challenge the implementation of the automatic reductions in an administrative hearing by demonstrating that their needs are still unmet after the reductions are taken. The Department does have a process for seeking an Exception to Rule (ETR), but this process does not ensure the due process rights of applicants because it does not grant administrative hearing rights to denials of initial requests for ETRs.

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14. The rulemaking file and administrative record do not contain any time-study, evaluation, or any other evidence to support the Department's assumptions regarding the automatic reductions in Children's Assessment rule, WAC 388-106-0213.

15. Prior to the implementation of WAC 388-106-0213, the Department assessed Samantha as needing 90 hours of personal care services per month, so that a paid care provider could assist her with bathing, dressing, eating, locomotion, personal hygiene, toilet use, and transfers. Samantha's care provider also addressed her significant behavioral support needs, including responding appropriately and safely to Samantha's aggression, sexual expression, and resistance to care.

16. On December 12, 2006, Samantha's needs for MPC services were reassessed and WAC 388-106-0213 was applied to her assessment.

17. The new assessment showed that Samantha was exhibiting increased behavioral problems that affected her ability to complete personal care tasks. The assessment determined that Samantha's "base hours" were 90 hours per month.

18. 90 and 39 hours are significantly lower than what she actually would need if she were to have all of her needs, in addition to personal care, fully paid for by the state.

19. The assessment's "base hours" were automatically reduced to 39 hours because Samantha lives with her mother and because of her age, pursuant to WAC 388-106-0213.

20. Samantha's mother requested an administrative hearing to appeal the reduction of her care hours.

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21. After the Assessment, Samantha's mother arranged for Samantha's treating physician, Jill Miller, M.D., to conduct an EPSDT screening of Samantha. Dr. Miller also executed a declaration regarding Samantha's needs. Based upon the EPSDT screening, Dr. Miller concluded that Samantha required 96 hours per month of personal care services in order "to maximize her potential and achieve her best possible functional level."

22. Samantha's mother provided Dr. Miller's EPSDT screening and her declaration to the Department in advance of Samantha's administrative hearing.

23. The administrative record does not show that the Department considered, weighed, or integrated Dr. Miller's recommendations as to Samantha's personal care needs. The Department did not change the Assessment or award personal care hours based upon Dr. Miller's recommendations.

24. Samantha's personal care needs are not fully met by the current level of MPC services provided at 39 hours per month.

CONCLUSIONS OF LAW

The Court makes the following conclusions of law from the foregoing findings of fact:

1. WAC 388-106-0213, the Children's Assessment Rule, violates federal Medicaid laws requiring comparability of amount, duration and scope of services among all recipients. Comparability provisions are codified at 42 U.S.C. § 1396a(a)(10)(B)(i); 42 C.F.R. § 440.240(b).

2. Just as in the rule struck in *Jenkins v. Washington State Dept. of Social and Health Services,* 160 Wn.2d 287 (2007), WAC 388-106-0213 imposes irrebuttable

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presumptions to reduce certain disabled children's MPC services based upon their age and whether they live with their parents. These presumptions are imposed without any consideration of each child's individualized circumstances nor whether each child's needs will be met after the reduction is imposed. Such irrebuttable presumptions treat similarly disabled children differently, in violation of the Medicaid comparability requirements.

3. The irrebuttable presumptions in WAC 388-106-0213 are also arbitrary and capricious because they create an irrebuttable presumption that does not permit any consideration of a participant's individual circumstances and include no basis for any consideration of a treating physician's opinion as to medical necessity of services.

4. WAC 388-106-0213 also violates federal Medical laws requiring Early and Periodic Screening Diagnosis and Treatment (EPSDT) for all children under the age of 21. EPSDT provisions are codified at 42 U.S.C. § 1396d(a)(4)(B); (13); 42 U.S.C. § 1396d(r)(5).

5. EPSDT is a broad legislative mandate requiring the Department to provide:

> ...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.

42 U.S.C. § 1396d(r)(5).

6. EPSDT requires the Department to meaningfully consider and weigh recommendations from a child's medical providers into the MPC assessment process in determining medical necessity.

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7. WAC 388-106-0213 violates EPSDT because the rule automatically overrides, without any consideration, the recommendations of a child's medical provider. The rule also violates EPSDT because it allows MPC services to be determined based upon overly restrictive criteria other than medical necessity.

8. WAC 388-106-0130 (3)(b) also violates federal Medicaid laws requiring comparability and EPSDT services, insofar as the rule authorizes the Department to reduce children's MPC services based upon WAC 388-106-0213.

9. A rule is invalid to the extent it is in conflict with or otherwise exceeds statutory authority and/or is arbitrary and capricious.

10. Petitioner has met her burden to show that WAC 388-106-0213 and WAC 388-106-0130(3)(b) are invalid because the rules are arbitrary and capricious and exceed the statutory authority of the agency by violating federal laws regarding EPSDT and comparability requirements.

11. The Department uses a set formula to assess the needs of children for MPC. That application results in an automatic determination that reduces assessed need based on the age of the child and the fact that the child resides at home with his or her natural, step, or adoptive parent or parents.

12. Here, as in *Jenkins*, there was a categorical reduction without any consideration of individual circumstances. Disabled children, such as Samantha, have greater needs, and the Department's rules do not take individual needs or circumstances into account. The Department performs no individualized assessments to determine whether the number of hours allowed bear any resemblance to the needs

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that were assessed. For this reason, the Department's rules violate comparability and EPSDT. Respondent must assess each child's individual needs.

