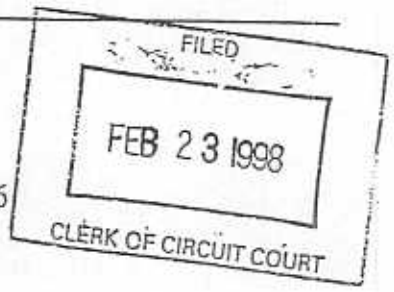
STATE OF WISCONSIN: CIRCUIT COURT: MILWAUKEE COUNTY
BRANCH 24

JEFFREY GLICK,
Petitioner,

v.

Case No. 96-CV-008806
DECISION



WISCONSIN DEPARTMENT OF HEALTH & FAMILY SERVICES,
Defendants.

DECISION

STATEMENT OF THE CASE

Petitioner Jeffrey Glick (Petitioner or Glick) has brought this action for judicial review of a decision of the Wisconsin Department of Health and Family Services, Bureau of Health Care Financing, which partially denied his request for Medical Assistance (MA) funding for an augmentative communication device (ACD), the DynaVox 2. The Bureau denied his request for the components of the device which exceeded a cap of $5,000.00 (a total of $1,634). The components of the device which were not authorized were a "color upgrade," "fold down mount," and "buddy switch." The following facts are based on the record developed at the August 29, 1996 hearing before the Division of Hearing and Appeals reviewing the Bureau's earlier decision. The facts are essentially undisputed, as both parties have noted.

Petitioner, age 17, has cerebral palsy, which profoundly impairs the intelligibility of his verbal speech, and functional speech communication is not expected. His comprehension of others' speech is at the 5th grade level. Petitioner has vision problems, including acuity of 20/70 with a "slight" field restriction and some alternating exotropia (affecting depth perception). He can view board work with 2 to 3 inch letters at a distance of 4 feet, and can count fingers at a distance of 5 to 7 feet. Petitioner uses a wheel chair with head straps and requires assistance for all transfers, position changes, and all self care needs.

An augmentative communication device is a computerized device which allows petitioner to communicate beyond nodding his head to indicate "yes" or "no." It would allow him to

communicate medical distress, personal needs (e.g. the need to use the bathroom), and to better perform his schoolwork.

Three components were not approved. The "buddy switch" activates the authorized system – the system does not work without it. The mount attaches the system to the wheelchair and keeps it in the proper position. The color monitor upgrade was found to be useful to the petitioner because he can see the contrasting colors with greater ease than the basic black and white monitor.

The Petitioner's prior authorization request was originally filed with the Bureau of Health Care Finance on March 18, 1996. The Bureau issued its partial denial on May 22, 1996. On June 21, 1996 petitioner appealed to the Division of Hearing and Appeals ("Division"). The Division issued its decision on October 16, 1996. The Division's Examiner noted that "the Bureau did not reject the authorization request on the basis of lack of medical necessity or appropriateness. Thus, I must conclude that the system satisfies those criteria. The Bureau's sole basis for denial was the total cost of the requested equipment." The Division of Hearing and Appeals went on to determine that: the denial did not deprive petitioner of equal access to medical care and services under 42 USC §1396a(a)(30)(A); the denial did not violate 42 CFR §447.204 by discouraging provider participation; the denial did not impose a deduction, cost-sharing, or co-payment which are prohibited by 42 U.S.C. §1396o and 42 C.F.R. §447.53. Finally, the Division determined that the Bureau is not required to go through Ch. 227 rule-making in order to set and use its reimbursement levels.

STANDARD OF REVIEW

This judicial review is pursuant to Wis. Stats. §227.53. In judicial review proceedings, the court's decision is based on the record established before the agency prior to the challenged decision. Wis. Stats. §227.57.

A judicial review is not a trial de novo. Wis. Stats. §227.57(2); *Wisconsin Environmental Decade v. Public Service Commission*, 79 Wis.2d 161, 170 (1977). The court must affirm the agency unless it finds ground to do otherwise under Wis. Stats. §227.57.

The burden of proof is upon the party seeking to overturn the agency action, not on the agency to justify its decision. *Weibel v. Clark*, 87 Wis.2d 696, 704 (1979), *City of LaCrosse v.*

DNR, 120 Wis.2d 168, 178 (Ct. App. 1984).

