# VIRGINIA DEPARTMENT OF EDUCATION

DIVISION OF SPECIAL EDUCATION AND STUDENT SERVICES

OFFICE OF DISPUTE RESOLUTION AND ADMINISTRATIVE SERVICES

# CASE CLOSURE SUMMARY REPORT

Case No. 18-098

School Division: Name of Parent:

 Name of Child:

Counsel Representing LEA: Counsel Representing Parent/Child:

 Jason Ballum n/a

Hearing Officer: Krysia Nelson Party Initiating Hearing: Parent

Prevailing Party: Public Schools

# Hearing Officer’s Determination of Issue(s) Raised in Parent’s Due Process Request:

1. LEA’s refusal of ESY for 2018 – **Issue withdrawn by parent**
2. LEA’s refusal to provide the student a full time 1-1 nurse for 2018-2019 – **Issue resolved in School Division’s favor – the Student does not require a full time 1-1 nurse in the school setting in order to receive FAPE.**
3. LEA’s refusal to provide a 1-1 aide for the student for 2018-2019 – **Issue withdrawn by parent**
4. LEA’s refusal to offer direct speech therapy services for 2018-2019 – **Issue withdrawn by parent**
5. LEA’s denial of Student’s use of communication software with which he is familiar – **Issue withdrawn by parent**
6. LEA’s refusal to provide the student adaptive PE for 2018-2019 – **Issue withdrawn by parent**
7. LEA’s refusal to conduct an educational evaluation (to determine his functional grade level in order to determine appropriate VAAP goals) – **Issue mooted by Hearing Officer Order that LEA conduct an Independent educational evaluation of the Student**

# Hearing Officer’s Orders and Outcome of Hearing:

1. Issues withdrawn: The parties reached an agreement on Issues 1 and 3-6, and the Parent filed a notice withdrawing these issues from the Hearing Officer’s consideration.
2. The School Division stipulated the lack of controversy on Issue 7, given its offer to conduct an educational evaluation responsive to the Parent’s request, pending receipt of her written consent. The Parent stipulated that she had signed a consent form for the evaluation, but did not produce a copy of the same to the Hearing Officer. Accordingly, in order to render the issue moot and ensure the completion of the mutually agreed upon educational evaluation, without regard to the Parent’s delivery to the School Division of signed documentation necessary to conducting the evaluation, the Hearing Officer exercised her authority to order an Independent Educational Evaluation that would comport with statutory requires and/or the parameters agreed to by the parties (and Ordered the same on the record of the hearing, August 15, 2018). ORDERED that the LEA conduct an Independent Educational Evaluation of the Student to include not just assessment for scholastic/academic aptitude, but also for achievement.
3. Accordingly, only Issue 2 remained for the Hearing Officer’s consideration. The Parent maintained that the Student could not attend school without a full-time 1-1 nurse to implement the Student’s Health Care plan (which requires the Student to be suctioned several times per day, and monitored for seizure activity). The Parent failed to carry her burden to establish that the student requires a full-time,. 1-1 nurse in the school setting.

This certifies that I have completed this hearing in accordance with regulations and have advised the parties of their appeal rights in writing. The written decision from this hearing is attached in which I have also advised the LEA of its responsibility to submit an implementation plan to the parties, the hearing officer, and the SEA within 45 calendar days.

Krysia Carmel Nelson, Hearing Officer Dated this 10th day of September, 2018

VIRGINIA DEPARTMENT OF EDUCATION

# DUE PROCESS HEARING REPORT

**School Division: Name of Student:**

**Party Initiating Hearing: Parent Name of Parent:**

Date of Decision: September 10, 2018 Case No. 18-098

 The Virginia Department of Education makes Hearing Officer decisions (such as this one) in due process cases available to the public. To preserve the privacy of the parties and other individuals involved, as well as to preserve the confidentiality of the proceeding, the following individuals shall be referred to herein as follows:

 Public Schools: “LEA” or “the School Division”

 : “The County”

 High School : “High School”

 : “Parent”

 : “Student”

 : “Special Ed Teacher”

 : “Assistant Principal”

 : “School Nurse”

 : “Supervisor of Student Services”

References to the Transcript will be as follows: Transcript page number Tx\_#\_

References to the Exhibits will be as follows:

Parent’s Exhibit number P-#

LEA Exhibit number SB-#

# INTRODUCTION

 The due process hearing was requested in writing by the Parent on June 7, 2018, (and received by the Virginia Department of Education, “VDOE,” on June 18, 2018) and this Hearing Officer was appointed to hear the case on June 21, 2018. The Parent’s request was then amended on July 2, 2018.

 This matter came for hearing on August 14 and 15, 2018, in The County, Virginia. Present in person in addition to this Hearing Officer, the Virginia Department of Education (“VDOE” Hearing Officer Evaluator, and the Court Reporter, were the Parent (who was *pro se*), counsel for the LEA and the LEA’s representative, its Supervisor of Student Services.

 There is no dispute that the Student is eligible for special education services under the Individuals with Disabilities Education Improvement Act (“IDEA”). The Student has multiple disabilities and requires the related services of a nurse in order to attend school.

 The Parent initially raised seven issues for the Hearing Officer’s resolution, five of which were resolved by party agreement and withdrawn by the Parent at the commencement of the hearing. Thus, at the commencement of the hearing, there remained two issues for resolution.

 The first was the Parent’s allegation that the LEA had refused to conduct an educational evaluation of the Student. The Parent contended that an evaluation conducted by the school psychologist was not an “educational” evaluation, but a “psychological” evaluation to which she had not consented, and that the psychologist’s report was deficient for “educational” purposes because it did not interpret the available data to correlate with functional grade level achievement. The LEA maintained that the psychologist’s report was an “educational” evaluation (and thus it had not “refused” the requested evaluation), but was nonetheless willing to conduct another evaluation and produce a report containing the information specifically sought by the Parent, pending receipt of the Parent’s consent. The Parent claimed that she had granted consent, but did not produce a copy of any written consent document to the Hearing Officer. In order to effectuate the intent of the parties and bring finality to the issue, the Hearing Officer exercised her authority to order an independent educational evaluation of the Student pursuant to 8 VAC 20-81-210(P)(8). To the extent there had been any controversy to begin with, this disposed of any remaining impasse on the evaluation issue. *See Order at Tx 152.*

 Accordingly, this left only a single issue for the Hearing Officer’s resolution. Relevant herein is that the Student has a tracheostomy through which he breathes, due to a paralyzed larynx. The “trach” tube requires suctioning throughout the day. The Parent contends that in order to attend school the Student requires a full time, 1-1 nurse with him at all times in the school setting. The LEA refuses to provide the Student a full time, 1-1 nurse, and has developed a health care plan that calls for the Student to be suctioned, on a schedule and as needed, by a school nurse. Also, part of the LEA’s plan is to train various (non-medical) staff members to perform the suctioning in the event of an emergency or if the school nurse is unavailable.

 In the course of a two-day hearing, both the LEAA and the Parent presented the testimony of witnesses and introduced documentary evidence into the record. This Hearing Officer heard the testimony of: the Parent, the High School’s Supervisor of Student Services, the High School’s Assistant Principal, the Student’s Special Ed Teacher, and the School Nurse. Admitted into evidence were Parent’s Exhibits 5-8, 10, 13, 14, 20b, 22 (hereinafter “P-#”); School Board Exhibits 1, 3-9, 15, 16, 18-22, 31, 32, 34, 36 (hereinafter “SB-#”).