13. In addition to assessing each child's individual needs, Respondent must meaningfully consider and weigh the EPSDT recommendations of medical providers into the MPC assessment process for children.

14. The administrative order applying the Children's Assessment rule to the Petitioner's case should be set aside because the rule is outside the statutory authority of the agency and is arbitrary and capricious.

15. Petitioner should receive MPC services, consistent with the Department's assessment of her unmet need for personal care assistance and after giving proper consideration to the recommendations of her treating physician.

16. Samantha was eligible for MPC services at 90 hours per month effective December 12, 2006. The Department is required to retroactively reimburse Samantha for any properly documented out of pocket expenses incurred in order to secure personal care services in addition to the 39 hours per month. To the extent that Samantha's current CARE assessment has determined her "base hours" to be a different number of hours per month, the Department shall immediately provide Samantha with those hours, without applying WAC 388-106-0213 or WAC 388-106-0130(3)(b).

AM BW SK

17. Petitioner should be awarded reasonable attorneys' fees for services received from Disability Rights Washington and Sirianni Youtz Meier and Spoonemore.

ORDER OF JUDGMENT

Based on the above Findings and Conclusions, the court enters the following DECLARATORY JUDGMENT AND ORDER as follows:

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1. WAC 388-106-0213 and WAC 388-106-0130(3)(b) are declared invalid because they are arbitrary and capricious and exceed the statutory authority of the agency.

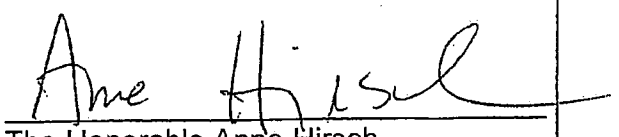
2. The administrative order applying WAC 388-106-0213 and WAC 388-106-0130 (3)(b) to Petitioner's case is reversed.

3. Petitioner was eligible for 90 personal care hours per month effective December 12, 2006, the date the rule was applied to her case. The Department shall retroactively reimburse Samantha for any properly documented out of pocket expenses incurred in order to secure personal care services in addition to the 39 hours per month. To the extent that Samantha's current CARE assessment has determined her "base hours" to be a different number of hours per month, the Department shall immediately provide Samantha with those hours, without implementation of WAC 388-106-0213 or WAC 388-106-0130(3)(b).

AH
BW
SK

4. Petitioners are entitled to reasonable attorneys' fees and costs under RCW 74.08.080 for services received from Disability Rights Washington and Sirianni Youtz Meier and Spoonemore in bringing this Petition for Judicial Review, in an amount to be determined by subsequent order.

Dated this 19th day of June, 2009.



The Honorable Anne Hirsch

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Presented by:

Attorneys for Petitioners:

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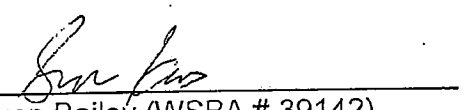
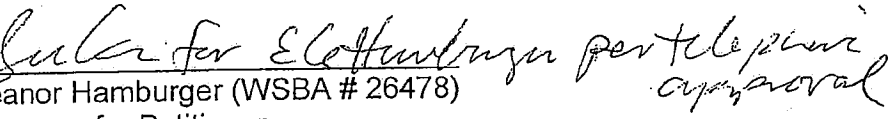


Regan Bailey (WSBA # 39142)
Susan Kas (WSBA # 36592)

SIRIANNI YOUTZ
MEIER & SPOONEMORE

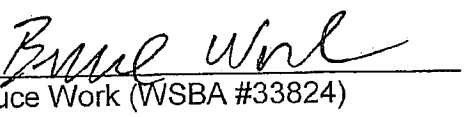


Eleanor Hamburger (WSBA # 26478)
Attorneys for Petitioner

Approved as to form and notice of presentation waived by:

Attorney for Respondent:

OFFICE OF THE ATTORNEY GENERAL



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APPENDIX B

FILED
MAR 13 2009
SUPERIOR COURT
BETTY J. GOULD
THURSTON COUNTY CLERK

STATE OF WASHINGTON
THURSTON COUNTY SUPERIOR COURT

KATY L., Petitioner, v. DEPARTMENT OF SOCIAL AND HEALTH SERVICES, Respondent.	NO. 08-2-01730-1 ORDER DENYING PETITIONER'S MOTION FOR PARTIAL SUMMARY JUDGMENT

The Motion for Partial Summary Judgment in this matter came before the Court on February 6, 2009. Petitioner appeared through her counsel, David Girard, Attorney at Law. Respondent Department of Social and Health Services (DSHS) appeared through its counsel, Jonathon Bashford, Assistant Attorney General.

The Court considered Petitioner's Motion for Partial Summary Judgment, Respondent's Response to Motion for Partial Summary Judgment, and Petitioner's Reply Brief in Support of her Motion for Partial Summary Judgment, and heard oral argument presented at the hearing.

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I. CONCLUSIONS OF LAW

1. This Court has jurisdiction of the parties and the subject matter of this litigation.

2. There are no material facts in dispute regarding the issues raised in Petitioner's Motion. No reference to the administrative record is necessary to rule on the issues of law raised in Petitioner's Motion.

