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No. 57411-6-I

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**COURT OF APPEALS FOR DIVISION I  
STATE OF WASHINGTON**

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DAVID J. JENKINS,

Appellant,

v.

DEPARTMENT OF SOCIAL AND HEALTH SERVICES,

Respondent.

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**BRIEF OF APPELLANT**

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DIVISION I

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## I. INTRODUCTION

The Community Options Program Entry System (COPES) is a long-term care program providing needy disabled individuals assistance with personal tasks such as bathing, dressing, eating and housekeeping. Administered by the Appellant Department of Social and Health Services (“Department” or “DSHS”) under a Medicaid waiver,<sup>1</sup> the program is designed so that individuals can remain in their own homes rather than in nursing homes.

Respondent David Jenkins is a COPES recipient who filed this lawsuit seeking judicial review of the administrative determination of the number of hours of COPES personal care for which he is eligible. The Department’s system for making such determinations involves a multi-faceted assessment of the recipient’s physical disability, medical condition, cognitive and behavioral functioning and specific elements of his or her living situation. Mr. Jenkins’ challenge focused on the so-called shared living rule set forth in WAC 388-106-0130(3)(b).<sup>2</sup> Under this rule,

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<sup>1</sup> As discussed more fully below, a Medicaid “waiver” is granted under an agreement with the federal government that allows states to provide services that traditionally are not covered by Medicaid. In addition to agreeing to participate in paying for the services, the federal government “waives” certain aspects of Medicaid law and regulations to programs administered under the waiver agreement.

<sup>2</sup> In June of 2005 the Department consolidated all rules relating to long-term care programs—including the rules pertinent to this appeal—into a new chapter 388-106 of the Washington Administrative Code. Wash. St. Reg. 05-11-082. In this brief, rules pertinent to this appeal are referred to by the current number, which is the same number used in the superior court decision that is the subject of this appeal. However, there are

the Department makes a modest reduction in the number of paid hours available to individuals who choose someone who lives with them as their caregiver. The rule is based on the premise that in such situations the need for publicly paid assistance is reduced because the caregivers would be performing some tasks—such as housekeeping, shopping for food, and preparing meals—for the residential unit even if they were not being paid to provide services to the recipient(s) with whom they reside.

Respondent contends that the shared living rule violates Medicaid law, the Americans with Disabilities Act, the due process and equal protection clauses of the state and federal constitutions and as a result is arbitrary and capricious and outside the scope of the Department's authority. The superior court agreed on all counts, and in addition held that a long-standing DSHS rule providing that Administrative Law Judges (ALJs) do not have authority to invalidate departmental regulations violates due process. These rulings are wrong as a matter of law and significantly affect the Department's ability to allocate limited public assistance resources across a needy population and to administer public

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references to the former WAC chapter (388-72A) and former section numbers throughout the record. A chart identifying the predecessor to each of the rules in Ch. 388-106 can be found in the Washington State Register (WSR) at 05-11-082, with the portion of the chart dealing with the rules that were formerly part of Ch. 388-72A beginning on p. 91. For the Court's convenience and pursuant to RAP 10.4(c), a copy of the current version of WAC Ch. 388-106 is in the Appendix (App.) at A14-36.

assistance programs on a fair and consistent basis statewide. They should be reversed.

## II. ASSIGNMENTS OF ERROR

1. The trial court erred by entering Conclusion of Law 2.1.<sup>3</sup>
2. The trial court erred by entering Conclusion of law 2.2.
3. The trial court erred by entering Conclusion of Law 2.3.
4. The trial court erred by entering Conclusion of Law 2.4.
5. The trial court erred by entering Conclusion of Law 2.5.
6. The trial court erred by entering Conclusion of Law 2.6.
7. The trial court erred by entering Conclusion of Law 2.7.
8. The trial court erred by entering Conclusion of Law 2.8.
9. The trial court erred by entering Conclusion of Law 2.9.
10. The trial court erred by entering Conclusion of Law 2.10.
11. The trial court erred by entering Conclusion of Law 2.11.
12. The trial court erred by entering Conclusion of Law 2.12.
13. The trial court erred by entering Conclusion of Law 2.13.
14. The trial court erred by entering Conclusion of Law 2.14.

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<sup>3</sup> The trial court's conclusions of law were set forth in the First Amended Findings of Fact, Conclusions of Law, and Order on Petition for Judicial Review. *See* Clerks Papers (CP) 1189-92, App. A1-8.

15. The trial court erred by entering its Order.<sup>4</sup>
16. The trial court erred by entering its Judgment For David Jenkins Awarding Retroactive And Continuing Benefits, Attorneys' Fees and Costs dated October 21, 2005.<sup>5</sup>

### III. ISSUES

1. Did the trial court err in holding that WAC 388-106-0130(b)(3) (the “shared living rule”) violates the so-called comparability requirement of 42 U.S.C. § 1396a(a)(10)(B)(i) and 42 C.F.R. § 440.240(b) that Medicaid services available to recipients “shall not be less in amount, duration, or scope than the medical assistance made available to any other” recipient in the same category, even though 42 C.F.R. § 440.250 relating to Medicaid waivers explicitly provides that “services provided under the waiver need not be comparable for all individuals within a group”? This issue pertains to Assignments of Error Nos. 1, 3, 4, 5 and 15.

2. Did the trial court err in holding that WAC 388-106-0130(b)(3) violates the Americans with Disabilities Act, 42 U.S.C. §

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<sup>4</sup> The trial court’s order was set forth in the First Amended Findings of Fact, Conclusions of Law, and Order on Petition for Judicial Review dated November 14, 2005. CP 1192-94, App. A5-7.

<sup>5</sup> The trial court’s order awarding Respondent retroactive benefits and attorneys’ fees and costs was set forth in the Judgment for Respondent Awarding Retroactive and Continuing Benefits, Attorneys’ Fees and Costs dated October 21, 2006. CP 1161-65, App. A9-13. Although this order was not separately identified in the Notice of Appeal, it is subject to review because it was incorporated by reference into the trial court’s final decision that was designated in the appeal (Conclusion of Law (COL), 2.14, CP 1189-90, App. A2-3, and Order ¶ 3.5, CP 1192-93, App. A5-6) and “prejudicially affects the decision designated in the notice” of appeal. RAP 2.4(b).

