IN THE SUPREME COURT OF THE STATE OF WASHINGTON

SAMANTHA A.,	)	
	)	No. 84325-2
Respondent,	)	
	)	
v.	)	En Banc
	)	
DEPARTMENT OF SOCIAL AND HEALTH SERVICES,	)	
	)	
Appellant.	)	Filed May 26, 2011
	)	

C. JOHNSON, J.—This case involves a challenge to a Department of Social and Health Services (DSHS) regulation, WAC 388-106-0213, that reduces the financial assistance payable for in-home personal care services (based upon the child's age and whether the child lives with a parent). The superior court found this regulation invalid as violating federal Medicaid comparability requirements under 42 U.S.C. § 1396a and Medicaid Early and Periodic Screening Diagnosis and Treatment (EPSDT) laws under 42 U.S.C. § 1396d. The superior court also awarded respondent Samantha A. attorney fees under RCW 74.08.080.

We affirm the superior court in part and hold that WAC 388-106-0213

violates federal comparability requirements under 42 U.S.C. § 1396a. Furthermore, we hold WAC 388-106-0130 invalid to the extent it authorizes WAC 388-106-0213. We also affirm the superior court's award of attorney fees. Because we find WAC 388-106-0213 invalid based on federal comparability requirements, we decline to reach or decide any other issues.

FACTS

Samantha A. is a 15-year-old[1] with a wide range of medical maladies.[2] Samantha is unable to perform a majority of the activities of independent daily living. Samantha has difficulty speaking and being understood. She is assaultive, disrobes in public, and wanders away if unsupervised. Samantha requires assistance with mundane tasks such as eating, using the restroom, dressing, and personal grooming.

DSHS has determined that Samantha is eligible for 24-hour institutional care because of the extreme nature of her needs. Because Samantha is cared for by a single mother committed to meeting Samantha's needs, Samantha is enrolled in the Medicaid Home and Community Based Waiver program, so she can receive benefits at home and not be institutionalized. As part of these in-home benefits, Samantha

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[1] Samantha was 12 years old when this appeal began.

[2] Samantha's conditions include: Down's Syndrome, obesity, vision issues and cataracts, hearing loss, speech and communication problems, developmental delay, and behavioral issues.

receives Medicaid personal care (MPC).

DSHS determines a child's MPC service level using DSHS's Comprehensive Assessment Reporting Evaluation (CARE) formula. Numerous regulations govern the operation of the CARE assessment formula. *See* WAC 388-106-0050 through -0235. In the initial stage of a CARE evaluation, the individual is scored on factors such as an individual's ability to perform daily activities and an individual's mental status. The individual is then assigned to 1 of 17 classification groups, each group having a set number of base MPC hours associated with it. WAC 388-106-0125. Once these base hours are established, an assessor individually considers the recipient's self-performance and the amount of informal support available for the recipient's activities of daily living (ADL) and instrumental activities of daily living (IADL).[3] The recipient's level of informal support for each ADL and IADL then reduces the base hours allocated to that recipient by a predetermined percentage. WAC 388-106-0130. This process is the same for children and for adults.

In 2005, DSHS adopted changes to its CARE assessment formula to be applied solely to children. Included in the changes was a new rule, WAC 388-106-0213, which establishes automatic reductions to a child's base MPC hours. This

[3] ADLs are defined to include: ability to bathe, bed mobility, body care, dressing, eating, locomotion both in the living environment and outdoors, medication management, toilet use, and personal hygiene. IADLs include: meal preparation, ordinary housework, essential shopping, wood supply, travel to medical services, financial management ability, and telephone use. *See generally* WAC 388-106-0010.

new rule mechanically categorizes certain ADL and IADL as being "met" based solely upon a child's age. The rule also further reduces a child's base MPC hours by mandating that the "status and assistance available are met or partially met over three-fourths of the time" if the child lives with their legally responsible natural parent, stepparent, or adoptive parent. WAC 388-106-0213(3).