# SUMMARY

 The Student is a rising 11th grader. He has, at times, attended school and at other times received homebound services. The Student is non-verbal and, at times, uses assistive technology to communicate. He is ambulatory but suffers from scoliosis. He has a history of epilepsy, but has been seizure free since 2014. He had a “trach” tube inserted during infancy, which requires regular suctioning. The Parent is his primary caregiver and generally performs suctioning multiple times a day.

 Last year, the Student received homebound services, but also attended the High School for two hours per day. The Parent hired a nurse to attend school with him. LEA witnesses testified that while the Student made good progress in the school setting over the course of the academic year, that the constant “hovering” presence of his nurse was detrimental to the Student’s motivation to engage with his peers and other school staff. LEA witnesses also testified that after observing the suctioning performed by the privately hired nurse, they came to believe that the Student did not require a nurse with him at all times in the school setting.

 LEA witnesses also testified that they believed the homebound setting did not provide the Student with a Free Appropriate Public Education (“FAPE”. Nor did they find satisfactory the split arrangement of service delivery both in the home and in school. Accordingly, the Individualized Education Plan (“IEP”) proposed by the LEA for the 2018-2019 school year provides for the Student to attend the High School full time. The proposed health care plan for the Student includes having the Student be suctioned by a school nurse (in her office) on a set schedule and as needed. The LEA has two other nurses who work in schools nearby the High School and who will be made available to substitute for the School Nurse should she be unavailable. Additionally, the LEA plans to train a group of non-medically licensed staff to suction the Student in case of emergency or school nurse unavailability. The LEA however, refuses to provide a nurse to accompany the Student throughout the day.

 The Parent vehemently objects to any arrangement that falls short of licensed nurse accompanying the Student throughout the day to both monitor his condition and suction his trach. The Parent argues that the Student’s medical needs can only be met by a licensed nurse, and that the risks associated with any delay or malpractice in performing the suctioning are unacceptable.

 While this *pro se* Parent made her opinion patently clear to all, she failed to prove by a preponderance of the evidence the Student’s need for a full-time, 1-1 nurse to accompany him throughout the day in the school setting. The single greatest deficit in the Parent’s case was the lack of any testimony from any medical professional in support of her position. There was neither testimony nor current report from the Student’s physician. While the Student suffers from a very serious medical condition and undeniably requires suctioning throughout the day, there is insufficient evidence in the record to support the Parent’s position that the suctioning throughout the day, there is the Student’s health condition must be provided by a nurse. As I will discuss below, there is merit to her concern that the suctioning not be performed by non-medically licensed LEA staff, but before me was only the question of whether the Student needs a full-time, 1-1 nurse to attend school, and not whether the proposed health care plan is legally sufficient.

# FINDINGS OF FACT

1. Notice requirements to the Parents were satisfied.
2. The Student does have a disability.
3. The Student does need special education and related services (including services).
4. The Student will be an 11th grader for the 2018-2019 academic year.
5. The Student has a tracheostomy in place which requires regular suctioning.
6. The Student meets the DSM-5 criteria for autism, with 3 symptoms of difficulty in social communication and interaction, and at least 2 symptoms of restricted or repetitive behaviors. He is nonverbal with occasional vocalizations, and maintains poor eye contact. He also has a behavior disorder marked by aggression. (P-8)
7. The Student uses vocalizations, gestures, adapted sign languages, pictures, and uses assistive technology to communicate. (SB-8)
8. The Student is able, through gestures, to indicate when his trach requires suctioning.
9. The Student also has a diagnosis of epilepsy, but has been seizure free since 2014. He is followed by a neurologist at the University of Virginia. (P-8)
10. The Student has a diagnosis of scoliosis and is followed by an orthopedist at the University of Virginia. (P-8)
11. The Student has Dandy-Walker malformation and is followed by a neurosurgeon at the University of Virginia. (P-8)
12. The Student has a full scale IQ of 51, and testing suggests that he has a moderate intellectual disability. (P-8)
13. The Student receives ABA therapy and speech-language therapy. (P-8)
14. The Student is able to use the bathroom by himself, but needs an adult to prompt him to wash his hands. He is able to pull on his own clothes independently. (SB-8, page 2 of 3)
15. The Student is able to get his own snack and lunch from his bags and is able to make selections from a refrigerator/freezer. (SB-8)
16. The Student is Medicaid eligible and is a Consumer of attendant and nursing care services through the CCC Plus Waiver program administered by the Virginia Department of Medical Assistance Services (“DMAS”).
17. The Parent is the Employer of Record for the providers of the Student’s attendant and nursing care services.
18. In determining service authorization, a DMAS case manager, or service facilitator, regularly (every 90 days) assesses the Student’s need for an institutional level of care (in other words, whether the Student can be served at home or whether he needs to be in a nursing home) Tx-297. The Student has never been institutionalized, nor resided in a nursing home, nor has he ever been recommended for an institutional level of care. Tx-197.
19. He is currently eligible to receive up to 70 hours of skilled nursing care per week, but his Parent is unable to staff the position. Tx 282-83.
20. To compensate for the staffing difficulties, he has been found eligible for 35 hours per week of attendant care. His attendant is prohibited by DMAS regulations from performing suctioning of his trach. The Parent has been trained to perform suctioning of his trach and is available to perform the suctioning as needed while the Student is with his attendant. Tx 283-84, 295-96.
21. By letter dated August 22, 2017, the student’s physician wrote a letter in support of homebound instruction for the 2017-2018 academic year. The letter states: “This is a letter of medical necessity for [the Student], who is a 15 year old young man with a number of medical issues secondary to a congenital brain anomaly, called Dandy Walker Syndrome. [The Student] has a tracheostomy, a seizure disorder, autism spectrum disorder, scoliosis and a static encephalopathy. He is on a number of medications for mood and seizure control. It is a medical necessity when [the Student] attends school that his nurse is with him at all times during the school day. At this time, it is an ongoing priority to recruit a home health nurse and when one is available, [the Student] will be able to attend school. Until a nurse is available, [the Student] requires homebound instruction. Thank you for your attention in this matter. Please feel free to contact me if you have questions regarding this letter. Sincerely…” (P-10)
22. 22-The School Nurse was qualified as an expert in the provision of nursing care. Tx 42.
23. 23-The School Nurse testified that she has known the Student for over four years and participated in the development of his health care plan, along with the rest of the IEP team and the Parent. Tx 44-45. The health care plan addresses the Student's health needs related to his seizures and tracheostomy.
24. 24-The School Nurse's office is two doors away from the Student's classroom and she is in her office for the entire school day. Tx 47. When she is absent from the building, a substitute nurse fills in for her. Tx 48.
25. 25-The School Nurse opined that the Student's trach has to be suctioned two to three times per instructional day, and that the whole suctioning procedure (including equipment preparation) takes three to four minutes. Tx 49, 58.
26. 26-According to the School Nurse, the implementation of the Student's health care plan anticipates that she would perform the trach suctioning, but that other staff would be trained to perform suctioning in an emergency. Tx 51 .
27. 27-The Student would be brought to the School Nurse's office for suctioning. Tx 54.
28. 28-While it is possible for a trach to become dislodged or fall out, there was no evidence that this had ever happened to the Student. The School Nurse testified that it is not common for a trach to become dislodged or fall out, but that it is an emergency situation if it does happen. Tx 57.
29. 29-The School Nurse opined that the Student does not require a dedicated I-I school nurse because a school nurse would be available on site at all times and he would always have someone with him who is trained to recognize his health needs. Tx 51.
30. 30-A trained EMT would travel on the Student's bus and be available to perform suctioning should the need arise while the Student was in transit. Tx. 54
31. 31-The Special Ed Teacher was qualified as "an expert in educational programming and IEP development for students with disabilities." Tx 172. She was not qualified as an expert in any capacity that rendered her qualified to opine on the Student's medical or health service needs.
32. 32-The Special Ed Teacher has neither medical training nor licensure and, at the time of the hearing, had not completed the training necessary to competently perform suctioning of a trach.
33. 33-The Special Ed Teacher testified that in addition to herself, there is at least one teaching assistant assigned to her classroom, and sometimes there are two. Tx 175.
34. The Special Ed Teacher opined that "from an educational perspective" a nurse is not required for the Student to receive an appropriate education because "we have a plan in place where we have our nurse two doors down [and] I and my assistants are being trained to -for emergency care." This opinion was based on her observation that "the nurse that came last year sat in a corner and did his suctioning in the classroom ... she didn't help him while he was in the classroom. It was my TA and I that let her know [the student needed to be suctioned.]'" T x 177.
35. 35*-*The Special Ed Teacher testified that "you can tell when he really does need to be cleaned if it's more frequently than normal," "listening to him ... you can hear the congestion." Tx 179.
36. 36-The Assistant Principal was qualified as "an expert in educational programming and IEP development for students with disabilities." Tx 203. The Assistant Principal was not qualified as an expert in any capacity that rendered her qualified to opine on the Student's medical or health service needs. She has neither medical training nor licensure and, at the time of the hearing, had not completed the training necessary to competently perform suctioning of a trach.
37. 37-Nonetheless, the Assistant Principal opined that the Student does not require a full time I-I nurse in the school setting. The information that led her to form this opinion was her observation of the Student in the school setting. Tx 21S.
38. 38-The Assistant Principal testified that she believes the Student to have a very serious medical need and that the suctioning, if not done properly, could present a life or death emergency. Tx 217.
39. 39-The Assistant Principal admitted seeing the physician's August 2017 letter and testified that she contacted the physician and spoke to him personally. Tx 20S. She testified that the physician did not provide any "medical rationale" for writing the letter.
40. 40-Her understanding of the conversation was "that the parent requested [the letter] and he was complying with the parent request" because the Parent "could be persistent." Tx 206.
41. 41-The physician did not participate in the development of the Student's August 2017 IEP, nor has he ever participated in any of the Student's IEP meetings with the LEA. Tx 20S.
42. 42-The Supervisor of Student Services admitted seeing this letter and testified that she called the physician's office twice but has never spoken to him, nor has he returned her calls. Tx *23S*
43. 43-The Supervisor of Student Services was qualified as an expert "in educational programming and IEP development for students with disabilities." Tx 248. The Supervisor of Student Services was not qualified as an expert in any capacity that rendered her qualified to opine on the Student's medical or health service needs. She has neither medical training nor licensure and, at the time of the hearing, had not completed the training necessary to competently perform suctioning of a trach.
44. 44-Nonetheless, the Supervisor of Student Services opined that the Student does not require a full time I-I nurse in the school setting. The information that led her to form this opinion was her observation that the Student only needs to be suctioned three times a day. Tx 234. "If he has a cold or congestion then it could be four, maybe five times a day. And the staff is very well-aware of that."
45. 45*-*The Supervisor of Student Services also testified that "the team felt that [the Student] did not need a I-I nurse with him at all times because of his suctioning or any other issues ... The team felt that with the healthcare plan in place, with training, with knowing [the Student] for as many of us have known him for a long time that he did not require that, although the team recognizes that he has a serious condition and we'd