12132, when the rule differentiates between recipients on the basis of their choice of providers and living arrangement, and not on the basis of their disabilities? This issue pertains to Assignments of Error Nos. 1, 6, 9, 10 and 15.

3. Did the trial court err in holding that WAC 388-106-0130(b)(3) violates the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution and article I, section 12 of the Washington Constitution, even though under the rule all similarly situated recipients are treated similarly and the rule does not affect a fundamental right pertaining to state citizenship? This issue pertains to Assignments of Error Nos. 1, 7, 8, 9, 10 and 15.

4. Did the trial court err in holding that the shared living rule violates Mr. Jenkins' due process rights under the Fourteenth Amendment to the Constitution of the United States and Article I, Section 3 of the Washington Constitution? This issue pertains to Assignments of Error Nos. 1, 2, 8, 9, 10 and 15.

5. Did the trial court err in holding that WAC 388-02-0225, which provides that an Administrative Law Judge (ALJ) does not have authority to invalidate an agency rule, "fails to comport with the spirit of the Washington Administrative Procedure Act, RCW 34.05 and is inconsistent with the Federal Administrative Procedure Act, Title 5" and

violates the Due Process Clause of the Fourteenth Amendment to the United States Constitution and the Due Process Clause of article I, section 3 of the Washington Constitution? This issue pertains to Assignments of Error Nos. 1, 11, 12, 13 and 15.

6. Did the trial court err as a matter of law in declaring that Respondent should receive personal care services consistent with his unmet need for assistance with housekeeping, laundry, shopping, and meal preparation as determined by the February 25, 2004 assessment or a later assessment without application of the shared living rule? This issue pertains to Assignments of Error Nos. 10 and 15.

7. Is Respondent David Jenkins a prevailing party under RCW 74.08.080(3) and therefore entitled to attorneys fees and costs? This issue pertains to Assignments of Error Nos. 14 and 16.

8. Assuming *arguendo* that David Jenkins is a prevailing party under RCW 74.08.080(3) and is therefore entitled to attorneys fees and costs, did the trial court err by including in the costs award reimbursement for such items as photocopying, postage, telecommunication, and “other” rather than limiting costs to those authorized to prevailing parties under RCW 4.84.010? This issue pertains to Assignments of Error Nos. 14 and 16.

9. In a judicial review of an administrative action under RCW 34.05.574, does the trial court have authority to order payment of back public assistance benefits rather than remanding the matter to the agency to determine benefits consistent with the court's ruling on the merits? This issue pertains to Assignments of Error Nos. 15 and 16.

10. Assuming *arguendo* that the trial court had authority to enter an order awarding a specific amount of back benefit payments, did the trial court err in ordering the Department to pay both prejudgment or postjudgment interest on the award? This issue pertains to Assignments of Error Nos. 15 and 16.

#### IV. STATEMENT OF THE CASE

##### A. The Benefit Program At Issue

Pursuant to RCW 74.39A.030(2) and 42 U.S.C. § 1396n(c), DSHS operates the Community Options Program Entry System (COPES), a home and community based services program funded in part by the federal government under Title XIX of the Social Security Act, commonly known as the Medicaid Act. The COPES in-home program serves more than 15,000 low income Washingtonians with functional disabilities ranging from mild to severe.<sup>6</sup> COPES is designed to enable such individuals to

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<sup>6</sup> A person with a functional disability is a "person who because of a recognized chronic physical or mental condition or disease, including chemical dependency, is

reside in their own homes and communities, rather than institutional settings such as nursing homes or hospitals, by providing assistance with certain personal care and household tasks. *See* RCW 74.39.005(3).

Specifically, COPES recipients receive assistance in performing “Activities of Daily Living” (ADLs) and “Instrumental Activities of Daily Living” (IADLs) that, because of their functional disability, they would otherwise be unable to perform by themselves. “Activities of daily living” are “self-care abilities related to personal care such as bathing, eating, using the toilet, dressing, and transfer,” RCW 74.39A.009(8), and include mobility (at home and elsewhere), medication management, and personal hygiene. WAC 388-106-0010. “Instrumental activities of daily living” are “routine activities performed around the home or in the community,” WAC 388-106-0010, and include meal preparation, ordinary housework, essential shopping, wood supply, travel to medical services, managing finances, and telephone use. *Id.*; *see also* RCW 74.39A.009(8). Assistance with ADLs and IADLs is known as “personal care services.” WAC 388-106-0010.

In order to enable a person with functional disabilities the chance to remain in his or her own home, the COPES program pays for someone to provide those personal care services that the individual cannot perform

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impaired to the extent of being dependent upon others for direct care, support, supervision, or monitoring to perform activities of daily living.” RCW 74.39A.009(8).

on his or her own or with assistance from friends or family (known as “informal supports”). *See* RCW 74.39A.005. When provided through the COPES program, the personal care services are delivered either by a home health agency or by a paid caregiver (referred to as an “individual provider”) who is employed by the in-home care recipient but is paid by the Department pursuant to a contract.<sup>7</sup>

**B. The CARE Assessment Process**

Eligibility for and the extent of services to be provided through COPES or any of the other home and community long-term care programs administered by DSHS<sup>8</sup> is determined by an individualized assessment of the recipient’s need for publicly paid services.<sup>9</sup> Pursuant to a legislative mandate that long-term care needs “be determined by a uniform system for comprehensively assessing functional disabilities,” RCW 74.39.005(2), the Department developed an assessment tool known as the “Comprehensive Assessment Reporting Evaluation”, or CARE,

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<sup>7</sup> This arrangement is described, albeit in a different context, in *Bennerstrom v. Dept. of Labor & Industries*, 120 Wn. App. 823, 828, 86 P.3d 826 (2004).

<sup>8</sup> In addition to the COPES program, DSHS administers the Medicaid Personal Care Program (42 U.S.C. § 1396d(a)(24) and RCW 74.09.520(2)); the Medically Needy In-Home Waiver program (42 U.S.C. § 1396n(c), RCW 74.09.700(2)(a)(i) and RCW 74.39.041(1)); and the Chore program (RCW 74.39A.110), each of which provides similar assistance to other eligible populations not covered by COPES. All of these programs could be affected by the decision in this case.