DSHS regulations do not require consideration of evidence from a child's medical provider regarding the amount of MPC services necessary to support a disabled child's condition. DSHS regulations also do not allow recipient children to challenge the automatic reductions imposed by WAC 388-106-0213 by showing their needs are still unmet following the reductions. DSHS does provide a process for seeking an exception to rule (ETR) from department staff, but this process does not grant any administrative hearing rights to denials of these ETR requests. *See* WAC 388-106-0140; WAC 388-440-0001.

Before the implementation of WAC 388-106-0213, DSHS assessed Samantha as needing 90 hours of MPC. The following year, Samantha was reassessed under the new rule. The new assessment showed that Samantha was exhibiting increased behavioral problems affecting her ability to complete personal care tasks. The new assessment calculated that Samantha still required 90 base

MPC hours. However, pursuant to WAC 388-106-0213, the CARE formula automatically reduced these 90 base hours to 39 hours. In effect, the CARE formula classified many of Samantha's dressing, eating, hygiene, and transportation needs as being met because of her age and because she lived with her mother. Although Samantha was eligible for 24-hour institutional care and had previously been assessed to require an average of three MPC hours daily, WAC 388-106-0213 operated to reduce Samantha's MPC hours to just over one hour a day.

Samantha's mother requested an ETR hearing to contest the reduction of MPC hours. Samantha's medical provider conducted an EPSDT exam[4] and determined that Samantha required 96 hours of MPC in order "to maximize her potential and achieve her best possible functional level." Ex. 8 (Mot. to Transfer to Washington State Supreme Ct.) at 8. DSHS neither approved additional MPC hours nor granted Samantha an ETR exception. The administrative record does not show that DSHS considered, weighed, or integrated the recommendations of Samantha's medical provider.

Samantha petitioned the Thurston County Superior Court for review. The superior court found that WAC 388-106-0213 violated federal Medicaid

[4] EPSDT allows authorized medical service providers to issue referrals for services for children under the age of 21 who are eligible for Medicaid. *See* WAC 388-534-0100(2)(a)(i). Access and services for EPSDT are governed by federal rules at 42 C.F.R., pt. 441, subpt. B.

comparability and EPSDT laws. Furthermore, the superior court invalidated another rule, WAC 388-106-0130(3)(b), to the extent that it authorizes WAC 388-106-0213. The superior court also awarded Samantha attorney fees. DSHS appealed to Division Two of the Court of Appeals. This court then granted Samantha's motion to transfer.

ISSUES

1. Whether WAC 388-106-0213 violates federal Medicaid comparability requirements.

2. Whether the superior court properly awarded Samantha attorney fees under RCW 74.08.080.

ANALYSIS

The Administrative Procedure Act provides that in a proceeding involving review of administrative rules, "the court shall declare the rule invalid only if . . . the rule exceeds the statutory authority of the agency . . . or the rule is arbitrary and capricious." RCW 34.05.570(2)(c).

We review an agency interpretation of federal law de novo under an "error of law" standard. *Skamania County v. Columbia River Gorge Comm'n*, 144 Wn.2d 30, 42, 26 P.3d 241 (2001) (citing *Wenatchee Sportsmen Ass'n v. Chelan County*, 141 Wn.2d 169, 175-76, 4 P.3d 123 (2000)).

1. Whether WAC 388-106-0213 violates federal Medicaid comparability

requirements.

MPC is a Medicaid state plan program authorized under 42 U.S.C. § 1396d(a)(24) and RCW 74.09.520(2). As a voluntary participant in the federal Medicaid program, Washington State must comply with Medicaid statutes and related regulations. *S.A.H. ex rel. S.J.H. v. Dep't of Soc. & Health Servs.*, 136 Wn. App. 342, 348, 149 P.3d 410 (2006). DSHS administers Medicaid medical assistance programs in Washington State. RCW 74.04.050; RCW 74.09.500.

The federal Medicaid comparability provision mandates that a state Medicaid plan must provide "that the medical assistance made available to any individual . . . shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual." 42 U.S.C. § 1396a(a)(10)(B)(i); *see also* 42 C.F.R. § 440.240(b). As with all Medicaid services, states "may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures." 42 C.F.R. § 440.230(d).

