

NO. 40811-2

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

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FAITH FREEMAN,

Appellant,

v.

DEPARTMENT OF SOCIAL AND HEALTH SERVICE,

Respondent.

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**DSHS RESPONSE BRIEF AND OPENING BRIEF ON CROSS-  
APPEAL**

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## I. INTRODUCTION

Faith Freeman is a Medicaid eligible client of the state Department of Social and Health Services (DSHS or the Department) Division of Developmental Disabilities.<sup>1, 2</sup> As a Medicaid client, she is entitled to compulsory Medicaid services. This includes, for the time between Ms. Freeman's 18th and 21st birthdays, early and periodic screening, diagnostic, and treatment (EPSDT) services, as defined by federal law, that are medically necessary. Ms. Freeman appeals agency action denying payment to her parents, in their capacity as her personal care providers, for their around-the-clock supervision of her. Ms. Freeman claims that medically necessary EPSDT services include all time spent by her parents with her, including time when they were not assisting her with a personal care task, as well as time not directly spent with her at all, such as when she was in one room of the family home and her parents were in another.<sup>3</sup> The final agency order as confirmed by the superior court correctly

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<sup>1</sup> The Appellant Faith Freeman will be referred to herein as Ms. Freeman. Her parents, Loren and Jean Freeman, will be referred to by first and last name; collectively as "the Freemans"; or by their role as parents, guardians, landlords, or personal care providers.

<sup>2</sup> At the time period relevant to this review, DSHS was the state Medicaid agency. In the 2011 legislative session, the Health Care Authority (HCA) was designated the Medicaid state agency; DSHS was ordered to cooperate with HCA in administering Medicaid services. Laws of 2011, ch. 15, §§ 24, 64.

<sup>3</sup> The Freemans, in their capacity as Ms. Freeman's guardian, essentially seek payment for 24-hour supervision of their daughter. At the administrative hearing, Ms. Freeman indicated through counsel that she requested the Freemans be paid for time when all family members were sleeping. IV RP 52. She now claims sleep is properly excluded, although it is unclear how this relates to her argument that the Department must provide all services recommended by a doctor without review, considering her physician recommended 24 hour per day supervision. *See* Opening Br. 6.

determined that general in-home supervision that does not impact Ms. Freeman's medical disabilities or conditions is not a medically necessary EPSDT service under the Medicaid program.

The superior court was also asked to determine the date from which Ms. Freeman was entitled to Department compensation to her Medicaid personal care providers. On that point, the superior court erroneously found this date to be the date of Medicaid eligibility instead of the date Ms. Freeman met all program requirements for authorization of the service. Additionally, the superior court erred in awarding attorney fees to Ms. Freeman as a partially prevailing party without an objective and reasoned basis for the specific amount awarded. From these errors, the Department appeals.

## **II. ISSUES AND ASSIGNMENT OF ERROR**

### **A. Counterstatement of Ms. Freeman's Issues**

1. Does general, around-the-clock supervision of a disabled adult in her own home, including standby availability of a caregiver in a separate room, qualify as Medicaid-covered "medical assistance" under 42 U.S.C. § 1396d(a)?

2. Where general supervision neither ameliorates any specific medical condition, illness, or defect, nor is "medically necessary," does the federal Medicaid Act require DSHS to provide such supervision as an EPSDT service?

3. Must DSHS defer to a clinician's mere statement that a service is "medically necessary," even when the service is not medical in nature, is not aimed at correcting or ameliorating a particular medical issue, and is not otherwise a Medicaid-covered service?

4. Where an administrative tribunal sends the parties an initial order with an appeal deadline of 21 days, and later amends the initial order with a new 21-day appeal deadline, does a review judge abuse his discretion by finding that compliance with the deadline set by the second notice is a timely appeal, either because the time for appeal ran from the second notice or because the second notice constitutes "good cause" for the appealing party to disregard the earlier deadline set by the first notice?

5. Is Ms. Freeman entitled to attorney fees on appeal?

**B. Department's Issues on Cross Appeal**

1. Do Medicaid regulations require a state to retroactively authorize and pay for personal care services provided by an unauthorized caregiver prior to the Medicaid patient completing all of the steps necessary to authorize the service? (Cross-Appellant's Assignment of Error, Conclusion of Law (CL) 8, CP 353).

2. Does an award of attorney fees that includes duplicative work and weighs the amount of work performed on prevailing claims inconsistently with the history of the case constitute an abuse of discretion? (Cross-Appellant's Assignment of Error, Finding of Fact 5, 6, CL 9, CP 352-53).

### III. COUNTER-STATEMENT OF THE CASE <sup>4</sup>

#### A. Procedural History

##### 1. History Of The First Administrative Appeal Of Ms. Freeman's 2004 Assessment For Personal Care Services

This case involves appeal of three separate assessments for personal care services performed by the Department in 2004, 2005, and 2006. Ms. Freeman first requested an administrative hearing to appeal the 2004 authorization of personal care, claiming in part that authorization for personal care must include every hour she is in the same home or company as her personal care providers. AR 49S, 62S, 113, 337, 1064. The Office of Administrative Hearings (OAH) limited the scope of the hearing and would not consider federal arguments, including EPSDT arguments. *See* AR 376-77. Ms. Freeman appealed the resulting Initial Order to the DSHS Board of Appeals, and the Board's Final Order to the Thurston County Superior Court. Administrative appeals of Ms. Freeman's 2005 and 2006 assessments were stayed pending this review. The superior court remanded the 2004 appeal back to OAH with instructions to allow evidence and arguments germane to Ms. Freeman's claims under Medicaid law, specifically her claims involving EPSDT

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<sup>4</sup> References are to the agency Adjudicative Record (AR), the agency Report of Proceedings (RP), and the superior court Clerk's Papers (CP). The agency Adjudicative Record was certified in two parts with independent page numbering, 1S- 205S, and 1-1294. The Report of Proceedings was certified in parts I-IV, each with independent page numbering.

services. AR 323-336, 386-88; *see* AR 49S. It was there consolidated with the 2005 and 2006 appeals. AR 376-379.

On this first petition for judicial review, Ms. Freeman was awarded attorney fees for the successful portions of her claims in achieving the remand. AR 386-88. Although Ms. Freeman did not succeed on her EPSDT claim for supervisory services, this issue was briefed and argued by the parties. *See* AR 325.

## **2. Procedural History Subsequent To Remand**

Following a hearing on the merits, OAH issued a second Initial Order on June 27, 2008. AR 30-60; *see* AR 19S. On the Department's motion, a Corrected Initial Order was entered on July 3, 2008. AR 1-28, 29. Both parties requested the DSHS Board of Appeals review the Corrected Initial Order. The Board of Appeals and, pursuant to a second petition for judicial review, the superior court confirmed that the constant general supervision requested by the Appellant was not an EPSDT service. AR 83S-92S; CP 353. Both parties now appeal from the Thurston County Superior Court order issued on this second petition. *See* CP 351-54.

**B. The Department Awarded Ms. Freeman Personal Care Services To Address Her Personal Care Needs**

**1. Personal Care Services Generally<sup>5</sup>**

The Department authorizes paid personal care services for eligible individuals with disabilities who live at home or in other community based residential settings. Personal care is 1 of 28 categories of “medical assistance” that may be covered by Medicaid. Coverage for personal care is mandatory when it qualifies as an EPSDT service. *See* 42 U.S.C. § 1396d(a)(24), d(r)5; 42 C.F.R. § 440.167. DSHS rules define “personal care services” as “physical or verbal assistance with activities of daily living and instrumental activities of daily living due to [a client’s] functional limitations.” WAC 388-106-0010. Activities of daily living (ADLs) consist of 12 basic tasks, such as bathing, dressing, eating, and toilet use. *Id.* Instrumental activities of daily living (IADLs) consist of 7 other “activities performed around the house or in the community,” such as food preparation, housekeeping, essential shopping, and telephone use. *Id.* The state definition of personal care is consistent with guidance from the federal Centers for Medicare and Medicaid Services (CMS), the federal agency responsible for regulating Medicaid.<sup>6</sup>

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<sup>5</sup> The citations in this section are to the current chapter describing the Department’s Comprehensive Assessment and Reporting Evaluation (CARE), WAC ch. 388-106. From the inception of the CARE tool in 2003 through 2005, the relevant rules were found at WAC ch. 388-72A. These rules are not substantially different in ways relevant to the current issues on appeal.

<sup>6</sup> The *State Medicaid Manual*, published by CMS, describes what activities are included in personal care services:

DSHS determines each recipient's personal care hours using an instrument called the Comprehensive Assessment and Reporting Evaluation (CARE) tool. WAC 388-106-0070. General, passive, or "plain" supervision as requested by Ms. Freeman is not a personal care task and does not generate paid personal care services under Washington's rules. WAC ch. 388-106; *see* III RP 82-83. However, the level of assistance a client requires to successfully complete a personal care activity, including active supervision of the activity, is weighed by the CARE tool in determining the amount of personal care hours awarded to the client. WAC 388-106-0105, III RP 84-85. The CARE tool assigns each client to 1 of 17 classification groups, each associated with a certain level of "base hours," based on a formula that considers a client's cognitive

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Personal care services . . . covered under a State's program may include a range of human assistance provided to persons with disabilities and chronic conditions of all ages which enables them to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may be in the form of hands-on assistance (actually performing a personal care task for a person) or cuing so that the person performs the task by him/her self. Such assistance most often relates to performance of ADLs and IADLs. ADLs include eating, bathing, dressing, toileting, transferring, and maintaining continence. IADLs capture more complex life activities and include personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management. Personal care services can be provided on a continuing basis or on episodic occasions. Skilled services that may be performed only by a health professional are not considered personal care services.