<sup>9</sup> The CARE assessment measures functional eligibility. In addition to meeting functional eligibility requirements, the recipient must also meet certain income and resource limitations in order to be financially eligible. Financial eligibility is not at issue in this appeal.

assessment to evaluate and inventory a long-term care recipient's<sup>10</sup> functional abilities and need for long-term care program services and to establish a plan of care. WAC 388-106-0055, App. A21-22.

The CARE assessment tool determines need for paid personal care services through a three-step process. The process begins with face-to-face interview with the recipient during which an assessor gathers certain information about him or her. WAC 388-106-0050, -0065, App. A22. The assessor then enters such information into the computerized CARE tool, which, pursuant to methodology established in Department rules and coded into the CARE computer program, classifies the recipient based on need for program services. WAC 388-106-0080 through -0120, App. A23-32. The base number of in-home care hours a client may receive is determined based on this classification. *Id.* Finally, the base number of in-home care hours is adjusted based on certain specified circumstances. WAC 388-106-0130, App. A32-35.

### **1. Information Gathering**

The face-to-face interview by a Department staff or designee<sup>11</sup>, which begins the assessment process, takes place in the recipient's home

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<sup>10</sup> In describing the CARE tool process in the brief, references to "recipient" can also be read to mean "applicant" because persons not previously enrolled in COPES go through the same CARE process to determine functional eligibility and hours of services.

<sup>11</sup> The Department administers many of its community based programs for the aged and disabled through regional area agencies on aging. RCW 74.38.030.

or place of residence. WAC 388-106-0050, App. 21. In addition to information gathered from the recipient during the face-to-face interview, the assessor may also gather information about the recipient from other sources, including the applicant/recipient's family members, in-home care provider, or health care providers. WAC 388-106-0075, App. 22.

The assessment focuses primarily on the recipient's ability to perform ADLs and, to a lesser extent, IADLs. *Id.* As discussed above, ADLs include such personal tasks as bathing, dressing, eating, mobility (at home and elsewhere), medication management, toilet use, and personal hygiene. WAC 388-106-0010, App. A14-15. IADLs include such tasks as food preparation, ordinary housework, shopping for essentials, and, for those who use wood as the sole source of heat or cooking, wood supply. *Id.*, A18. The assessor determines the level of assistance, if any, that the client used in the preceding seven days in performing specific ADLs, WAC 388-106-0075, App. A22, and codes each activity, which in turn generates a numbered "ADL score" of between zero and 28. WAC 388-106-0105, App. A27-28.

In addition, information gathered by the assessor is used to generate a cognitive performance score (CPS), WAC 388-106-0090, App. A23-24, and to determine whether the individual's clinical needs are complex, WAC 388-106-0095, App. A24-26, whether he or she requires

exceptional care, WAC 388-106-0110, App. A28-29, and whether the client's mood and behavior—as reflected in current behavior or manifested within the previous five years—affects the recipient's need for paid assistance. WAC 388-106-0100, App. A26-27.

Certain information that is not factored into the CARE assessment is also obtained during the information gathering phase of the assessment process. This additional information is used to establish a plan of care, which assists the client in directing his or her caregiver in providing care to the client. WAC 388-106-0055, App. A21-22. An assessment may, therefore, identify some client care needs that COPES is not able to meet through paid in-home care.

## **2. Calculation And Classification**

The scores assigned to the ADLs by the CARE tool through this process are totaled, and depending on whether the client has a clinically complex medical condition, is cognitively impaired, or exhibits certain behavior/mood characteristics, the client is assigned to one of fourteen “care groups” using a formula specified in Department rules. WAC 388-106-0125, App. A32. CARE classification groups range from Group A Low to Group E High. Two CARE classification groups are identified as demonstrating exceptional care needs. *Id.* The other twelve reflect different combinations of the client's scores on the ADL portion of the

assessment and the client’s cognitive performance, the clinical complexity of the client’s medical condition and the client’s mood and behavior assessment. *Id.*

### **3. Adjustment For Specific Circumstances**

Each of the fourteen care groups has been assigned a “base” number of hours of services for those clients whose assessment places them in the respective group, but that does not conclude the process. The CARE assessment tool adjusts those hours—either up or down—based on three factors:

- The availability of “informal supports” (i.e., friends, family, or others not paid by DSHS who provide assistance with personal care tasks). The CARE tool codes particular personal care tasks as “met,” “partially met,” or “unmet” depending on the frequency with which such tasks are met by informal supports. WAC 388-106-0130(2)(a), App. A32. As explained in greater detail below, the shared living rule is based on the natural availability of informal supports in shared living situations.
- The client’s distance from essential facilities, such as laundry or stores. WAC 388-106-0130(4), App.A34-35.
- Whether the client relies on wood exclusively for heat. *Id.*

These adjustments, if applicable, result in a final maximum number of hours per month that will be paid for through COPES. WAC 388-106-0130(5), App. A35. The client may be reassessed and the number of hours changed if there is a change in any of the relevant factors. WAC 388-106-0140, App. A35.

#### **4. The Shared Living Rule**

Where the recipient resides with another eligible client or chooses to receive COPES services from someone living in the same residential unit with the recipient, the Department applies the shared living rule, WAC 388-106-0130(3)(b), App. A34. The Department applies this rule when a recipient's paid caregiver lives in the same household as the recipient by reducing a client's base hours of support by approximately 15 percent. The rule recognizes that where the client and caregiver share the same residence, certain personal services needs will naturally be met by informal supports.<sup>12</sup> The rule serves to limit the use of public funds paid

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<sup>12</sup> Washington is not alone in differentiating among providers of in-home health care. Some examples: California provides that "[t]he need for services in common living areas shall be prorated to all the housemates, the recipient's need being his/her prorated share." California Dept. of Social Services Manual of Policies and Procedures, Section 30-763.3.311, available on line at: <http://www.dss.cahwnet.gov/getinfo/pdf/ss2.pdf> (visited Jan. 23, 2006). New York will not pay spouses or children, including sons and daughters-in-law, for providing in-home care (18 NYCRR 505.14(h)(2)), while Oregon limits payments to spouses (ORS 411.803 and OAR 411-030-080), and Michigan denies payment to a client's "responsible relative or legal dependent." Michigan Family Independence Agency, Adult Services Manual (ASM), part 363, page 16 of 26, available online at: <http://www.mfia.state.mi.us/olmweb/ex/asm/363.pdf> (visited January 23, 2006).