The "interpretation of facts and their application to found facts, is a question of law for the courts," but courts should defer to agencies in certain situations. *Barron Electric Cooperative v. Public Service Commission*, 212 Wis.2d 752, 760 (Ct. App. 1997). There are 3 levels of deference which a court will pay to an agency's decision. *Id.* The highest level of deference to an agency is granted where:

> "(1) it is charged with administration of the statute being interpreted; (2) its interpretation 'is one of long-standing'; (3) it employed its expertise or specialized knowledge in arriving at its interpretation'; and (4) its interpretation 'will provide uniformity and consistency in the application of the statute.' Where great deference is appropriate, the agency's interpretation will be sustained if it is reasonable -- even if an alternative reading of the statute is more reasonable. We will also pay great deference to an agency's interpretation 'if it is intertwined with value and policy determinations' inherent in the agency's statutory decision-making function." *Id.* at 761.

In regard to the element of whether the agency's interpretation is "of long standing," the determinative question is "the agency's experience in administering the particular statutory scheme," regardless of whether the agency has addressed the same "or even substantially similar facts." *Id.* at 764. The Wisconsin Department of Health and Social Services (DHSS) began administering the Medicaid program in Wisconsin on July 1, 1966. HARVEY L. MCCORMICK, MEDICARE AND MEDICAID CLAIMS AND PROCEDURES 610 (6th ed. 1986). The (DHSS) was replaced by the Department of Health and Family Services pursuant to the 1995-97 state budget. Wis. Stats. §15.19 (1995-96). Thus, this court will grant great deference to the department's interpretations of law.

ANALYSIS

This case presents essentially six questions: (1) Does the Bureau's written policy limiting the prior authorization for augmentative communication systems to $5,000.00 per 10 year life expectancy deny "equal access" to health care? (2) Does the Bureau's policy violate the federal regulation regarding rehabilitation services? (3) Does the federal regulation requiring a service

to be sufficient in "amount, duration and scope of service to reasonably achieve its purposes" require states to optimize the provision of durable medical equipment for each individual? (4) Is the department's $5,000.00 funding limit on augmentative communication devices arbitrary and capricious? (5) Is the department's policy limiting reimbursement to $5,000.00 an illegal cost-sharing or co-payment? (6) Is the Bureau's written policy an invalidly promulgated rule under Wis. Stats. Chapter 227?

1. Does the Bureau's written policy limiting the prior authorization for augmentative communication systems to $5,000.00 per 10 year life expectancy deny "equal access" to health care?

Title 42 U.S.C. §1396a(a)(30)(A) and 42 C.F.R. §447.204 address the right of medical assistance recipients to 'equal access' to medical care. Title 42 U.S.C. §1396a(a)(30)(A) requires a state medical assistance plan to

> "provide such methods and procedures relating to the utilization of, and the payment for, care and services under the plan ... as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."

42 C.F.R. §447.204 provides:

> "The agency's payments must be sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population."

What is the "general population?" *Clark et al. v. Kizer*, 758 F. Supp. 572 (E.D.Cal. 1990) analyzed the legislative history of the "equal access" provisions, stating:

> "The equal access regulation, 42 C.F.R. §447.204, provides that:
>
> > The agency's payments must be sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.
>
> This regulation was originally adopted in 1966 and has been in its present

form since 1978. In December 1989 Congress codified this regulation, adding the phrase 'in the geographic area' at the end. 42 U.S.C. §1396a(a)(30(A).

Whether the State is violating the equal access provision turns upon interpreting the language 'available to recipients at least to the extent that those services are available to the general population.' As I have previously noted, the first step in statutory construction is to determine whether there is binding authority construing the statute. *Tello v. McMahon*, 677 F. Supp. 1436, 1441 (E.D. Cal. 1988). The parties have cited no binding authority construing §1396a(a)(30)(A) nor has the court's independent research revealed such authority.

Turning, therefore, to the language of the statute, it appears that the language is not clear and unambiguous. *See INS v. Cardoza Fonseca*, 480 U.S. 421, 107 S.Ct. 1207, 94 L.Ed.2d 434 (1987). It is unclear from the text of the statute what constitutes the 'general population' to whose access recipients' is to be compared. The legislative history, however, does illuminate this issue. According to the House Budget Committee report, the test for evaluating access is to compare the access of Medicaid recipients living in a specific geographic area with the access of individuals in the same area who have private or public insurance coverage. H.R. Rep. No. 247, 101st Cong., 1st Sess. 390, reprinted in 1989 U.S. Code Cong. & Ad. News at 1906, 2116." 758 F. Supp. At 575-76.