WAC 388-106-130(3)(b) mandates DSHS to reduce MPC service hours for children under the age of 18 pursuant to the framework established in WAC 388-106-0213. Under WAC 388-106-0213(2), DSHS provides automatic cuts to MPC hours based upon a child's age. Also, under WAC 388-106-0213(3), DSHS

reduces MPC hours based upon a presumption that a child's needs are "met or partially met" when that child lives with a legally responsible natural parent, stepparent, or adoptive parent.

DSHS argues that WAC 388-106-0213(2) properly withholds payment for assistance with needs that are based upon age, not disability. DSHS reasons that all children below certain ages are presumed to have the same personal care needs. Put another way, DSHS argues that assisting a four-year-old with bathing fulfills a developmental need, not a medical need; therefore, DSHS will withhold providing paid assistance regarding bathing needs for all four-year-old children. DSHS also argues that the age- and parent-based reductions in WAC 388-106-0213 create a global benchmark in order to avoid paying for a service that is unrelated to a child's disability. Thus, the question posed to us here is whether DSHS violates federal Medicaid comparability requirements by promulgating a rule that creates across-the-board coverage reductions based solely upon a child's age and whether the child lives with a parent.

This court addressed a similar issue in *Jenkins v. Department of Social & Health Services*, 160 Wn.2d 287, 157 P.3d 388 (2007). In *Jenkins*, we invalidated a DSHS regulation, known as the "shared living rule," that automatically reduced a

recipient's benefits by 15 percent because they lived with their paid caregiver. Like the reductions imposed under WAC 388-106-0213 in this case, the shared living rule operated to reduce the base number of hours determined to be appropriate after DSHS's initial CARE assessment. In holding the shared living rule invalid, we specifically instructed that

> DSHS may use the CARE assessment program to initially classify, rate, and determine a recipient's level of need because this process is consistent with the Medicaid program's purpose. DSHS violates the comparability requirement when it reduces a recipient's benefits based on a consideration other than the recipient's actual need.

Jenkins, 160 Wn.2d at 299. We further clarified by stating, "Once a person is assessed to require and receive a certain number of care hours, the assessment cannot be reduced absent a specific showing that fewer hours are required. To 'presume' some recipients need fewer hours of care without individualized determination violates the comparability requirement." *Jenkins*, 160 Wn.2d at 300.

Our holding in *Jenkins* controls the resolution of this case. Subsections (2) and (3) of WAC 388-106-0213 establish irrebutable presumptions in the CARE formula that diminish a recipient's care hours without an individualized determination of need. Because the regulation fails to account for an individual recipient's actual needs and because the regulation treats similarly situated

recipients differently, WAC 388-106-0213 is invalid under federal comparability requirements.

DSHS argues that WAC 388-106-0213(2) properly withholds payment for care or services related to a child's developmental care. But this ignores what the regulation actually does. The regulation reduces MPC benefits based upon a consideration other than a recipient's actual need. Although routine assistance with daily bathing fulfills a developmental care requirement for a healthy four-year-old child, a disabled four-year-old may need significantly greater assistance with bathing or may even need multiple daily baths. While one disabled child may only require 30 minutes a day to meet her individualized bathing needs, another similarly disabled child may require two or three times more assistance. But instead of addressing the actual needs of an individual recipient, WAC 388-106-0213(2) operates to deny coverage based solely upon age and not upon the existence or extent of disability.

WAC 388-106-0213(3) is equally flawed. On its face, the rule treats similarly situated individuals differently because children with comparable disabilities are treated differently based not upon need, but upon whom the child lives with. Under the presumptions contained in WAC 388-106-0213(3), a child

living with a legally responsible parent has her MPC hours reduced while a child living with a caregiver, or any other person exercising custodial responsibility, retains more payable MPC hours because the reductions imposed by

WAC 388-106-0213(3) would not apply. In other words, two categorically needy recipients who are individually assessed as requiring the same needs will ultimately be treated differently simply because one recipient lives with a legally responsible parent and the other lives with someone other than a parent.