for certain household tasks (such as meal preparation, housekeeping, and shopping) that benefit the entire living unit, and not just the recipient. The rule furthers the legislative policy of not using public funds to displace naturally occurring informal support provided by family and other household members. *See* RCW 74.39A.005 (the purpose of home and community programs is to support and complement informal services provided by family and friends).<sup>13</sup>

Rules similar to the shared living rule have been applicable to Washington public assistance programs since at least 1977. *See* former WAC 388-15-215(3) (“Chore services [are] provided for the person needing the service, not for other household members unless they are part of the total chore service plan which includes them as eligible service clients.”)<sup>14</sup> The rule has been part of the Medicaid Personal Care program—and thus has been part of the state’s Medicaid Plan—since at least 1993.<sup>15</sup>

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<sup>13</sup> The rule also implements the legislative direction to “maximize the use of financial resources in directly meeting the needs of persons with functional limitations.” RCW 74.39.005(5).

<sup>14</sup> *See* DSHS Administrative Order 1238, filed with the Code Reviser on August 31, 1977 under Docket No. 8438, File No. 41. No Washington State Reference citation is available because the act creating the Washington State Register did not take effect until January 1, 1978. *Laws of 1977, 1st Ex. Sess., ch. 240 § 16.*

<sup>15</sup> *See* former WAC 388-15-890, WSR 93-10-023, effective May 29, 1993; repealed by WSR 00-04-056, effective February 28, 2000 and replaced in that same action by WAC 388-71-0465, which was repealed and replaced when the CARE tool was adopted. WSR 04-19-023.

Part of the development of the CARE assessment tool included a time study of caregivers in a variety of settings. The study concluded that the percentage of time devoted by caregivers to household tasks not involving the client ranged from a low of 26 percent to a high of 46 percent. The range for caregivers who resided in the same household as their clients was narrower: 33 percent to 42 percent. Based on that study, the CARE assessment tool was calibrated to adjust the hours authorized for live-in caregivers by approximately 15 percent—even though the study results indicated that this was much less than the amount of time that caregivers typically devote to tasks that benefit the entire residential unit rather than the individual client.<sup>16</sup>

#### **5. Examples Illustrate How The CARE Assessment Works**

Attached in the Appendix at A37-39 are three illustrative examples of how the CARE assessment works with respect to hypothetical COPES clients whose situations are similar, but not identical, and all of whose caregivers reside with them.<sup>17</sup>

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<sup>16</sup> A copy of the draft study report was included in the rule-making file for the adoption of Ch. 388-72A, the predecessor to the current version of the rules outlining the CARE assessment process. While some portions of the rule-making file are included in the record at the superior court the draft study report inexplicably was not. However, the final study report may be downloaded from the Department's Internet website at <http://www.aasa.dshs.wa.gov/professional/> by clicking on the link called "Time Study Report (Word Format)."

<sup>17</sup> These illustrative exhibits display the CARE Assessment calculations for each hypothetical client on one page, and are intended to give the Court an understanding of the practical application of the assessment process in general and the shared living rule in

For Client 1, (App. A37) the total of the ADL scores is 20. The client's condition is not clinically complex, and the client does not have significant cognitive impairment or mood issues. This combination places Client 1 in Care Group A (high), which has a base allotment of 78 hours. WAC 388-106-0125, App. A32. Because the caregiver lives with the client, and no other adjustment factors apply, the number of hours authorized is 85% of the base, or 63 hours.<sup>18</sup>

Client 2's situation (App. A38) is identical to that of Client 1, except that Client 2's mood and behavior issues require a higher level of assistance. With a total ADL score of 20 plus the mood and behavior issues, but no other relevant factors, Client 2 is placed in Care Group B (High), with a base hour allocation of 155 hours. WAC 388-106-0125, App. A32. When adjusted per the shared living rule, the allocation is 85% of the base, or (rounded up) 132 hours.

Client 3's situation (App. A39) is the same as that of Client 2, except that Client 3's medical condition meets the criteria for clinically complex. WAC 388-106-0095. Accordingly, Client 3 is placed in Care

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particular. Because these three pages were not part of the record below, appellant moved for permission to include them in the appendix pursuant to RAP 10.3(a)(7). By notification order of February 6, 2006 this motion was passed to the panel.

<sup>18</sup> The actual mathematical computation with respect to Client 1 yields a result of 63.18 hours, but the Department rounds to the nearest whole hour.

Group C (high), with a base allocation of 180 hours. When adjusted per the shared living rule, the allocation is 85% of the base, or 153 hours.

These examples are not exhaustive illustrations of the thousands of circumstances that exist among the more than 15,000 Washington residents who receive publicly funded in-home long-term care.<sup>19</sup> However, they do provide some illustration of how the CARE assessment tool recognizes and addresses the numerous variations that exist in the clients who are served through COPES and the Department's other long-term care in-home program.

**C. Mr. Jenkins Was Properly Assessed Using the CARE Assessment**

Mr. Jenkins receives personal care services through COPES, and, like many COPES clients, has significant functional disabilities caused by a number of medical conditions. At the time of the assessment at issue, these included Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome, hepatitis, hypertension, anxiety disorder, arthritis, osteoarthritis, neurothopy, herpes simplex NOS, candidiasis, and liver failure. AR 000002.<sup>20</sup> He has periods of dizziness and vertigo, headaches,

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<sup>19</sup> The number of clients is expected to increase. See Caseload Forecast Council reports available at <http://www.cfc.wa.gov/humanServices/homeAndCommunity/htm> (visited Jan. 23, 2006).

<sup>20</sup> The Administrative Record before the Department was not separately paginated by the clerk of the superior court. References to the Administrative Record are indicated as "AR" and the page number assigned by the Department.

nausea, and vomiting, has trouble sleeping, and easily becomes irritated or agitated. AR 000107. His short and long-term memory is good, AR 000112, and although he has mood swings and is sometimes depressed, he was able to leave the house for some period of time on most days. AR 000113.

