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COURT OF APPEALS
DIVISION II

NO. 39536-3

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

STATE OF WASHINGTON
BY cm
DEPUTY

WASHINGTON STATE DEPARTMENT OF SOCIAL AND
HEALTH SERVICES

Appellant,

v.

SAMANTHA A.,

Respondent.

SECOND AMENDED BRIEF OF RESPONDENT

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I. NATURE OF THE CASE

A. *Invalidation of Children's Medicaid Personal Care Regulations*

In this litigation, Samantha A. challenges the Children's Medicaid Personal Care (MPC) regulations, WAC 388-106-0213 and WAC 388-106-0130 (3)(b), because the rules violate federal Medicaid law regarding the Early and Period Screening, Diagnostic and Treatment (EPSDT) service benefit and Medicaid comparability. The superior court's ruling invalidating these regulations should be affirmed.

This case is about two simple questions and the conclusions reached by Thurston County Superior Court:

First, must the Washington State Department of Social and Health Services ("Department") consider the recommendations of a child's medical provider when assessing the child's needs for MPC services?

Answer: Yes. Numerous courts across the country have recognized an important role for treating physicians in determining whether a Medicaid service is necessary. In line with these decisions, the Superior Court correctly held that the Department must "meaningfully consider and weigh recommendations from a child's medical providers in the MPC assessment process in determining medical necessity." Clerk's Papers ("CP") 255 at Conclusion of Law ("CL") 6.

Second, must the Department determine each child's need for MPC services individually, rather than employing automatic, across-the-board reductions based upon a child's age and living situation?

Answer: Yes. As our Supreme Court found, "The needs of a [MPC] recipient are not presumed met without an individual assessment." *Jenkins v. Washington State Dept. of Social and Health Services*, 160 Wn.2d 287, 300, 157 P.3d 388, 393 (2007). The superior court similarly concluded:

WAC 388-106-0213 imposes irrebuttable 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.

CP 254 at CL 2 (emphasis added). The superior court properly held that the Department may not impose blanket reductions to children's MPC services based upon assumptions about their living situations. *See* CP 256 at CL 11-12.

Federal law requires states to provide MPC services to children under the age of 21 if necessary to correct or ameliorate their conditions or illnesses. A recent policy directive from the Center for Medicare and

Medicaid Services (CMS),¹ the federal agency charged with regulating how states implement Medicaid, confirmed that the EPSDT requirement such automatic reductions in care to Washington's MPC program for children:

Since PCS [personal care services] for children is a component of the mandatory EPSDT benefit, as discussed above, States generally cannot impose limitations on medically necessary services for individuals under age 21, because such limitation would be inconsistent with the EPSDT statutory benefit....*For children, however, the final coverage decision must be made on an individualized determination of medical necessity, made on a case-by-case basis. An across-the-board reduction in services that caps the services provided to a child regardless of medical necessity does not meet this standard.*

Letter from Barbara Richards, Associate Regional Administrator, CMS, to Kathy Leitch, Assistant Secretary, DSHS dated July 29, 2009 (emphasis added), attached hereto as Appendix A. CMS's policy statement makes clear -- the Department's rules regarding children's MPC services run afoul of federal Medicaid requirements.

The Department's attempt to recast the superior court's ruling into a decision regarding whether MPC services should replace basic parental responsibilities (*See* Appellant's opening Brief at 2) is a distortion of the

¹CMS's interpretations are entitled to "respectful consideration" due to the agency's expertise. *Katie A., ex rel. Ludin v. Los Angeles County*, 481 F.3d 1150, 1155 (9th Cir. 2007).

court's ruling. No such finding of fact or conclusion of law appears in the superior court's decision. Nor is this what Samantha A. seeks.

B. Award of Attorney Fees

The Department also objects to the superior court's award of attorneys fees to Samantha A. and raises one additional issue:

Issue: Did the trial court properly determine Samantha A.'s reasonable attorneys fees using the "lodestar method"?

Answer: Yes. The superior court did not abuse its discretion in determining that, based on the uncontroverted evidence, the amount of attorney fees Samantha A. requested was reasonable. *First*, the Department failed to present any evidence to justify a downward adjustment of the lodestar amount. *Second*, RCW 74.08.080 does not permit a \$25,000 fee cap. *Third*, the Department's claim of a "\$25,000 cap" is inconsistent with the intent of RCW 74.08.080(3). *See Tofte v. DSHS*, 85 Wn.2d 161, 165, 531 P.2d 808, 810 (1975).

II. ASSIGNMENTS OF ERROR

Pursuant to RAP 10.3 (h), Respondent Samantha A. assigns error to the Conclusions of Law 7-11 and the "Decision and Order" in the final

administrative agency decision:² See AR 11-13. The application of WAC 388-106-0213 and 0130 to Samantha A. and to other Medicaid-eligible children and youth under 21 is invalid because the agency rules conflict with federal Medicaid law governing EPSDT and comparability.

III. ISSUES PRESENTED

1. Do the Department's MPC rules violate the requirements of the federal EPSDT mandate by preventing "meaningful consideration" of the treatment recommendations of a treating physician as part of the MPC assessment process?

2. Do the Department's MPC rules violate federal Medicaid comparability requirements by employing automatic, across-the-board cuts in MPC services based upon a child's age and living situation?

3. Did the superior court properly determine Samantha A.'s reasonable attorneys fees?

IV. STATEMENT OF CASE

A. Background.

Samantha A., now fifteen, was twelve when this appeal began. Agency Record ("AR") 4 (included in Administrative Record).

² Respondent concedes that both the administrative law judge and the review judge did not have authority to invalidate the disputed rules.

Samantha's disabilities are severe. She has Down's Syndrome, Obesity, Vision Issues/Cataracts, hearing loss, speech and communication problems, developmental delays, and behavior problems. *Id.*; CP 250-51. Samantha lives with her mother and sister in King County, Washington. AR 4. Her mother is a single, working parent who is committed to meeting Samantha's needs and keeping her from being institutionalized. CP 251.

Samantha is a Medicaid beneficiary and receives MPC services to help her with activities of daily living. CP 251 at Finding of Fact ("FF") 5. She functions at the equivalent of a kindergarten to first grade level and has substantial behavioral needs. AR 4. For example, she is "frequently easily agitated and resistive to care," and "wanders away and is not safe when unsupervised in public." CP 251 at FF 2. Additionally, she needs help cutting food into pieces, needs to be cued to eat, requires assistance to use the bathroom, dressing, and brushing her teeth and hair, among many other activities. *Id.* Based on these extraordinary care needs, DSHS has determined that Samantha would be eligible to receive twenty-four hour institutional care. CP 251 at FF 3.

The Department has enrolled Samantha A. on the Home and Community Based Waiver program for persons with developmental disabilities so that Samantha can be safely maintained at home, outside of

an institution. CP 251 at FF 5. As part of the benefits of this DSHS program, Samantha A. is eligible for MPC services. *Id.*

On May 17, 2005, DSHS changed the rules which governed the way it assessed MPC services. Included in the rule changes was a new rule, WAC 388-106-0213, which established special, automatic reductions to MPC services to be applied only to children. CP 251 at FF 7. The new rule took effect on June 17, 2005. *Id.*

B. Samantha A.'s administrative appeal

On December 12, 2006, Samantha's need for MPC services was reassessed under the new rule. AR 6. The Assessment noted that Samantha had been experiencing significant behavioral problems at least one to three times daily. AR 5-6. Samantha's behaviors included becoming resistant, easily irritated or agitated, assaultive, acting out sexually, breaking and throwing items, attempting to elope, wandering, screaming and yelling. *Id.* The Assessment described Samantha's need for appropriate and safe behavioral interventions in these circumstances. *Id.* The Assessment also noted that Samantha continued to need assistance with activities of daily living, showing no improvement from prior assessments. AR 6. The Assessment determined that Samantha's "base hours" to be 90 hours per month. *Id.*

After DSHS determined that Samantha's "base hours" were 90 hours of MPC per month,³ pursuant to WAC 388-106-0213, the CARE tool automatically reduced her MPC services to 39 hours. *Id.* The Department applied this reduction based on WAC 388-106-0213, which presumes that care needs are automatically met for children under the age of 18 who live with one or both parents and are under the age of 18, regardless of the nature or severity of their disabilities. CP 253 at FF19. In Samantha's case, the reduction occurred even though the Assessment showed that Samantha's condition had worsened. The CARE assessment automatically coded the following needs as "met" or "partially met": transferring, dressing, eating, personal hygiene, toilet use, bathing, walking, medication management, transportation, shopping, housework and meal preparation. AR 6.