Subsections (2) and (3) of WAC 388-106-0213 rely on DSHS's presumptions regarding what needs are developmental in nature and what needs should be provided by a legally responsible parent. However, in *Jenkins* we specifically noted that DSHS's presumptions cannot be used to avoid an individualized determination of a recipient's actual need. *Jenkins*, 160 Wn.2d at 300 ("To 'presume' some recipients need fewer hours of care without individualized determination violates the comparability requirement.").

DSHS essentially argues that the presumptions in WAC 388-106-0213 create valid utilization control measures necessary to ensure that DSHS pays only for care-related needs and not for developmental needs. While, as a general matter, DSHS may establish utilization control criteria, DSHS's argument is unavailing in the present case because WAC 388-106-0213 functionally ignores the particular needs of any disabled child. DSHS's power to place limits on eligibility and assistance requirements is not unfettered, but is limited by federal comparability requirements

that any individual's "medical assistance . . . shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual." 42 U.S.C. § 1396a(a)(10)(B)(i). Federal Medicaid law further mandates that utilization control measures shall "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against *unnecessary* utilization of such care and services." 42 U.S.C. § 1396a(a)(30)(A) (emphasis added).

Despite DSHS's assertion that WAC 388-106-0213 essentially establishes utilization control parameters, there is no mechanism within WAC 388-106-0213 targeting the regulation at the "unnecessary" utilization of care and services. Determining whether care or services are "unnecessary" impliedly involves determining whether a particular recipient requires such care or services. This is what occurs during the initial CARE evaluation when the recipient is placed into 1 of 17 classification groups. This is also what occurs when the recipient's base MPC hours are later reduced by an assessor's individualized findings regarding the recipient's self-performance and the amount of informal supports for ADL and IADL.

Unlike these reductions applied earlier in the CARE formula, the reductions

contained in WAC 388-106-0213 are not based on the actual needs of any individual recipient. To the contrary, WAC 388-106-0213 relies upon DSHS's presumptions about what care is already being provided to children of certain ages and to children living with a parent. But DSHS's presumptions are problematic for several reasons. First, DSHS's age- and parent-based presumptions cannot be refuted by showing that a child's actual needs are still not being met following the reduction. While DSHS's regulations provide for an ETR proceeding to contest the reduction, the challenging party has no fair hearing rights regarding ETR proceedings. *See* WAC 388-106-0140; WAC 388-440-0001. In this case, Samantha was denied an ETR despite having a medical provider recommendation indicating that Samantha required roughly the same amount of MPC hours as the initial CARE assessment provided her. Second, DSHS fails to show the basis or process that the department relied upon to arrive at its presumptions regarding the age- and parent-based needs of a child. Neither the rule-making file nor the administrative record contains any time-study, evaluation, or any other evidence to support DSHS's presumptions. Clerk's Papers at 253. In this case, Samantha's MPC hours were reduced from 90 to 39, approximately a 56 percent decrease in hours. DSHS does not produce any evidence showing how it arrived at a 56 percent

reduction. Nor does DSHS produce any evidence showing why the reduction cannot be 40 percent, 30 percent, or even 5 percent. In short, DSHS's age- and parent-based reductions represent arbitrary amounts applied without any supporting evidence and without regard to an individual recipient's actual needs.