It is helpful to look at the language of the House Budget Committee report cited by the *Clark* court:

"The Committee bill clarifies that the equal access test is to be applied in relation to the supply of providers in a geographic area. Thus, if a particular geographic area within a State has a smaller number of physicians per thousand insured population than other parts of the State or than the State as a whole, the Medicaid payments would have to be at a level that insures that Medicaid beneficiaries in that area have at least the same access to physicians as the rest of the insured population in that area. The Committee would not require that Medicaid payment levels be high enough to induce physicians to relocate into this area.

The Committee expects that the Secretary, in determining whether services are available to Medicaid beneficiaries at least to the extent that services are available to the general population, will compare the access of beneficiaries to the access of other individuals in the same geographic area with private or public insurance coverage (whether in the form of indemnity, service, or pre-paid benefits). It is obvious that Medicaid beneficiaries are likely to have better access to care than individuals without insurance coverage and without the ability to pay for services directly. The question which the Secretary must ask is whether

> Medicaid beneficiaries have access to provider services that is at least as great as that of others in the area who have third party coverage."

1989 U.S. Code Cong. & Ad. News at 2116-17.

Petitioner quotes from *Arkansas State Medical Society, Inc. et al. v. Reynolds*, 6 F.3d 519, 526 (8th Cir. 1993) for the proposition that Medicaid beneficiaries have a mandatory right to equal access to medical care, but does not quote the language defining the scope of the "general population": "Congress must have meant that Medicaid recipients are entitled to access equal to that of the insured population." *Id.* at 527.

This case law clarifies that the access provided by state medical assistance plans must be equal to that available to the general insured population. Did the petitioner present any evidence at the hearing regarding the availability of augmentative communication devices in the community of people with health insurance in Wisconsin? No. The only evidence in the record regarding this issue is a July 17, 1995 letter from Family Health Plan, the health insurer of petitioner's father. That letter provides in relevant part:

> "Family Health Plan provides a wide range of medical goods and services (primarily but not exclusively) based on Medicare Coverage Guidelines. However, there are limits to the benefits covered under your contract.
> At this time, your request has been reviewed and denied for the following reason:
> NOT PRIMARILY MEDICAL IN NATURE."

Therefore, based upon the only evidence regarding the availability of the augmentative communications device in the insured population (which happened to be submitted by petitioner), petitioner has failed to show that the device at issue is available to the general insured population. Thus, petitioner failed to show that the medical assistance program has denied him access to a medical device which is available to the general insured population. This issue does not militate in petitioner's favor.

2. Does the Bureau's policy violate the federal regulation regarding rehabilitation services?

Petitioner argues that he is prevented from obtaining the appropriate device. Under C.F.R.

440.130(d) the Medicaid benefits provided are to include services recommended "for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level." Although 42 C.F.R. §440.130 does not define "services" to include "devices", as does §440.110(c)(1), that language has been relied upon to determine that an augmentative communication device is a prosthetic device to which a beneficiary was entitled. *Fred C. v. Texas Health and Human Services Com'n*, 924 F. Supp. 788, 792 (W.D. Tex. 1996).

Therefore, petitioner is entitled to the entire DynaVox augmentative communication device which was prescribed for him.

3. Does the federal regulation requiring a service to be sufficient in "amount, duration and scope of service to reasonably achieve its purposes" require states to optimize the provision of durable medical equipment for each individual?

First, are Augmentative Communication Devices covered by Wisconsin's Medicaid program? Speech therapy and augmentative communication devices are not included in the mandatory Medicaid provisions. 42 U.S.C. §1396d(a)(1)-(5), (17). The Medicaid statute includes "physical therapy and related services" among the optional services which states may elect to provide. 42 U.S.C. §1396d(a)(11). The regulations define "related services" to include services for individuals with speech, hearing, and language disorders." 42 C.F.R. §440.110(c)(1)(1996). "Services for individuals with speech, hearing, and language disorders ... includes any necessary supplies and equipment." *Id.* Such services must be "provided by or under the direction of a speech pathologist ... for which a patient is referred by a physician ...."