~~3. WAC 388-106-0130 and WAC 388-106-0213 do not violate federal Medicaid requirements for Early Periodic Screening, Diagnosis and Treatment (EPSDT), 42 U.S.C. § 1396d(r).~~ JDB MG RDH

4. When authorizing Medicaid personal care hours in accordance with a service plan approved by the state, DSHS is not required by 42 U.S.C. § 1396d(a)(24) or Medicaid EPSDT requirements to ~~give weight to~~ follow a physician's recommendation regarding such authorization. JDB MG RDH

5. WAC 388-106-0130 and WAC 388-106-0213 do not violate the federal Medicaid "comparability" requirement, 42 U.S.C. § 1396a(a)(10)(B). ~~The concerns of the Supreme Court in *Jenkins v. Dep't of Soc. & Health Servs.*, 160 Wn.2d 287, 157 P.3d 388 (2007), are not applicable to this case.~~ JDB MG RDH

6. WAC 388-106-0130 and WAC 388-106-0213 do not violate the Due Process requirements of Amendments V and XIV of the U.S. Constitution; or of Article I, Section 3 of the Washington State Constitution.

7. Petitioner has failed to demonstrate she should prevail as a matter of law. On the issues presented to the Court pursuant to Petitioner's Motion for Partial Summary Judgment, Respondent has shown that it would prevail as a matter of law.

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II. ORDER

Having reviewed the motion and briefs in this matter, and based upon the arguments presented by counsel at the hearing on the motion, the Court hereby orders the following:

1. Petitioner's Motion for Partial Summary Judgment is denied.

2. Further proceedings in this matter will be restricted to issues not already presented on Petitioner's Motion for Partial Summary Judgment, HOWEVER THE SCOPE OF THE PHYSICIANS' CONSIDERATION MAY BE TRIED

RDH 3-13-09

DONE IN OPEN COURT this 13th day of March, 2009.

HONORABLE RICHARD D. HICKS
Superior Court Judge

Presented by:

ROBERT M. MCKENNA
Attorney General

Jonathon Bashford, WSBA # 39299
Assistant Attorney General
Attorneys for Department of Social and Health Services

Approved as to Form:

DAVID GIRARD P.S.

David Girard, WSBA # 17658
Attorney for Petitioner

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APPENDIX C

Effective: July 15, 2008

United States Code Annotated Currentness
Title 42. The Public Health and Welfare
Chapter 7. Social Security (Refs & Annos)
Subchapter XIX. Grants to States for Medical Assistance Programs (Refs & Annos)
§ 1396d. Definitions

For purposes of this subchapter--

(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) of this section, 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, 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 1396a(a)(10)(A) of this title) not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter, 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 606(b)(1) of this title with whom a child is living if such child is (or would, if needy, be) a dependent child under part A of subchapter IV of this chapter,

(iii) 65 years of age or older,

(iv) blind, with respect to States eligible to participate in the State plan program established under subchapter XVI of this chapter,

(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 subchapter XVI of this chapter,

(vi) persons essential (as described in the second sentence of this subsection) to individuals receiving aid or assistance under State plans approved under subchapter I, X, XIV, or XVI of this chapter,

(vii) blind or disabled as defined in section 1382c of this title, with respect to States not eligible to participate in the State plan program established under subchapter XVI of this chapter,

(viii) pregnant women,

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(ix) individuals provided extended benefits under section 1396r-6 of this title,

(x) individuals described in section 1396a(u)(1) of this title,

(xi) individuals described in section 1396a(z)(1) of this title,

(xii) employed individuals with a medically improved disability (as defined in subsection (v)), or

(xiii) individuals described in section 1396a(aa)[FN1] of this title,

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) 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;

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(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 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; and

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

(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

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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,

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 subchapter I, X, XIV, or XVI of this chapter), 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 subchapter XVIII of this chapter 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 subchapters I, X, XIV, or XVI of this chapter, or part A of subchapter IV of this chapter, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, 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 1396a(a)(10)(A) of this title, and, except in the case of individuals 65 years of age or older and disabled individuals entitled to health insurance benefits under subchapter XVIII of this chapter who are not enrolled under part B of subchapter XVIII of this chapter, 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.

(b) Federal medical assistance percentage; State percentage; Indian health care percentage

Subject to section 1396u-3(d) of this title, the term "
Federal medical assistance percentage" for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum, (2) the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be 50 per centum, (3) for purposes of this subchapter and subchapter XXI of this chapter, the Federal medical assistance percentage for the District of Columbia shall be 70

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percent, and (4) the Federal medical assistance percentage shall be equal to the enhanced FMAP described in section 1397ee(b) of this title with respect to medical assistance provided to individuals who are eligible for such assistance only on the basis of section 1396a(a)(10)(A)(ii)(XVIII) of this title. The Federal medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of section 1301(a)(8)(B) of this title. Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined in section 1603 of Title 25). Notwithstanding the first sentence of this subsection, in the case of a State plan that meets the condition described in subsection (u)(1) of this section, with respect to expenditures (other than expenditures under section 1396r-4 of this title) described in subsection (u)(2)(A) of this section or subsection (u)(3) of this section for the State for a fiscal year, and that do not exceed the amount of the State's available allotment under section 1397dd of this title, the Federal medical assistance percentage is equal to the enhanced FMAP described in section 1397ee(b) of this title.

(c) Nursing facility

For definition of the term "nursing facility", see section 1396r(a) of this title.