never put him in harm's way.... He functions like other students function. When assistants are around he kind of pushes away. He gets aggravated. We're almost inhibiting him from what he can do because we want to stick a I-I nurse with him for everything. He doesn't need a I-I nurse all the time. He needs time to grow, be independent. He should be around other kids and learn without the shadow of a nurse over him. The nurse that [the Parent] provided [in the past] was in the classroom where there was no gloves being used, where there was no water available to sterilize her hands. We feel that we know the student more, know his needs. And we felt that with no documentation from a doctor that said he must have around the clock nursing care, he doesn't get around the clock nursing care at home. He's got a provider that's very well-versed that has done this repetitive motion again and again. We've had school staff throughout the years do the same type of repetitive motion with the same amount of care that she provides at home. We believe we can provide that for him and he can receive his education with not a shadow standing over him non-stop .... If we didn't feel we could provide this level of care none of us would put ourselves in a position where we would want him to become injured or, you know, suffer death .... We're not saying that we are doctors. We're not. Most of us are not nurses [but] based on what [the Parent] has provided, she tells us that he needs around the clock care [and we don't think he does]." Tx 259-261.

1. 46-The Parent admitted at the hearing that she told the Supervisor of Student Services that she wants a nurse to be with the Student at all times so that she has "eyes and ears" in the school building to "know what's happening" when she isn't there. Tx 261-262, 309.
2. 47-During the 2017-2018 academic year, the Student attended the High School for approximately 2 hours per day, accompanied by the private nurse employed by the Parent.
3. 48-The IEP proposed by the LEA for the 2018-2019 academic year calls for the Student to attend the High School full time. The health care plan and IEP call for a "school staff member" to perform suctioning of the trach "when indicated by the student, signs and symptoms present, and according to health plan." (SB 21)
4. 49-LEA witnesses testified that the plan for the Student's trach suctioning would be thus: the School Nurse would plan to perform the suctioning and the Student would be brought to her office for that purpose; her office is located in close proximity to the Student's assigned classroom; if the School Nurse was absent for any reason, another of the two school nurses in the School Division would come to the High School as her substitute; if no nurse or nurse substitute was available, then a number of other staff members would be trained to perform suctioning of the trach, including the Assistant Principal, the Supervisor of Student Services, and the Special Education Teacher.
5. 50-The Assistant Principal, Supervisor of Student Services, and the Special Education Teacher testified uniformly that: they are not licensed medical or health professionals, they lack any experience or training in suctioning a trach, they are undergoing training from the School Nurse in suctioning a trach in the event they may need to perform that service for the Student.

# DISCUSSION AND CONCLUSIONS OF LAW

The Individuals with Disabilities Education Improvement Act of 2004 ("IDEA"), *20 U.S.c.* § *1401* et seq., its implementing federal regulations of 2006,34 *C.F.R. §300.1* et seq. and Virginia's implementing regulations, 8 *VAC 20-81-10* et seq., require that all students with a disability be provided with a free appropriate public education which includes special education and related services designed to meet their unique needs. *See, Cedar Rapids Community Sch. Dist. v. Garret F.,* 526 *U.S.* 66, 68, (1999); *Board of Educ. ojHendrick Hudson Cellf. Sch. Dist. v. Rowley,* 458 *U.S.* 176, 188-89 (1982). The instruction must "meet the State's educational standards, approximate the grade levels used in the State's regular education, and comport with the child's IEP." *Rowley,* 458 *U.S. at* 189. An

IEP is defined in the IDEA as a written statement for a child with a disability that is developed in a meeting involving a local or State special education representative, the teacher, and the child's parents. The statement must include, among other things, the specific educational and related services to be provided to an eligible child. Related Services are, in part, defined to mean:

Transportation and such developmental, corrective, and other supportive services as are required to assist a child with a disability to benefit from special education and includes speech language pathology and audiology services; interpreting services; psychological services; physical and occupational therapy; recreation, including therapeutic recreation; early identification and assessment of disabilities in children; counseling services, including rehabilitation counseling; orientation and mobility services; and medical services for diagnostic or evaluation purposes. Related services also includes school health services and school nurse services; social work services in schools; and parent counseling and training. Related services do not include a medical device that is surgically implanted including cochlear implants, the optimization of device functioning (e.g., mapping), maintenance of the device, or the replacement of that device. The list of related services is not exhaustive and may include other developmental, corrective, or supportive services (such as artistic and cultural programs, and art, music and dance therapy), if they are required to assist a child with a disability to benefit from special education. Nothing in this section:

1. Limits the responsibility of a public agency to appropriately monitor and maintain medical devices that are needed to maintain the health and safety of the child, including breathing, nutrition, or operation of other bodily functions, while the child is transported to and from school or is at school; or
2. Prevents the routine checking of an external component of a surgically implanted device to make sure it is functioning properly.

