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**SUPREME COURT OF THE STATE OF WASHINGTON**

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WASHINGTON STATE DEPARTMENT OF SOCIAL AND HEALTH  
SERVICES,

Appellant,

v.

SAMANTHA A.,

Respondent.

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**RESPONSE TO AMICUS BRIEF OF THE ARC OF  
WASHINGTON STATE, THE NATIONAL HEALTH LAW  
PROGRAM, NORTHWEST HEALTH LAW ADVOCATES, AND  
TEAMCHILD**

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## I. INTRODUCTION

Amici urge this Court to hold that Medicaid personal care service hours should be substantially based on a recommendation from a child's physician, rather than on the more comprehensive assessment required by state statute and developed by the Department of Social and Health Services (Department or DSHS). Amici's argument is inconsistent with federal law, is not relevant to the issue of the validity of the Department's rule, and requests relief that is beyond the scope of this case. It should be rejected.

## II. ARGUMENT

### A. **The Federal Medicaid Personal Care Statute Explicitly Allows States To Independently Authorize Personal Care Services**

A considerable portion of amici's brief is given over to discussion of the Medicaid program in general and the EPSDT benefit in particular. For the most part, DSHS has no dispute with amici's assertions on these issues. Indeed, many of the same points were made in prior briefings by DSHS itself. DSHS fully recognizes the importance of Medicaid and the authority of the EPSDT mandate, and works hard to ensure that those programs are administered properly and fairly. More specifically, DSHS agrees with amici that "[a]ny clinical contact between an EPSDT recipient and a treating clinician is a covered child health screening," and that

“EPSDT requires the Department to furnish all medically necessary corrective or ameliorative *health care* that a provider identifies in a screening.” *See* Amici Br. at 9-10 (emphasis added). DSHS further agrees with amici that EPSDT requires substantial deference to a physician’s recommendations regarding a patient’s need for further assessment in areas beyond the physician’s expertise, and his or her specific treatment needs within the area of the physician’s expertise.

Where the Department and amici diverge is in the interpretation of statutes and case law related to personal care services. Amici claim that the law is clear that a state must give “substantial deference” to the recommendations of a physician in regards to personal care services. However, the relevant law requires no such thing. Personal care services are unique among the 28 types of Medicaid services listed in 42 U.S.C. § 1396d(a) in that the definition for personal care services includes an option for states to authorize the service themselves. Federal law defines “personal care services” as services that are:

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). Amici's assertion that this option is only for the purpose of facilitating access to MPC services in the absence of a physician's authorization (Amici Br. at 2, 18) is neither logical nor supported by legislative history.

The plain language of the statute is unambiguous. There are *two separate ways* personal care services may be authorized: either by a physician *or* by the state itself. Further, it is the state's decision which of those options is taken. No mitigating language is included. The statute does not say, as it could have, "services may be authorized by the State only in the absence of a physician's authorization." Rather, it pointedly uses the phrase, "at the option of the State." That language is an explicit grant of discretion to the states to choose whether to have assessments of personal care services done by physicians or by the state.

The legislative history of 42 U.S.C. § 1396d(a)(24) clearly supports this interpretation. As amici themselves note, prior to the 1996 revision of Medicaid laws that included the current language for 42 U.S.C. § 1396d(a)(24), personal care services were part of a range of services called "home health aide services" that could only be authorized by a physician. Amici Br. at 17, n.15. The subsequent addition of language that

both sets personal care services apart as a distinct category and provides an option to states to authorize the service themselves can only be interpreted as a recognition by Congress that deferring entirely to physicians for authorization of such services was inappropriate. Amici opine that Congress considered such a limitation to be inappropriate due to the general dearth of physicians' prescriptions for personal care services, but if that were the case Congress would have added language providing an option for state approval only when physicians' recommendations were not available. Because the final language does not limit a state's authority to the circumstance of an absent physician, Congress can only have intended to allow states the option of exercising full authority regarding the authorization of personal care services.

DSHS's interpretation of the personal care statute is *precisely the same* as the drafters of the federal regulation implementing that statute. The Health Care Financing Administration (HCFA, precursor to the Centers for Medicare and Medicaid Services (CMS)) within the federal Department of Health and Human Services squarely addressed this issue in their comments related to the proposed adoption of 42 C.F.R. § 440.167:

*We propose to leave to the State's option the decision of whether personal care services are to be authorized by a physician in accordance with a plan of*

*treatment, or otherwise authorized in accordance with a service plan approved by the State. . . . [W]e believe that these proposed revisions would allow states to maintain a high level of flexibility in providing and defining optional personal care services.*

Supplementary Information on Proposed Medicaid Personal Care Services Rule, 61 Fed. Reg. 9405 (March 18, 1996). (Emphasis added).