DSHS argues that the initial CARE assessment provides a sufficiently individualized determination of a disabled child's needs. As support, DSHS points to the extensive criteria embodied in the regulations governing the CARE assessment process. But this argument is contradicted by our holding in *Jenkins* in which we stated that, *following* the initial CARE assessment, the base level of MPC hours cannot be reduced absent a "specific showing" that fewer hours are necessary. *Jenkins*, 160 Wn.2d at 300. In this case, Samantha's base MPC hours were mechanically reduced from 90 to 39 hours without any personalized determination that Samantha's needs would continue to be met. There is nothing in the record before this court to show that DSHS made any determination that Samantha's needs would be met.[5]

DSHS also presents an additional justification specific to WAC 388-106-0213(3), which reduces MPC hours when a child lives with a "legally responsible

[5] We also note that Samantha's medical provider assessed Samantha as needing 96 hours of MPC care. Therefore, both the initial CARE assessment and Samantha's medical provider arrived at a similar figure for base MPC hours. Despite this recommendation and despite DSHS not presenting any evidence contradicting this recommendation, WAC 388-106-0213 automatically reduced Samantha's MPC hours to 39.

natural/step/adoptive parent." DSHS argues that parents have statutory obligations to provide care for their children. Since Medicaid is a "payor of last resort," DSHS reasons that they must identify third parties that may be responsible for a portion of the services otherwise provided by Medicaid. Br. of Appellant at 30. In response, Samantha persuasively argues that DSHS incorrectly equates MPC services with the care provided by all parents to their children.

The statutes that DSHS relies upon to justify its parent-based reductions are not instructive in this case. DSHS first points to RCW 26.09.002 ("Parents have the responsibility to make decisions and perform other parental functions necessary for the care and growth of their minor children."). But this statute applies to domestic relations, and more specifically, to provide guidance for creating parenting plans following a dissolution of marriage. DSHS fails to indicate how this statute controls when determining the amount of in-home medical assistance available for a disabled child. Second, DSHS cites RCW 74.13.350 ("It is the intent of the legislature that parents are responsible for the care and support of children with developmental disabilities."). Although this statute pertains to children with developmental disabilities, this statute specifically addresses voluntary placement agreements when placing foster children in out-of-home care

facilities.[6] Again, DSHS fails to show how this statute applies under the facts of this case. Furthermore, if we were to apply RCW 74.13.350 in the manner that DSHS asserts we should, the statute would presumably allow DSHS to reduce a developmentally disabled child's MPC hours to zero. We decline to do so.[7]

MPC services are unlike the care parents typically provide to their children because MPC services are "medical assistance" administered by DSHS in compliance with federal requirements. RCW 74.09.500, .520. Furthermore, MPC providers are statutorily required to obtain specialized training before[8] caring for the disabled and there is nothing in the statutes cited by DSHS to suggest that parents must acquire specialized medical training simply to parent a disabled child.[9]

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[6] The language of RCW 74.13.350 makes it clear that the statute was not intended to be used in the manner DSHS now asserts. RCW 74.13.350 states:

> It is the intent of the legislature that parents are responsible for the care and support of children with developmental disabilities. The legislature recognizes that, because of the intense support required to care for a child with developmental disabilities, the help of an out-of-home placement may be needed. It is the intent of the legislature that, when the sole reason for the out-of-home placement is the child's developmental disability, such services be offered by the department to these children and their families through a voluntary placement agreement.

As the text details, RCW 74.13.350 applies in situations in which the child's developmental disability is such that the parents are unable to care for the child. But this is not implicated by the facts in the present case. Samantha's mother seeks to care for Samantha at home in order to prevent institutionalization, not place Samantha in a foster home.

[7] DSHS also argues that courts have interpreted federal Medicaid law to support holding that parents are primarily responsible for the care and support of children with developmental disabilities, therefore parents should shoulder the responsibility of paying for purely parental functions. DSHS first cites *Poindexter v. Department of Human Services*, 372 Ill. App. 3d 1021, 869 N.E.2d 139, 311 Ill. Dec. 465 (2006). But *Poindexter* involved a determination of financial eligibility for Medicaid under the Medicare Catastrophic Coverage Act of 1988; therefore this citation is not instructive given the particular facts of this case. DSHS also cites *Germosen v. Gupta*, 237 A.D.2d 121, 654 N.Y.S.2d 746 (1997). The *Germosen* holding involved whether the availability of Medicaid operates to preclude recovery against tortfeasors. Again, this citation is not helpful in the case currently before us.