Id. The record contains the "Augmentative Communication Summary" letter dated 6/02/95; 5/9/96, from speech pathologist Sandra Weber prescribing the DynaVox device. It also includes the April 15, 1995 prescription of Dr. Gregory Goetz that "Jeffrey Glick (DOB 4/24/79) needs a communication prosthesis as advised by his speech pathologist. He has severe cerebral palsy."

Prosthetic devices are defined by 42 C.F.R. §440.120(c)(2) (1996) as replacement, corrective or supportive devices prescribed to prevent or correct physical deformity or malfunction. In *Fred C. v. Texas Health and Human Services Com'n*, 924 F. Supp. 788, 792 (W.D.Tex. 1996) the defendant state agency conceded that an augmentative communication device (ACD) used to receive speech is a prosthetic device, and the court held that "logic dictates that an ACD to impart communication is also a prosthetic device." Thus, augmentative communication devices fall within Wisconsin's Medicaid coverage for prosthetic devices. *See* 3 Medicare and Medicaid Guide (CCH) ¶15,506 at 6506 (Nov.-1996).

Second, does the Wisconsin Medicaid program provide sufficient funding for augmentative communication devices?

§440.230 CFR Ch. IV (October, 1996) provides:

"Sufficiency of amount, duration, and scope.
(a) The plan must specify the amount, duration, and scope of each service that it provides for --
(1) 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 sections 440.210 and 440.220 to an otherwise eligible recipient 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 utilization control procedures."

There is evidence that the petitioner requires the 3 denied components of the augmentative communication device. He needs the "buddy switch" to turn the device on, the wheelchair mount to carry it with him, and the color monitor upgrade to see and use it properly. The plain language of §440.230(b) requires that "[e]ach service must be sufficient in amount, duration, and scope to

reasonably achieve its purpose." If petitioner cannot turn on, carry, or see and use the device, then the $5,000.00 which the Wisconsin Medicaid program is willing to provide is not "sufficient in amount, duration, and scope to reasonably achieve its purpose." This court will not uphold the Division's decision, because it violates §440.230 CFR.

§HSS 108.02(2) Wisconsin Admin. Code requires the department to comply with federal and state statutes when establishing reimbursement methods and payment levels. Thus, by violating federal law the state has also violated state law.

4. Is the department's $5,000.00 funding limit on augmentative communication devices arbitrary and capricious?

Petitioner contends that the Bureau's $5,000.00 per ten years cap on the amount it will provide for an augmentative communication device is arbitrary and capricious. The $5,000.00 limit is arbitrary and capricious because it is not rational, not governed by any fixed standard, and there is no relationship between the cap and the service provided. It applies to any communication device, regardless of how sophisticated a device a person may need. It was set about nine years ago, it is not indexed for inflation, and the Bureau has not identified what it was based on. Petitioner contends the 10 year period is arbitrary and capricious because it does not consider the need for repairs, technological advances, or the development of a growing child.

A policy is arbitrary and capricious if it lacks a rational basis. *In the Matter of the Incorporation of Town of Pewaukee*, 186 Wis.2d 515, 522 (Ct. App. 1994)(citing *Westring v. James*, 71 Wis.2d 462, 477 (1975). When applying the arbitrary and capricious standard, a reviewing court "determines whether the agency's action had a rational basis, not whether the agency acted on the basis of factual findings. Rational choices can be made in a process which considers opinions and predictions based on experience." *J.F. Ahern Co. v. Building Comm'n*, 114 Wis.2d 69, 96 (Ct. App. 1983).

Was there a rational basis for the $5,000 per ten years limitation? §HSS 107.02(3)(e)

provides:

> "Departmental review criteria. In determining whether to approve or disapprove a request for prior authorization, the department shall consider:
> 1. The medical necessity of the service;
> 2. The appropriateness of the service;
> 3. The cost of the service;
> 4. The frequency of furnishing the service;
> 5. The quality and timeliness of the service;
> 6. The extent to which less expensive alternative services are available;
> 7. The effective and appropriate use of available services;
> 8. The misutilization practices of providers and recipients;
> 9. The limitations imposed by pertinent federal or state statutes, rules, regulations or interpretations, including medicare, or private insurance guidelines;
> 10. The need to ensure that there is closer professional scrutiny for care which is of unacceptable quality;
> 11. The flagrant or continuing disregard of established state and federal policies, standards, fees or procedures; and
> 12. The professional acceptability of unproven or experimental care, as determined by consultants to the department."