Mr. Jenkins was already enrolled in COPES at the time the CARE assessment was developed and put into use, and he was previously assessed using the “Legacy” Comprehensive Assessment tool, which was replaced by the CARE tool. AR 000002. *Id.* Under the legacy assessment tool, Mr. Jenkins was determined to be eligible for 184 paid in-home care hours. *Id.*

In February, 2004, during a periodic reassessment, Respondent was first assessed using the CARE tool. *Id.* As explained in greater detail below, the February, 2004 assessment using the CARE tool resulted in a determination that 153 hours of paid in-home care were available to Respondent. AR 000127.

Other than challenging the shared living rule, Mr. Jenkins does not contest the accuracy of the February, 2004 CARE assessment on which the Department action at issue in this case was based. In that assessment, he was determined to require extensive assistance in eight ADLs and limited assistance in two others, with a total ADL score of 20. He was

also determined to have medical conditions that are clinically complex, to present mood and behavior issues, and to have a CPS score of 0, indicating no cognitive performance issues complicating his care. AR 000105-000126. Mr. Jenkins was, therefore, assigned to Care Group C (High), with the base hours determined to be 180 per month. WAC 388-106-0125, App. A32.

Mr. Jenkins has chosen his partner, Paul Racchetta, as his individual provider. AR 000106. Because Mr. Racchetta lives with Mr. Jenkins, the shared living rule applied, and resulted in a reduction in the number of hours from the base of 180 per month to a final number of 153 per month. AR 000127. This final number constitutes the total number of hours per month available to Respondent through the COPES program. WAC 388-106-0130(5), -0135, App. A35.

#### **D. Procedural History**

Following the assessment of Respondent and the determination of the number of personal care hours available to him, Respondent requested a fair hearing to challenge the Department's reduction of his in-home care hours. AR 000001.<sup>21</sup> Respondent claimed only that the shared living rule was invalid; he did not argue that the February, 2004 assessment was otherwise incorrect. AR 000002. On November 30, 2004 the

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<sup>21</sup> Mr. Jenkins did not request a stay of the Department's determination as authorized under WAC 388-02-0310.

Administrative Law Judge issued an interim order in which she ruled that pursuant to WAC 388-02-0225, which provides that ALJs may not invalidate DSHS rules, she was without jurisdiction to determine the validity of the shared living rule, and dismissed the appeal. AR 000006.<sup>22</sup>

On December 29, 2004 Respondent filed a petition for judicial review in King County Superior Court.<sup>23</sup> CP 1-12. Following briefing and oral argument on August 22, 2005, the superior court, sitting in its appellate capacity, issued a ruling invalidating both the shared living rule and WAC 388-02-0225. CP 884-90. The Department filed a timely motion for reconsideration, which was granted in part and denied in part by order of November 14, 2005. CP 1185-86.<sup>24</sup> In the meantime, the superior court granted Mr. Jenkins' request for back benefits in the amount of \$2,294.72 plus interest, and awarded attorneys' fees and costs in the amount of \$37,666.92, plus interest.<sup>25</sup> CP 1161-65. The costs requested by Mr. Jenkins and awarded by the superior court included \$1551.92 for

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<sup>22</sup> WAC 388-02-0225 is set forth in its entirety *infra* at p. 56.

<sup>23</sup> Respondent failed to appeal the November 30, 2005, initial order to the DSHS Board of Appeals as he had the opportunity to do pursuant to WAC 388-02-0560 through -0595. However, the Department did not object to Respondent's failure to exhaust administrative remedies.

<sup>24</sup> Among other things, the trial court limited the effect of its order to Mr. Jenkins pursuant to RCW 34.05.570(2)(b)(i), which limits declaratory judgment actions challenging a rule generally to Thurston County. Respondent has not cross-appealed that decision, and the scope of the trial court's order is no longer an issue in this case.

<sup>25</sup> The attorney fee award was approximately \$26,000 less than initially requested by Respondent (CP 891-901); Mr. Jenkins has not cross-appealed that part of the trial court's decision.

such items as photocopying, postage, telecommunication, and unidentified “other” expenses. CP 900 (request), CP 1162 (award). The Department’s appeal was filed on December 2, 2005. CP 1198-99.<sup>26</sup>

## **V. STANDARD OF REVIEW AND BURDEN OF PERSUASION**

The Administrative Procedure Act (APA) governs the Court’s review of the trial court’s ruling invalidating the shared living rule and WAC 388-02-0225. *See generally* RCW 34.05.570; *Burnham v. Dep’t of Social & Health Servs.*, 115 Wn. App. 435, 438, 63 P.3d 816, *review denied*, 150 Wn.2d 1013 (2003).

The validity of the rule is a question of law that the Court of Appeals reviews de novo. *Littleton v. Whatcom County*, 121 Wn. App. 108, 117, 86 P.3d 1253 (2004). The Court assumes the rule is valid. *Assn. of Washington Business v. Dep’t of Revenue*, 121 Wn. App. 766, 770, 90 P.3d 1128 (2004). Respondent has the burden of proving the rule is invalid. RCW 34.05.570(1)(a); *Washington Independent Telephone Assn. v. Utilities and Transportation Commission*, 148 Wn.2d 887, 903, 64 P.3d 606 (2003).

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<sup>26</sup> Mr. Jenkins did not seek a stay of the administrative order at the superior court as authorized under RCW 34.05.550. The Department has superseded the trial court’s award of back benefits and attorneys’ fees pursuant to RAP 8.1(f) and RCW 4.92.080. However the Department did not seek to stay the prospective effect of the trial court’s order, and Mr. Jenkins’ benefits have been restored to their prior level pending resolution of this appeal. CP 986-98.

“Administrative rules adopted pursuant to a legislative grant of authority are presumed to be valid and should be upheld on judicial review if they are reasonably consistent with the statute being implemented.” *Campbell v. Dep’t of Social and Health Servs.*, 150 Wn.2d 881, 892, 83 P.3d 999 (2003). “However, an agency rule will be declared invalid if it exceeds the statutory authority of the agency.” *Campbell*, 150 Wn.2d at 892; *see also* RCW 34.05.570(2)(c).

Finally, Respondent must prove that the administrative decision is invalid. RCW 34.05.570(1)(a); RCW 34.05.570(3). The Court of Appeals applies the APA standards directly to the agency record, sitting in the same position as the trial court, which was sitting in its appellate capacity. *Burnham*, 115 Wn. App. 438. Respondent must show he has been “substantially prejudiced” by the rule and by the decision. RCW 34.05.570(1)(d); *Assn. of Washington Business*, 121 Wn. App. 770.