CMS *State Medicaid Manual*, Pt. 4, § 4480. According to its Foreword, the *State Medicaid Manual* "is an official medium by which [CMS] issues mandatory, advisory, and optional Medicaid policies and procedures to the Medicaid State agencies." It is online at <http://www.cms.hhs.gov/Manuals/PBM/> as publication number 45.

performance, clinical complexity, moods and behaviors, performance on activities of daily living, and need for exceptional care. WAC 388-106-0125; *see* AR 101S.<sup>7,8</sup> Clients with more severe disabilities are assigned to classification groups with more base hours, while those with less severe disabilities are assigned to classification groups with fewer base hours. WAC 388-106-0080; WAC 388-106-0125. Assessments using the CARE tool may take between two and eight hours. I RP 156.

## **2. Initiation Of Paid Personal Care Services For Ms. Freeman**

Loren and Jean Freeman are Faith Freeman's parents. They are also her legal guardians, landlords, and paid personal care providers.<sup>9</sup> AR 59S, 1148, 1184-85. The Freemans applied for Medicaid eligibility on their daughter's behalf in July of 2004, the month of her 18th birthday. AR 51S. Ms. Freeman was determined to meet Medicaid criteria for

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<sup>7</sup> During the time period relevant to this appeal, there were 14, not 17 classification groups. AR 101S; former WAC 388-72A-0070 (effective 3/22/03).

<sup>8</sup> Base hours are not a measure of the time required to assist an individual with personal care tasks, but are rather a distribution by DSHS of the fixed allocation of funds appropriated by the legislature for personal care services. *See* RCW 74.09.520(4) ("The personal care services benefit shall be provided to the extent funding is available according to the assessed level of functional disability."). Base hours in the CARE assessment process will be adjusted upward or downward depending on individual circumstances. WAC 388-106-0130(2),(4); WAC 388-106-0140(2); WAC 388-44-0001.

<sup>9</sup> Ms. Freeman lives in the same house as her parents. AR 59S. Pursuant to a written rental agreement signed by Loren Freeman as landlord and then signed by Loren and Jean Freeman as guardians of Ms. Freeman, Ms. Freeman receives her own room and access to common areas in her parents' home in exchange for rent deducted from her income by the Freemans and paid to themselves. AR 60S-61S; 1184-85. The rental agreement has a clause that requires 10-day notice to enter Ms. Freeman's room as landlord, which the Freemans purport they attempt to comply with strictly. *Id.* Loren and Jean Freeman as guardians have designated themselves as Ms. Freeman's paid personal care providers. AR 59S.

categorically needy medical assistance, and received a Medicaid card backdated to July 1, 2004. *Id.*, AR 1067.

The Department initiated Ms. Freeman's initial CARE assessment prior to her birthday on July 9, 2004. AR 51S, 62S, 1065. On July 18, 2004, following an opportunity to review the assessment results, Ms. Freeman and her guardians received a service summary outlining the personal care services for which she qualified. AR 62S. However, Ms. Freeman and her parents, as both guardians and providers, did not sign and return the service summary to the Department indicating acceptance of the services until August 27, 2004. *Id.* The Department sent a notice authorizing the Freemans to provide personal care to Ms. Freeman on September 7, 2004, beginning with the month of September. AR 62S, 1068-69.<sup>10</sup>

Each of Ms. Freeman's three assessments from 2004 through 2006 resulted in an award of personal care services. *See* AR 100S-106S. At the time of hearing, the Department employees involved in Ms. Freeman's 2004, 2005, and 2006 assessments had experience performing hundreds of assessments to determine eligibility for personal care services. I RP 49, 155. Ms. Freeman's 2004 CARE assessment was based on information provided by and interviews with Ms. Freeman, her parents, and

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<sup>10</sup> Although the superior court awarded personal care hours back to July of 2004, the Freemans were not authorized to provide paid personal care services to Ms. Freeman until September 2004. CP 353; *see* AR 62S, 95S.

Ms. Freeman's primary care physician, Dr. Henry de Give. *See* AR 61S. At the option of Ms. Freeman's guardians, these services are received in her home as opposed to another setting. *See e.g.* II RP 36-37, 174; AR 1190-91. Pursuant to the superior court order under appeal, Ms. Freeman is entitled to receive 190 hours of personal care per month to assist with activities of daily living for each of the assessment periods at issue. CP 353.<sup>11</sup>

**C. Physician Recommendations Regarding "Supervisory" Services**

Ms. Freeman has a diagnosis of Trisomy 21 (Down syndrome) with documented mental retardation.<sup>12</sup> AR 1179; *see* AR 50S. Additionally, Ms. Freeman introduced the reports and/or testimony of two physicians at the 2008 OAH hearing to support her claim that general supervision is a medically necessary EPSDT service. Dr. Henry de Give performed an EPSDT screening examination of Ms. Freeman after she turned 18, in which he noted that she required "24/7 supervision." AR at 1177. Dr. de Give describes a limited need for assistance with certain activities of daily living and instrumental activities of daily living, such as

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<sup>11</sup> While factual determinations made by the Department assessor in utilizing the CARE assessment and, consequently, Ms. Freeman's classification group, were previously at issue, the Department has not further appealed the superior court's resolution of these issues.

<sup>12</sup> The Department intends no disrespect by use of the term "mental retardation" as opposed to "intellectual disability" as preferred by the newly adopted respectful language legislation. *See* RCW 44.04.280. This terminology is used only to avoid confusion as "mental retardation" was the term used by the diagnosing professionals in the record.

shopping, managing finances, and toileting. AR 1178-79. Dr. de Give did not provide any estimate of how long such assistance with activities of daily living could be expected to take in his report or in testimony.

In 2006, Dr. de Give signed a declaration, presented to the superior court in the first petition for judicial review of the 2004 appeal, in which he described the recommended supervision in language that recited terminology of federal Medicaid law verbatim (specifically, 42 U.S.C. § 1396d(a)(13) and 42 U.S.C. § 1396d(r)(5)) including that 24 hour per day supervision was necessary as “a remedial service for the maximum reduction of [Ms. Freeman’s] physical and mental disability” and to “restore her to her best functional level,” and that 24 hour per day supervision was “medically necessary to correct or ameliorate [Ms. Freeman’s] Trisomy 21 and physical illness” identified at the screening. AR 1175-76. Dr. de Give did not provide any context for how he was using these terms or what he understood their definitions to be. He gave no further explanation of why or how the recommended service complied with these requirements other than to state Ms. Freeman “needed constant supervision in order to maintain her health and safety.” *Id.*

Dr. de Give’s testimony at the hearing was often ambiguous and did not provide support for the statements in his declaration. He reiterated that Ms. Freeman required around-the-clock supervision but indicated that such supervision would not ameliorate or prevent the worsening of her

essential medical condition, Trisomy 21. III RP 43.<sup>13</sup> He stated the requested supervision would have no affect on her mental retardation or her mental condition, and would not increase her IQ. III RP 46-47. Rather, it would prevent a tragedy due to Ms. Freeman's lack of judgment, which in turn is caused by the Trisomy 21 and resulting intellectual deficits. *Id.* He noted that what would benefit Ms. Freeman "most" would be to live "in a familiar place, a familiar setting with parents who are able to care for her as long as possible," and to be involved in a "rigid exercise program" and get "as much mental stimulation as possible." III RP 46. Dr. de Give did not tie the idea of what would benefit "most" to any particular change in functional level or disability. He added that she would also need "supervision ongoing to make sure that she didn't get into any dangerous situations," "physical help with her toileting and with her menses," and "somebody who was able to watch her around the clock." III RP 46.<sup>14</sup>

Dr. Daria Sciarrone saw Ms. Freeman for an EPSDT screening exam in June 2007. AR 1260-1263. The resulting EPSDT screening report

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<sup>13</sup> The transcript indicates that Dr. de Give testified that supervision "would prevent worsening of her condition but would prevent a tragedy." This is undoubtedly a mis-transcription, since the sentence makes no sense as written. From a number of other comments, it is clear that Dr. de Give likely said that supervision *would not* prevent worsening of her condition. For example, he testified that "the medical condition itself, the Trisomy 21 would not be ameliorated [by supervision]. But the disabilities that result from that would be." III RP 44.