(my emphasis added) 8 *VAC 20-81-10.* "Nursing services" thus clearly fall under the category of"related services" and "school health services" must be provided by a qualified school nurse or other qualified person. 34 *CFR 300.34 (c)(13).*

In *Cedar Rapids Community School District v. Garrett F.,* 526 *U.S.* 66 (1999), the United States Supreme Court determined that a school district may be required to fund continuous nursing services as a related service to enable a ventilator-dependent student to attend the school, and that such services are not "medical services." Federal courts have adopted a bright-line rule that declares a disabled child who requires health services to receive F APE is entitled to them under the IDEA as long as the services are provided by an individual other than a physician. Of course, other than excluding a physician from the universe of possible providers, the law provides little to no guidance on the selection of a "qualified" person. And, that is one part of the current dispute I am charged with resolving.

It is perhaps important to note that staffing and other administrative decisions are left to the discretion of the school district tasked with providing services under the IDEA. *See, Rowley; Letter to Wessels, 161DELR* 735 *(OSEP 1990).* Thus, while parents may understandably want an "ideal" nurse for a medically fragile child, the law is clear that a school division's obligations are met by providing "qualified" I personnel. School divisions are never required to employ a person of the parent's choosing. *See, e.g., North Belld School District, 70IDELR* 139 *(2017).*

The United States Supreme Court has held that the burden of proof in special education matters rests with the party filing the claim or initiating the action. *Schaffer v. Weast.* 546 *U.S.* 49 *(2005).* Parents are required to offer expert testimony to support their position. *Weast v. Schaffer.* 377 *F.3d* 449. 456 (4" *Cir. 2004).* Thus, the Parent bears the burden of production and proof that the Student requires a full time I-I nurse in the school setting.

The LEA argues that the Parent's failure to offer any expert testimony is dispositive and ends my inquiry. Superficially, the LEA is correct and I find that the failure to offer the testimony of the Student's treating physician was fatal to the Parent's case. But the Parent has no legal training and did her best to present her case without any assistance. Accordingly, I believe it does a disservice to the process to summarily rule in the LEA's favor without a full explanation of why, even with the testimony of the Student's treating physician, this would still be a complex case and, also, why the LEA's proposed health care plan might be problematic in its own right.

A. Nursing and School **Health** Services Under **IDEA**

Courts and special education hearing officers across the country have considered many cases in which a student requires nursing or school health services. These cases are instructive in that they provide a wide array of examples of how the medical needs of students are accommodated in the school setting, as well as the quantity and quality of evidence that courts and hearing officers and have outcome determinative. J summarize some the relevant rulings, below:

I In some states, tracheostomy care is skilled care that cannot be provided by unlicensed persons and must be provided by a licensed nurse or under the direction and supervision of a licensed nurse. The Virginia Nurse Practice Act does not speak clearly to this issue. *Va. Code. 54./-3000 et seq.* There is no clear exemption for unlicensed persons to provide trach care in a school setting. *See, Va. Code 54./-300/;* /8 *VAC 90-/9-260 (delegable nursing tasks);* /8 *VAC 90-19-280 (non-delegable nursing tasks).*

In *Cedar Rapids Cmty. Sch. Dist.* v. *Garret F. by Charlene F.,* 106 F.3d 822 (8th Cir. 1997), the student was quadriplegic and ventilator dependent. His health care needs at school were met with a constant pcrsonal attcndant and access to a nurse. *[d. at* 823. The Eighth Circuit described Garret's needs as follows:

During the School day, Garret requires a personal attendant within hearing distance of him at all times to see to his health care needs. Garret requires urinary bladder catheterization about once a day, suctioning of his tracheostomy as needed, food and drink on a regular schedule, repositioning, ambu bag administration if the ventilator malfunctions, ventilator setting checks, observation for respiratory distress or autonomic hyperreflexia, blood pressure monitoring, and bowel disimpaction in cases of autonomic hyperreflexia.

*Garret F .. 106 F.3d at 823.*

In *Skelly* v. *The Broof..jield Lagrange Park School District* 95.968 *F. SlIpp.* 385 *(N.D. /II. 1997),* Eddie Skelly, was a four-year old boy who suffered from a rare neurological-muscular disease known as Pelizaeus-Merzbacher Leukodystrophy ("PMD"). As a result of PMD, Eddie received a tracheostomy tube which was not used for breathing but rather as a "pulmonary toilet." *Id. at* 386. Occasionally, the tracheostomy tube would need to be suctioned if Eddie was unable to cough up secretions. *[d. at* 389. The disputed issue was whether the school district was Eddie required "medical services" and that, therefore, the district was under no obligation to pay for the services under the medical services exclusion in the IDEA. *[d. at 387.*

The court, following *Garret F.,* found that the suctioning procedure required by Eddie did not have to be performed by a physician and thus Eddie's condition did not require excluded "medical services" within the meaning of the IDEA. *[d. at* 394-395. The court stated:

The 5uctioning of a tracheostomy tube is a common, standard maintenance procedure that need not be performed by a physician and therefore is not an excluded "medical service" under *20 U.S.c.* § *1401 (a)(I* 7), even if a nurse is required to perform the procedure. Consistent with the testimony [in the record], however, it appears that Eddie's tracheostomy suctioning need not be performed by a licensed nurse but merely a properly trained individual.

*Skelly.* 968 *F. Supp. at 395.*

In *Neely v. Ruthelford COUnty School District.* 68 *F.3d* 965 *(6th Cir.* 1995), the student, Samantha, suffered from Congenital Central Hypoventilation Syndrome which required a tracheostomy. 68 *F.3d at* 967. She also required suctioning to insure that secretions did not block her tracheostomy. *Jd.* Accordingly, Samantha needed a well-trained individual to be readily accessible to her while she attended school. *1d.* The Sixth Circuit held that the services required by Samantha were inherently burdensome to the school district and excludable as medical services. *1d. at* 971-73. The Court of Appeals explained:

The district court found the services in question to be "medical in nature." We believe the better interpretation of *Tatro* to be that a school district is not required to provide every service which is "medical in nature." The services at issue in *Tatro* could be provided by someone other than a nurse and a layperson, with minimum training, could provide it. *Tatro.* 468 *U.S. at* 894. It was, therefore, the kind of service that was not unduly expensive or beyond the range of the school system's competence. *1d. at* 892. We believe it is appropriate to take into account the risk involved and the liability factor of the school district inherent in providing a service of a medical nature such as is involved in this controversy .... We agree that the services requested by Samantha are inherently burdensome ... The undue burden derives from the nature of the care involved ... The care requested by Samantha falls within the "medical services" exclusion of the IDEA.

*Neely.* 68 *F.3d at* 971. 973. This case was decided before the Supreme Court decided *Garret F.,* and thus the conclusion that the services in question were "medical in nature" is no longer good law. However, the quote above is instructive in this case as it illustrates the range of thinking when it comes to trach care: two federal courts agreed that trach care was risky and had to be provided by a licensed medical professional, while the court in *Skelly* felt otherwise.