Samantha's mother requested an administrative hearing to appeal the reduction in Samantha's services. AR 227-28. She also took Samantha to see her treating primary care physician, Jill Miller, M.D. AR 140. Dr. Miller conducted an EPSDT screening, and made

³As the superior court noted, given Samantha's documented supervision and care needs, she would need far more than 90 hours each month if the state were to pay for all her needs. CP 337-38.

recommendations regarding her needs.⁴ AR 137-140. She also submitted a declaration regarding her recommendations to DSHS in advance of the administrative hearing. AR 234-35. Dr. Miller recommended that Samantha receive 96 hours per month of MPC services in order to “maximize her potential and achieve her best possible functional level.” AR 234. She noted that Samantha’s progress with her activities of daily living had halted and in some cases regressed due to the decrease in her MPC hours. AR 138.

Despite Dr. Miller’s EPSDT recommendations, DSHS did not change the disputed Assessment. *See* AR 43-44 (DSHS received and stipulated to Dr. Miller’s recommendations); AR 83 (Samantha’s disputed CARE assessment was not revised to reflect Dr. Miller’s EPSDT screening and recommendations). DSHS did not approve additional MPC hours pursuant to the state’s EPSDT rule, WAC 388-534-0100. It did not authorize an Exception for Samantha to the automatic cuts, in light of Dr. Miller’s recommendations. AR 228; Verbatim Report of Recorded

⁴DSHS claims that there is no support for Samantha A.’s position that Dr. Miller conducted an “EPSDT screening.” App. Br. at 12, n. 10. Federal law is very clear about what constitutes an EPSDT screening. *See* 42 U.S.C. § 1396d (r)(1). Dr. Miller’s evaluation of Samantha A. met all the requirements of an EPSDT screening. AR 137-140.

Proceedings at the Administrative Hearing (VRRP) 42:21-43:8 (included in the Administrative Record). The Department did not reject the recommendations by Dr. Miller, or provide an explanation as to why the recommendations were not acted upon. DSHS simply ignored the information provided by Dr. Miller, because the CARE rules require it to do so.⁵

After DSHS cut Samantha's services, her condition worsened. Samantha's mother observed that Samantha's speech deteriorated and her maladaptive behaviors increased after the reduction of her personal care hours. AR 7; 141-42. Dr. Miller also observed a decline in her condition. AR 234-35. DSHS stipulated to the decline in Samantha's condition, and offered no evidence to dispute the testimony that Samantha had deteriorated due to the decrease in her MPC services. AR 7; 43-44.

Samantha's administrative hearing was held on August 28, 2007. AR 1. She appealed the decision to the DSHS Board of Appeals, which rendered a final decision on November 21, 2007. *Id.*

⁵The Department admitted as much at the administrative hearing. *See* VRRP 35-36; 41:6-42:15. The Department never argued that it had considered and rejected the treating physician's recommendations. Instead, when ALJ Mauer asked DSHS to make its argument, the Department's attorney stated "My argument, my only argument that I can make here is that these are the rules we have. They haven't been invalidated *yet*." VRRP 36:5-7. (emphasis added).

C. *Samantha A. Petitions for Judicial Review.*

On December 21, 2007, Samantha A. petitioned for judicial review in Thurston County Superior Court. CP 5-14. Samantha A. submitted an Amended Petition on March 12, 2008. CP 41-47. Samantha challenged the validity of the DSHS rules governing the children's Medicaid personal care assessment, WAC 388-106-0213 and 388-106-0130 (3)(b). CP 10-13 at ¶ 7.5; CP 45 at ¶ 7.5.

Samantha A. filed a Motion for Partial Summary Judgment on her claim that the children's MPC rules violated EPSDT. CP 60-72. In response to Samantha A.'s Motion, the Department argued that it provided "due respect" for the opinions of treating physicians. CP 94. The superior court denied the motion because the Department claimed in its summary judgment brief that it gave "due respect" to a treating physician's recommendation. That claim is described in the superior court's October 15, 2008 letter opinion:

[T]he State asserts that if a treating physician determined that a given number of hours of personal care services were medically necessary, while the State in its assessment, found a different lesser number available, the State would give that physician's recommendation "due respect" and would discuss the recommendation with the doctor to determine the basis for the recommendation and the difference from the State's position.

...

It is this aspect of how the State considers, weighs, and integrates a treating physician's recommendations for

personal care services with the amount of services the State has otherwise determined are appropriate which is the impediment to summary judgment. I am unable to presently determine if this due respect and discussion process is merely a pro forma exchange such that it is meaningless or whether it is a proper exercise of discretion.

CP 150; 158.

In its trial briefing, however, the Department did not produce any evidence of “due respect” given to the opinions of treatment physicians – not in the Samantha A. administrative record, existing regulations, the Department’s policy or any other source. CP 192-215. The Department abandoned its “due respect” claim. CP 206-208. At trial and on appeal, the Department argues that it may ignore the recommendations of a treating physician when assessing a child’s need for MPC. CP 206-208; Appellant’s Opening Brief at 18-25.

The superior court rejected the Department’s argument. The court’s June 8, 2009 letter opinion said:

The Department’s rules, WAC 388-106-0213 (and 388-106-130 (sic) insofar as it incorporated 388-106-0213) impair Samantha’s rights under the Federal Medicaid Act to receive “necessary health care, diagnostic services, treatment and other measures” of sufficient amount, duration and scope as identified through “early and periodic screening, diagnostic and treatment services (EPSDT).” The Department’s rules amount to an arbitrary and capricious reduction in Samantha’s Medicaid benefits, both because they create an irrebutable presumption that does not permit any consideration of a participant’s individual circumstances, and additionally because the rules include no basis for any consideration of a treating physician’s opinion as to medical necessity of services.

CP 248-49 (emphasis added). The superior court also said:

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.

...

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

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

CP 251-52 at CL 7, 11-13 (emphasis added). On July 10, 2009, the Department filed its Notice of Appeal, attaching the superior court's Findings of Fact and Conclusions of Law. CP 260-71.

D. *Samantha A. Petitions for Attorneys Fees.*

On July 10, 2009 Samantha A. asked the superior court to award reasonable attorneys fees and costs pursuant to RCW 74.08.080(3). CP 324-76. By agreement of the parties, the hearing was continued until September 11, 2009. CP 412. After oral argument on September 11, 2009, the superior court entered an order that Samantha A. was entitled to full recovery of all the fees and costs she sought. CP 443-445.

The Department did not file a second Notice of Appeal regarding the separate fee order, but did assign error to it. Appellant's Opening Brief at 4.

V. STANDARD OF REVIEW

A. *Conclusions of Law*

Appellate courts apply the standards of the Administrative Procedure Act (APA), RCW 34.05.570, directly to the agency record in reviewing agency actions. *Spokane County v. City of Spokane*, 148 Wn. App. 120, 124, 197 P.3d 1228, 1230 (2009); *Verizon Northwest, Inc., v. Washington Employment Sec. Dept.*, 164 Wn.2d 909, 915, 194 P.3d 255, 260 (2008). Appellate courts sit in the same position as the superior court and review the agency's legal determinations de novo using the "error of law" standard. *Verizon*, 164 Wn.2d at 915; *Jenkins v. DSHS*, 160 Wn.2d at 297 (2007) ("We review an agency's interpretation of federal law de

novo under an “error of law” standard”). A rule shall be declared invalid if:

“the rule violates constitutional provisions; the rule exceeds the statutory authority of the agency; the rule was adopted without compliance with statutory rule-making procedures; or the rule is arbitrary and capricious.”

Jenkins, 160 Wn.2d, at 295 (citing RCW 34.05.570(2)(c)). The Department’s rulemaking authority is limited to adopting, amending, or rescinding administrative rules to ensure personal care services are “provided in conformance with federal regulations.” RCW 74.09.520(3).

B. *Factual Findings.*

“Administrative findings of fact will be upheld on review [by the Court of Appeals or Supreme Court] when supported by substantial evidence” in the record before the agency. *Western Ports Transp., Inc. v. Employment Sec. Dept. of State of Wn.*, 110 Wn. App. 440, 449, 41 P.3d 510, 515 (2002) (citing RCW 34.05.570(3)(e)). “Substantial evidence is evidence in sufficient quantum to persuade a fair-minded person of the truth of the declared premises.” *Id.* (citing *Heinmiller v. Department of Health*, 127 Wn.2d 595, 607, 903 P.2d 433(1995)).⁶

⁶The Appellant assigns error to six findings of fact by the trial court, but does not address these disputed factual findings in its Argument. Appellant’s Opening Brief at 2 and 3. Furthermore, FF 15 and 21 were *stipulated* by the Department at the administrative hearing. AR 43-44. Appellant cannot dispute the stipulated facts it now does not like.