<sup>14</sup> Dr. de Give's primary concern seemed to be Ms. Freeman's hypertonia (low muscle tone). III RP 43. Dr. de Give didn't explain how increased attention to exercise related to the need for 24 hour per day supervision.

does not mention a need for supervision or prescribe supervision services. Prior to the screening exam, Loren Freeman sent Dr. Sciarrone a letter in which he asked her to respond to several questions. AR 1257–1259.<sup>15</sup> In her subsequent handwritten responses, Dr. Sciarrone agreed with questions regarding Ms. Freeman’s need for 24/7 “supervision/attending.” *Id.* Due to the ambiguity of the questionnaire and Dr. Sciarrone’s responses, the Department sent her two follow-up letters asking her to clarify her responses. AR 883-885; *see* III RP 140-150. Dr. Sciarrone reiterated that Ms. Freeman needs “plain supervision” and “has need to be assisted w/ self care/toileting.” AR 883. She did not provide an estimate of the level of assistance required for these specific tasks or the amount of time required to complete them. Dr. Sciarrone did not testify at the hearing.

Loren Freeman testified at hearing that Ms. Freeman’s cognitive level and abilities were stable and not expected to change. II RP 164-66. He testified about the types of things he and Jean Freeman do with Ms. Freeman—the “services” they are requesting compensation for—including taking her to various places in the community such as church, as well as time spent simply being in the same house as Ms. Freeman, whether or not they were in the same room, and time spent when both she

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<sup>15</sup> Loren Freeman prefaced the questionnaire by advising Dr. Sciarrone against following the Department’s suggestion to contact the Department’s representative if she had questions, since in his experience, “the department uses such oral contacts as an opportunity to inject policy standards that are not consistent with the law.” AR 1257.

and her parents are sleeping. II RP 248-254; *see* IV RP 52. Loren Freeman “billed” Ms. Freeman for every hour in the month in which she was not in school or another form of paid care for the period in question from her 18th to 21st birthday. III RP 236-38; IV RP 50; AR 1230-1232. He then, as Ms. Freeman’s guardian, brought an administrative appeal on Ms. Freeman’s behalf seeking an order to require the Department to pay him and his wife for every hour that Ms. Freeman lived in their home.

**D. The Department’s Determination That General Supervision Is Not An EPSDT Service**

Following appeal of OAH’s Corrected Initial Order on remand, the DSHS Board of Appeals review judge found the constant supervision recommended by Ms. Freeman’s physicians to be largely undefined, describing it essentially as aimed at general safety or ensuring Ms. Freeman comes to no harm. AR 90S. Overturning the Initial Order, the review judge concluded he could not find the requested service met the requirements of an EPSDT service simply because the physician recited the language from the relevant regulations. AR 83S-92S. Instead, after analyzing the description of the services recommended and what they purported to do, the review judge concluded the services were not medical or remedial services resulting in the reduction of Ms. Freeman’s disability or restoration of her functioning level. He stated that as the requested supervision would neither cure nor improve any of Ms. Freeman’s medical

conditions, it was not a covered EPSDT service at all. *Id.* In relevant part, the superior court agreed that the requested supervision was not remedial in nature and was not an EPSDT service under either 42 U.S.C. § 1396d(a)(13) or (a)(24). CP 353.

#### IV. ARGUMENT IN RESPONSE

##### A. Standard of Review

The Administrative Procedure Act, chapter 34.05 RCW, governs this Court's review of agency action. *See generally* RCW 34.05.570; *Utter v. Dep't of Soc. & Health Servs.*, 140 Wn. App. 293, 402, 165 P.3d 399 (2007). A reviewing court applies the Administrative Procedure Act standards directly to the agency final order, sitting in the same position as the trial court, which was sitting in its appellate capacity. *Verizon Nw., Inc. v. Empl. Sec. Dep't*, 164 Wn.2d 909, 915, 194 P.3d 255 (2008). Under the Administrative Procedure Act the "burden of demonstrating the invalidity of agency action is on the party asserting invalidity." RCW 34.05.570(1)(a).

RCW 34.05.570(3) provides nine grounds on which an agency adjudication may be reversed. Notably, Ms. Freeman has not specifically cited *any* ground under the Administrative Procedure Act on which her appeal is based. She argues, "DSHS failed to invoke the jurisdiction of the Board of Review" and that "supervisory services prescribed in her EPSDT screenings qualify as medical assistance under 42 U.S.C. §

1396d(a),” but does not identify how these claims provide a basis for reversal. If Ms. Freeman intends to suggest that the Department’s final order exceeds its statutory authority per RCW 34.05.570(3)(b), or that the Department “has erroneously interpreted or applied the law” per RCW 34.05.570(3)(d), those allegations fail, as is explained in detail below. *See* Opening Br. 33. Ms. Freeman identifies factual findings from the final agency order in her assignment of error, but then states, “the only factual issues on appeal are the additional findings of fact” regarding attorney fees. Opening Br. 12.<sup>16</sup> Ms. Freeman appears to argue that supervision is a form of medical assistance as a matter of law; and, as a result, factual inquires, such as whether her parents’ supervision actually has any ameliorative affect on any of her conditions or restores or improves her functioning level, are irrelevant. *See Id.*

When reviewing an administrative action, courts review findings of fact for substantial evidence in light of the whole record. RCW 34.05.570(3)(e). Questions of law are reviewed de novo.

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<sup>16</sup> In her briefing to this court, Ms. Freeman has not challenged the validity of any personal care rules. *See* Opening Br. 2-4; 12-14. Ms. Freeman similarly did not argue invalidation of any rule before the Superior Court. CP 394-414. To the extent Ms. Freeman’s original Petition for Judicial Review requested remedies including invalidation of one or more rules pursuant to RCW 34.05.570(2)(c) or (3)(a), those claims are now abandoned. *See* RAP 10.3(4), (6); *Graves v. Dep’t of Empl. Sec.*, 144 Wn. App. 302, 311-312, 182 P.3d 1004 (2008) (Court of Appeals would not review claims where only passing mention was made in the appellant’s brief); *Saviano v. Westport Amusements, Inc.*, 144 Wn. App. 72, 84, 180 P.3d 874 (2008) (appellate court does not address issues that a party neither raises appropriately nor discusses meaningfully with citations to authority on appeal from a trial court’s judgment).

*Ames v. Dep't of Health*, 166 Wn.2d 255, 260-61, 208 P.3d 549 (2009). However, the court must accord “substantial weight to an agency’s interpretation of a statute within its expertise, and to an agency’s interpretation of rules that the agency promulgated.” *Verizon Nw.*, 164 Wn.2d at 915 (internal citations omitted). As a result, if there is ambiguous regulatory language, the Court should uphold an agency’s interpretation where it is plausible and consistent with the legislative intent. *ZDI Gaming, Inc., v. Gambling Comm’n*, 151 Wn. App. 788, 806, 214 P.3d 938 (2009); *Alpine Lakes Prot. Soc’y v. Dep’t of Natural Res.*, 102 Wn. App. 1, 14, 979 P.2d 929 (1999).

**B. General Supervision As Requested By Ms. Freeman Is Not An EPSDT Service The Department Must Provide**

Medicaid is a cooperative state-federal program through which states receive federal funding to assist with the medical treatment of needy individuals. *Wilder v. Virginia Hosp. Ass’n*, 496 U.S. 498, 502, 110 S. Ct. 2510, 110 L. Ed. 2d 455 (1990). The Medicaid Act prescribes substantive requirements governing the scope of each state’s program. *See* 42 U.S.C. § 1396; *Curtis v. Taylor*, 625 F.2d 645, 649 (5th Cir. 1980). One such requirement is that states must provide “early and periodic screening, diagnosis and treatment services,” more commonly referred to as EPSDT services, to Medicaid eligible individuals under the age of 21. 42 U.S.C. § 1396d(r).

States, however, do have some power to limit services otherwise mandated by the Medicaid Act. For example, states may establish the amount, duration, and scope of an EPSDT benefit, so long as limitations are reasonable and the EPSDT service is sufficient to achieve its purpose. *See Moore ex rel. Moore v. Reese*, 637 F.3d 1220, 1235 (11th Cir. 2011); *S.D. ex rel. Dickson v. Hood*, 391 F.3d 581, 593 (5th Cir. 2004). Additional limitations may include criteria such as medical necessity or utilization control procedures. *Moore*, at 1232-33, 42 U.S.C. § 1396a(30)(a); 42 C.F.R. § 440.230(d). Washington recognizes its duty to comply with EPSDT regulations. *See* former WAC 388-534-0100.<sup>17</sup>

The scope of EPSDT services prescribed by the Medicaid Act is broad but not without limitation. In addition to screening, vision, dental, and hearing services, states are directed to provide:

[S]uch other necessary health care, diagnostic services, treatment, and other measures *described in section (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) (emphasis added). Therefore, the state must provide EPSDT coverage consistent with a two pronged inquiry: first, a requested service must fall within one of the 28 types of medical assistance described in section (a) of 42 U.S.C. § 1396d, and, second, such

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<sup>17</sup> The current version of this regulation can be located at WAC 182-534-0100.

service must be medically necessary to correct or ameliorate the Medicaid eligible client's condition, illness or defect.