The Bureau has offered no evidence about how the $5,000.00 per ten years of life expectancy limit was set. The $5,000.00 was set about ten years ago. This limit applies to all communication devices, regardless of the sophistication of the device needed by the recipient, technological changes, inflation, or replacement needs during those ten years. Additionally, the ten year limit does not take into account the changing communication needs of a growing child. These factors show that the limit does not take into account several of the provisions of §HSS 107.02(3)(e), including subsections (1), (2), (3), (4), (5), (7), and (10).

Therefore, after considering all of these factors, this court determines that the Bureau's $5,000.00 per ten years cap on the amount it will provide for an augmentative communication device is arbitrary and capricious.

5. Is the department's policy limiting reimbursement to $5,000.00 an illegal cost-sharing or co-payment?

Under federal law, cost sharing or co-payments cannot be imposed on recipients the

age of petitioner, who is 17. Under Title 42 U.S.C. §1396o(b):

> "The state plan shall provide that in the case of individuals other than those described in subparagraph (A) or (E) of section a(a)(10) of this title who are eligible under the plan --
>
> (2) no deduction, cost sharing, or similar charge will be imposed under the plan with respect to --
> (A) services provided to individuals under 18 years of age (and at the option of the state, individuals under 21, 20, or 19 years of age, or any reasonable category of individuals 18 years or over)..."

Petitioner contends that the Bureau's position that petitioner can still get the communication device he needs but that he will have to obtain additional funding above the $5,000.00 to be paid by Medicaid from another source is not de jure cost sharing, but is de facto cost sharing.

Respondent cites Wis. Stats. §49.45(18) for the proposition that the Wisconsin medical assistance program allows for some nominal cost-sharing in limited circumstances. Specifically, §49.45(18) provides in pertinent part that "any person eligible for medical assistance under s. 49.46, 49.468 or 49.47 shall pay up to the maximum amounts allowable under 42 CFR 447.53 to 447.58 for purchases of services provided under s. 49.46(2)." Those sections of the CFR allow for nominal cost sharing to be imposed upon beneficiaries, such as requiring them to pay deductibles of up to $2.00 per month, coinsurance of up to 5% of the agency's payment, or co-payments of up to $3.00. Respondent contends that the agency is willing to pay all of the cost of the device up to $5,000.00 without obligating the beneficiary to spend any funds to receive the medical assistance-paid communications device up to the maximum allowable cost of $5,000.00. If the beneficiary chooses to use his own money to pay for the amount of the cost over $5,000.00, the agency will still pay for the first $5,000.00. The respondent focuses upon the narrowly defined exceptions to the prohibition on cost sharing, rather than on what is cost sharing.

Is this case really an example of cost sharing? The portions of the price of the DynaVox device which the state will not pay for could not be characterized as an "enrollment fee, premium, or similar charge." Title 42 U.S.C. §1396o(a)(1). However, is it a "deduction, cost sharing or similar charge?" It would be a cost sharing or similar charge if the entire device, all $6,600 worth, were required to be covered under Medicaid. This court has already determined that the entire cost must be covered by the state's medical assistance program. Therefore, because the beneficiary must pay for additional components exceeding the amount that the state pays the

beneficiary is required to share in the cost which the state must pay. Thus, the Division's decision is overturned because it imposes impermissible cost-sharing on petitioner.

6. Is the Bureau's written policy an invalidly promulgated rule under Wis. Stats. Chapter 227?

The policy of the Department of Health and Family Services to limit its coverage is not stated in an administrative rule promulgated by the agency, but is expressed in communications from the Department, such as the March 26, 1996 letter from the Department to the Prentke Romich Company:

> "Wisconsin Medicaid has a policy which has been in effect for approximately the last eight years. Medicaid has a $5000 cap and a 10 year life expectancy on reimbursement of an augmentative/alternative communication system, including all component parts. ... One repair is usually authorized beyond the $5000 cap, but the prior authorization will then note that the recipient is to seek alternative funding until the life expectancy of 10 years is reached."