In *Detsel v. Board ofEducation ofAuburn City School District. 820 F.2d* 587 *(2d Cir.* 1987), Melissa Detsel had a tracheostomy and required the application of a saline solution and the suctioning of mucus. Melissa also required the services of a trained individual to monitor her throughout the school day. There, the district court held that the School District was not obligated to provide the services required by Melissa. The district court explained:

It is clear that the Supreme Court considered the extent and nature of the services performed in the *Tatro* decision. Unlike CIC, the services required by Melissa are extensive. This is not a simple procedure which the child may perform herself. Constant monitoring is required in order to protect Melissa's very life. The record indicates that the medical attention required by Melissa is beyond the competence of a school nurse. A specially trained individual is required. Preferably a health professional. The Supreme Court in *Tatl"O* reasoned that the regulations had permissibly interpreted § *1401(17)* in providing that school nursing services did not fall within the medical services exclusion. In so doing, the Court stated that Congress could well have decided to exclude costly and complicated services .... Indeed, the Court noted that "children with serious medical needs are still entitled to an education. For example, the Act specifically includes instruction in hospitals and at home within the definition of special education .... This dictum is in line with the Court's earlier decision in *[Rowley]* wherein it held that Congress did not intend to "maximize each handicapped child's potential." *[Rowley.* 458 *U.S. at 198* (holding that EAHCA, the predecessor to IDEA, did not require provision of a sign language interpreter for a deaf child enrolled in public school)].

In light of the foregoing, the court holds that the Education of the Handicapped Act (the predecessor to the IDEA) does not require the defendant school district and board of education to provide a severely physically disabled child with [constant] in-school nursing care.

*Detsel.* 637 *F. Supp. 1022. 1026-27 (N.D. NY.* 1986). The Second Circuit Court of Appeals affirmed. *Detsel. 820 F.2d at* 588. Again, it is important to note that this case preceded *Garret F.,* but the discussion of the seriousness,

and precariousness, of the child's condition is instructive. Specifically, some children do in fact require round the clock nursing care and medical attention "beyond he competence of a school nurse."

In *Fulginiti* v. *RoxblllY Township Public Schools, 921 F. Supp. 1320 (D.N.J. 1996); afFd. 116 F.3d* 468 *(3d Cir. 1997),* Carissa Fulginiti required constant monitoring while she attended school because her tracheostomy tube and air passages could become clogged with saliva and mucus. 921 *F. Supp. at 1320.* When necessary, a suctioning device was used to clear the blockages. In describing Carissa's needs, the district court stated:

To participate in and benefit from public education, Carissa requires extensive "related services:" she must receive special education and speech, physical and occupational therapy, special transportation and nurse supervision. Most significantly, the supervision of a full-time nurse or another specially trained person is required during her transportation to and from school, and while there, to monitor her tracheostomy tube and provide suctioning when necessary .... Put simply, if Carissa is to attend school, someone must be with her constantly to monitor her air passage and maintain their clarity.

*Fulginiti,* 921 *F. Supp. at 1321.* Citing, *inter alia, Neely,* the district court granted summary judgment in favor of the Roxbury Township Public Schools. The district court stated:

The application of the determinative reasoning of all cases which have dealt directly with factual circumstances similar to the present controversy compels the conclusion of the court that to require the present Board to assume the responsibility amounts to an undue burden.

*Fulginiti.* 921 *F. SlIpp. at* 1325. (emphasis added). The district court was subsequently affirmed by the Third Circuit Court of Appeals in an unpublished order. See *Fulginiti v. RoxblllY Township Public Schools. 116 F.3d* 468 *(3d Cir. 1997)* (table); *see also Granite School District V. Shall/IOn M..* 787 *F. Supp. 1020 (D.Ut. 1992)* (held constant nursing/tracheostomy care required by handicapped student fell within "medical services" exclusion to the IDEA and thus, was not "supportive" service that school had to provide as a matter of federal law); *Bevin H. V. Wright.* 666 *F. Supp.* 71 *(W.D.Pa. 1987)* (held that nursing services required were so varied, intensive and costly as not to be properly includable as "related services" which school district was responsible to provide to child without charge). Again, these cases preceded *Garret F.* and so the focus on the now-changed definition of "related services" renders legally irrelevant the conclusions related to "undue burden." But the Parent is hardly the first to claim a student requiring trach care requires constant nursing services.

In *San Francisco Unified School District.* 37 *IDELR 144 (2002).* a special education hearing officer in California ruled that a 3 year old student with uncontrolled seizures required 1-1 services throughout the school day to both monitor his health generally, and to administer emergency medication and ventilation. In addition, the hearing officer had to determine what credentials were required of the personnel who would deliver these services to the student both in the school setting and on the bus. The hearing officer held that "at a minimum" the student required the services of a trained one-to-one aide with a nurse immediately available at all times to assist. The hearing officer cautioned the school division that California law governed what nursing tasks the student required could be performed by unlicensed medical professionals.

In *Sail Diego Unified School District. 41 IDELR 195 (2004),* another California special education hearing officer concluded that a 6 year old student who required frequent suctioning of his oral secretions, feeding via a gastronomy tube, administration of asthma medication by a nebulizer machine and seizure care, didn't require a I-I nurse. As in the case before me, the student in this California case required continuous monitoring throughout the day to assess the need for trach suctioning. The student's mother argued that he was medically fragile and required a nurse to monitor him to ensure that he was promptly and appropriately suctioned. The hearing officer disagreed, finding no legal requirement in California law "that the type of specialized physical health care services student requires can only be met by a nurse." Finding that the student was suctioned at home by individuals who were not nurses, and that the actual use of the suctioning machine and the suctioning procedure itself "is not complicated or

technical," the hearing officer concluded that the student's health care needs could be met by a trained and dedicated 1-1 special education technician supervised by a full-time school nurse and that having the school nurse on site, with an office in close proximity to the student's classroom, was sufficient for purposes of promptly responding to the student's needs and performing the nursing services (such as trach suctioning) the student required.

In *New Britain Board of Education.* 47 *JDELR* 86 *(2006),* the parents of a 20 year old student with a tracheostomy tube wanted her to have not only \-\ nursing care, but for the school division to guarantee the assignment of the same nurse to the student at all times (in order to maintain a continuity of care). A special education hearing officer in Connecticut ruled in the school division's favor. The hearing officer concluded that a parent could not dictate the identity of the nurse assigned to provide health care services to a student. The hearing officer ruled that the qualifications, and not the identity, of the individual were important. The hearing officer also found that the evidence was insufficient to establish the student's need for I-I nursing care when her physician and the school division's medical advisor both believed it was not medically necessary and the student had been successfully served by a I-I paraprofessional with a nurse present at the school to perform nursing tasks and assist the student, as needed.

In *Department of Education, State of Hawaii,* 47 *JDELR* 148 *(2007),* a special education hearing officer in Hawaii held that a school division's offer to provide limited nursing services throughout the school day to a medically fragile 5 year old with tracheostomy and gastrostomy tubes did not satisfy the child's need for around the clock nursing care. In that case, the child's trach required suctioning every 15 minutes and the evidence was that the child had required 24-hour a day care since birth. Significant to the hearing officer's conclusion was testimony from the child's pediatrician that she herself had difficulty replacing the child's trach tube and that the child specifically required a nurse by her side when in school to attend to her medically complex and diverse needs.