Ms. Freeman argues that any service—in this case constant “supervisory care”—must be provided without limitation if prescribed in an EPSDT screening as “medically necessary”. Opening Br. 23, 28-29.<sup>18</sup> Her contentions in support of this argument are inconsistent with the plain language of the Medicaid Act, infringe on the authority of state and federal agencies and the courts to interpret statutory and regulatory language, are unsupported by the case law she cites, and would lead to absurd results in this case. The Medicaid Act does not obligate the Department to provide “supervisory care” because general supervision is neither a type of medical assistance covered by the EPSDT mandate nor has the required impact on Ms. Freeman’s medical conditions to be considered an EPSDT service.

**1. Around The Clock General Supervision Is Not A Covered Type Of “Medical Assistance” As Defined By 42 U.S.C. § 1396d(a)**

The Medicaid Act defines EPSDT services to include the 28 types

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<sup>18</sup> In making this argument, Ms. Freeman appears to contend that a physician is exclusively entitled to determine and/or define: 1) what services are the types of EPSDT-mandated covered medical assistance under 42 U.S.C. § 1396d(a); 2) what it means under 42 U.S.C. § 1396d(a)(13) to result in a maximum reduction of physical or mental disability and restore an individual to the best possible functional level; and 3) what it means to correct or ameliorate defects, illnesses, and conditions discovered by EPSDT screening services. Additionally, Ms. Freeman claims that her physician solely decides what “medically necessary” means, whether a given service is medically necessary, and what amount of a given service is medically necessary.

of medical assistance described in 42 U.S.C. § 1396d(a). 42 U.S.C. § 1396d(r)5. Ms. Freeman erroneously claims general supervision is both an “other . . . rehabilitative service” pursuant to subsection (a)(13) and a personal care service pursuant to subsection (a)(24) and. Because it is neither, it is not a type of screening, diagnostic, or treatment service required by the Medicaid Act.

**a. General Supervision That Does Not Impact Ms. Freeman’s Disability And Neither Improves Nor Restores Her Functional Level Is Not An “Other Remedial Service” Under 42 U.S.C. § 1396d(a)(13)**

The covered types of medical assistance defined by § 1396(d)(a) include:

[O]ther 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.

42 U.S.C. § 1396d(a)13. A service will only be considered an “other service” under this category of medical assistance if it meets the particular criteria in this subsection. The requested general supervision in this case does not.

The supervision requested by Ms. Freeman is neither medical nor remedial. General supervision, including passive supervision when the

Freemans are not even in the same room as their daughter, is not expressly medical in nature. Nor can it be considered remedial, because it does not seek to heal or restore any of Ms. Freeman's medical problems.

Further, the language of 42 U.S.C. § 1396d(a)13 clearly requires a nexus between the service requested and the reduction of *disability* or restoration of an individual's *functional level*. As discussed *infra*, general supervision would do nothing to change Ms. Freeman's underlying condition of Trisomy 21, and it would not improve her resulting intellectual disability or increase her IQ. *See* Argument section (B)(2)(a) *infra* at 28-30; III RP 43-47. Nothing in the record establishes that general supervision, which under Ms. Freeman's theory is provided even when she is alone in her room, reduces Ms. Freeman's disability or improves her functional level. Such supervision does not have any direct relationship to the cognitive disability causing her lack of judgment. As concluded by the DSHS Board of Appeals and the superior court, supervision is not an "other diagnostic, screening, preventive, or rehabilitative" service defined in 42 U.S.C. § 1396d(a)(13).

The Department is unaware of any case law in which supervision of a child is discussed in the context of EPSDT. Ms. Freeman relies on the inapposite Ohio state court case of *Parents League for Effective Autism vs.*

*Jones-Kell*,<sup>19</sup> 565 F. Supp. 2d 905, 916-97 (S.D. Ohio 2008); Opening Br. 24-25. *Parents League* involved the distinction between rehabilitative services, which restore functioning to a prior level, and habilitative services, which improve functioning level reduced by disability. The court concluded that the “other services” described at § 1396d(a)(13) should be construed to include services that are either rehabilitative or habilitative. *Parents League*, at 915-917.<sup>20</sup> General supervision as requested by the Freemans is neither: it doesn’t restore *or* improve Ms. Freeman’s functional ability.

General supervision is neither medical nor remedial. It would not lead to the maximum reduction of Ms. Freeman’s disability. It does nothing to improve or restore her functional level. Simply observing that supervision is required for the general safety of a person with Ms. Freeman’s cognitive ability requires no medical expertise and is not

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<sup>19</sup> Ms. Freeman’s brief is confusing in this regard as she first takes issue with the superior court’s order that the requested service was not *remedial* in nature, and then provides an analysis of why the service could be considered a “rehabilitative” service. The definition at issue uses both terms, including rehabilitative services which are either remedial or medical in nature.

<sup>20</sup> Ms. Freeman’s quote from *Parents League* reciting that Medicaid requires states to cover services found by a physician to be medically necessary is taken out of context. The court did not hold all the relevant language of the Medicaid Act superfluous, such that a physician’s statement of medical necessity was entirely dispositive of any EPSDT inquiry. Instead, the court found that plaintiff had provided sufficient evidence that the requested service *is* a medically necessary service that provides for the maximum reduction of mental or physical disability. *Id.* at 917. Nearly all cases cited by Ms. Freeman take great care to review the evidence provided of the medical necessity of a requested service and its nexus with particular results. *See e.g. Rosie D. v. Romney*, 410 F. Supp. 2d 18, 23-24, 30-32 (D. Mass. 2006).

“within the scope of [a physician’s] practice under state law.” As found by the DSHS final order and the superior court, passive, “plain,” or general supervision is not an “other . . . rehabilitative service” as defined by 42 U.S.C. § 1396d(a)(13).

**b. General Supervision Is Not A Personal Care Service Under 42 U.S.C. § 1396d(a)(24)**

Personal care services are another required type of medical assistance described in 42 U.S.C. § 1396d(a). 42 U.S.C. § 1396d(a)(24). Personal care services offered in Washington State provide active physical and verbal assistance with specific enumerated tasks: activities of daily living (bathing, bed mobility, body care, eating, locomotion, walking, medication management, toilet use, transfers, and personal hygiene) and instrumental activities of daily living (meal preparation, housework, shopping, wood supply, travel to medical services, managing finances, telephone use). WAC 388-106-0010. A client who requires assistance in the form of supervision to successfully complete these activities will receive personal care services to enable performance of those tasks. WAC 388-106-0105, III RP 84-85. However, general, passive, or plain supervision of the ambiguous nature requested by Ms. Freeman is clearly not a personal care task under Medicaid law or under the Department’s personal care rules.

Ms. Freeman does not argue that the “supervisory care” requested

is a personal care service under the Department's rules. Nor does she argue her allotted personal care assistance is insufficient to enable performance of personal care tasks.<sup>21</sup> Instead, Ms. Freeman argues the Department must include general supervision as a personal care task because a former version of the Department's rule did so.<sup>22</sup> The pertinent question, however, is whether the current, applicable version of the Department's rule comports with the definition of personal care in the Medicaid Act. It does.

The Medicaid Act provides little specificity about the nature of personal care services covered by 42 U.S.C. § 1396d(a)(24). A more detailed description of personal care services, however, is provided in the *CMS State Medicaid Manual*. *CMS State Medicaid Manual* § 4480 (a personal care provider gives hands-on assistance or cueing to enable

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<sup>21</sup> Neither Loren Freeman nor Ms. Freeman's medical providers attempted to quantify the level of assistance or amount of time required for personal care tasks. See Statement Of The Case section (C) *supra* at 10-14. Loren Freeman's "billing" statement consisted of a time sheet which indicated how many hours a day Ms. Freeman was at home or otherwise in the company of one of her parents, however, presented no evidence of the amount of time required to complete the personal care tasks enumerated in the Department's rules. AR 1230-1232.

<sup>22</sup> Ms. Freeman also argues supervision must be a type of EPSDT medical assistance because supervision is provided at community residential placements. Opening Br. 25. While it is true that clients may be supervised in certain residential programs that are funded by Medicaid, such as adult family homes or supported living agencies that support clients in their own homes, supervision is not a separate service funded by Medicaid, nor is it a personal care service. The relevance of these programs to the present case is unclear. Ms. Freeman originally appealed her award of personal care services, not a denial under one of these programs. Her choice to remain at home and be cared for by her parents as personal care providers, as opposed to living in an adult family home, is her own, not the Department's. The Department similarly does not control the type of qualifications and licensure her parent providers choose to pursue.

persons with disabilities to accomplish activities of daily living and instrumental activities of daily living that they would normally do for themselves if they did not have a disability); *see* Statement of the Case section (B)(1) *supra* at 6-8. Courts have accorded CMS interpretations of the Medicaid Act, such as that found in the *State Medicaid Manual*, ‘respectful consideration’ based on the agency’s expertise, the statute’s complexity and technical nature, and the broad authority delegated to the Secretary of Health and Human Services under the Act.” *Katie A., ex rel. Ludin v. Los Angeles Cy.*, 481 F.3d 1150, 1155 n.11 (9th Cir. 2007) (citations omitted). Like the CMS description, Washington State offers personal care services that provide active physical and verbal assistance enabling clients to accomplish daily tasks.<sup>23</sup> The Department’s regulations are entirely consistent with federal definitions of personal care.