The record also contains letters from NUPRO Assistive Technologies and Cerebral Palsy Inc., among others, acknowledging this Wisconsin Medicaid policy.

§HSS 108.02 "Department rights and responsibilities" provides that

> "(2) Reimbursement Methods and Payment Levels. The Department may establish the reimbursement methods and payment levels for program services subject to the requirements of federal and state statutes, regulations and chs. HSS 101 to 107 and this chapter. Notice of specific changes or updates to payment levels shall be communicated to the service providers by the department through periodic publication of provider handbooks."

However, is the department's policy limiting payments for augmentative communications devices to $5,000.00 per ten years a "rule" which Wisconsin law would require to have been promulgated as an administrative rule? Wis. Stats. §227.10(1) requires administrative agencies to "promulgate as a rule each statement of general policy." Wis. Stats. §§227.16-227.21 set forth the promulgation procedure. "Whether [an agency's action] is a rule within the meaning of sec. 227.01(13), Stats., is a pure question of law for us to decide with no deference to [the agency's]

view." *Milwaukee Area Joint Plumbing Apprenticeship Comm. v. DILHR*, 172 Wis.2d 299, 317 (Ct. App. 1992).

Wis. Stats. §227.01(13) provides in pertinent part:

> "'Rule' means a regulation, standard, statement of policy or general order of general application which has the effect of law and which is issued by an agency to implement, interpret or make specific legislation enforced or administered by the agency or to govern the organization or procedure of the agency...."

Case law has held that the elements of a rule are:

> "(1) a regulation, standard , statement of policy or general order, (2) of general application, (3) having the effect of law, (4) issued by an agency, to implement, interpret or make specific legislation enforced or administered by the agency." *Milwaukee Area Joint Plumbing Apprenticeship Comm. v. DILHR*, 172 Wis.2d 299, 321 (Ct. App. 1992).

Does the $5,000.00 per 10 year policy meet this definition? First, the Department has characterized the limit as a "policy." Second, the record shows that the limit has general application, applying to all medical assistance recipients applying for coverage for augmentative communications devices. Third, it has the effect of law, because the department has the authority and the means to force compliance with this policy through denying applications for amounts exceeding the limit. *Frankenthal v. Wisconsin Real Estate Brokers Bd.*, 3 Wis.2d 249, 257 (1958). Fourth, the policy was issued by the Department of Health and Social Services (now the Department of Family and Social Services). Fifth, the policy helps the department make decisions while implementing the Medicaid legislation, which is administered by the department.

Does the policy fall under any of the statutory exceptions to what is considered a rule under Wis. Stats. §227.01(13)? Under Wis. Stats. §227.01(13)(k) something is not a rule if it "[r]elates to expenditures by a state agency, the purchase of materials, equipment or supplies by or for a state agency, or printing or duplicating of materials for a state agency." Although the amounts paid by the department medical assistance recipients to receive obtain augmentative communication devices is not the "purchase of materials, equipment or supplies by or for a state agency, or printing or duplicating of materials for a state agency," it clearly "relates to expenditures by a state agency." Thus, this exception in Wis. Stats. §227.10(13)(k) applies and this court concludes that the department's policy is not a rule. It is not invalid because it was not

formally promulgated as an administrative rule. Wis. Stats. §227.01(13)(n) is also potentially applicable. It states: "Fixes or approves rates, prices or charges, unless a statute specifically requires them to be fixed or approved by rule." Neither party has cited, and this court cannot find, a statute specifically requiring the agency's policy to be fixed or approved by rule. Although another trial court's decision is not precedential authority binding this court, the Dane County Circuit Court addressed the issue of whether a cap on the amount the Department would pay for home care services was a "rate" exempted from rule-making by Wis. Stats. §227.01(13)(n). In *Christopher Locke et al. v. Wisconsin Dept, of Health and Social Services, et al.*, Dane County Circuit Court Case No. 95CV3186, the court determined that the caps were not "rates." However, as noted above, this court has already determined that the Department's policy is exempted from rule-making by §227.10(13)(k).

CONCLUSION AND ORDER

Accordingly, plaintiff Jeffrey Glick's complaint is hereby granted.

Dated at Milwaukee, this 23d day of February, 1998.

BY THE COURT:

Hon. Charles F. Kahn
Milwaukee County Circuit Court