(d) Intermediate care facility for mentally retarded

The term "intermediate care facility for the mentally retarded" means an institution (or distinct part thereof) for the mentally retarded or persons with related conditions if--

(1) the primary purpose of such institution (or distinct part thereof) is to provide health or rehabilitative services for mentally retarded individuals and the institution meets such standards as may be prescribed by the Secretary;

(2) the mentally retarded individual with respect to whom a request for payment is made under a plan approved under this subchapter is receiving active treatment under such a program; and

(3) in the case of a public institution, the State or political subdivision responsible for the operation of such institution has agreed that the non-Federal expenditures in any calendar quarter prior to January 1, 1975, with respect to services furnished to patients in such institution (or distinct part thereof) in the State will not, because of payments made under this subchapter, be reduced below the average amount expended for such services in such institution in the four quarters immediately preceding the quarter in which the State in which such institution is located elected to make such services available under its plan approved under this subchapter.

(e) Physicians' services

In the case of any State the State plan of which (as approved under this subchapter)--

(1) does not provide for the payment of services (other than services covered under section 1396a(a)(12) of this title) provided by an optometrist; but

(2) at a prior period did provide for the payment of services referred to in paragraph (1);

the term "physicians' services" (as used in subsection (a)(5) of this section) shall include services of the type which an optometrist is legally authorized to perform where the State plan specifically provides that the term "physicians' services", as employed in such plan, includes services of the type which an optometrist is legally authorized to perform, and shall be reimbursed whether furnished by a physician or an optometrist.

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(f) Nursing facility services

For purposes of this subchapter, the term "nursing facility services" means services which are or were required to be given an individual who needs or needed on a daily basis nursing care (provided directly by or requiring the supervision of nursing personnel) or other rehabilitation services which as a practical matter can only be provided in a nursing facility on an inpatient basis.

(g) Chiropractors' services

If the State plan includes provision of chiropractors' services, such services include only--

(1) services provided by a chiropractor (A) who is licensed as such by the State and (B) who meets uniform minimum standards promulgated by the Secretary under section 1395x(r)(5) of this title; and

(2) services which consist of treatment by means of manual manipulation of the spine which the chiropractor is legally authorized to perform by the State.

(h) Inpatient psychiatric hospital services for individuals under age 21

(1) For purposes of paragraph (16) of subsection (a) of this section, the term "inpatient psychiatric hospital services for individuals under age 21" includes only--

(A) inpatient services which are provided in an institution (or distinct part thereof) which is a psychiatric hospital as defined in section 1395x(f) of this title or in another inpatient setting that the Secretary has specified in regulations;

(B) inpatient services which, in the case of any individual (i) involve active treatment which meets such standards as may be prescribed in regulations by the Secretary, and (ii) a team, consisting of physicians and other personnel qualified to make determinations with respect to mental health conditions and the treatment thereof, has determined are necessary on an inpatient basis and can reasonably be expected to improve the condition, by reason of which such services are necessary, to the extent that eventually such services will no longer be necessary; and

(C) inpatient services which, in the case of any individual, are provided prior to (i) the date such individual attains age 21, or (ii) in the case of an individual who was receiving such services in the period immediately preceding the date on which he attained age 21, (I) the date such individual no longer requires such services, or (II) if earlier, the date such individual attains age 22;

(2) Such term does not include services provided during any calendar quarter under the State plan of any State if the total amount of the funds expended, during such quarter, by the State (and the political subdivisions thereof) from non-Federal funds for inpatient services included under paragraph (1), and for active psychiatric care and treatment provided on an outpatient basis for eligible mentally ill children, is less than the average quarterly amount of the funds expended, during the 4-quarter period ending December 31, 1971, by the State (and the political subdivisions thereof) from non-Federal funds for such services.

(i) Institution for mental diseases

The term "institution for mental diseases" means a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

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(j) State supplementary payment

The term "State supplementary payment" means any cash payment made by a State on a regular basis to an individual who is receiving supplemental security income benefits under subchapter XVI of this chapter or who would but for his income be eligible to receive such benefits, as assistance based on need in supplementation of such benefits (as determined by the Commissioner of Social Security), but only to the extent that such payments are made with respect to an individual with respect to whom supplemental security income benefits are payable under subchapter XVI of this chapter, or would but for his income be payable under that subchapter.

(k) Supplemental security income benefits

Increased supplemental security income benefits payable pursuant to section 211 of Public Law 93-66 shall not be considered supplemental security income benefits payable under subchapter XVI of this chapter.

(l) Rural health clinics

(1) The terms "rural health clinic services" and "rural health clinic" have the meanings given such terms in section 1395x(aa) of this title, except that (A) clause (ii) of section 1395x(aa)(2) of this title shall not apply to such terms, and (B) the physician arrangement required under section 1395x(aa)(2)(B) of this title shall only apply with respect to rural health clinic services and, with respect to other ambulatory care services, the physician arrangement required shall be only such as may be required under the State plan for those services.

(2)(A) The term "Federally-qualified health center services" means services of the type described in subparagraphs (A) through (C) of section 1395x(aa)(1) of this title when furnished to an individual as an [FN2] patient of a Federally-qualified health center and, for this purpose, any reference to a rural health clinic or a physician described in section 1395x(aa)(2)(B) of this title is deemed a reference to a Federally-qualified health center or a physician at the center, respectively.