In support of her proposition that “supervisory care” is a personal care service, Ms. Freeman relies on *S. D. v. Hood*, a Fifth Circuit case that considered the inclusion of incontinence briefs in other state Medicaid plans as evidence that CMS endorsed a definition of a covered category of medical assistance (home health care services) that included incontinence

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<sup>23</sup> Similar to the CARE algorithm, CMS contemplates “supervision” as personal care assistance when a client requires cueing along with active supervision to ensure the client completes a personal care task, such as dressing, properly. *CMS State Medicaid Manual* at § 4480(C)1.

briefs. 391 F.3d 581; Opening Br. 23. Reliance on *S.D. v. Hood* is misplaced.

First, there is no evidence in the record that the supervisory services requested by Ms. Freeman were ever explicitly included (and, therefore, tacitly endorsed by CMS) in Washington's state plan or in any other state Medicaid plan. Instead, Ms. Freeman cites to a former version of a Department rule, involving an entirely different assessment process for personal care, that was repealed and replaced by the CARE tool prior to Ms. Freeman's 2004 assessment. *See* former WAC 388-71-0203, former WAC 388-72A-0010; WAC ch. 388-106; *see also* WSR 04-19-103, WSR 05-11-082, WSR 06-05-022; I RP 207, 212-214. Further, adoption of a state plan does not imply that every administrative regulation has been thoroughly vetted and approved by CMS. Indeed, the only relevant evidence in the record in this case is that the prior system of personal care rules, including the rule cited by Ms. Freeman, was changed to the CARE system to comply with an audit by federal regulators.<sup>24</sup> I RP 212-214. The existence of a former rule, particularly a rule that was part of a group of regulations altered at the behest of federal regulators, in no way indicates CMS has approved a definition of personal care that must

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<sup>24</sup> Personal care services were formerly assessed under a different tool, called the "Legacy" tool. I RP 207. The CARE tool was developed to replace the Legacy tool following an audit and instruction by federal regulators. I RP 212-214.

include the general supervision requested by Ms. Freeman.<sup>25</sup>

The supervision requested by Ms. Freeman is not a type of medical assistance required by § 1396d(r)5. As it is not an EPSDT service, the state is not required to provide it.

**2. Even If General Supervision Were “Medical Assistance,” It Would Still Not Be An EPSDT Service Because It Does Not Correct Or Ameliorate Ms. Freeman’s Identified Conditions And It Is Not Medically Necessary**

If a service is a covered type of medical assistance, the Medicaid Act requires states to provide that service only if it additionally (1) is necessary to correct or ameliorate the defects, physical and mental illnesses, and conditions discovered by EPSDT screening services, and (2) is medically necessary. The supervision requested by Ms. Freeman is neither. Thus, even if general supervision qualified as medical assistance under 42 U.S.C. § 1396d(a), which it does not, the Department would not be required to provide it.

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<sup>25</sup> Even assuming CMS was aware of and approved the Department’s prior assessment and allocation of personal care, that system did not award the service requested by Ms. Freeman. What limited testimony was provided on the matter established that supervision needs were considered under the old rules, but personal care hours still were far less than 24 hours per day. I RP 207-208. The CRM testified to her best memory, a client would only receive additional hours up to the maximum amount that could be awarded: not more than 96 hours of personal care per month, although this may have been a slight underestimate. *See Id.*, former WAC 388-71-0203(4)(b) (indicating maximum hours to be 116).

**a. General Supervision Does Not Correct Or Ameliorate Any Identified Defect, Illness, Or Condition**

The Medicaid Act does not require a state to provide any and every service that is beneficial to a child simply because it was recommended by a physician.<sup>26</sup> Under the plain language of § 1396d(r)5, Medicaid requires coverage of EPSDT services only if the service corrects or ameliorates specific *medical* problems: the defects and physical and mental illnesses and conditions discovered by the screening services.<sup>27</sup> The Medicaid Act does not require any service or benefit that might be said to improve the general well-being and safety of a child if it does not correct or ameliorate

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<sup>26</sup> For example, while Dr. de Give testified it would be to Ms. Freeman's maximum benefit to "live in a familiar place," Medicaid EPSDT requirements do not mandate the state Medicaid agency to pay Ms. Freeman's rent or her parents' mortgage. See III RP 43; see also *Moore*, 637 F.3d at 1242-44 (state is not required to fund desirable but medically unnecessary services.)

<sup>27</sup> At the superior court, much emphasis was placed on whether EPSDT covers services provided by non-medical providers. Such emphasis misdirects attention from the context of the case, which, at its core is about medical care. Whether or not a service is provided by a medical provider, Medicaid requirements are inherently *medical* in nature. Medicaid was designed to fund states that provide *medical* coverage to low income individuals. *Wilder*, 496 U.S. at 502. States must only provide a recommended EPSDT service if it is *medically* necessary. The EPSDT requirements at 42 U.S.C. § 1396d(r)5 mandate provision of the types of *medical* assistance described in its subsection (a). All cases discussing EPSDT, including those cited by Ms. Freeman, have involved treatments or products that are undeniably medical in nature. See, e.g., *Rosie D. v. Romney*, 410 F. Supp. 2d 18 (D. Mass. 2006) (behavioral supports and crisis services); *Chisholm v. Hood*, 133 F. Supp. 2d 894 (E.D. La. 2001) (services from a licensed psychologist); *Pittman by Pope v. Sec'y, Fla. Dep't of Health & Rehab. Servs.*, 998 F.2d 887 (11th Cir. 1993) (organ transplants); *Punikaia v. Clark*, 720 F.2d 564 (9th Cir. 1983) (hospital care); *Atkins v. Rivera*, 477 U.S. 154, 106 S. Ct. 2456, 91 L. Ed. 2d 131 (1986) (medical assistance eligibility); *Collins v. Hamilton*, 349 F.3d 371 (7th Cir. 2003); *Pediatric Specialty Care v. Arkansas*, 293 F.3d 472 (8th Cir. 2002) (health management services); *S.D. ex rel. Dickson v. Hood*, 391 F.3d 581 (5th Cir. 2004) (incontinence underwear).

a specific medical defect, illness, or condition.<sup>28</sup> 42 U.S.C. § 1396d(r)5.

Determining whether a prescribed service corrects or ameliorates a condition, defect, or illness of Ms. Freeman requires first determining the parameters of the service prescribed and second the effects of that service on Ms. Freeman's conditions, defects, or illnesses. Ms. Freeman's opening brief refers to the requested service as "supervisory care." At hearing or in written reports, Dr. de Give and Dr. Sciarrone reference generally to "supervision," but provide little other information germane to what is encompassed by that term.<sup>29</sup>

Dr. de Give stated Ms. Freeman requires, "supervision ongoing to make sure that she didn't get into any dangerous situations." III RP 46. While not prescribing supervision as part of her EPSDT screening, Dr. Sciarrone later described a "need" for "plain supervision." AR 883. At hearing, Ms. Freeman requested her parents be compensated for every hour spent with her in the community or under the same roof, including when Ms. Freeman was alone in her room, watching TV, or sleeping. II RP 248-254, III RP 247-48; IV RP 50-52; AR 1230-1232. The Board of Appeals review judge described the service as "keeping track of [Ms. Freeman] and ensuring that she comes to no harm." AR 90S.

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<sup>28</sup> In context, the Medicaid Act's use of the word "condition" does not mean one's general state of being, but instead references specific "conditions" that, like defects and illnesses, are appropriate for identification through medical screening.

<sup>29</sup> See Statement of the Case section (C) *supra* at 10-14.

Dr. de Give also testified that the recommended “supervision,” or the general availability of adults, would have no effect on Ms. Freeman’s underlying medical condition, Down Syndrome. III RP 43, 47. Such services would not improve her mental retardation or increase her IQ.<sup>30</sup> Instead, Dr. de Give testified that supervision would prevent worsening of Ms. Freeman’s condition because it would “prevent a tragedy” such as Ms. Freeman being “abducted.” *Id.* Such results, while desirable, do nothing to correct or ameliorate Ms. Freeman’s identified medical conditions.

Nothing in the Medicaid Act or case law interpreting the Medicaid Act requires the Department to defer to an EPSDT screening provided by a medical provider that recites verbatim and without explanation the Medicaid requirement that his prescribed treatment is “medically necessary” to “correct or ameliorate” a condition, when the facts of the case and the physician’s direct testimony indicate otherwise.