C. Attorneys fee award.

The standard of review for an attorney fee award is whether the trial court abused its discretion, and the appellate court must give deference to the trial court's discretion. *Rettkowski v. Dep't of Ecology*, 128 Wn.2d 508, 519, 910 P.2d 462 (1996); *Morgan v. Kingen*, 166 Wn.2d 526, 539, 210 P.3d 995, 1000 (2009). A court abuses its discretion when it bases its decision on untenable grounds or gives untenable reasons. *Rettkowski*, 128 Wn .2d at 519.

VI. ARGUMENT

A. The Department's rules are invalid because they violate the EPSDT and Comparability provisions of the Federal Medicaid Act.

1. The federal Medicaid Act

Medicaid is a cooperative program between federal and state governments established by the federal Social Security Act to allow the states to receive federal financial funding to provide medical assistance to low income individuals. 42 U.S.C. § 1396; *Lankford v. Sherman*, 455 F.3d 496, 504 (9th Cir. 2006). State participation is voluntary, but when a state chooses to participate and accept federal dollars, it agrees to comply

(footnote continuation)

These factual conclusions of the agency are thus based on substantial evidence and must be upheld.

with the requirements of the federal Medicaid Act, related implementing regulations, and CMS guidance in return for the federal funding, 42 U.S.C. § 1396, *et seq.*; *Alexander v. Choate*, 469 U.S. 287, 289 n. 1, 105 S. Ct. 712, 83 L.Ed.2d 661 (1985); Washington Medicaid State Plan⁷ Numbered Pages General Program Administration, (“As a condition of receipt of federal funds,...The Department...agrees to administer the program in accordance with the provisions of this State plan, the requirements of title XI and XIX of the Act, and all applicable Federal regulations and other official issuances”).

Washington State has elected to participate in the Medicaid program. RCW 43.20A.010; *S.A.H. ex rel. S.J.H. v. State, Dept. of Social and Health Services*, 136 Wn. App. 342, 348, 149 P.3d 410 (2006). The Department, the state’s designated agency to administer Medicaid, is required to promulgate rules consistent with the “spirit and purpose” of the Medicaid Act and federal regulations. RCW 74.04.055; 74.08.090; *S.A.H.*, 136 Wn. App. at 348 (recognizing that Washington State’s Medicaid program must comply with EPSDT).

⁷Each state participating in the Medicaid program is required under 42 U.S.C. § 1396a to submit a “state plan” describing the state’s Medicaid program to CMS for approval. Washington’s State Plan is attached hereto as Appendix B, downloaded on December 21, 2009 from http://hrsa.dshs.wa.gov/medicaidsp/Numbered%20Pages%20-%20Gen%20Program%20Admin/SP_Numbered_Pages_General_Program_Administrati%20on.pdf.

**2. The federal Early and Periodic Screening
Diagnosis and Treatment (EPSDT) mandate.**

- a. States cannot limit or reduce mandatory EPSDT services if they are necessary to correct or ameliorate a condition or disability.*

States participating in Medicaid are required to ensure the provision of EPSDT services to Medicaid eligible children under the age of 21. 42 U.S.C. § 1396d(a)(4)(B). Congress enacted this provision so that “no Medicaid-eligible child in this country, whatever his or her economic circumstances, w[ould] go without treatment deemed medically necessary by his or her clinician.” *Rosie D. v. Romney*, 410 F.Supp.2d 18 (Mass. Dist. Ct. 2006).

Required EPSDT services include:

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

42 U.S.C. § 1396d(r)(5); *see also S.A.H.*, 136 Wn. App. at 349; *S.D. ex rel. Dickson v. Hood* 391 F.3d 581, 589 -590 (5th Cir. 2004) (Medicaid law imposes a “mandatory duty” to provide EPSDT-eligible children with all the services and treatments necessary to correct or ameliorate identified health problems). MPC is one of the twenty-eight identified forms of

“medical assistance” described in subsection (a) that states must provide if found to be necessary. *Katie A., ex rel. Ludin v. Los Angeles County*, 481 F.3d 1150, 1154 (9th Cir. 2007); Appellant’s Opening Brief at 18.

Provision of all necessary care to prevent conditions from worsening is the hallmark of EPSDT. It was crafted to be the nation’s largest preventative health program for children because Congress was concerned that children with untreated health problems face a greater risk of preventable chronic illness and disability. *Eklhoff v. Rodgers*, 443 F. Supp.2d 1173, 1181, (D.Ariz.,2006) quoting H.R. 3299, 101st Cong. § 4213 (1989); *See also Emily Q v. Bonta*, 208 F. Supp. 2d 1078, 1090 (C.D. Cal. 2001) (EPSDT services must include care that is proactive and seeks to “make services available so that young people can receive medical care before health problems become chronic and irreversible damage occurs”); *Stanton v. Bond*, 504 F.2d 1246, 1249 (7th Cir. 1974); CENTERS FOR MEDICARE AND MEDICAID SERVICES, STATE MEDICAID MANUAL § 5010⁸ (“Assure that health problems found are diagnosed and treated

⁸§5010 of the State Medicaid Manual is attached as Appendix C, downloaded on December 21, 2009 from <http://www.cms.hhs.gov/Manuals/PBM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS021927&intNumPerPage=10>

early, before they become more complex and their treatment more costly”).

While states may limit Medicaid coverage for adults to that which is provided for in the State Medicaid Plan, they may not similarly limit necessary Medicaid services for children under EPSDT. *See Ekloff*, 443 F.Supp.2d at 1179 (coverage required for incontinence briefs for children although not covered under the Medicaid state plan for adults); *Pereria v. Kozlowski*, 996 F.2d 723, 727 (4th Cir. 1993) (necessary heart transplant to a child Medicaid recipient required even though not covered by adult plan); *Pediatric Specialty Care, Inc. v. Arkansas Dept of Human Servs.*, 293 F.3d 472, 480 (8th Cir 2002) (provision of early intervention day treatment services to children required, even though such services are not provided in the adult plan). In case after case around the country, courts also have held that states do not have discretion to use of other criteria to limit the provision of necessary EPSDT services for children. *See Jackson v. Millstone*, 369 MD 575, 801 A.2d 1034 (Md. 2002) (denying states discretion to use an “appropriateness” test in deciding whether a person under 21 can receive medically necessary treatment); *SD v. Hood*, 391 F.3d 581, 593 (5th Cir. 2004); *Ga. Dep’t of Community Health v. Freels*, 576 S.E. 2d 2, 6 (Ga. App. 2002). The use of criteria that does not relate to

the necessity of the service is impermissible. *See Rosie D. v. Romney*, 410 F. Supp. 2d 18, 26 (D. Mass. 2007).

b. *EPSDT requires state Medicaid agencies to “meaningfully consider” the recommendations of treating medical providers.*

States may not ignore the recommendations of treating medical providers when determining Medicaid services to children. Courts across the country recognize the essential role a treating medical provider plays when determining children’s need for Medicaid services.⁹ A Florida appellate court, addressing children’s access to Medicaid personal care services, held that the state had to give “considerable and substantial weight” to the recommendations of a child’s treating medical provider in determining the number of personal care hours. *See C.F. v. Department of Children and Families*, 934 So. 2d. 1, 7 (Fla. Dist. Ct. App. 2005).

Other federal and state courts reviewing denials of EPSDT services have held similarly. In Massachusetts, a federal district court held that “if a licensed clinician finds a particular service to be medically necessary to help a child improve his or her functional level, this service must be paid

⁹Courts have also recognized the role of a medical provider’s recommendation in determining whether any Medicaid service is necessary. *See Weaver v. Reagan*, 886 F.2d 194, 200 (8th Cir. 1989); *Pinneke v. Preisser*, 623 F.2d 546, 549 (8th Cir. 1980); *Holman v. Ohio Dep’t of Human Services*, 757 N.E.2d 382, 388-89 (Ohio Ct. App. 2001); *A.M.L. v. Dep’t of Health*, 863 P.2d 44, 47-48 (Utah Ct. App. 1993).

for by a state's Medicaid plan pursuant to the EPSDT mandate." *Rosie D.*, 410 F. Supp. 2d 26. *See also Collins v. Hamilton*, 349 F.3d 371 (7th Cir. 2003) (holding that a state's discretion to exclude services that have been deemed necessary by a treating provider has been circumscribed by the express mandate of the statute"); *Pediatric Specialty Care, Inc. v. Ark. Dep't of Human Servs.*, 293 F.3d 472 (8th Cir. 2002) (holding that EPSDT requires states to "arrange for corrective treatments prescribed by physicians"); *Urban v. Meconi*, 930 A.2d 865 (Del. S. Ct. 2007) (holding that necessity determinations must give "substantial weight" to the medical provider's opinion and refrain from substituting its own judgment for "competent medical evidence"); *Hummel v. Ohio Dep't of Job and Fam. Services*, 844 N.E. 2d 360, 364 (Ohio Ct. App. 2005) (under EPSDT, the "medical opinion and diagnosis of a patient's treating physician are entitled to substantial deference").