RCW 74.08.080(3) provides for an award of attorneys’ fees to a party that, pursuant to RCW 74.08.080, successfully challenges Department action: “[i]n the event that the superior court, the court of appeals, or the supreme court renders a decision in favor of [an] appellant, said appellant shall be entitled to reasonable attorneys’ fees and costs.” Respondent was awarded attorneys’ fees and costs by the superior court. *See* CP 1161-65. Further, attorneys’ fees are recoverable “only for the

attorney's efforts expended on theories which ultimately prove successful." *Blade v. Dept. of Social & Health Servs.*, 25 Wn. App. 630, 633, 610 P.2d 929 (1980). No fees are recoverable for work at the administrative level. *Id.*

If this Court agrees with the Department and reverses the decision below in its entirety, Respondent will no longer be a prevailing party and the award of attorneys' fees and costs should be vacated. In the event the Court vacates only some of the superior court's decision, attorneys' fees both at that level and on appeal should be limited to the issue(s) on which Respondent prevails. *Id.*

Whether the court had authority to order back benefits, whether Respondent is entitled to recover items not specified in RCW 4.84 as "costs", and whether either the back benefits or attorneys' fee awards bear interest are issues of law that this Court decides *de novo*.

## **VI. SUMMARY OF ARGUMENT**

The shared living rule complies with federal Medicaid law because COPES recipients do receive comparable benefits, and in any event the comparability requirement was waived by the federal agency responsible for administering the federal Medicaid program. The rule also complies with the Americans with Disabilities Act because the number of paid hours a recipient needs does not vary according to the recipient's

disabilities but upon the recipient's choice of caregiver and living arrangement.

The shared living rule does not violate the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution or the Privileges and Immunities Clause of the Washington Constitution, because all similarly situated recipients are treated similarly. Further, receipt of public assistance is not a fundamental right arising because of state citizenship, and is not entitled to heightened protection under the latter provision.

Nor does the shared living rule violate Mr. Jenkins' due process rights. Governments have considerable leeway under the federal and state due process clauses to establish eligibility requirements for public assistance benefits. Such requirements violate due process only if they are patently arbitrary and have no rational relationship to legitimate state interests. The shared living rule furthers the state's legitimate interest in making need-based allocations of limited public assistance resources among a needy population. Because it is rationally related to a legitimate state interest the shared living rule does not violate Mr. Jenkins' due process rights.

The Department's regulation prohibiting ALJs conducting individual fair hearings from invalidating departmental regulations is

consistent with the widely held view that ALJs are fact-finders but not law-makers. Accordingly, it is consistent with RCW 34.05, the state Administrative Procedure Act and its federal counterpart, even though the latter has no application to state agencies. Moreover, this long-standing rule furthers the legislative direction that public assistance programs be administered on a consistent and fair basis state-wide. Because this regulation is rationally related to a legitimate state interest, it does not violate Mr. Jenkins's due process rights.

The superior court exceeded its authority under the judicial review provisions of the Administrative Procedure Act, RCW 34.05, by awarding back benefits. Rather the superior court should have remanded the matter to the Department for a re-determination of benefits consistent with the court's decision on the merits. Further the court erred by including in its costs award items other than those authorized under RCW 4.84.010. Finally, because the state has not waived sovereign immunity with respect to public assistance benefits or attorneys' fee awards, the superior court erred by ordering the Department to pay prejudgment and postjudgment interest on back benefits and attorneys fees and costs.

The decision of the court below should be reversed and the administrative decision of the Department should be affirmed.

## VII. ARGUMENT

### A. The Shared Living Rule Complies With Federal Medicaid Law

The superior court held that the Department acted arbitrarily and exceeded its statutory authority by adopting a rule that conflicts with federal Medicaid law, more specifically the comparability of services requirements of 42 U.S.C. § 1396a(a)(10)(B)(i) and 42 C.F.R. § 440.240(b). Conclusions of Law (COL) 2.3, 2.9 and 2.10, CP 1189-91, App. A2-4; Order ¶ 3.1, App. A5. This holding was based on an incorrect analysis of applicable federal law, and should be reversed.

#### 1. The Medicaid Program In General

Medicaid is a joint program of the federal and state governments for the benefit of low-income individuals. *See generally* 42 U.S.C. § 1396a-1396v. Under the Medicaid program, the federal government provides financial assistance to the states so that they can furnish medical care to needy individuals. 42 C.F.R. § 430.0; *Cordall v. State*, 96 Wn. App. 415, 423, 980 P.2d 253 (1999), *review denied*, 139 Wn.2d 1017 (2000).<sup>27</sup> The states administer the program under federal guidelines.

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<sup>27</sup> The amount of reimbursement that a state receives for its Medicaid-related expenditures is determined by the Federal medical assistance participation, or FMAP, rate, which is a percentage calculated for each state based on the relationship of the participating state's per capita income to the national per capita income, with a minimum FMAP rate of fifty (50%) percent, and the maximum of eighty-three (83%) percent. 42 CFR § 433.10. Washington's FMAP is slightly above the statutory minimum of fifty (50%) percent.

*Louisiana v. Dep't of Health & Human Servs.*, 905 F.2d 877, 878 (5th Cir. 1990). States are not required to offer Medicaid programs, but if they do, they must comply with applicable federal laws. *Independent Acceptance Co. v. State of California*, 204 F.3d 1247, 1249 (9th Cir. 2000).

The states—subject to the approval of the federal government—determine who is eligible for the program, the services that will be offered, the payment levels to service providers, and administrative procedures. *Rite Aid of Pennsylvania, Inc. v. Houstoun*, 171 F.3d 842, 845 (3d Cir. 1999).<sup>28</sup>

Speaking broadly, Medicaid services fall into two categories—“state plan” services and “waiver” services. “In order to participate in the Medicaid program, a State must have a plan for medical assistance approved by” the federal Department of Health and Human Services (DHHS). *Pharmaceutical Research and Mfrs. Of America v. Walsh*, 538 U.S. 644, 650, 123 S. Ct. 1855, 155 L. Ed. 2d 889 (2003); *see also* 42 U.S.C. § 1396a(b); 42 C.F.R. § 430.10. “A state plan defines the categories of individuals eligible for benefits and the specific kinds of medical services that are covered.” *Walsh*, 538 U.S. at 650. Within

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<sup>28</sup> Just as the scope of services includes both mandatory and optional services, federal law requires that certain individuals (“categorically needy”) be entitled to participate in Medicaid, while whether a participating state includes others (“medically needy”) is up to the state. These distinctions are not significant for the purposes of resolving the issue in this case.