(B) The term "Federally-qualified health center" means an entity which--

(i) is receiving a grant under section 254b of this title,

(ii)(I) is receiving funding from such a grant under a contract with the recipient of such a grant, and

(II) meets the requirements to receive a grant under section 254b of this title,

(iii) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant, including requirements of the Secretary that an entity may not be owned, controlled, or operated by another entity, or

(iv) was treated by the Secretary, for purposes of part B of subchapter XVIII of this chapter, as a comprehensive Federally funded health center as of January 1, 1990;

and includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93-638) [25 U.S.C.A. § 450f et seq.] or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act [25 U.S.C.A. § 1651 et seq.] for the provision of primary health services. In applying clause (ii), [FN3] the Secretary may waive any requirement referred to in such clause for up to 2 years for good cause shown.

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(m) Qualified family member

(1) Subject to paragraph (2), the term "qualified family member" means an individual (other than a qualified pregnant woman or child, as defined in subsection (n) of this section) who is a member of a family that would be receiving aid under the State plan under part A of subchapter IV of this chapter pursuant to section 607 of this title if the State had not exercised the option under section 607(b)(2)(B)(i) of this title.

(2) No individual shall be a qualified family member for any period after September 30, 1998.

(n) Qualified pregnant woman or child

The term "qualified pregnant woman or child" means--

(1) a pregnant woman who--

(A) would be eligible for aid to families with dependent children under part A of subchapter IV of this chapter (or would be eligible for such aid if coverage under the State plan under part A of subchapter IV of this chapter included aid to families with dependent children of unemployed parents pursuant to section 607 of this title) if her child had been born and was living with her in the month such aid would be paid, and such pregnancy has been medically verified;

(B) is a member of a family which would be eligible for aid under the State plan under part A of subchapter IV of this chapter pursuant to section 607
of this title if the plan required the payment of aid pursuant to such section; or

(C) otherwise meets the income and resources requirements of a State plan under part A of subchapter IV of this chapter; and

(2) a child who has not attained the age of 19, who was born after September 30, 1983 (or such earlier date as the State may designate), and who meets the income and resources requirements of the State plan under part A of subchapter IV of this chapter.

(o) Optional hospice benefits

(1)(A) Subject to subparagraph (B), the term "hospice care" means the care described in section 1395x(dd)(1) of this title furnished by a hospice program (as defined in section 1395x(dd)(2) of this title) to a terminally ill individual who has voluntarily elected (in accordance with paragraph (2)) to have payment made for hospice care instead of having payment made for certain benefits described in section 1395d(d)(2)(A) of this title and for which payment may otherwise be made under subchapter XVIII of this chapter and intermediate care facility services under the plan. For purposes of such election, hospice care may be provided to an individual while such individual is a resident of a skilled nursing facility or intermediate care facility, but the only payment made under the State plan shall be for the hospice care.

(B) For purposes of this subchapter, with respect to the definition of hospice program under section 1395x(dd)(2) of this title, the Secretary may allow an agency or organization to make the assurance under subparagraph (A)(iii) of such section without taking into account any individual who is afflicted with acquired immune deficiency syndrome (AIDS).

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(2) An individual's voluntary election under this subsection--

(A) shall be made in accordance with procedures that are established by the State and that are consistent with the procedures established under section 1395d(d)(2) of this title;

(B) shall be for such a period or periods (which need not be the same periods described in section 1395d(d)(1) of this title) as the State may establish; and

(C) may be revoked at any time without a showing of cause and may be modified so as to change the hospice program with respect to which a previous election was made.

(3) In the case of an individual--

(A) who is residing in a nursing facility or intermediate care facility for the mentally retarded and is receiving medical assistance for services in such facility under the plan,

(B) who is entitled to benefits under part A of subchapter XVIII of this chapter and has elected, under section 1395d(d) of this title, to receive hospice care under such part, and

(C) with respect to whom the hospice program under such subchapter and the nursing facility or intermediate care facility for the mentally retarded have entered into a written agreement under which the program takes full responsibility for the professional management of the individual's hospice care and the facility agrees to provide room and board to the individual,

instead of any payment otherwise made under the plan with respect to the facility's services, the State shall provide for payment to the hospice program of an amount equal to the additional amount determined in section 1396a(a)(13)(B) of this title and, if the individual is an individual described in section 1396a(a)(10)(A) of this title, shall provide for payment of any coinsurance amounts imposed under section 1395e(a)(4) of this title.

(p) Qualified medicare beneficiary; medicare cost-sharing

(1) The term "qualified medicare beneficiary" means an individual--

(A) who is entitled to hospital insurance benefits under part A of subchapter XVIII of this chapter (including an individual entitled to such benefits pursuant to an enrollment under section 1395i-2 of this title, but not including an individual entitled to such benefits only pursuant to an enrollment under section 1395i-2a of this title),

(B) whose income (as determined under section 1382a of this title for purposes of the supplemental security income program except as provided in paragraph (2)(D)) does not exceed an income level established by the State consistent with paragraph (2), and

(C) whose resources (as determined under section 1382b of this title for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual may have and obtain benefits under that program or, effective beginning with January 1, 2010, whose resources (as so determined) do not exceed the maximum resource level applied for the year under subparagraph (D) of section 1395w-114(a)(3) of this title (determined without regard to the life insurance policy exclusion provided under subparagraph (G) of such section) applicable to an individual or to the individual and the individual's spouse (as the case may be).