The treating medical provider's recommendation is no less significant for MPC services, the services at issue in this case. Federal law clearly includes personal care within its definition of "Medical assistance" and thus the list of services mandated by EPSDT. 42 U.S.C. §§ 1396d(r)(5); 1396d(a)(24). As the Florida appellate court found, "[B]ecause C.F. is a minor entitled to EPSDT benefits, his need for PCA

[MPC] services must be evaluated under the more expansive federal [EPSDT] definition.” *C.F.*, 934 So.2d at 6.

The Department’s argument that federal EPSDT law applies to every service that a treating medical provider could recommend, *except for personal care*, has no legal basis. Appellant’s Opening Brief at 21. Federal law allows the state, at its option, to assess personal care services without employing a physician. 42 U.S.C. § 1396a(a)(24). Although the Department may use its own assessment process to authorize MPC services, federal Medicaid law does not permit the Department to disregard the treating medical provider’s recommendations for a child’s MPC services.

CMS’s recent policy statement regarding Washington’s MPC program for children confirms two significant issues: *First*, the EPSDT mandate applies to Washington’s MPC program for children, even though the state opts to use its own assessment process. *Second*, EPSDT prevents automatic across-the-board reductions to children’s services without an individualized assessment of medical necessity.

Earlier this year, the Department attempted to implement across-the-board cuts to the Washington State MPC program, the very program at issue in this case. It applied the cuts to adults *and* children. Plaintiffs, Virginia and Parker Koshelnik-Turner, both Medicaid recipients under the

age of 21 who were covered by the EPSDT mandate, moved to enjoin the cuts as applied to children. *See Koshelnik-Turner v. Dreyfus*, NO. 3:09-cv-05379-RBL (W.D. Wash. 2009), Dkt No. 3. Judge Ronald B. Leighton temporarily enjoined the cuts to children's services and encouraged CMS to "weigh in" on whether the EPSDT mandate applied to the Department's assessment of children's need for MPC services. *See Id.*, Dkt. 25.

CMS did "weigh in." On July 29, 2009, the agency wrote Kathy Leitch, Assistant Secretary for the Department. *See Id.*, Dkt. #36-2, Letter from Barbara Richards, Appendix A. CMS opined that the EPSDT mandate applies to MPC programs – even those utilizing the state assessment process authorized under 42 U.S.C. 1396d(a)(24) as Washington does. "Since PCS [personal care services] for children is a component of the mandatory EPSDT benefit, as discussed above, States generally cannot impose limitations on medically necessary services for individuals under age 21, because such limitation would be inconsistent with the EPSDT statutory benefit." Letter from Barbara Richards, Appendix A. The Department cannot ignore the EPSDT mandate because it has opted to use its own state assessment for MPC services.¹⁰

¹⁰Shortly after the issuance of the CMS policy statement, the Department settled the *Koshelnik-Turner* case. *Koshelnik-Turner* Dkt. #43.

“Meaningful consideration” -- the term adopted by the trial court (CP 251 at CL6) – is the touchstone of the EPSDT mandate. “[M]eaningful consideration of recipients' individual circumstances is a key factor in the validity of the regulation under the federal EPSDT statutes and regulations.” *Semerzakis v. Commissioner of Social Services*, 873 A.2d 911, 927 (Conn. 2005) (emphasis added). Without “meaningful consideration” of treating medical providers’ recommendations, state regulations that employ a standardized assessment procedure fall into “fatal conflict” with the federal EPSDT law. *Id.* In *Semerzakis*, the disputed assessment process related to children’s orthodontic coverage. In that case, EPSDT-eligible children seeking orthodontia underwent a standardized assessment process to determine their need for the service. *Id.* at 915. Children who had a certain score were eligible. *Id.* For children who did not meet the required score, the state’s regulation required the Medicaid agency to “consider additional information of a substantial nature” including the particular recommendations of treating medical providers. *Id.* at 915, 926.

This second prong represented “a safety net for the consideration of individual circumstances of recipients who have a genuine medical need for orthodontic treatment that is not reflected in their assessment score.” *Id.* at 927. Thus, state regulations that allow for individualized

consideration of treating medical providers' recommendations -- outside of the standardized assessment process -- are generally valid under EPSDT. *Id.* Conversely courts have invalidated state regulations that do not allow for such "meaningful consideration" of individual recommendations of medical necessity. *See Chappell v. Bradley*, 834 F. Supp. 1130, 1134 (N.D. Ill. 1993); *Jacobus v. Dept. of PATH*, 857 A.2d 785, 790-92 (Vt. 2004)).

Finally, the Department cannot evade its EPSDT obligations with respect to MPC services based on Washington law. See Appellant's Opening Brief at 24. RCW 74.09.520(4) and RCW 74.39.005(2) require the Department to "design and implement" an assessment process that is "uniform" and comprehensive, but these requirements do not prevent the Department from "meaningfully considering" treating medical providers' recommendations as part of the assessment process. Even if a conflict between the state statute and the federal EPSDT mandate existed (which Respondent does not concede it does), the federal EPSDT law would control. *See Lankford*, 451 F.3d at 510 ("While Medicaid is a system of cooperative federalism...once the state voluntarily accepts the conditions imposed by Congress, the Supremacy Clause obliges it to comply with federal requirements"); *State v. Awawdeh*, 72 Wn. App. 373, 376, 864 P.2d 965, 967 (1994) (holding that state law is preempted by federal

statutes where “the goals sought or the obligations imposed reveal a purpose to preclude state authority”) (citing *Inlandboatmen's Union v. Department of Transp.*, 119 Wn.2d 697, 701, 836 P.2d 823 (1992)).

c. *The Department's rules do not allow it to consider MPC recommendations for children by treating medical providers.*

The EPSDT requirement for consideration of the treating medical provider's recommendations must be implemented in one of two ways: (1) the state must obtain, consider and give substantial weight to the recommendations of children's treating physicians *as part of its CARE assessment process*; or (2) by establishing a “second prong” whereby children's treating medical providers may submit their personal care treatment recommendations for “meaningful consideration” *outside of the standardized CARE assessment process*. *Semerzakis*, 873 A.2d 911. The Department's rules do neither.

The Department's CARE assessment does not permit any consideration (meaningful or otherwise) of children's treating medical providers' recommendations. No consideration of a treating medical provider's recommendation is permitted under WAC 388-106-0130 or -0213. Neither rule provides for EPSDT benefits based upon a recommendation by a treating medical provider. *See* WACs 388-106-

0130, and 0213, attached hereto as Appendix D. The CARE tool formula above dictates a child's MPC benefit.

A child's CARE assessment is based largely upon adults' reports about what the child actually did or did not do in the last 7 days. *See* WAC 388-106-0213 (2); -0075; -0010 (limiting the coding of children's CARE assessment to activities of daily living that occurred or didn't occur in the preceding 7 days). The Department may request this specific information from other sources that witnessed the child's activities in the preceding 7 days. WAC 388-106-0050; 0075. "Other sources" including a treating medical provider may also be contacted. *Id.*

Information from the "other sources" is explicitly limited by rule. The information sought -- including that from a medical provider -- may only address whether the client did or did not do certain activities within the relevant time period. *See* WAC 388-106-0010; 0050 (2); 0075 (reports from other sources may only change the *coding* of a client's "self-performance" of activities). *The medical provider's EPSDT recommendations cannot increase the ultimate number of personal care hours the child receives nor prevent the automatic reductions mandated in WAC 388-106-0213 (2) and (3).*

WAC 388-106-0140 reflects this limitation. It poses the question “What may change the maximum number of hours that I can receive for in-home personal care services?” In response, DSHS states:

The maximum number of in-home personal care hours you can receive may change:

(1) When you have a change in any of the criteria listed in WAC 388-106-0125 and/or 388-106-0130; or

(2) Because you meet the criteria in WAC 388-440-0001, an exception to rule is approved by the department for in-home personal care hours in excess of the amount determined to be available to you by the CARE tool.