**b. General Supervision Having No Direct Impact On Ms. Freeman’s Medical Conditions Is Not Medically Necessary**

Although the standard of “medical necessity” is not explicitly

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<sup>30</sup> At hearing, Dr. de Give provided testimony regarding how attention to exercise was recommended to alleviate Ms. Freeman’s hypertonia. *See e.g.* III RP 43. However, the 24-hour supervision and availability of adults was clearly requested to address safety concerns stemming from Ms. Freeman’s lack of judgment, not her need for exercise. That Ms. Freeman’s condition and personal care needs were stable and not expected to improve was repeatedly stated by Ms. Freeman in her own presentation of the case. *See e.g.* II RP 164-65, AR 278.

denoted in the Medicaid Act, it has become a judicially accepted component of the federal scheme. *Moore*, 637 F.3d at 1232-33 (citations omitted). Even if a category of medical services or treatments is mandatory under the Medicaid Act, participating states must provide those medical services or treatments for Medicaid recipients only if they are medically necessary. *Id.*

Washington's definition of medical necessity states:

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

Former WAC 388-500-0005.<sup>31</sup>

For the same reasons the general supervision services requested by Ms. Freeman are not necessary to correct or ameliorate Ms. Freeman's Down Syndrome or mental retardation, the services are not medically necessary. General supervision does not *alleviate* any of Ms. Freeman's *conditions* because it is not designed to address Ms. Freeman's medical conditions or directly impact their symptoms. Nor does it prevent the

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<sup>31</sup> This definition is now found at WAC 182-500-0070.

worsening of Ms. Freeman's Down Syndrome or intellectual disability. Therefore, supervision is not "necessary" to prevent, diagnose, correct, cure, alleviate, or prevent worsening of Ms. Freeman's medical conditions because supervision is not calculated to address her medical conditions at all. Dr. de Give's testimony made clear the prescribed supervision was instead aimed to address Ms. Freeman's general safety. III RP 43-47

Ms. Freeman argues that the last sentence of the Department's definition of medical necessity ("[f]or the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all.") indicates that the "supervisory care" she requested must be a covered EPSDT service. Opening Br. 27-28. This argument is doubly flawed. First, the Medicaid Act, not the Department's rule, determines what types of medical assistance are within the covered scope of EPSDT services. As discussed above, if a service is not a type of medical assistance listed in 42 U.S.C. § 1396d(r)(5) (and by inference § 1396d(a)), it is not required at all. Second, focusing purely on whether the type of general supervision at issue is medically necessary, the plain language of the rule indicates that it is not.

The first sentence of the rule establishes that to be "medically necessary" a requested service must be reasonably calculated to do one of a list of things, i.e. prevent, correct, cure, etc. a medical condition. The second sentence then identifies factual scenarios that disqualify a service

from being considered “medically necessary,” even if it otherwise met the criteria in the first sentence. The availability of an equally effective “course of treatment” including “mere observation” or “no treatment at all” is a factual scenario that negates finding that an otherwise qualifying service is medically necessary.<sup>32</sup> Given this structure, the rule can not reasonably be read to affirmatively establish that observation or, to take Ms. Freeman’s argument to its logical extreme, doing nothing, are themselves “recommended services” calculated to “prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions.” Instead, they are circumstances by comparison to which a requested service will lack medical necessity.

Regardless of whether the 24-hour general supervision requested by Ms. Freeman is potentially a type of medical assistance encompassed by EPSDT regulations, the record does not establish the requested service is medically necessary to correct or alleviate any of the illnesses or conditions discovered through her EPSDT screening.

**3. The Department Is Entitled To Review A Physician’s Statement That Providing A Service Is Medically Necessary**

**a. States Are Entitled To Review Medical Necessity**

States are entitled to establish the amount, duration, and scope of

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<sup>32</sup> The rationale for this portion of the rule is obvious. If doing nothing is as effective as a requested service in correcting, curing, or alleviating a condition, the requested service is not properly described as “necessary”.

the services provided under the EPSDT benefit; so long as certain EPSDT mandates are followed. *Moore*, 637 F.3d at 1236 (citations omitted); 42 C.F.R. § 440.230; *see also S.D. v. Hood*, 391 F.3d at 591. A state may review the amount of care prescribed by a treating physician and make its own determination of medical necessity. *See Moore*, at 1257; 42 C.F.R. § 440.230(d) (providing that the state Medicaid agency “may place appropriate limits on a service based on such criteria as medical necessity”; CMS *Manual* § 5122(F) (instructing state Medicaid agencies that “[y]ou make the determination as to whether the service is necessary”); *Rush v. Parham*, 625 F.2d 1150, 1155 (5th Cir. 1980) (holding that a “state Medicaid agency can review the medical necessity of treatment prescribed by a doctor”).

The Department is not required to provide services prescribed by a physician “without limitation” as Ms. Freeman claims. *See* Opening Br. 23. First, the service must be an EPSDT service. Here, it is not. However, even assuming that the supervisory services requested by Ms. Freeman could be a covered form of medical assistance, the Department is not bound by a physician’s statement that a service, or a particular amount of the service, is medically necessary. For personal care services, the role of the Department is increased as provision of these services need not involve a recommendation from a medical professional at all. 42 U.S.C. § 1396d(a)(24); 42 C.F.R. 440.167.

Ms. Freeman has not offered any relevant authority in support of her blanket proposition that “the EPSDT Screening is Controlling” or that “the opinion of the screening physician is controlling” to determine the type or amount of “medically necessary” personal care services she requires. *See* Opening Br. 28-30. First, Ms. Freeman cites to a superior court order that affords no authority, persuasive or otherwise. Second, she references two letters, one of which does not appear in the record below and is impermissibly attached to the Appellant’s brief. RAP 10.3(8); *see* Opening Br. App., Attach. T. Although the letters are from a federal agency, because they lack the indicia of deliberative administrative review, they are not entitled to deference. *Cordall v. State ex rel. Dep’ts of Veterans Affairs & Soc. & Health Servs.*, 96 Wn. App. 415, 980 P.2d 253 (1999). Lastly, Ms. Freeman excerpts *S.D. v. Hood* out of context. *See* Opening Br. 29.

None of the referenced authority is related to the question of whether the Department can determine if the amount of a service identified in an EPSDT screen is medically necessary or place other appropriate limitations on the amount, duration, and scope of a type of medical assistance enumerated by 42 U.S.C. § 1396d(a). In fact, none of the federal case law cited by Ms. Freeman that interprets EPSDT precisely interprets the question of whether a physician’s recommendation regarding a *covered* service is entirely beyond review. Instead, nearly all the federal

cases cited by Ms. Freeman involve whether a requested service is included in the mandatory 28 covered categories of medical assistance.<sup>33</sup> In *Moore ex rel. Moore v. Reese*, however, the Eleventh Circuit considered explicitly the question of whether a state Medicaid agency must provide all “services” recommended by physicians in EPSDT screenings, including the exact amount of service prescribed, without review or analysis. The court concluded that the state can review a physician’s determination that a particular service is medically necessary as well as the determination that a particular amount of a service is

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<sup>33</sup> See Opening Br. iv-v, 19; see e.g. *Jackson v. Millstone*, 369 Md. 575, 801 A.2d 1034 (2002) (whether EPSDT requires state to cover liver transplant); *Katie A. ex rel. Ludin v. Los Angeles Cy.*, 481 F.3d 1150 (9th Cir. 2007) (whether EPSDT requires state to offer wrap around services and therapeutic foster care); *Burnham v. DSHS*, 63 P.3d 816, 115 Wn. App. 435 (2003) (whether a service dog is included in the definition of durable medical equipment); *S.A.H. ex. Rel. S.J.H. v. State, DSHS*, 136 Wn. App. 342, 149 P.3d 410 (2006) (this case did not involve a disputed EPSDT service at all, but the parameters of when the state must pay for transportation to such services); *S.D. ex rel. Dickson v Hood*, 391 F.3d 581 (5th Cir. 2004) (whether Medicaid Act’s definition of home health supplies must include incontinence underwear when necessary to correct or ameliorate a condition of the Appellant; however the state conceded the service was necessary to correct or ameliorate the Appellant’s incontinence); *Collins v. Hamilton*, 349 F.3d 371 (7th Cir. 2003) (whether psychiatric residential treatment facilities are included within the “inpatient psychiatric hospital” category of medical assistance; state argued other inpatient services remove the need to offer such services at all, but did not appear to contest whether the service was necessary to the particular Appellant); *Pediatric Specialty Care, Inc. v. Ark. Dep’t of Human Services*, 293 F.3d 472 (8th Cir. 2002) (injunction to estop budget cutbacks that would eliminate early intervention day services, found to be a covered type of EPSDT service); *Pittman by Pope v. Sec’y Fla. Dep’t of Health & Rehab.*, 998 F.2d 887 (11th Cir. 1993) (whether EPSDT requires state to provide medically necessary liver-bowel transplant); *Parents League for Effective Autism Services v. Jones-Kelley*, 565 F. Supp. 2d 905 (S.D. Ohio 2008) (injunction to estop state from implementing budget cuts that would reduce the EPSDT service of ABA therapy). *Rosie v. Romney* is a case cited by Appellant which involved whether the state’s structure of services provided a sufficient amount of certain in-home support services in a way that clients could meaningfully access, but did not involve the amount of in-home support services prescribed to a particular Appellant. 410 F. Supp. 2d 18 (D. Mass. 2006).

medically necessary. 637 F.3d 1220 at 1255.<sup>34</sup>

**b. The Department Is Best Suited To Determine Medical Necessity For Personal Care Services**

“Personal care services” are defined by the Medicaid Act 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.) Unlike the other 27 forms of medical assistance covered by the Medicaid Act, personal care services uniquely provide the Department the options of allowing physicians to authorize the service or leaving such decisions to the state. Washington chose the latter. *See* WAC ch. 388-106.