(2)(A) The income level established under paragraph (1)(B) shall be at least the percent provided under subparagraph

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(B) (but not more than 100 percent) of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 9902(2) of this title) applicable to a family of the size involved.

(B) Except as provided in subparagraph (C), the percent provided under this clause, with respect to eligibility for medical assistance on or after--

(i) January 1, 1989, is 85 percent,

(ii) January 1, 1990, is 90 percent, and

(iii) January 1, 1991, is 100 percent.

(C) In the case of a State which has elected treatment under section 1396a(f) of this title and which, as of January 1, 1987, used an income standard for individuals age 65 or older which was more restrictive than the income standard established under the supplemental security income program under subchapter XVI of this chapter, the percent provided under subparagraph (B), with respect to eligibility for medical assistance on or after--

(i) January 1, 1989, is 80 percent,

(ii) January 1, 1990, is 85 percent,

(iii) January 1, 1991, is 95 percent, and

(iv) January 1, 1992, is 100 percent.

(D)(i) In determining under this subsection the income of an individual who is entitled to monthly insurance benefits under subchapter II of this chapter for a transition month (as defined in clause (ii)) in a year, such income shall not include any amounts attributable to an increase in the level of monthly insurance benefits payable under such subchapter which have occurred pursuant to section 415(i) of this title for benefits payable for months beginning with December of the previous year.

(ii) For purposes of clause (i), the term "transition month" means each month in a year through the month following the month in which the annual revision of the official poverty line, referred to in subparagraph (A), is published.

(3) The term "medicare cost-sharing" means (subject to section 1396a(n)(2) of this title) the following costs incurred with respect to a qualified medicare beneficiary, without regard to whether the costs incurred were for items and services for which medical assistance is otherwise available under the plan:

(A)(i) premiums under section 1395i-2 or 1395i-2a of this title, and

(ii) premiums under section 1395r of this title, [FN4]

(B) Coinsurance under subchapter XVIII of this chapter (including coinsurance described in section 1395e of this title).

(C) Deductibles established under subchapter XVIII of this chapter (including those described in section 1395e and section 1395*l*(b) of this title).

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(D) The difference between the amount that is paid under section 1395*l*(a) of this title and the amount that would be paid under such section if any reference to "80 percent" therein were deemed a reference to "100 percent".

Such term also may include, at the option of a State, premiums for enrollment of a qualified medicare beneficiary with an eligible organization under section 1395mm of this title.

(4) Notwithstanding any other provision of this subchapter, in the case of a State (other than the 50 States and the District of Columbia)--

(A) the requirement stated in section 1396a(a)(10)(E) of this title shall be optional, and

(B) for purposes of paragraph (2), the State may substitute for the percent provided under subparagraph (B) or [FN5] 1396a(a)(10)(E)(iii) [FN6] of such paragraph any percent.

In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1315 of this title, the Secretary shall require the State to meet the requirement of section 1396a(a)(10)(E) of this title in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this subchapter.

(5)(A) The Secretary shall develop and distribute to States a simplified application form for use by individuals (including both qualified medicare beneficiaries and specified low-income medicare beneficiaries) in applying for medical assistance for medicare cost-sharing under this title in the States which elect to use such form. Such form shall be easily readable by applicants and uniform nationally.

(B) In developing such form, the Secretary shall consult with beneficiary groups and the States.

(6) For provisions relating to outreach efforts to increase awareness of the availability of medicare cost-sharing, see section 1320b-14 of this title.

(q) Qualified severely impaired individual

The term "qualified severely impaired individual" means an individual under age 65--

(1) who for the month preceding the first month to which this subsection applies to such individual--

(A) received (i) a payment of supplemental security income benefits under section 1382(b) of this title on the basis of blindness or disability, (ii) a supplementary payment under section 1382e of this title or under section 212 of Public Law 93-66 on such basis, (iii) a payment of monthly benefits under section 1382h(a) of this title, or (iv) a supplementary payment under section 1382e(c)(3) of this title, and

(B) was eligible for medical assistance under the State plan approved under this subchapter; and

(2) with respect to whom the Commissioner of Social Security determines that--

(A) the individual continues to be blind or continues to have the disabling physical or mental impairment on the basis of which he was found to be under a disability and, except for his earnings, continues to meet all non-disability-related requirements for eligibility for benefits under subchapter XVI of this chapter,

(B) the income of such individual would not, except for his earnings, be equal to or in excess of the amount which

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would cause him to be ineligible for payments under section 1382(b) of this title (if he were otherwise eligible for such payments),

(C) the lack of eligibility for benefits under this subchapter would seriously inhibit his ability to continue or obtain employment, and

(D) the individual's earnings are not sufficient to allow him to provide for himself a reasonable equivalent of the benefits under subchapter XVI of this chapter (including any federally administered State supplementary payments), this subchapter, and publ
icly funded attendant care services (including personal care assistance) that would be available to him in the absence of such earnings.

In the case of an individual who is eligible for medical assistance pursuant to section 1382h(b) of this title in June, 1987, the individual shall be a qualified severely impaired individual for so long as such individual meets the requirements of paragraph (2).

(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 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--

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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 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 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.