Id. There is no “second prong” or safety net alternative. *Semerzakis*, 873 A.2d 911, at 927. The treating medical provider is not mentioned. EPSDT is ignored.

The Department’s Exception to Rule (ETR) rule, WAC 388-440-0001, is also insufficient to serve as a “second prong” to prevent Washington’s assessment process from falling into “fatal conflict” with EPSDT. *See* Appellant’s Opening Brief at 11; *Semerzakis*, 873 A.2d 911, at 927. The ETR rule requires a recipient to show more than just medical necessity in order to obtain the requested service. For example, under WAC 388-440-0001(b), clients must show that their needs “differ from the majority.” As discussed above in Section V.A.2, additional criteria such as this are impermissible under EPSDT. *See Rosie D.*, 410 F. Supp. 2d at 26. Moreover, WAC 388-106-1315 only allows appeals if

services have been reduced due to an ETR being terminated. The initial decision by DSHS to grant an “Exception to Rule” is entirely discretionary and cannot be appealed to ensure satisfaction of Medicaid fair hearing requirements in 42 C.F.R. § 431.220. For these reasons, the Department’s ETR does not save its MPC rule for children.

As the superior court found, the Department’s rules “override, without any consideration, the recommendations of a child’s medical provider.” CL 7. Because the rules do not allow the Department to consider medical provider recommendations, they violate EPSDT.

3. WAC 388-106-0213 (2) and (3) contain irrefutable presumptions that violate Medicaid comparability.

a. The Children’s MPC rules reduce MPC services without an individualized determination of each child’s need.

The two rules at issue here, WAC 388-106-0130(3)(b) and WAC 388-106-0213 result in across-the-board reductions in children’s MPC services based upon the Department’s “irrefutable presumptions” about children’s needs. WAC 388-106-0130 requires the Department to reduce MPC services for children under the age of 18 pursuant to the “guidelines” codified in WAC 388-106-0213. The two rules automatically reduce the MPC services of children under the age of 18 by presuming that when a child lives with a “natural/step/adoptive” parent, her assessed needs are

“met” (*i.e.*, that no assistance is required – whether that is the case or not) three-quarters of the time. *See* WAC 388-106-0213(3). The rules also impose automatic reductions for all children based upon age, not actual need. WAC 388-106-0213(2). The Department imposes these reductions as across-the-board cuts. These reductions are not based upon the Department’s assessment of each child’s individual needs.

In *Jenkins*, the Washington Supreme Court affirmed this Court when it invalidated a different provision of the CARE tool called the “shared living” rule which established an irrebuttable presumption that 15 percent of an adult recipient’s needs were met if the recipient lived with his or her in-home paid caregiver. 160 Wn.2d at 292 (affirming *Gasper v. DSHS*, 129 P.3d 849 (2006)). Based upon the Medicaid recipient’s living situation, the Department automatically reduced the number of service hours the recipient could receive. *Id.*

The Supreme Court rejected the Department’s use of this sort of irrebuttable presumption:

We agree that DSHS may use the CARE assessment program to initially classify, rate, and determine a recipient's level of need because this process is consistent with the Medicaid program's purpose. *DSHS violates the comparability requirement when it reduces a recipient's benefits based on a consideration other than the recipient's actual need.* A 15 percent reduction across the board for all recipients who live with their caregivers does not address, and in fact *ignores, the realities of the recipients' individual situations.*

Id. at 299 (emphasis added). The court continued:

Once a person is assessed to require and receive a certain number of care hours, *the assessment cannot be reduced absent a specific showing that fewer hours are required.* To “presume” some recipients need fewer hours of care without individualized determination violates the comparability requirement....*The needs of a recipient are not presumed met without an individual assessment.*

Id. at 300. (emphasis added).

The “shared living” rule was invalid because the rule assumed that an individual’s personal care needs were met “without an individualized determination” simply because the recipient lived with his or her caregiver. *Id.* (citing to 42 U.S.C. § 1396a(a)(10); 42 C.F.R. § 440.240.)

The irrebuttable presumptions in WAC 388-106-0213 (2) and (3) operate similarly to the invalid shared living rule. After the Department determines a child’s “base hours” for MPC services, WAC 388-106-0213 requires it to automatically reduce the hours depending upon the child’s living situation and age. The Department never assesses whether the child’s needs will be met if services are reduced. *See Jenkins*, 160 Wn.2d at 300. There is no mechanism in the rule by which these reductions may be disputed. As a result, younger children receive fewer MPC services than similarly situated older children or adults with the same needs, in violation of 42 U.S.C. § 1396a(a)(10)(B) and 42 C.F.R. § 440.240. *See also* Appellant’s Opening Brief at 25-26 (admitting that the rule treats

children differently than adults and results in fewer hours for children based on living situation and age). Just like the shared living rule, WACs 388-106-0130(3)(b) and 388-106-0213 (2) and (3) violate Medicaid comparability.

b. The Department's assumptions about children's living situation and age violate Medicaid Comparability and EPSDT.

The Department argues that it may reduce children's MPC services because parents would ordinarily provide these services to their children, if the children were non-disabled. Appellant's Opening Brief at 26 and 29. The Department cannot avoid its obligation to individually assess the needs of Medicaid child recipients by arguing that its "irrebuttable presumptions" about children's needs reflect parental responsibilities. Appellant's Opening Brief at 26 and 29. The Department's irrebuttable presumptions for children are just as improper as its presumptions were about adults who live with their caregivers, which the Supreme Court held to be invalid in *Jenkins*. Specifically, the Department's argument fails for the following reasons:

First, federal and state law entitle Medicaid eligible children to all medically necessary MPC services. 42 U.S.C. §§ 1396d(r)(5); 1396d(a)(24); RCW 74.09.520; *see* Letter from Barbara Richards, Appendix A ("medically necessary PCS [personal care services] are part

of a mandatory benefit for individuals under age 21”). There is no exception to EPSDT or Medicaid comparability that permits states to reduce services based upon assumptions about what parents should or should not do for their children. No law establishes a specific amount of personal care assistance that parents must provide to their disabled children before public assistance will be provided.

Second, the Department’s decision to reduce MPC services of children is based upon an arbitrary guess about what nondisabled children need. The Department asserts that its rule “codifies the age below which all children are presumed to have the same personal care needs” and results in reductions based on a “global benchmark” of what nondisabled children need by virtue of their age. Appellant’s Opening Brief at 27 and 29. However, the Department can provide no explanation for how it determined these ages or arrived at its “benchmark.” Indeed, the rulemaking record and administrative record show that the Department did not create WAC 388-106-0213 based on any time-study, evaluation, or assessment measuring the amount of time and effort parents of nondisabled children undertake to perform the identified tasks. CP 253 at FF 14; CP at 161, ¶2; *compare to Jenkins*, 160 Wn.2d at 202. No evidence in the record before the court supports the Department’s litigation-driven assertion that WAC 388-106-0213 is based upon a

reliable “reference to what a fully abled child can do.” *See* Appellant’s Opening Brief at 29. The reductions in WAC 388-106-0213 are apparently based on the rule-drafter’s hunch about what parents of non-disabled children do. The Department’s rule -- which cuts some children’s MPC services by 75 percent based upon nothing more than a guess -- is arbitrary and capricious. CP 267, 268 at CL 3, 9, 10.

Third, the Department’s position incorrectly equates MPC services to the care provided by all parents to their children. *See* Appellant’s Opening Brief at 31-32. Unlike the care parents provide, MPC services are, as a matter of federal and state law, “medical assistance.” 42 U.S.C. §§ 1396d(r)(5); 1396d(a)(24); RCW 74.09.520. Appellant opted to provide Medicaid personal care services to adults and is required to offer it to children. *See* Appendix A, Letter from Barbara Richards. Washington state law also treats MPC differently than routine parenting functions. Unlike parents, MPC providers are required to receive specific training on how to care for people with disabilities. RCW 74.39A.073. Even parents must complete training to be an MPC provider of their adult son or daughter with a developmental disability. RCW 74.39A.075. State law thus does not contemplate that parenting functions and MPC services are synonymous.

Fourth, the Department's presumption that "all children below a certain age require the same sort of assistance regardless of whether they have a disability" ignores the individual nature of children's needs when they have a disability. Appellant's Opening Brief at 26.