In *City of Chicago Public School District* 299, *109 LRP* 57368 *(2009),* a special education hearing officer in Illinois was called upon to determine whether a medically fragile 17 year old with a gastrostomy tube required a full time private nurse assistant. The student's mother, herself a licensed registered nurse (who was in fact employed by the school district to train medical assistants), testified that her child required "consistency and constant care in order to function," pointing to several letters from the child's pediatrician to support her position. The issue in that case was not whether the child required a nurse assistant, but rather whether it had to be the same individual who served the child at home (hired and paid for by the mother). The hearing officer concluded that the mother failed to prove her case by a preponderance of the evidence, despite bringing in the child's pediatrician to testify at the hearing.

In *East Haddam Board of Education, 118 LRP 10350 (2017),* a special education hearing officer in Connecticut held that the health needs of a medically fragile 5 year old could be met by a I-I paraprofessional supervised and assisted by an on-site school nurse. The child had a neurologic disorder attendant with frequent seizures, breathing difficulties, food allergies, and a variety of functional impairments that required constant supervision and assistance with activities of daily living. While the parents asserted the child required a I-I nurse to receive FAPE, the hearing officer concluded that the child's school health needs could be met by a combination of "school nurse" services provided by a school nurse to administer medications, and "school health services" provided by a paraprofessional specially trained by the school nurse to monitor and record seizure activity, breathing difficulties, and the host of other symptoms and conditions attendant with the child's diagnosis. The hearing officer was careful to delineate assignment of services in accordance with the permissible scope of practice for nurses as determined by Connecticut state law.

In conclusion, not only is there an absence of medical and factual basis to support the Parent's assertion that the Student demands the high level of service (both constant monitoring and the performance of skilled nursing tasks) that would require a full time I-I nurse, the multitude of cases summarized above does nothing but illustrate how review ofa parent's demand for nurse services for a child is very fact sensitive and case specific. Even when a child's pediatrician is brought in to testify, their testimony may not uniformly comport with parental opinions about the level of care the child requires. Likewise, medical history and past need is not always determinative of the status quo: a physician will be called upon to testify regarding a child's then current medical condition, and for that reason past recommendations can change in light of the stability of the child's condition and recent degrees of improvement or deterioration. In other words, the quantum of evidence that must be presented is significant, and the quality of the evidence must be specific to the child's then-current status. In all regards, the evidence in this case was lacking for purposes of any meaningful review.

B. Why the Student's Medicaid Eligibility is Relevant to the Resolution of this Question

While the deficiencies in the Parent's case are themselves dispositive of the issue, it is important to note that the Parent's assertions are not corroborated by other evidence in the record. Namely, because the Student is Medicaid eligible, another state agency, the Virginia Department of Medical Assistance Services ("DMAS"), is tasked with regularly assessing his need for skilled nursing services -and those assessments refute the Parent's claim that he requires full time nursing care.

It is well settled that specialized government agencies are afforded significant deference in their area of specialized competence. While the degree of deference granted to an agency "depends on the nature of the issue, whether it is legal or factual, deference also turns on whether the issue falls within the area of expertise and specialized competence of the agency itself." *Buschenfeldl v. Va. Ret. Sys ..* 95 *Va. Cir. 220,* 222 *(2017); citing JO/nston-Willis, Ltd., v. Kenley.* 6 *Va. App. 231 {I988}.* I believe that the purposes of Medicaid, as set forth below, and the determination of the agency charged with enforcing it as to what "medically necessary" "nursing services" a child requires, is crucial to consideration of the same question in an educational setting. The statutory origin of the defined terms aside, in either the medical or educational context, the inquiry is fact specific, case specific, and relies upon expert medical assessment. Clearly, matters involving medicine fall outside the specialized competence of the Department of Education.

In 1965, Congress enacted the Medicaid Act, 42 *U.S.c.* § *1396 et seq.,* as Title XIX of the Social Security Act. Medicaid is a jointly financed federal-state cooperative program, designed to help states furnish medical treatment to their needy citizens. States devise and fund their own medical assistance programs, subject to the requirements of the Medicaid Act, and the federal government provides partial reimbursement. *See* 42 *U.S.c.* §§ *1396b(a), 1396d(b}.* A state's participation in the Medicaid program is voluntary, but once a state opts to participate it must comply with federal statutory and regulatory requirements. *See Alexander v. Choate.* 469 *U.S.* 287. 289 *n.1 (I* 985}. All states, including Virginia, have chosen to participate in Medicaid.

The Medicaid Act, as supplemented by regulations promulgated by the Department of Health and Human Services ("HHS"), prescribes substantive requirements governing the scope of each state's program. *Section 13960* provides that a "State plan for medical assistance" must meet various guidelines, including the provision of certain categories of care and services. *See* 42 *U.S.c.* § *13960.* Some of these categories are discretionary, while others are mandatory for participating states.ld. § *1396a(a}{I0)* (listing mandatory categories).

In 1989, Congress amended the Medicaid Act to broaden the categories of services that participating states must provide to Medicaid-eligible children. The 1989 Amendment mandates that participating states provide Early and Periodic Screening, Diagnostic, and Treatment ("EPSDT") services to all Medicaid-eligible persons under the age of

21. *Omnibus Budget Reconciliation Act of1989. Pub. L. No. 101-239.* § *6403. 103 Stat. 2106.* 2262-64; 42 *U.S.c.* § *1396d(a)(4)(B}, (r).* The goal of the EPSDT program is to provide low-income children with comprehensive health care. The EPSDT program, codified at 42 *U.S.c.* § *1396d(r),* mandates four specific categories of services: screening, vision, dental, and hearing services. 42 *U.s.c.* § *1396d(r)(I)-(4}.* Additionally, the catch-all EPSDT provision in § *1396d(r)(5}* mandates that participating states provide to Medicaid-eligible children "[such other necessary health care, diagnostic services, treatment, and other measures described in *subsection (a)* of this section to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or

not such services are covered under the State plan." *Id.* § *1396d(r)(5)* (emphasis added). In turn, § *1396d(a)(1)-(29)* enumerates 29 categories of care and services defined as "medical assistance," including "private duty nursing services" in § *J396d(a)(8).* The 1989 Amendment, however, made it incumbent upon states to provide all 29 categories of care, including "private duty nursing services," to Medicaid-eligible children who qualify under the EPSDT provision. Although eliminating a state's discretion over the categories of medical services and treatment that must be provided to children, the 1989 Amendment did not change the "medical necessity" limitation on such Medicaid-required services and treatment.

To clarify the contours of the "private duty nursing services" mentioned in § *1396d(a)(8),* a federal regulation provides that "[p ]rivate duty nursing services means nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility." 42 *C.F.R.* § *440.80.* That federal regulation specifies that the state has the option to provide the required private duty nursing services in a home, hospital, or skilled nursing facility:

These services are provided

(a) By a registered nurse or a licensed practical nurse;

(b) Under the direction of the recipient's physician; and

(c) To a beneficiary in one or more of the following locations at the option of the State

(I) His or her own home;

(2) A hospital; or

(3) A skilled nursing facility.

*ld.* In addition, another federal regulation provides that each service in the state plan "must be sufficient in amount, duration, and scope to reasonably achieve its purpose" and that the state Medicaid agency "may place appropriate limits on a service based on ... medical necessity":

(a) The plan must specify the amount, duration, and scope of each service that it provides for

(I) The categorically needy; and

(2) Each covered group of medically needy.

(b) Each service must be sufficient in amount. duration. and scope to reasonably achieve its purpose.

(c) The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under § § *440.2J0* and *440.220* to an otherwise eligible beneficiary solely because of the diagnosis, type of illness, or condition.

(d) The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.

*Id.* § *440.230* (emphasis added).