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(s) Qualified disabled and working individual

The term "qualified disabled and working individual" means an individual--

(1) who is entitled to enroll for hospital insurance benefits under part A of subchapter XVIII of this chapter under section 1395i-2a of this title;

(2) whose income (as determined under section 1382a of this title for purposes of the supplemental security income program) does not exceed 200 percent of the official poverty line (as defined by the Office of Management and Budget and revised annually in accordance with section 9902(2) of this title) applicable to a family of the size involved;

(3) whose resources (as determined under section 1382b of this title for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual or a couple (in the case of an individual with a spouse) may have and obtain benefits for supplemental security income benefits under subchapter XVI of this chapter; and

(4) who is not otherwise eligible for medical assistance under this subchapter.

(t) "Primary care case management services", "primary care case manager", "primary care case management contract", and "primary care" defined

(1) The term "primary care case management services" means case-management related services (including locating, coordinating, and monitoring of health care services) provided by a primary care case manager under a primary care case management contract.

(2) The term "primary care case manager" means any of the following that provides services of the type described in paragraph (1) under a contract referred to in such paragraph:

(A) A physician, a physician group practice, or an entity employing or having other arrangements with physicians to provide such services.

(B) At State option--

(i) a nurse practitioner (as described in subsection (a)(21) of this section);

(ii) a certified nurse-midwife (as defined in section 1395x(gg) of this title); or

(iii) a physician assistant (as defined in section 1395x(aa)(5) of this title).

(3) The term "primary care case management contract" means a contract between a primary care case manager and a State under which the manager undertakes to locate, coordinate, and monitor covered primary care (and such other covered services as may be specified under the contract) to all individuals enrolled with the manager, and which--

(A) provides for reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment with respect to medical emergencies;

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(B) restricts enrollment to individuals residing sufficiently near a service delivery site of the manager to be able to reach that site within a reasonable time using available and affordable modes of transportation;

(C) provides for arrangements with, or referrals to, sufficient numbers of physicians and other appropriate health care professionals to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care;

(D) prohibits discrimination on the basis of health status or requirements for health care services in enrollment, disenrollment, or reenrollment of individuals eligible for medical assistance under this subchapter;

(E) provides for a right for an enrollee to terminate enrollment in accordance with section 1396u-2(a)(4) of this title; and

(F) complies with the other applicable provisions of section 1396u-2 of this title.

(4) For purposes of this subsection, the term "primary care" includes all health care services customarily provided in accordance with State licensure and certification laws and regulations, and all laboratory services customarily provided by or through, a general practitioner, family medicine physician, internal medicine physician, obstetrician/gynecologist, or pediatrician.

(u) Conditions for State plans

(1) The conditions described in this paragraph for a State plan are as follows:

(A) The State is complying with the requirement of section 1397ee(d)(1) of this title.

(B) The plan provides for such reporting of information about expenditures and payments attributable to the operation of this subsection as the Secretary deems necessary in order to carry out the fourth sentence of subsection (b) of this section.

(2)(A) For purposes of subsection (b) of this section, the expenditures described in this subparagraph are expenditures for medical assistance for optional targeted low-income children described in subparagraph (B).

(B) For purposes of this paragraph, the term "optional targeted low-income child" means a targeted low-income child as defined in section 1397jj(b)(1) of this title (determined without regard to that portion of subparagraph (C) of such section concerning eligibility for medical assistance under this subchapter) who would not qualify for medical assistance under the State plan under this subchapter as in effect on March 31, 1997 (but taking into account the expansion of age of eligibility effected through the operation of section 1396a(l)(1)(D)) of this title. Such term excludes any child eligible for medical assistance only by reason of section 1396a(a)(10)(A)(ii)(XIX) of this title.

(3) For purposes of subsection (b) of this section, the expenditures described in this paragraph are expenditures for medical assistance for children who are born before October 1, 1983, and who would be described in section 1396a(l)(1)(D) of this title if they had been born on or after such date, and who are not eligible for such assistance under the State plan under this subchapter based on such State plan as in effect as of March 31, 1997.

(4) The limitations on payment under subsections (f) and (g) of section 1308 of this title shall not apply to Federal payments made under section 1396b(a)(1) of this title based on an enhanced FMAP described in section 1397ee(b) of this title.

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(v) "Employed individuals with a medically improved disability" defined

(1) The term "employed individual with a medically improved disability" means an individual who

(A) is at least 16, but less than 65, years of age;

(B) is employed (as defined in paragraph (2));

(C) ceases to be eligible for medical assistance under section 1396a(a)(10)(A)(ii)(XV) of this title because the individual, by reason of medical improvement, is determined at the time of a regularly scheduled continuing disability review to no longer be eligible for benefits under section 423(d) or 1382c(a)(3) of this title; and

(D) continues to have a severe medically determinable impairment, as determined under regulations of the Secretary.

(2) For purposes of paragraph (1), an individual is considered to be "employed" if the individual

(A) is earning at least the applicable minimum wage requirement under section 206 of Title 29 and working at least 40 hours per month; or

(B) is engaged in a work effort that meets substantial and reasonable threshold criteria for hours of work, wages, or other measures, as defined by the State and approved by the Secretary.

(w) "Independent foster care adolescent" defined

(1) For purposes of this subchapter, the term "independent foster care adolescent" means an individual--

(A) who is under 21 years of
age;

(B) who, on the individual's 18th birthday, was in foster care under the responsibility of a State; and

(C) whose assets, resources, and income do not exceed such levels (if any) as the State may establish consistent with paragraph (2).