In this case, Ms. Freeman’s physicians did not describe how much assistance Ms. Freeman required with activities of daily living or instrumental activities of daily living or how much time would be required

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<sup>34</sup> In *Moore*, the requested service, private duty nursing, was clearly a covered type of medical assistance. The dispute was whether the Department could review the number of hours requested by the physician for medical necessity. In concluding that the state could play a role in determining whether such services were necessary the court also reviewed cases involving whether a particular covered service was medically necessary for the individual not just the amount of the identified service. *Id.*, at 1244-55. *See also Okla. Chapter of Am. Acad. of Pediatrics v. Fogarty*, 366 F. Supp. 2d 1050, 1114 (N.D.Okla. 2005) (allowing state exclude coverage of experimental drug to children, even when prescribed by physician).

to provide that assistance. Instead, both physicians described a few discrete personal care tasks that require assistance, such as toileting and hygiene, and then recommended 24-hour supervision for safety reasons. AR 883, 1175-76; *see* Statement of the Case section (C) *supra* at 10-14. Even if the Department was required to provide the amount of personal care services recommended by Ms. Freeman's physicians, the Department is not required to allow physicians to define what personal care services include. There is no evidence in the record to indicate that a physician has determined that the 190 monthly hours awarded to complete personal care tasks is insufficient.

Similarly, nothing in EPSDT requires states to merely defer to physician recommendations for a particular number of personal care hours. By singling out personal care services as the one type of medical assistance 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. In this case, there is no indication Dr. de Give or Dr. Sciarrone attempted to determine the level of assistance Ms. Freeman required with activities such as dressing or bathing. Even to the extent Dr. de Give recognized a need for assistance with certain personal care tasks, such as toileting, there was no analysis—or attempt at analysis—of how much time assistance would take. Obviously, care providers do not spend the recommended

24 hours per day on toileting and menses assistance. No evidence was presented to establish that Dr. de Give specifically, or physicians generally, are accustomed to assessing and addressing personal care needs at all, much less that he was an expert at determining personal care needs. In contrast, the Department regularly assesses the need for personal care services for all in-home clients served through the Aging and Disabilities Services Administration within DSHS, and it does so using a sophisticated assessment instrument (CARE). *See e.g.* AR I 49-78, 154-56. In regards to personal care services, the Department is the expert, not the physician.

**C. The DSHS Board Of Appeals Exercised Its Jurisdiction Consistent With The Administrative Procedure Act**

A reviewing officer (such as a DSHS Board of Appeals review judge) shall exercise all the decision-making power that he would have if he presided over the initial hearing, with due regard given to the presiding officer's ability to observe witnesses. RCW 34.05.461(4); *Kabbae v. Dep't of Soc. & Health Servs.*, 144 Wn. App. 432, 444, 192 P.3d 903 (2008). Ms. Freeman argues the Department "failed to invoke appellate jurisdiction" when requesting review of the initial order. However, as Ms. Freeman timely appealed the initial order, this is a moot issue. Given the APA mandated scope of review, the review judge was required to review the entire record, correcting erroneous findings of fact and conclusions of law, not just those findings or conclusions useful to

Ms. Freeman.<sup>35</sup> Ms. Freeman's argument is also incorrect. The Department's request for review was timely filed under the language of the relevant rule. Alternatively, good cause existed to extend the deadline.

**1. The Department Timely Requested Review of The Initial Order**

Washington courts must give "great deference . . . to an agency's interpretation of its own properly promulgated regulations." *Silverstreak, Inc. v. Dep't of Labor & Industries*, 159 Wn.2d 868, 884, 154 P.3d 891 (2007), citing *Marquis v. City of Spokane*, 130 Wn.2d 97, 111, 922 P.2d 43 (1996). Therefore, when concluding that the Department timely requested review, the review judge's reasonable analysis of the regulations at issue is entitled to deference. Upon receiving an initial order with significant clerical errors, the Department requested a corrected order. Former WAC 388-02-0530; see AR 29, 30-58.<sup>36</sup> A Corrected Initial Order issued, including a notice that the Corrected Initial Order would become final if the DSHS Board of Appeals did not receive a petition for review within 21 days. AR 28. A DSHS Board of Appeals clerk confirmed this

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<sup>35</sup> At most, the review judge could have declined to read the Department's arguments or admit them into the record, but the judge would not be required to endorse erroneous findings or conclusions into his final order. Ms. Freeman's confusion in this regard is highlighted by her requested remedy: reinstatement of an initial order which she herself appealed.

<sup>36</sup> These rules have been amended, although not significantly, since the time of the case.

deadline.<sup>37</sup> AR 160S-161S. The Department's appeal was received by the DSHS Board of Appeals within this 21-day deadline. As found by the Board of Appeals review judge, the request was timely.

Ms. Freeman argues that finding the Department timely requested review of the Corrected Initial Order is inconsistent with the DSHS Board of Appeal's position in other cases. In support, Ms. Freeman refers to case law interpreting statutory review deadlines pertaining to the abuse of children. Opening Br. 16-18, citing *Ruland v. Dep't of Soc. & Health Servs.*, 144 Wn. App. 263, 182 P.3d 470 (2008). The *Ruland* case involved a Department regulation that reiterated explicit statutory language setting a 30-day deadline to request review of findings in a CPS report. *Id.*, RCW 26.44.125(4) (request for review *must* be filed within thirty days of notice of finding or the alleged perpetrator *shall have no right* to further review) (emphasis added); WAC 388-15-105. Unlike *Ruland*, the relevant regulations here do not contain an unequivocal deadline and accompanying consequence for failure to timely request review. The regulations cited by Ms. Freeman do not address the factual situation posed by this case at all.<sup>38</sup>

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<sup>37</sup> Both Ms. Freeman and the Department appealed the OAH decision within 21 days of the Corrected Initial Order on July 16, 2008, and July 22, 2008, respectively. AR 20S, 21S.

<sup>38</sup> The regulations at issue state respectively, "if the [administrative law judge] corrects an initial order and a party does not request review, the corrected order becomes final 21 calendar days after the original initial order was mailed," and "requesting a corrected order does not automatically extend the deadline to request review of the initial

Ms. Freeman fails to identify any authority that would hold prior interpretation of an unrelated and substantively distinct rule determinative of all rules involving deadlines. The Board of Appeals review judge's determination that the Department timely requested review is consistent with the plain language of the relevant administrative regulations.

**2. Alternatively, The Deadline To Request Review Was Extended For Good Reason**

A review judge may accept a request for review after the deadline if the party shows "good reason." WAC 388-02-0580. Here, in addition to finding the request timely, the review judge alternatively exercised his discretion, finding good reason to allow the request past the due date in the initial notice, as, before that deadline passed, the parties received a corrected order with a bolded notice indicating a new deadline. AR 81S-82S. Ms. Freeman reasonably can not, and did not, argue such a finding was an abuse of the review judge's discretion.

Because the Department's appeal was timely and, in any event, good reason existed to extend the deadline, Ms. Freeman's argument that the DSHS Board of Appeals lacked jurisdiction to enter the final order in this case is without merit.

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order." WAC 388-02-0555(2), (4). As discussed cogently in the Review Decision and Final Order, by its very language WAC 388-02-0555(2) proscribes finality of an initial order when review of the corrected order is *not requested*, not cases where it is. AR 78S-80S. Further, simply because extension is not automatic does not mean that it is not possible, such as in this case where a new deadline was prominently indicated on the corrected order prior to the lapsing of the Initial Order's deadline.

## V. DEPARTMENT'S ARGUMENT ON CROSS-APPEAL

### A. Standard of Review

On cross-appeal, the state assigns error to the court's factual and legal conclusions regarding attorney fees and application of Medicaid law. An award of attorney fees is reviewed for abuse of discretion. *Harmony at Madrona Park Owners Ass'n v. Madison Harmony Dev., Inc.*, 143 Wn. App. 345, 363, 177 P.3d 755 (2008). Like Ms. Freeman's claims, the legal issues on cross-appeal are reviewed de novo.

### B. Requiring Assessment And Authorization Of Care Providers Prior To Authorizing Personal Care Services Are Permissible Utilization Controls Of A Medicaid Service

Utilization controls, such as authorization prior to receipt of service, are an accepted Medicaid service limitation. *Ladd v. Thomas*, 962 F. Supp. 284, 294-95, (D.Conn. 1997); 42 C.F.R. § 440.230(d). The superior court erroneously concluded that because Ms. Freeman was Medicaid eligible beginning July 1, 2004, she now must receive back-compensation for personal care services to July 1, 2004. This ruling conflates the date at which Ms. Freeman was Medicaid eligible generally and the date at which she was authorized to receive a particular service.