The Department's example of a young child's bathing needs illustrates this problem. *Id.* at 29. Some small children with disabilities will have similar bathing needs as their peers. Other children with disabilities may require significantly more assistance. For example, a child may require multiple baths in a day because of incontinence. Others, like Samantha, may have challenging behaviors that require more caregiver time (and possibly more than one caregiver) to complete her bathing.

The Department's irrebuttable assumptions about what parents of non-disabled children do "ignores the realities of the recipients' individual situations." *Jenkins*, 160 Wn.2d at 299. Across-the-board cuts result in service reductions that do not reflect an individual's actual needs. *Id.* Using the Department's bathing example: if a child under the age of five is assessed to need "total" bathing assistance, WAC 388-106-0213 does not simply subtract the amount of time nondisabled children at certain ages are presumed to need help with bathing from the amount of time the child with a disability is assessed to need this assistance. Instead, the rule

requires the Department to reduce the amount of time the child is assessed to need bathing assistance by 100 percent. These reductions occur even if the child, due to a mental or physical disability, needs someone to spend two, three, or four times as long as a parent of a non-disabled child would to provide bathing assistance.

In other words, under the rules, it does not matter whether a four-year-old child with a disability needs someone to spend half an hour or 2 hours providing bathing assistance each day. The Department's rules prevent coverage of *any* MPC services for bathing the child. The rule eliminates all of the service hours for that task. After the cut is made, the Department does no assessment to determine whether the child's needs will be met. *See Jenkins*, 160 Wn.2d at 300. There is no mechanism in the rule to dispute these reductions. The Department's presumption that the needs of the child with a disability are identical to her peers' needs is irrebuttable.

Fifth, the Department's assumptions that the care needs of children with disabilities can be mostly or completely met by parents and informal caregivers contradicts the State's own policies to assume total responsibility to provide for 24 hour, 7 days a week out-of-home care to children with disabilities like Samantha's. The Department's position is at odds with the legislature's recognition that some parents are unable to care

for a child with disabilities. The Department runs institutions like Fircrest and Francis Hadden Morgan, which provide 24-hour per day, 365 days per year care to children and adults with developmental disabilities.¹¹ RCW 71A.20.010. The legislature also created a voluntary placement foster care program for children with developmental disabilities under RCW 74.13.350¹² because it “recognizes that, *because of the intense support required to care for a child with developmental disabilities*, the help of an out-of-home placement may be needed.” RCW 74.13.350 (emphasis added).

The needs of children with these kinds of disabilities are no less intense simply because their parents choose to keep them in their own homes. The Department’s position in this case -- that children with extraordinary care needs can and should have most or all of their needs met by their parents -- flies in the face of the Department’s own out-of-home placement programs that were designed to provide children with

¹¹Without MPC and other support services, children become at high risk of institutionalization. Predictors of Out of Home Placement among Children with Developmental Disabilities; DSHS, Division of Developmental Disabilities, July 2008. <http://www.dshs.wa.gov/pdf/ms/rda/research/5/34.pdf>

¹²This is the statute the Department cites to stand for the proposition that the legislature intends parents of children with disabilities to be responsible for their care. Appellant’s Opening Brief at 29.

disabilities the care the legislature has acknowledged parents cannot always be expected to provide.

B. The superior court's award of attorney fees was not an abuse of discretion and should be upheld.

The Superior court applied well-settled law to well-supported facts when it awarded Samantha A. attorneys fees. Both parties agree that “the proper analytical framework to guide a trial court in an attorney fee case is the ‘lodestar’ method”. CP 395; *see also Highland School Dist. No. 203 v. Racy*, 149 Wn. App 307, 316, 202 P.3d 1024, 1029 (2009) (holding that the trial court must have an “objective basis” for its award and does not abuse its discretion in applying the lodestar amount absent mandatory authority requiring this method). The “lodestar method” is to multiply “a reasonable hourly rate by the number of hours reasonably expended on the matter.” *Broyles v. Thurston County*, 147 Wn. App 409, 452, 195 P.3d 985,1107 (2008).

Samantha's attorneys provided detailed declarations accounting for the amount of time they spent on each activity, listing the amount of time to the tenth of the hour and describing the activities they were conducting. CP at 317-323, 377-388. They also testified in their declarations that the amount of time they billed was reduced to account for activities that could be perceived as duplicative or unnecessary (i.e. time spent reviewing one another's edits, strategizing with one another). *Id.* Their declarations, and

declarations by two other Medicaid attorneys practicing in their geographic area, also provided evidence that the rates charged were reasonable. *Id.*; CP at 426-440. Based on this evidence, the superior court granted Samantha's request for fees.

The Department argues that the superior court should have imposed a \$25,000 cap on attorney fees. Appellant's Opening Brief at 35. Such a cap would have been a reduction of the lodestar amount without proper justification. After reaching the "lodestar amount," courts may to adjust the award "either upward or downward to reflect factors not already taken into consideration". *Broyles*, 147 Wn. App at 452. For this adjustment, courts may consider 1) assumption of risk by the attorneys, and 2) quality of their work. *Id.*; *Morgan*, 166 Wn.2d at 539. Neither of these factors would weigh in favor of a reduction. To the contrary, Samantha's counsel took her case without guarantee of compensation and the superior court favorably acknowledged their work. CP 339. Both of these factors would instead support an upward fee adjustment which Samantha and her attorneys did not request. The Department provided no other evidence to suggest the lodestar amount should be reduced.

The Department's sole argument for this drastic reduction relies on an inapplicable statute.¹³ As the Department correctly points out, the "EAJA is the basis for attorney fees for judicial reviews of agency actions that are *not otherwise provided for by statute.*" Appellant's Opening Brief at 35 (emphasis added). This appeal, however, was brought under RCW 74.08.080 which explicitly provides for attorneys fees for successful appeals of the Department's decisions.

RCW 74.08.080(3) provides:

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 superior court reasonably exercised discretion in refusing to impose a cap on attorney fees because the plain language of RCW 74.08.080 does not include any cap.

Furthermore, "Attorney fee awards under cost-shifting statutes should include consideration of the purpose of the statute." *Highland School Dist.*, 149 Wn. App at 316 The legislative intent for RCW 74.08.080 does not justify imposing a fee cap:

¹³In *Jenkins v. DSHS*, the Supreme Court specifically declined to use cost limitations from RCW 4.84.010 for a case in which costs were authorized under RCW 74.08.070, the statute that applied in that case and that applies here. *Jenkins v. Department of Social and Health Services*, 160 Wn.2d at 302.

“[T]he fundamental underpinning of the fee award provision is a policy at once *punitive and deterrent* – a corrective policy which would discipline respondent for violations of Title 74 RCW or of its own regulations, by shifting to the respondent the costs of righting its mistakes.”

Tofte, 85 Wn.2d at 165 (emphasis added). Limiting fee awards to \$25,000 for cases challenging benefit-reducing rules would severely compromise the deterrent effect of the fee-shifting statute. *Id.*

The case at bar epitomizes the legislative policy behind the fee-shifting statute. At every turn, the Department has ignored the clear legal requirements in this area. **First**, during the rulemaking process, the Department disregarded oral and written testimony that its proposed rules violated EPSDT. Rulemaking Record 409, 484, 486-488 (included in Administrative Record). **Second**, after the *Jenkins* decision was issued, the Department continued to implement the irrebutable presumption in the children’s MPC rules, even though the rules were similarly flawed and vulnerable to challenge. *See Jenkins*, 160 Wn.2d 287; VRRP 36:5-7. **Third**, and most recently, the Department took no action to address the legal violations in this case even after it was told by CMS that across-the-board reductions in MPC services to children were improper. Appendix A, Letter from Barbara Richards. It is precisely this conduct that the legislature intended to deter by enacting RCW 74.08.080(3).

If a court strays from the lodestar formula of a reasonable hourly rate multiplied by a reasonable number of hours worked, it “will typically have a difficult time establishing that the award of attorney fees is actually reasonable.” *Highland School Dist.* 149 Wn. App at 317. “The burden of justifying any deviation from the ‘lodestar’ rests on the party proposing the deviation.” *Bowers v. Transamerica Title Insurance Co.*, 100 Wn.2d 581, 598 (1983) (citing *Copeland v. Marshall*, 641 F.2d 880, 892 (D.C. Cir. 1980)).

In this case, the Department has not met its burden to justify a downward deviation from the lodestar amount. The Department asked for a significant reduction in the lodestar amount without submitting any evidence that the two factors courts may consider for an adjustment would justify a reduction or citing to any other applicable objective standard. *See Morgan v. Kingen*, 166 Wn.2d at 526. The superior court’s attorney fee decision was a reasonable decision that should be upheld.