In the final adoption of the rule, this point was again emphasized in response to comments:

Section 1905(a)(24) of the Act provides that personal care services must be authorized “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.” In accordance with this section of the Act, we proposed to include this provision in new § 440.167. *We believe that the statute clearly indicates Congress' intent to allow States the flexibility to utilize alternative means of plan of care authorization. . . . Our revisions do not preclude physician authorization of personal care services. Rather, in accordance with the statute, we are allowing States to determine the appropriate method for plan of care authorization.* Therefore, we will not continue to require that the plan of care be authorized by a physician.

Supplementary Information on Final Medicaid Personal Care Services Rule, 62 Fed. Reg. 47896 (Sept. 11, 1997). (Emphasis added). Amici’s interpretation of congressional intent is thus contrary to the interpretation of the federal agency that drafted the rule and is charged with implementing the statute.

**B. The EPSDT Statutes Do Not Require DSHS To Defer To Treating Physicians In Regard To The Amount Of Personal Care Services It Authorizes**

Despite this history, amici argue that such a grant of authority violates the rule of statutory construction that statutes be read in a way that harmonizes any potential conflicts between them. Amici Br. at 16. They assert that a reading of 42 U.S.C. § 1396d(a)(24) that would allow states to authorize personal care services themselves conflicts with statutes related to the EPSDT benefit—42 U.S.C. § 1396a(a)(43), 42 U.S.C. § 1396d(a)(4)(B), and 42 U.S.C. § 1396d(r)(5). That assertion is misplaced. The Department’s interpretation of 42 U.S.C. § 1396d(a)(24) is not that the statute allows states to ignore a physician’s recommendation as to *whether* paid personal care services are indicated, but that the statute allows states the ability to independently determine the appropriate *amount* of personal care services that may be authorized for individuals. This does not conflict with the language or intent of EPSDT.

The EPSDT mandate requires that the state provide (or arrange to be provided) such services as are “disclosed by . . . child health screening services” (42 U.S.C. § 1396a(a)(43)(C)), but it does not require the state to provide any level or amount of such services as may be recommended by a screener. Indeed, the EPSDT statutes do not contemplate that such micro-management should occur at the screening stage at all. It is

sufficient that a screener recognize a need for visual or dental or hearing services, or such other “necessary health care, diagnostic services, treatment, and other measures . . . to correct or ameliorate defects” (42 U.S.C. § 1396d(r)), but the further determination of the quantity of such services is—and must be—left to the specialist. In the matter of personal care services, a child’s pediatrician might recognize the general need for such services, but the determination of the amount of such services must come from a specialist.<sup>1</sup>

None of the cases cited by amici, nor any of the many other cases examining the parameters of the EPSDT benefit, have concluded that a screener may dictate what a specialist should do. On the contrary, reliance on a generalist screener to determine particular treatments in a separate specialty has been one of the reasons courts have found states deficient in the provision of EPSDT services. *See Rosie D. v. Romney*, 410 F. Supp. 2d 18, 34 (D. Mass. 2006) (holding that assessments by pediatricians and emergency room doctors of children’s mental health problems “lack depth and comprehensiveness,” and could not be “the foundation of the child’s

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<sup>1</sup> Amici appropriately do not allege that DSHS fails entirely to assess the need for personal care services when a physician recommends such services. This is because such a circumstance would never arise, since a physician’s referral for personal care services is unnecessary. Any Medicaid eligible recipient can request such services independently without physician involvement. WAC 388-106-0025 (“To apply for long-term care services, you must request an assessment from the department and submit a Medicaid application.”).

long-term treatment”). Conversely, cases affirming the primacy of the opinions of “treating physicians” involve physicians who specialize in the area of their recommendation. *See, e.g., Urban v. Meconi*, 930 A.2d 860, 862 (Del. 2007) (surgery for macromastia recommended by specialist plastic surgeon, the “treating physician,” following referral from primary care physician); *Hummel v. Ohio Dep’t of Job & Fam. Servs.*, 164 Ohio App.3d 776, 2005-Ohio-6651, 844 N.E.2d 360, 364 (specific treatment for autism recommended by the “treating physician” who was “an expert in autism”); *Holman v. Ohio Dep’t of Health*, 143 Ohio App.3d 44, 2001-Ohio-3155, 757 N.E.2d 382, 384, 389 (abdominoplasty recommended by plaintiff’s “examining physician” who was “an expert in obesity,” and by her surgeon, the “treating physician”); *A.M.L. v. Dep’t of Health*, 863 P.2d 44, 48 (Utah Ct. App. 1993) (mammoplasty recommended by plastic surgeon following referral from primary care physician, both described as “treating physicians”).

The fact that the specialists in the area of personal care services are DSHS employees does not offend EPSDT requirements. EPSDT treatments do not need to be provided by or even overseen by physicians—personal care services being a good example of a type of care that is authorized and provided entirely separately from the medical arena. *See also S.A.H. ex rel. S.J.H. v. Dep’t of Soc. & Health Servs.*, 136 Wn.