The superior court relied on Medicaid law that extends eligibility for covered Medicaid services to either (1) three months prior to the date of application for Medicaid if the applicant would otherwise have been eligible, or (2) the first day of the month of eligibility. 42 U.S.C. §

1396a(34); 42 C.F.R. § 435.914(b).<sup>39</sup> However, regulations describing a “look-back” eligibility period prior to an application for Medicaid are irrelevant in this case as Ms. Freeman was not eligible for Medicaid until she turned 18 and she applied the month of her 18th birthday. *See* 42 C.F.R. § 435.914(a). The record clearly establishes Ms. Freeman’s Medicaid eligibility began July 1, 2004—the first day of the month she applied and became Medicaid eligible. Ms. Freeman’s request for compensation for the contested time period of July 1, 2004, through September 1, 2004, is not a request for compensation for a service provided prior to Ms. Freeman’s Medicaid eligibility or application date. Instead, Ms. Freeman requests payment for services for a time in which she was Medicaid eligible, but had not yet established program requirements for compensation for receipt of the particular service. Ms. Freeman and her providers did not complete program requirements to receive personal care until September 1, 2004. Accordingly, the Department began providing compensation for personal care to

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<sup>39</sup> In relevant part, 42 C.F.R. § 435.914 states,

- (a) The agency must make eligibility for Medicaid effective no later than the third month before the month of application if the individual--
- (1) Received Medicaid services, at any time during that period, of a type covered under the plan; and
  - (2) Would have been eligible for Medicaid at the time he received the services if he had applied (or someone had applied for him), regardless of whether the individual is alive when application for Medicaid is made.
- (b) The agency may make eligibility for Medicaid effective on the first day of a month if an individual was eligible at any time during that month.

Appellant's providers at that time.

Under Department rules, and like many other forms of medical care, receipt of paid personal care services first requires assessment and authorization.<sup>40</sup> See former WAC 388-72A-0053; WAC 388-106-0010. Authorization of personal care services requires assessment with the CARE tool and, if the client qualifies for the service, acceptance of the service by the client. Additionally, a qualified provider must be identified to provide the service to the specific client and authorized to do so. Ms. Freeman and her providers did not so agree until the end of August 2004. AR 95S. Her providers received authorization to provide personal care services beginning September 2004, and thus Ms. Freeman was entitled to have them compensated beginning at this time.

The superior court's holding that Ms. Freeman is entitled to be compensated for personal care services prior to proper authorization of those services was in error.

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<sup>40</sup> Utilization controls, such as prior authorization requirements, are an accepted Medicaid service limitation. *Ladd v. Thomas*, 962 F. Supp. 284, 294-95, (D.Conn 1997); 42 C.F.R. § 440.230(d). The Department requires prior authorization of many other medical services recommended by medical professionals. Additionally, any medical service requires the step of assessment and recommendation by a qualified provider before it will be compensated. Patients, whether Medicaid eligible or not, do not receive treatment, testing, or prescriptions until the medical professional has determined they are necessary. Personal care services are unique in that the assessment step is taken by the Department. Requiring personal care services be assessed and authorized prior to being compensable is no different than what is required for other forms of medical care, and does not violate Medicaid regulations.

**C. An Award Of Attorney Fees For Duplicative Claims Or Claims Upon Which Ms. Freeman Did Not Prevail Constitutes An Abuse Of Discretion**

Attorneys' fees are not recoverable absent specific statutory authority, contractual provision, or recognized grounds in equity. *Cosmopolitan Eng'r Group, Inc. v. Ondeo Degremont, Inc.*, 159 Wn.2d 292, 296-97, 149 P.3d 666 (2006); *Wagner v. Foote*, 128 Wn.2d 408, 416, 908 P.2d 884 (1996). A statute awarding attorneys' fees against the state must be strictly construed because it constitutes a waiver of sovereign immunity. *Rettkowski v. Dep't of Ecology*, 76 Wn. App. 384, 389, 885 P.2d 852 (1994), *aff'd in part, rev'd on other grounds in part* 128 Wn.2d 508, 910 P.2d 462 (1996). The applicant bears the burden of showing entitlement to an award and must document the number of hours expended and the reasonable hourly rate charged. *Mahler v. Szucs*, 135 Wn.2d 398, 433, 957 P.2d 632 (1998).

When awarding reasonable attorney's fees, the superior court must provide an objective basis. *Bowers v. Transamerica Title Ins. Co.*, 100 Wn.2d 581, 599, 675 P.2d 193 (1983). The superior court must sufficiently explain the basis for its fee award and enter findings in support of its decision. *Mahler v. Szucs*, 135 Wn.2d 398, 435, 957 P.2d 632 (1998). The court is required to exclude from the requested hours any wasteful or duplicative hours and any hours pertaining to unsuccessful theories or claims. *Housing Authority of Seattle v. Bin*, 163 Wn. App. 367,

378, 260 P.3d 900 (2011).

Per statute, a successful petitioner for judicial review of an agency order involving public assistance is entitled to reasonable attorney fees. RCW 74.080.080(3). However, this statute gives no guidelines as to whether an Appellant has prevailed. *Id.* The Equal Access to Justice Act (EAJA) does provide such guidelines. It also allows attorney fees in cases involving review of agency action, and explicitly defines “prevailing party.” RCW 4.84.350. The EAJA defines a prevailing party as one that “obtained relief on a significant issue that achieves some benefit that the qualified party sought.” RCW 4.84.350(1). This definition of “prevailing party” is instructive. The vast majority of Ms. Freeman’s argument in the superior court was that Ms. Freeman was entitled to 24-hour supervision as an EPSDT service. Ms. Freeman did not prevail on this issue. The determination that she prevailed on claims warranting 70 percent of her attorney’s total time is without justification and is unsupported by the record below.

Here, the superior court found Ms. Freeman prevailed on 70 percent of her claims, and additionally awarded 70 percent of her requested and uncompensated claims from the original superior court order remanding her 2004 appeal. In awarding fees on the original case, the superior court necessarily is awarding fees that are duplicative or for

issues that Ms. Freeman has abandoned.<sup>41</sup> Like this appeal, the primary unresolved issue from the first petition for judicial review is whether the state is required to provide supervision to Ms. Freeman as an EPSDT service. *See* AR 325. Ms. Freeman did not prevail on this claim.

The finding that Ms. Freeman prevailed on 70 percent of claims is contradicted by Ms. Freeman's own briefing to the superior court, which overwhelmingly concentrated on whether EPSDT regulations require the Department to fund supervision 24 hours per day. CP 394-414. In determining the Medicaid Act did not require the services requested by Ms. Freeman, the review judge authored a conclusion of law lasting nine and a half pages. The review judge ultimately found that supervision as requested by Ms. Freeman was not a medical or remedial service properly considered a covered type of medical assistance under 42 U.S.C. § 1396d(a)(13), did not reduce Ms. Freeman's disability or restore her functioning level, was not a personal care service under 42 U.S.C. § 1396d(a)(24), and did not ameliorate Ms. Freeman's medical conditions. AR 83S-92S. The superior court agreed on all relevant grounds.

Because awarding any of Ms. Freeman's attorney fees on remand constitutes in error and because the superior court did not provide an

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<sup>41</sup> If Ms. Freeman argued any claims in the first petition for review that she now prevails upon, the legal work is necessarily duplicative to that in the second review. If she argued any claims in the first petition that she has not now prevailed on, those claims were either abandoned or rejected by the superior court. Either way, she is not entitled to compensation.

objective and reasonable basis for its award, the award of 70 percent of fees was an abuse of discretion. In addition, as Ms. Freeman's claim that personal care services must be compensated from July 1, 2004, should be reversed on appeal, no fees should be awarded on this claim. Lastly, Ms. Freeman is not entitled to fees from this Court for any claims that are unsuccessful.

## VI. CONCLUSION

In order to establish entitlement to an EPSDT service under the Medicaid Act, the recommended service first must be a type of medical assistance covered by the federal Medicaid program and second must be medically necessary to ameliorate a specific condition identified by the EPSDT screen. General supervision as described and requested in this case is not a type of medical assistance; nor does it improve, cure, or correct Ms. Freeman's disabilities or illnesses.

This Court should affirm the superior court by holding that jurisdiction has been proper throughout the administrative phases of the appeal, and that the Medicaid Act does not require the Department to offer 24-hour supervision to Ms. Freeman in her home as an EPSDT service.

This Court should reverse the superior court and reinstate the Board of Appeal's final order, entitling Ms. Freeman to compensation for personal care services provided by qualified providers from the date such services were properly authorized, September 1, 2004. Additionally, this

Court should remand the issue of attorney fees to the superior court with instructions to revise the award to exclude any fees from the original petition for judicial review and to only allow fees for claims on which Ms. Freeman ultimately prevailed.

RESPECTFULLY SUBMITTED this 21st day of December 2011.

ROBERT M. MCKENNA  
*Attorney General*

A handwritten signature in black ink, appearing to read 'C Mach', with a wavy underline.

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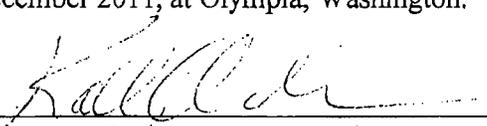
I certify that I served a copy of this document, DSHS Response Brief and Opening Brief on Cross-Appeal, on all parties or their counsel of record on the date below as follows:

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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 21st day of December 2011, at Olympia, Washington.

  
\_\_\_\_\_  
KATHY ANDERSON, Legal Assistant

# WASHINGTON STATE ATTORNEY GENERAL

**December 21, 2011 - 4:19 PM**

## Transmittal Letter

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