DHHS, the state plan is reviewed by the federal Centers for Medicare and Medicaid Services (“CMS”) for compliance with federal law. 42 C.F.R. §§ 430.14, 430.15; *Louisiana*, 905 F.2d at 878.<sup>29</sup> CMS must approve a plan before the state can receive federal funding. 42 C.F.R. § 430.30; *Louisiana*, 905 F.2d at 878.<sup>30</sup>

In addition to state plan services, Section 1915(c) of the Social Security Act authorizes CMS to exempt states from certain Medicaid requirements in certain circumstances. Home and Community Based Services (HCBS) offered under waivers—by definition optional—are typically referred to as “waiver” services.<sup>31</sup> The statute authorizing HCBS waivers provides in relevant part as follows:

The Secretary [of DHHS] may by waiver provide that a [State Plan] may include as “medical assistance” under such plan payment for part or all of the cost of home or community-based services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that[,] but for the provision of such services[,] the individuals would require the level of care provided in a hospital or a nursing facility or

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<sup>29</sup> CMS is the agency within the U.S. Department of Health & Human Services that administers Medicaid at the federal level. *Walsh*, 538 U.S. at 650 n.3. Some of the cases cited in this brief refer to the agency by its former name, the Health Care Financing Administration (HCFA).

<sup>30</sup> Some state plan services are mandatory, while others are optional. *See* 42 U.S.C. § 1396a(a)(10); *M.A.C. v. Betit*, 284 F. Supp. 2d 1298, 1302, (D. Utah 2003) (“Each state participating in the Medicaid program must provide certain mandatory services. However, some Medicaid services are optional at the discretion of each state.”).

<sup>31</sup> As noted above at 1, the COPES program is a waiver service. A copy of the waiver can be found at CP 1054-1150.

intermediate care facility for the mentally retarded[,] the cost of which could be reimbursed under the State plan.

42 U.S.C. § 1396n(c)(1)<sup>32</sup>; *see also* 42 C.F.R. § 441.301; *Skandalis v. Rowe*, 14 F.3d 173, 174 (2nd Cir. 1994). The purpose of the waiver provision is to encourage states to experiment and innovate in serving the needs of their Medicaid clients. *Bryson v. Shumway*, 380 F.3d 79, 82 (1st Cir. 2002) (“The waiver program is designed to allow states to experiment with methods of care, or to provide care on a targeted basis, without adhering to the strict mandates of the Medicaid system.”).

Without a waiver, states could not get federal funding for home and community services such as COPES. *Rowe*, 14 F.3d at 174.

The Act is designed to encourage states to participate in Medicaid by freeing them to adapt their programs to local conditions, and to develop effective approaches to health care through *innovation and experiment*. The Secretary [of DHHS] has been careful *not to impose too many restrictions* on a state’s ability to adopt waiver programs, since [DHHS] “believe[s] that Congress intended to give the States *maximum flexibility* in operating their waiver programs. We expect this flexibility to *foster initiative* and to encourage States to administer cost-effective programs that meet *specific local needs*.”

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<sup>32</sup> As if Medicaid laws were not complicated enough, the enumerated sections of the Social Security Act are codified with an entirely different numbering system in the United States Code. Thus, the statute cited here is in fact Section 1915(c) of the Social Security Act, and HCBS waivers are often referred to as Section 1915(c) waivers.

*Id.*, 14 F.3d at 181 (citing 50 Fed. Reg. at 10,021) (emphasis added); *see also Fisher v. Oklahoma Health Care Authority*, 335 F.3d 1175, 1178 (10th Cir. 2003).

There are certain items that a state must include in an application for a Section 1915(c) waiver. 42 C.F.R. § 441.301. For example, the state must specify the Medicaid statutes that it wants CMS to waive for purposes of the new or expanded services. 42 C.F.R. § 441.301(a)(2).

States applying for waivers are required to complete quite detailed applications, using a standard form provided by CMS. *See* [http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/05\\_HCBSWaivers-Section1915\(c\).asp#TopOfPage](http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/05_HCBSWaivers-Section1915(c).asp#TopOfPage) (as viewed Jan. 23, 2006). CMS conducts an exhaustive review of all waiver applications. *Id.* As these guidelines show, CMS approves waivers only after reviewing all aspects of the programs for compliance with federal law.

Once a waiver is granted, the Secretary [of DHHS] is required to monitor the implementation of the waiver programs to ensure that all of the requirements are being met, and to terminate any noncomplying waiver.

*Wood v. Tompkins*, 33 F.3d 600, 602 (6th Cir. 1994) (citing 42 U.S.C. § 1396n(f)(1)).

**2. The Comparability Requirement Has Been Waived And In Any Event The Shared Living Rule Is Consistent With The Comparability Requirement.**

The court below held that the Department acted arbitrarily and capriciously and exceeded the scope of its authority by applying the shared living rule to Mr. Jenkins. This ruling was based on the conclusion that such application does not comport with a provision of federal Medicaid law, the “comparability rule,” 42 U.S.C. § 1396a(a)(10)(B) (Section 1902(a)(10))(B) of the Medicaid Act) and corresponding federal regulations, 42 C.F.R. §§ 230(b)-(c) and 42 C.F.R. § 240.240(b). COL 2.1, 2.3, 2.4, 2.5, CP 1189-90; App.A2-3; Order ¶ 3.1, CP 1192, App. A5. This holding is based on a misunderstanding of federal Medicaid law and should be reversed.

The trial court’s holding that the shared living rule violates the comparability rule is incorrect for two reasons: (1) the requirement does not apply to the COPES program and (2) in any event, all COPES recipients have the same amount, duration, and scope of services available to them.