[8] RCW 74.39A.073(1) ("[A]ll persons employed as long-term care workers for the elderly or persons with disabilities must meet the minimum training requirements in this section."); *see also* RCW 74.39A.075 (detailing training required in order for a parent to be the individual provider for a disabled adult or child).

Consistent with our holding in *Jenkins*, we affirm the superior court and hold that the reductions embodied in WAC 388-106-0213(2) and (3) violate federal Medicaid comparability requirements because the reductions are imposed without any consideration of a child's individualized circumstances or whether a child's needs will continue to be met after the reduction.[10]

2. Whether the superior court properly awarded Samantha attorney fees under RCW 74.08.080.

Pursuant to RAP 18.1(a), respondents request attorney fees on appeal under RCW 74.08.080.[11] Because respondents prevail, we grant their request. Additionally, DSHS disputes the roughly $85,000 in attorney fees awarded to Samantha by the superior court. DSHS argues that the superior court should have capped its award at $25,000 pursuant to the Equal Access to Justice Act (EAJA).

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[9] In additional briefing to the court, DSHS argues that its regulations specifically exempt parents of disabled children from the training requirements that apply to other personal care providers. WAC 388-825-355(2) ("If you provide personal care for children . . . there is no required training but DDD [(division of developmental disability)] retains the authority to require training of any provider"). DSHS's argument is unpersuasive because the regulation cited by DSHS applies to "individuals and agencies *contracted with* to provide . . . [p]ersonal care services." WAC 388-825-305(2) (emphasis added). There is nothing before this court to indicate that Samantha's mother contracted with DSHS to provide MPC services to Samantha.

[10] We need not resolve any issues regarding the amount of deference that DSHS must give medical provider recommendations under federal EPSDT law. Since Samantha's medical provider issued a recommendation that nearly corresponded with the initial CARE assessment prior to the implementation of WAC 388-106-0213 (Samantha's provider recommended 96 MPC hours and the CARE assessment established a baseline of 90 MPC hours), our invalidation of the reductions contained in WAC 388-106-0213 effectively renders the issue moot.

[11] RCW 74.08.080(3) states:

> When a person files a petition for judicial review . . . of an adjudicative order entered in a public assistance program, no filing fee shall be collected . . . ; In the event that the superior court, the court of appeals, or the supreme court renders a decision in favor of the appellant, said appellant shall be entitled to reasonable attorneys' fees and costs.

See RCW 4.84.350(2) ("The amount awarded a qualified party under subsection (1) of this section shall not exceed twenty-five thousand dollars."). DSHS argues that the EAJA is the basis for attorney fees for judicial reviews of agency actions, including *eligibility* for MPC services; therefore, the EAJA should apply in this case, in which the issue centers on the available *amount* of MPC services. DSHS asserts that it is illogical that judicial action to determine the amount of services should permit the appellant to receive greater attorney fees than a judicial action to determine overall eligibility for services.

DSHS's argument is unsupported by the statutory language of the EAJA. The EAJA states: "*Except as otherwise specifically provided by statute*, a court shall award a qualified party that prevails in a judicial review of an agency action . . . reasonable attorneys' fees." RCW 4.84.350(1) (emphasis added). In this case, the superior court's award of attorney fees was otherwise provided by statute, namely RCW 74.08.080(3) (providing "reasonable attorneys' fees" for an appellant challenging an adjudicative order entered in a public assistance program). Therefore, the EAJA does not apply to the case before us. We affirm the superior court's order awarding reasonable attorney and costs.

CONCLUSION

We affirm the superior court and hold that WAC 388-106-0213 is invalid against federal Medicaid comparability requirements. We further hold that WAC 388-106-0130(3)(b), to the extent that it authorizes WAC 388-106-0213, is invalid. We also uphold the superior court's award of attorney fees and grant respondent Samantha's reasonable attorney fees and costs on appeal.

AUTHOR:
Justice Charles W. Johnson

WE CONCUR:

Justice Gerry L. Alexander

Richard B. Sanders, Justice Pro Tem.

Justice Tom Chambers

Justice Susan Owens