VII. ATTORNEY FEES

Pursuant to RAP 18.1(a), Respondent requests an award of attorney fees and costs on appeal. The attorney fees and costs are supported by RCW 74.08.080, the same statute cited above that awards fees and costs to the prevailing party in Superior Court as well as the Court of Appeals and the Supreme Court.

VIII. CONCLUSION

For the foregoing reasons, the superior court decision should be affirmed.

DATED: January 13, 2010.

DISABILITY RIGHTS WASHINGTON



Susan Kas, WSBA # 36592
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**SIRIANNI YOUTZ
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Attorneys for Appellants

Certificate of Service

I certify, under penalty of perjury pursuant to the laws of the State of Washington, that on January 13, 2010, I caused to be served by legal messenger a true and correct copy of the foregoing Second Amended Brief of Respondent upon counsel of record as indicated below:

Bruce Work
Assistant Attorney General
7141 Cleanwater Drive SW
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Attorneys for Appellant
Washington State Department of Social and Health Services

DATED: January 13, 2010 at Seattle, Washington.

Mona Rennie

Mona Rennie, Legal Assistant
Disability Rights Washington

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COURT OF APPEALS
DIVISION II
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STATE OF WASHINGTON
BY LM
DEPUTY



JUL 29 2009

Region 10
2201 Sixth Avenue, MS/RX 43
Seattle, Washington 98121

Kathy Leitch, Assistant Secretary
Aging and Disability Services Administration
Department of Social and Health Services
P.O. Box 45015
Olympia, WA 98504-5010

Dear Ms. Leitch:

I am writing in response to your letter dated July 9, 2009, regarding the delivery of personal care services and the pending court order in the *Koshelnik-Turner v. Dreyfus* case. The question you asked the Centers for Medicare & Medicaid Services (CMS) to respond to in your letter is as follows:

Do States have flexibility under Medicaid to make adjustments to benefit levels for in-home personal care services because of budget constraints, so long as the client health and safety and opportunity to live in the community are not compromised?

Background

Medicaid is a jointly funded Federal-State program that provides medical assistance benefits to needy individuals in accordance with an approved State plan. Within a broad Federal framework under title XIX of the Social Security Act (the Act), 42 U.S.C. 1396 et seq., each State has considerable flexibility in administering State Medicaid programs.

Under section 1905(a)(24) of the Act, 42 U.S.C. 1396d(a)(24), a State may elect to provide a benefit under its approved State Medicaid plan for personal care services (PCS), including "in home personal care services." The requirements set forth at 42 CFR 440.167 allow for delivery of PCS as an optional service to individuals who are not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease.

In addition to this optional benefit, medically necessary PCS are also part of a mandatory benefit for individuals under age 21. Section 1905(r) of the Act, 42 USC 1396d(r)(5) defines "early and periodic screening, diagnostic, and treatment services" (EPSDT) which must be provided to eligible individuals under the age of 21. Section 1905(r)(5) specifies that coverage of EPSDT must include "such other necessary health care, diagnostic services, treatment, and other measures described in section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan."

Page 2 - Kathy Leitch, Assistant Secretary

Medicaid benefits must be provided in accordance with an approved Medicaid State plan, as well as all relevant federal and state statute and regulations. Under Federal regulations at 42 CFR 430.10, the Medicaid State plan is required to be "a comprehensive written statement...describing the nature and scope of [the State] Medicaid program." In addition, 42 CFR 430.12(c) specifies that a formal State Plan amendment is required to be submitted for review and approval by CMS whenever necessary to reflect change in Federal law, regulations, policy interpretations, or court decisions; or material changes in State law, organization, or policy, or in the State's operation of the Medicaid program.

Response

A State may limit the amount, duration, or scope of an optional service as long as the limitations are consistent with the requirements of 42 CFR 440.230 and are specified in the approved State plan. Since PCS for children is a component of the mandatory EPSDT benefit, as discussed above, States generally cannot impose limitations on medically necessary services for individuals under age 21, because such limitation would be inconsistent with the EPSDT statutory benefit. Appropriate limitations consistent with 42 CFR 440.230(d), based on such criteria as "medical necessity or on utilization control procedures" are permissible. For example, a requirement for prior authorization for additional services is permitted. For children, however, the final coverage decision must be based on an individualized determination of medical necessity, made on a case-by-case basis. An across-the-board reduction in services that caps the services provided to a child regardless of medical necessity does not meet this standard.

Thank you for contacting me with regard to this matter. Should additional information be required please feel free to contact me at (206) 615-2267 or barbara.richards@cms.hhs.gov.

Sincerely,



Barbara K. Richards
Associate Regional Administrator
Division of Medicaid and Children's
Health Operations

cc:

Cindy Mann, Director, CMSO
Jackie Garner, Consortium Administrator, CMCHO
Terry Pratt, Acting Group Director, DEHPG
Dianne Heffron, Acting Group Director, FCHPG

NUMBERED PAGES

**GENERAL PROGRAM
ADMINISTRATION**

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: WASHINGTON

Citation

42 CFR
430.10

(Omitted
45 CFR
Part 201,
AT-70-141)

As a condition for receipt of Federal funds under
title XIX of the Social Security Act, the

DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Single State Agency)

submits the following State plan for the medical
assistance program, and hereby agrees to administer
the program in accordance with the provisions of this
State plan, the requirements of titles XI and XIX of
the Act, and all applicable Federal regulations and
other official issuances of the Department.

Introduction

5010. OVERVIEW

A. Early and Periodic Screening, Diagnostic and Treatment Benefit.--Early and periodic screening, diagnostic and treatment services (EPSDT) is a required service under the Medicaid program for categorically needy individuals under age 21. The EPSDT benefit is optional for the medically needy population. However, if the EPSDT benefit is elected for the medically needy population, the EPSDT benefit must be made available to all Medicaid eligible individuals under age 21.

B. A Comprehensive Child Health Program.--The EPSDT program consists of two, mutually supportive, operational components:

- o assuring the availability and accessibility of required health care resources and
- o helping Medicaid recipients and their parents or guardians effectively use them.

These components enable Medicaid agencies to manage a comprehensive child health program of prevention and treatment, to systematically:

- o Seek out eligibles and inform them of the benefits of prevention and the health services and assistance available,
- o Help them and their families use health resources, including their own talents and knowledge, effectively and efficiently,
- o Assess the child's health needs through initial and periodic examinations and evaluation, and
- o Assure that health problems found are diagnosed and treated early, before they become more complex and their treatment more costly. Although "case management" does not appear in the statutory provisions pertaining to the EPSDT benefit, the concept has been recognized as a means of increasing program efficiency and effectiveness by assuring that needed services are provided timely and efficiently, and that duplicated and unnecessary services are avoided.

C. Administration.--You have the flexibility within the Federal statute and regulations to design an EPSDT program that meets the health needs of recipients within your jurisdiction. Title XIX establishes the framework, containing standards and requirements you must meet.

WAC 388-106-0130

How does the department determine the number of hours I may receive for in-home care?

(1) The department assigns a base number of hours to each classification group as described in WAC 388-106-0125.

(2) The department will deduct from the base hours to account for informal supports, as defined in WAC 388-106-0010, or other paid services that meet some of an individual's need for personal care services, including adult day health, as follows:

(a) The CARE tool determines the adjustment for informal supports by determining the amount of assistance available to meet your needs, assigns it a numeric percentage, and reduces the base hours assigned to the classification group by the numeric percentage. The department has assigned the following numeric values for the amount of assistance available for each ADL and IADL:

				Value
Meds	Self Performance	Status	Assistance Available	Percentage
Self administration of medications	Rules for all codes apply except independent is not counted	Unmet	N/A	1
		Met	N/A	0
		Decline	N/A	0
		Partially met	<1/4 time	.9
			1/4 to 1/2 time	.7
			1/2 to 3/4 time	.5
			>3/4 time	.3
Unscheduled ADLs	Self Performance	Status	Assistance Available	Value Percentage
Bed mobility, transfer, walk in room, eating, toilet use	Rules apply for all codes except: Did not occur/client not able and Did not occur/no provider = 1; Did not occur/client declined and independent are not counted.	Unmet	N/A	1
		Met	N/A	0
		Decline	N/A	0
		Partially met	<1/4 time	.9
			1/4 to 1/2 time	.7
			1/2 to 3/4 time	.5
			>3/4 time	.3
Scheduled ADLs	Self Performance	Status	Assistance Available	Value Percentage
Dressing, personal hygiene, bathing	Rules apply for all codes except: Did not occur/client not able and Did not occur/no provider = 1; Did not occur/client	Unmet	N/A	1
		Met	N/A	0
		Decline	N/A	0
		Partially met	<1/4 time	.75
			1/4 to 1/2 time	.55

	declined and independent are not counted.		1/2 to 3/4 time	.35
			>3/4 time	.15
IADLs	Self Performance	Status	Assistance Available	Value Percentage
Meal preparation, Ordinary housework, Essential shopping	Rules for all codes apply except independent is not counted.	Unmet	N/A	1
		Met	N/A	0
		Decline	N/A	0
		Partially met	<1/4 time	.3
			1/4 to 1/2 time	.2
			1/2 to 3/4 time	.1
			>3/4 time	.05
IADLs	Self Performance	Status	Assistance Available	Value Percentage
Travel to medical	Rules for all codes apply except independent is not counted.	Unmet	N/A	1
		Met	N/A	0
		Decline	N/A	0
		Partially met	<1/4 time	.9
			1/4 to 1/2 time	.7
			1/2 to 3/4 time	.5
			>3/4 time	.3

Key:

> means greater than

< means less than

(b) To determine the amount of reduction for informal support, the value percentages are totaled and divided by the number of qualifying ADLs and IADLs needs. The result is value A. Value A is then subtracted from one. This is value B. Value B is divided by three. This is value C. Value A and Value C are summed. This is value D. Value D is multiplied by the "base hours" assigned to your classification group and the result is the number of in-home hours reduced for informal supports.

(3) Also, the department will adjust in-home base hours when:

(a) There is more than one client receiving ADSA-paid personal care services living in the same household, the status under subsection (2)(a) of this section must be met or partially met for the following IADLs:

- (i) Meal preparation;
- (ii) Housekeeping;
- (iii) Shopping; and
- (iv) Wood supply.

(b) You are under the age of eighteen, your assessment will be coded according to age guidelines codified in WAC 388-106-0213.

(4) In addition to any determination of unmet need in (2)(a) when you are not affected by (3) above, the department will score the status for meal preparation as unmet when you adhere to at least one of the following special diets:

- (a) ADA (diabetes);
- (b) Autism diet;
- (c) Calorie reduction;
- (d) Low sodium;
- (e) Mechanically altered;
- (f) Planned weight change program;
- (g) Renal diet; or

(h) Needs to receive nutrition through tube feeding or receives greater than twenty-five percent of calories through tube or parenteral feeding.

(5) In addition to any determination of unmet need in (2)(a) when you are not affected by (3) above, the department will score the status for housework as unmet when you are incontinent of bladder or bowel, documented as:

- (a) Incontinent all or most of the time;
- (b) Frequently incontinent; or
- (c) Occasionally incontinent.

(6) After deductions are made to your base hours, as described in subsections (2) and (3), the department may add on hours based on your living environment:

Condition	Status	Assistance Available	Add On Hours
Offsite laundry facilities, which means the client does not have facilities in own home and the caregiver is not available to perform any other personal or household tasks while laundry is done.	N/A	N/A	8
Client is >45 minutes from essential services (which means he/she lives more than 45 minutes one-way from a full-service market).	Unmet	N/A	5
	Met	N/A	0
	Partially met	<1/4 time	5
		between 1/4 to 1/2 time	4
		between 1/2 to 3/4 time	2
>3/4 time	2		
Wood supply used as sole	Unmet	N/A	8

source of heat.	Met	N/A	0
	Declines	N/A	0
	Partially met	<1/4 time	8
		between 1/4 to 1/2 time	6
		between 1/2 to 3/4 time	4
>3/4 time		2	

(7) In the case of New Freedom consumer directed services (NFCDS), the department determines hours as described in WAC 388-106-1445.

(8) The result of actions under subsections (2), (3), (4), (5) and (6) is the maximum number of hours that can be used to develop your plan of care. The department must take into account cost effectiveness, client health and safety, and program limits in determining how hours can be used to meet your identified needs. In the case of New Freedom consumer directed services (NFCDS), a New Freedom spending plan (NFSP) is developed in place of a plan of care.

(9) You and your case manager will work to determine what services you choose to receive if you are eligible. The hours may be used to authorize:

- (a) Personal care services from a home care agency provider and/or an individual provider.
- (b) Home delivered meals (i.e. a half hour from the available hours for each meal authorized).
- (c) Adult day care (i.e. a half hour from the available hours for each hour of day care authorized).
- (d) A home health aide if you are eligible per WAC 388-106-0300 or 388-106-0500.
- (e) A private duty nurse (PDN) if you are eligible per WAC 388-71-0910 and 388-71-0915 or WAC 388-551-3000 (i.e. one hour from the available hours for each hour of PDN authorized).
- (f) The purchase of New Freedom consumer directed services (NFCDS).

[Statutory Authority: RCW 74.08.090, 74.09.520, 08-23-011, § 388-106-0130, filed 11/6/08, effective 12/7/08; 08-03-111, § 388-106-0130, filed 1/22/08, effective 2/22/08. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.030, 06-16-035, § 388-106-0130, filed 7/25/06, effective 8/25/06. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020, 06-05-022, § 388-106-0130, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0130, filed 5/17/05, effective 6/17/05.]

WAC 388-106-0213

How are my needs assessed if I am a child applying for MPC services?

If you are a child applying for MPC services, the department will complete a CARE assessment and:

- (1) Consider and document the role of your legally responsible natural/step/adoptive parent(s).
- (2) The CARE tool will determine your needs as met based on the guidelines outlined in the following table:

Activities of Daily Living (ADLs)																		
Ages	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
• = Code status as Met																		
Medication Management																		
Independent, self-directed, administration required, or must be administered	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Locomotion in Room^{Note}																		
Independent, supervision, limited or extensive	•	•	•	•														
Total	•	•																
Locomotion Outside Room^{Note}																		
Independent or supervision	•	•	•	•	•	•												
Limited or extensive	•	•	•	•														
Total	•	•																
Walk in Room^{Note}																		
Independent, supervision, limited or extensive	•	•	•	•														
Total	•	•																

of																			
bathing																			
Total	▪	▪	▪	▪	▪														
Dressing																			
Independent or supervision	▪	▪	▪	▪	▪	▪	▪	▪	▪	▪	▪	▪							
Limited or extensive	▪	▪	▪	▪	▪	▪	▪												
Total	▪	▪	▪	▪	▪														
Personal Hygiene																			
Independent or supervision	▪	▪	▪	▪	▪	▪	▪	▪	▪	▪	▪	▪							
Limited or extensive	▪	▪	▪	▪	▪	▪	▪												
Total	▪	▪	▪	▪	▪														

Instrumental Activities of Daily Living

Ages		0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
▪ = Code status as Met																			
Telephone																			
Independent, supervision, limited, extensive, or total	▪	▪	▪	▪	▪	▪	▪	▪	▪	▪	▪	▪	▪	▪	▪	▪	▪	▪	▪
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	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Meal Preparation																			
Independent, supervision, limited, extensive, or total	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•

NOTE: If the activity did not occur, the department codes self performance as total and status as met.

Ages																		
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
Additional guidelines based on age																		
Diagnosis	•	•	•	•	•	•												
Is client comatose? = No																		
Pain Daily = No	•	•	•	•	•	•												
Any foot care needs																		
Status = Need met	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Any skin care (other than feet)																		
Status = Need met	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Speech/Hearing																		
Score comprehension as understood	•	•	•															
MMSE can be administered = no	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Memory																		
Short term memory ok	•	•	•	•	•	•	•	•	•	•	•	•						

Long term memory ok	▪	▪	▪	▪	▪	▪	▪	▪	▪	▪	▪								
Depression																			
Select interview = unable to obtain	▪	▪	▪	▪	▪	▪	▪	▪	▪	▪	▪								
Decision making																			
Rate 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	▪	▪	▪	▪	▪	▪													
Treatment																			
Passive range of motion Need = No	▪	▪	▪	▪															

(3) In addition, determine that the status and assistance available are met or partially met over three-fourths of the time, when you are living with your legally responsible natural/step/adoptive parent(s).

[Statutory Authority: RCW 74.08.090, 74.09.520, 07-24-026, § 388-106-0213, filed 11/28/07, effective 1/1/08; 07-10-024, § 388-106-0213, filed 4/23/07, effective 6/1/07. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020, 06-05-022, § 388-106-0213, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0213, filed 5/17/05, effective 6/17/05.]