The Centers for Medicare and Medicaid Services ("CMS"), a federal agency within HHS, is charged with administering the Medicaid Act. Among other things, CMS sets forth guidelines for participating states to follow in their Medicaid programs and monitors state agency compliance with Medicaid requirements. CMS is required to determine that each state plan is in conformity with the specific requirements of the EPSDT mandate in the Medicaid Act. To facilitate this objective, the federal CMS publishes a "State Medicaid Manual" to direct participating states in their implementation of Medicaid requirements, including the EPSDT mandate in the Medicaid Act. *See eMS,*

*U.S. DEP'T OF HEALTH* & *HUMAN SERVS., Pub. No.* 45. *State Medicaid Manual* ("CMS Manual")2. In the chapter devoted to EPSDT services, the CMS Manual describes the EPSDT mandate of the Medicaid Act as "a comprehensive child health program of prevention and treatment" designed to "[a]ssure that health problems found are diagnosed and treated early, before they become more complex and their treatment more costly." *Id.* § *5110(B).*

In the subsection entitled "Limitation of Services," the CMS Manual advises participating states, in language tracking § *1396d(r)(5),* that they make the determination as to whether a Medicaid-required service is medically necessary:

[EPSDT] services must be "necessary ... to correct or ameliorate defects and physical or mental illnesses or conditions ..." and the defects, illnesses and conditions must have been discovered or shown to have increased in severity by the screening services. You make the determination as to whether the service is necessary.

*Id.* § *5122(F)* (emphasis added).

The CMS Manual also instructs the states that 42 *C.F.R.* § *440.230* allows the state Medicaid agency "to establish the amount, duration and scope of services provided under the EPSDT benefit" so long as (1) any limitations imposed are reasonable; (2) the EPSDT service is sufficient to achieve its purpose; and (3) the state's definition of the service comports with the statutory requirement that the state provide all services "that are medically necessary to ameliorate or correct ... conditions discovered by the screening services":

*42 CFR 440.230* allows you to establish the amount, duration and scope of services provided under the EPSDT benefit. Any limitations imposed must be reasonable and services must be sufficient to achieve their purpose (within the context of serving the needs of individuals under age 2\). You may define the service as long as the definition comports with the requirements of the statute in that all services included in §\905(a) of the Act that are medically necessary to ameliorate or correct defects and physical or mental illnesses and conditions discovered by the screening services are provided.

*Id.* (emphasis added).

While emphasizing the need for state Medicaid agencies to fulfill their EPSDT obligations, the CMS Manual underscores the need for the state agency to avoid "unnecessary services":

Although "case management" docs not appear in the statutory provisions pertaining to the EPSDT benefit, the concept has been recognized as a means of increasing program efficiency and effectiveness by assuring that needed services are provided timely and efficiently, and that duplicated and unnecessary services are avoided.

*CMS Manual* § *501O(B).*

**In** Virginia, the Department of Medical Assistance Services ("DMAS") is the single state agency tasked with administering the Medicaid program. DMAS long-term care state regulations can be found at 12 *VAC 30-10-220 et seq.,* 12 *VAC 30-20-10 et seq,* 12 *VAC 30-30-10 et seq.,* 12 *VAC 30-40-10 et seq.,* 12 *VAC 30-50-130 et seq,* 12 *VAC 30-50-320 et seq,* 12 *VAC 30-60-30 et seq.,* 12 *VAC 30-90-10 et seq,* 12 *VAC 30-50-440 el seq.,* 12 *VAC 30-120-90 et seq.,* 12 *VAC 30-120-900 el seq.* (EDCD Waiver). DMAS publishes a provider manual, which compiles the legal requirements of its programs and explains them in layman's terms: www.virginiamedicaid.dmas.virginia.gov/wpslportallProviderManual

Virginia's Consumer-Directed Fiscal/Employer Agent Services program supports people who are eligible for Medicaid through DMAS and choose to direct their own services. Attendants provide personal care services for participants found eligible for certain programs, including the Elderly Disabled with Consumer-Directed Support (EDCD) Waiver. The EDCD Waiver is now known as the CCC Plus Waiver. Eligible participants are also referred to as "Consumers," and if a consumer is unable to manage his/her own affairs, then the program allows a consumer

2 https:llwww.cms.gov/Regulations-and-GuidanceIGuidanceIManualslPaper-Based-Manuals-ltems/CMS02I 927.html

to designate an "Employer of Record" who is then responsible for recruiting, hiring, firing, and all employer-related administrative duties related to the employment of a consumer's attendants. A company, peG Public Partnerships (" PPL") is the DMAS approved fiscal intermediary for the EDCD Waiver/CCC Plus Waiver program. In essence, PPL is the payroll agent for every employer of record such that Medicaid funds are paid directly to attendants in accordance with time sheets submitted to PPL and approved by an employer of record for services rendered to a consumer. *See, generally, www.publicpartnerships.com; W1VW. virginia.gov; www.dmas.virginia.gov*

Once a consumer has been found eligible for services, the consumer must select a program, or service, facilitator who is an independent contractor trained and compensated by DMAS. A consumer's service facilitator is like a case manager who is required to visit the consumer at regular intervals (generally every 90 days) to assess the consumer's ongoing need for services and to authorize services by type and quantity (e.g. x number of hours per week of attendant care, or x number of hours per week of skilled nursing care). It is the service facilitator who makes the initial determination of whether the consumer requires an institutional level of care, or whether the consumer can be served at home.

The Fourth Circuit has held that when a consumer disagrees with the quantity, duration, or scope of services authorized by a service facilitator, the opinion and recommendation of the consumer's treating physician is not binding on the state agency administering Medicaid. In *Jimmy Chip E v. Buscemi,* 64 *Fed. Appx. 219* (4" *Cir. 2016),* Jimmy Chip E ("Chip"), a participant in South Carolina's Medicaid waiver program, contended that he had a right to receive services ordered by his treating physician and that the state agency's failure to promptly provide such services violated the *Medicaid Act,* 42 *U.S.c.* § *13960 (2012),* and 42 *U.S.c.* § *1983 (2012).* Chip's claim rested on a one page 2010 affidavit from his treating physician. The affidavit did not purport to be an "order," nor did it state that, in the absence of the specific care recommended, Chip would face risk of institutionalization. The Fourth Circuit held that "while a treating physician's opinion is entitled to deference, agencies are not bound by a treating physician's statement." *See* 42 *U.S.c.* § *1396n(i)(I)(G)(ii)(J){aa) (2012)* (providing that the treating physician should be consulted in determining a care plan); *see alsa Moore ex rei. Moore v. Reese,* 637 *F.3d 1220,* /255 *(1 lth Cir. 201 I)* (holding that a private physician's word is "not dispositive"). These cases are instructive because they make clear that in disputes between the state and Medicaid patients, a fact finder must take evidence and decide between the conflicting recommendations of a patient's physician and a state-retained medical expert witness.

Thus, the relevance of this detailed discussion of Medicaid programs is that as a quasi-judicial officer of the Virginia Department of Education, I believe I am bound to afford substantial deference to the medical assessments made by trained agents of DMAS who are legally bound by federal law to consider what services a Medicaid beneficiary requires as a matter of "medical necessity." Furthermore, it is instructive that the law in this federal circuit does not require them, nor a reviewing court, to blindly adopt the recommendations ofa beneficiary's treating physician.

The Student is Medicaid eligible and the Parent testified that his service facilitator, who assesses him regularly, has authorized him to receive 35 hours of attendant services per week, pending the hiring of a nurse to deliver up to 70 hours per week of skilled nursing care. The Student has never been institutionalized, has never resided in a nursing home, and has never received round the clock skilled nursing care. He does not currently receive *allY* skilled nursing care. By law, if he required round the clock skilled nursing care, and that care could not be delivered in his home, then he would not be authorized to receive attendant care -rather, he would be admitted to a nursing home.