App. 342, 351, 149 P.3d 410 (2006) (transportation to medical appointments authorized by DSHS and provided by recipient's mother). More to the point, DSHS is undisputedly the expert in the assessment and authorization of personal care services. The Department's assessment instrument, known by the acronym CARE (for Comprehensive Assessment and Reporting Evaluation), is a highly refined assessment tool that was developed by DSHS over a number of years. The process of administering the assessment is time consuming: assessors meet with recipients in the recipient's own home (not a clinic or office), and information is gathered from the recipient as well as her care providers, family members, and others. WAC 388-106-0050. Questions are asked about the recipient's level of self performance in regards to 12 activities of daily living and 7 instrumental activities of daily living, the amount of physical or supervisory support needed for each of those tasks, and the amount of informal (unpaid) support available to the recipient. WAC 388-106-0075. The assessment process also involves questions about a recipient's moods and behaviors, clinical complexity, and need for exceptional care. WAC 388-106-0085.

In short, the CARE assessment provides a far more thorough and detailed assessment of a recipient's needs for paid personal care assistance than any physician could reasonably be expected to provide. According

substantial deference to physicians' recommendations in regard to personal care services would be to inappropriately assign authority to a generalist over a specialist. EPSDT does not mandate such an irrational result.

**C. The Children's Personal Care Rules Are Irrelevant To The Remedy Sought By Amici**

Amici describe the issues presented in their brief as whether the children's Medicaid personal care rules violate the EPSDT mandate by preventing consideration of the treatment recommendations of treating physicians and/or by failing to give substantial deference to treating physicians. Amici Br. at 4. By describing the issues in this way, amici imply that these identified rules affirmatively preclude physician input in the area of children's personal care needs in some way that the rest of the personal care rules do not. But the operation of the rules at issue here is not separate from the operation of the CARE assessment as a whole, and the CARE assessment itself has no specific provision for physician input. Basic consideration of a physician's treatment recommendations as part of the MPC process is *allowed* under Department rules; it is just not given preference over other relevant input. *See* WAC 388-106-0075 ("To assess your need for personal care services, the department gathers information from you, your caregivers, family members, *and other sources.*") (Emphasis

added.)). Invalidation of the children's personal care rules as requested by amici thus would not facilitate deference to physicians' recommendations; for that to occur, there would need to be a new rule.

All of the rules regarding the CARE assessment work together. The children's personal care rules operate to account for the obvious fact that disabled and able bodied children have the same needs for personal care assistance at certain ages, and for the legal principle that parents have a particular duty towards their own children. The CARE tool incorporates these factors into its algorithm, and adjusts children's base hours accordingly. *See Appellant's Br. at 7-10.*

If a physician's recommendation differs from the department's determination, the disagreement *might* be with the adjustment to base hours following the determination of informal supports, but it might just as likely be with the base hours themselves. In this case, for example, Samantha's physician recommended 96 hours of personal care services (the amount she had previously been authorized), but Samantha would have received only 90 hours if the children's personal care rule did not exist. *See Appellant's Br. at 11-12.* Samantha's physician's disagreement was thus, at least in part, with the CARE assessment itself. Furthermore, although the children's personal care rules apply only to children under age 18, the EPSDT mandate extends to young adults age 18 to 21. For

that group of recipients, any physician recommendation that differed from the department's determination would automatically involve all CARE rules *other than* the children's personal care rules, rendering them all irrelevant if the alleged requirement to accord substantial deference to treating physicians were in force.

Amici thus seem to seek a different remedy than Samantha herself in this case, despite their conclusion that the superior court order should be affirmed. Rather than an invalidation of the rules at issue, as the superior court ordered, amici are in fact asking this Court to order the Department to adopt a *new* rule that would set aside the Department's determination of the proper number of paid personal care hours for any Medicaid eligible recipient under the age of 21 in favor of the recommendation of the recipient's physician.<sup>2</sup> Adopting a new rule would be the *only* way that amici's alleged EPSDT mandate could really be accomplished.

But this Court is not the appropriate forum for amici's implicit request, since courts cannot order an administrative agency to create a new rule. If amici believe that such a rule is needed, they can and must petition the Department for such a rule under RCW 34.05.330(1). *Northwest Ecosystem Alliance v. Forest Practices Board*, 149 Wn.2d 67, 75, 66 P.3d

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<sup>2</sup> Amici suggest that while a state must give substantial deference to a physician's recommendation, it need not "reflexively rubber stamp a clinician's statement" (Amici Br. at 10). In practice, however, that is likely to be a distinction without a difference.

614 (2003). If the Department denies the petition, they can appeal the denial to the Governor per RCW 34.05.330(3), or seek judicial review under RCW 34.05.570(4)(b) of the agency's alleged failure to carry out a statutory duty. *Northwest Ecosystem* at 75. Those are the only proper routes for the remedy amici seek.

### III. CONCLUSION

Because federal Medicaid law gives states full authority to authorize personal care services independently, and because the adoption of a new rule would be necessary to address amici's essential claim, amici's request that this Court affirm the superior court order in this case should be denied.

RESPECTFULLY SUBMITTED this 25th day of October 2010.

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