(2) The levels established by a State under paragraph (1)(C) may not be less than the corresponding levels applied by the State under section 1396u-1(b) of this title.

(3) A State may limit the eligibility of independent foster care adolescents under section 1396a(a)(10)(A)(ii)(XVII) of this title to those individuals with respect to whom foster care maintenance payments or independent living services were furnished under a program funded under part E of subchapter IV of this chapter [42 U.S.C.A. § 670 et seq.] before the date the individuals attained 18 years of age.

(x) For purposes of subsection (a)(27) of this section, the strategies, treatment, and services described in that subsection include the following:

(1) Chronic blood transfusion (with deferoxamine chelation) to prevent stroke in individuals with Sickle Cell Disease who have been identified as being at high risk for stroke.

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(2) Genetic counseling and testing for individuals with Sickle Cell Disease or the sickle cell trait to allow health care professionals to treat such individuals and to prevent symptoms of Sickle Cell Disease.

(3) Other treatment and services to prevent individuals who have Sickle Cell Disease and who have had a stroke from having another stroke.

CREDIT(S)

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[FN1] So in original. Probably means the subsec. (aa) of 42 U.S.C.A. § 1396a relating to certain breast or cervical cancer patients.

[FN2] So in original. Probably should be "a".

[FN3] So in original. Probably should be clause "(iii),". See References in Text note below.

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APPENDIX D

Age G .delines to Assess Children for MP n CARE

AGE GUIDELINE GRID 8/07

	Ages																	
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
For ADLs/IADLs code Status = Met																		
Medication Management																		
Independent, Supervision, Limited, Extensive, or	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Total																		
Telephone																		
Independent, Supervision, Limited, Extensive, or	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Total																		
Locomotion in Room																		
Independent, Supervision, Limited or Extensive	■	■	■	■														
Total	■	■																
Locomotion Outside Room																		
Independent or Supervision	■	■	■	■	■	■												
Limited or Extensive	■	■	■	■														
Total	■	■																
Walk in Room																		
Independent, Supervision, Limited or Extensive	■	■	■	■														
Total	■	■																
Bed Mobility																		
Independent, Supervision, Limited or Extensive	■	■	■															
Total	■	■																
Transfers																		
Independent, Supervision, Limited, Extensive or	■	■	■															
Total & under 30 pounds																		
(Total & over 30 pounds = no age limit)																		
Toilet Use																		
Support Provided for Nighttime wetting only (Independent, Supervision, Limited, Extensive)	■	■	■	■	■	■	■	■										
Independent, Supervision, Limited, Extensive	■	■	■	■	■	■												
Total	■	■	■	■														
Eating																		
Independent, Supervision, Limited, Extensive, or	■	■	■															
Total																		
Meal Preparation																		
Independent, Supervision, Limited, Extensive, or	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Total																		
Bathing																		
Independent or Supervision	■	■	■	■	■	■	■	■	■	■	■	■						
Physical Assistance All/Part	■	■	■	■	■	■	■	■										
Total	■	■	■	■	■													
Dressing																		
Independent or Supervision	■	■	■	■	■	■	■	■	■	■	■	■						
Limited or Extensive	■	■	■	■	■	■	■	■										
Total	■	■	■	■	■													
Personal Hygiene																		
Independent or Supervision	■	■	■	■	■	■	■	■	■	■	■	■						
Limited or Extensive	■	■	■	■	■	■	■	■										
Total	■	■	■	■	■													

Age G. .elines to Assess Children for MPC . CARE

AGE GUIDELINE GRID 8/07

	Ages 0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
Transportation																		
Independent, Supervision, Limited, Extensive, or Total	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Shopping																		
Independent, Supervision, Limited, Extensive, or Total	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Wood Supply																		
Independent, Supervision, Limited, Extensive, or Total	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Housework																		
Independent, Supervision, Limited, Extensive, or Total	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Finances																		
Independent, Supervision, Limited, Extensive, or Total	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Pet Care																		
Independent, Supervision, Limited, Extensive, or Total	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Additional guidelines based on age																		
Diagnosis																		
Is client comatose? = no	■	■	■	■	■	■												
Pain																		
Pain daily = no	■	■	■	■	■	■												
Passive Range of Motion																		
Needs = No	■	■	■	■														
Any Foot Care Needs																		
Status = Need Met	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Any Skin Care (other than feet)																		
Status = Need Met	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Speech/Hearing																		
Comprehension = Understood	■	■	■															
MMSE																		
Can be administered = no	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Memory																		
Short term and long term memory = ok	■	■	■	■	■	■	■	■	■	■	■	■						
Depression																		
Select interview = unable to obtain	■	■	■	■	■	■	■	■	■	■	■	■						
Suicide																		
Have you thought..= unable to obtain	■	■	■	■	■	■	■	■	■	■	■	■						
Decision making																		
how client makes decisions = independent	■	■	■	■	■	■	■	■	■	■	■	■						
Bladder/Bowel																		
Support Provided for Nighttime wetting only- Individual Management = Does not need/use	■	■	■	■	■	■	■	■	■	■	■	■						
Support Provided for daytime wetting-Individual Management = Does not need/use	■	■	■	■	■	■												
[1] If Activity Did Not Occur code Self Performance = Total, Status = Met	■	■																