The Parent's insistence that the Student requires a full time 1-1 nurse in the school setting is not substantiated by any evidence presented at the hearing, nor is the Parent's belief that the Student requires this level of care corroborated by any DMAS service authorization. To the contrary, the LEA's position that the Student does NOT require this level of care is corroborated by the evidence that DMAS has not now, nor ever, authorized the Student to receive such an intense level of nursing care as an alternative to institutionalizing the Student and providing private duty nursing services in a hospital or skilled nursing facility.

C. **Ruling Limited in** Scope

While I find that the Parent failed to prove her case by a preponderance of the evidence, it is equally important to note the limits of my decision and what I am NOT concluding. I cannot, and do not, conclude that the LEA's health care plan is legally sufficient.

I. Who can suction the Student's trach?

By way of observation, the LEA's suggestion that non-medically trained, non-medically licensed, school staff may suction the Student's trach is potentially problematic in light of the Virginia Nurse Practice Act. *Va. Code 54.1-3000 e/ seq ..* 18 *VAC 90-19-100 e/ seq.*

Interpreting the Virginia Nurse Practice Act exceeds the scope of my authority, given that I can resolve the issue presented without reaching the question of the legality of staff assignments in the proposed health care plan. The implementing regulations of the Nurse Practice Act provide some, but not great, clarification on what is or isn't a "non-delegable nursing task." 18 *VAC 90-19-260 alld -280.* Equally unhelpful is that neither the Board of Nursing nor the Virginia Department of Health Professionals publishes any kind of laundry list of what tasks can and can't be delegated.

The case law review provided herein is not helpful to resolving this scope of practice question because the scope of nurse practice is very state specific. My cursory research reveals that some states provide more guidance than others on who can and can't perform trach suctioning, and there is no clear consensus that would permit me to speculate how Virginia would come out on the issue, particularly when Virginia has not gone to the lengths other states have in issuing clear guidance on the issue one way or the other.

Thus, whether trach care is a nursing task that can be provided by unlicensed personnel under the direct supervision of a licensed registered nurse is a question for another day. But, it is one the LEA is cautioned to explore and resolve sooner rather than later.

Nonetheless, the DMAS Provider Manual prohibits an attendant from performing trach suctioning for a consumer (subject to an exception in the Nurse Practice Act that applies in a situation not present here). Indeed, the Parent testified that the Student's attendant is prohibited from performing trach suctioning, and for that reason the Parent is available to suction the Student's trach even when the attendant is with the Student in the home. An unpaid, family caregiver is exempt from the Nurse Practice Act, and thus the Parent in this case is, by law, not engaged in the unlicensed practice of nursing.

Thus, if DMAS has concluded that an attendant cannot suction a trach because that is a nursing skill that must be performed by an appropriately trained and licensed medical professional, then I believe I may be required to afford that determination deference (assuming no clearer guidance from the Virginia Board of Nursing or Department of Health Professionals), should the issue be presented to me for resolution in the future.

2. Who should be part of the team that develops the Student's health care plan

That 110 *physiciall* participated in the development of the proposed health care plan is nothing short of astounding. I offer, by way of unsolicited guidance, the approach set forth in the Brief of *Amicus Curiae* for the American Academy of Pediatrics, the National Association of School Nurses, and the Family Voices in Support of Respondent Garett F. that was submitted to the United States Supreme Court in the *Cedar Rapids* case:

The role of the primary care physician under these circumstances is to coordinate the health care Garret receives, both at home and at school. The overall direction of medical care and health related services for children with chronic and disabling conditions is the responsibility for the primary care physician and the medical community, wherever the services may be provided, and whoever may provide them. It is important that the child's personal physician and the school physician, the school nurse, the school administrator and the family develop a written health plan as an integral component of the child's IEP. Thus, it is the role and responsibility of a child's primary care physician to inform the school health professionals about the child's medical needs and child's degree of fragility.

Working with this information, school health professionals (e.g., physicians and nurses) can decide whether services should be provided by a nurse or delegated to an adequately trained and appropriately supervised health professional. The specific decisions with respect to whether a registered nurse, licensed vocational nurse, or other health professional is required must be made on a case by case basis and must be redetermined whenever there is a change in the child's condition.

Further guidance is afforded by a *Dear Colleague Letter,-J* issued by the Office of Special Education and Rehabilitative Services and OSEP in 2016, in which it is suggested that "best practices" require the physician of a medically fragile student to be part of the placement team. 67 *IDELR* 245 (4/26//6).

Again, I emphasize that I am not ruling on the appropriateness of the proposed health care plan because that issue was not specifically placed before me for resolution. But the recommendations cited above were submitted to the United States Supreme Court for consideration in connection with the *Cedar Rapids* case, and I would thus consider them worthy of consideration should the issue be presented to me for resolution in the future.

# IDENTIFICATION OF PREVAILING PARTIES

Pursuant to 8 V AC 20-81-210 (P)( 12) this Hearing Officer has the authority to determine the prevailing party on each issue that is decided. Having found that the Parent failed to present sufficient evidence to support her position by a preponderance of the evidence, the Hearing Officer identifies the LEA as the prevailing party on this single issue presented and decided.

# APPEAL INFORMATION

8 VAC 20-8 1-2 I O(T) Right of Appeal (34 CFR 300.516; Va. Code §22.1-214D)

1. A decision by the special education hearing officer in any hearing, including an expedited hearing, is final and binding unless the decision is appealed by a party in a state circuit court within 180 days of the issuance of the decision, or in a federal district court within 90 days of the issuance of the decision. The appeal may be filed in either a state circuit court or a federal district court without regard to the amount in controversy. The district courts of the United States have jurisdiction over actions brought under § 1415 of the Act without regard to the amount in controversy.

, Dear Colleague Letter on Children with Disabilities Residing in Nursing Homes that addresses the responsibilities of states, school districts, and other public agencies in addressing the special educational needs of children with disabilities who reside in nursing homes

1. On appeal, the court receives the record of the administrative proceedings, hears additional evidence at the request of a party, bases its decision on a preponderance of evidence, and grants the relief that the court determines to be appropriate.
2. If the special education hearing officer's decision is appealed in court, implementation of the special education hearing officer's order is held in abeyance except in those cases where the special education hearing officer has agreed with the child's parent(s) that a change in placement is appropriate in accordance with subsection J of this section. In those cases, the special education hearing officer's order shall be implemented while the case is being appealed.
3. If the special education hearing officer's decision is not implemented, a complaint may be filed with the Virginia Department of Education for an investigation through the provisions of 8 V AC 20-81-200.

# IMPLEMENTATION PLAN

The LEA is responsible to submit an implementation plan to the parties, the hearing officer, and the Virginia Department of Education within 45 calendar days. The implementation plan shall include the Order issued verbally on August 15,2018, and any stipulations entered into between the parties, pertaining to the independent educational evaluation of the Student.

Krysia Carmel Nelson, Hearing Officer Dated this 10" day of September, 2018

# CERTIFICATE OF SERVICE

I, Krysia Cannel Nelson, do hereby certify that this 10" day of September, 2018, I e-mailed a copy of this decision to:

xxxxxxxx: xxxxxxxxxxxx Jason Ballum: JBallum@Reedsmith.com Alan Bart: ABart@Reedsmith.com Brian Miller (VDOE evaluator): MillerLawLimited@aol.com Art Stewart (VDOE): Arthur.stewart@doe.virginia.gov