**a. The comparability requirement**

The basic rule is that “states must provide comparable medical assistance to all Medicaid recipients within each classification, so long as the medically needy do not receive greater benefits than the categorically needy (although the reverse is permitted).” *Schott v. Olszewski*, 401 F.3d

682, 686 (6th Cir. 2005).<sup>33</sup> Federal law does impose different requirements on states as they offer Medicaid state plan services to different categories of recipients—these categories are the “classification” referred to by the *Schott* court. Thus, medical assistance available under a state’s plan to any categorically needy recipient “shall not be less in amount, duration, or scope than the medical assistance made available to any other” categorically needy recipient served under the state’s plan. 42 U.S.C. § 1396a(a)(10)(B)(i); 42 C.F.R. § 440.240(b). Similarly, the medical assistance available to any medically needy recipient “shall not be less in amount, duration, or scope than the medical assistance made available to” any other medically needy recipient under the state plan. 42 U.S.C. § 1396a(a)(10)(C)(i); 42 C.F.R. § 440.240(b). Finally, the medical assistance available to the categorically needy under the state plan must be at least equal to the amount, duration, and scope of assistance available to the medically needy. 42 U.S.C. § 1396a(a)(10)(B)(ii); 42 C.F.R. § 440.240(a). This is the “comparability” rule applicable to Medicaid programs.

Respondent and the superior court misread the comparability requirement as applying between recipients instead of between categorical groups. As the United States Supreme Court has explained:

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<sup>33</sup> As discussed above at p. 28, n.28, coverage of those deemed “categorically needy” is mandatory while coverage of the “medically needy” is optional with the states.

[The Social Security] Act provided that the medical assistance afforded to an individual who qualified under any categorical assistance program could not be different from that afforded to an individual who qualified under any other program . . . . In other words, the amount, duration, and scope of medical assistance provided to an individual who qualified to receive assistance for the aged could not be different from the amount, duration, and scope of benefits provided to an individual who qualified to receive assistance for the blind.

*Schweiker v. Hogan*, 457 U.S. 569, 573 n.6, 102 S. Ct. 2597, 73 L. Ed. 2d 227 (1982). The comparability provisions do not limit the broad discretion that states otherwise have to structure their Medicaid programs, particularly waiver programs.

Congress allows states to seek waivers of the comparability requirement as a means of facilitating the offering of home-based and community-based services. Before Section 1915(c) was enacted in 1981, Medicaid

provided little coverage for long term care services in a noninstitutional setting. Many elderly, disabled, and chronically ill persons were living in institutions not for medical reasons, but because of the paucity of health and social services available to them in their homes and communities. Further, even where the necessary services were available outside the institution, individuals were sometimes unable to pay for them and they were not covered by Medicaid.

[Legislation in 1981] added new section 1915(c) to the [Social Security] Act to encourage the provision of services to Medicaid recipients in noninstitutional settings. This section authorizes the Secretary to waive Medicaid statutory requirements to enable a State to cover a broad

array of home and community-based services. These services must be furnished . . . only to persons who would otherwise require the level of care provided in [a facility such as a nursing home], the cost of which could be reimbursable under the State's plan.

53 Fed. Reg. 19950-01 (June 1, 1988).

**b. Waiver of the comparability requirement is standard for all HCBS waivers, including COPES**

The comparability provisions of federal Medicaid law do not apply to the COPES program because CMS waived that provision as part of the Department's Section 1915(c) waiver applications. Therefore, the trial court was incorrect in holding that the shared living rule violates the comparability provision.

Guidance provided to states by CMS describes the legal and context within which Home and Community Based (HCBS) waivers operate and specifically refers to the general Medicaid comparability requirement:

**§1902(a)(10)(B) (Comparability).** The waiver of this provision of the Act permits a state to limit the provision of waiver services to Medicaid beneficiaries who require the level of care in an institutional setting, are in the target group(s) specified in the waiver, and offer services to waiver participants that are not provided to other Medicaid beneficiaries. *All HCBS waivers operate under a waiver of this statutory provision[.]*

Application for a §1915(c) Home and Community-Based Waiver [Version 3.3] -- Instructions, Technical Guide and Review Criteria, at 6. (Emphasis added.)<sup>34</sup> Similarly, in a section of the same publication providing technical guidance to states about completing the application form for an HCBS waiver, CMS explains:

HCBS waivers target services only to specified groups of beneficiaries (e.g., persons with developmental disabilities or older persons) rather than making them available to all beneficiaries. *Thus a waiver of §1902(a)(10)(B) [42 U.S.C. §1396a(10)(B)] is an integral and necessary feature of all HCBS waivers.* HCBS waivers also include services that are not otherwise available under the State plan and thus not available to beneficiaries who do not participate in the waiver. *In order to make those services available, a waiver of comparability also is necessary.* The waiver application incorporates the request for a waiver of §1902(a)(10)(B) [42 U.S.C. §1396a(10)(B)]. *Submission of the application constitutes the state's request for this waiver.*

*Id.* at pp. 43-44 (emphasis added).

Indeed, Item No. 10 of the waiver application submitted by the Department is an assertion by the state to CMS as follows:

A *waiver of the amount, duration and scope of services requirements contained in section 1902(a)(10)(B) of the Act [42 U.S.C. § 1396a(a)(10)(B)] is requested*, in order that services not otherwise available under the approved

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<sup>34</sup> This 315 page document can be viewed on the Internet in pdf format at [http://new.cms.hhs.gov/MedicaidStWaivProgDemoPGI/05\\_HCBSWaivers-Section1915\(c\).asp#TopOfPage](http://new.cms.hhs.gov/MedicaidStWaivProgDemoPGI/05_HCBSWaivers-Section1915(c).asp#TopOfPage) (with no space between the hyphen after “Waivers” and “Section”) by scrolling down to a link called “Version 3.3 HCBS Waiver Application Instructions, Technical Guide & Review Criteria [ZIP 1132KB]”, clicking on that link and then clicking on the file. A copy of the cover page of the document and the pages cited are in the App. A40-43.

Medicaid State plan may be provided to individuals served on the waiver.

CP 1057, Item 10 (emphasis added).

Accordingly, by approving the waiver requests for the COPES program, CMS relieved the Department from any requirement that otherwise would have existed with respect to the comparability of services available under these programs. *Rowe*, 14 F.3d at 181 (“[T]he waiver program expressly contemplates a waiver of the ‘comparability’ requirement (so that individuals within the program may receive varying levels of service)[.]” (citing 42 U.S.C. § 1396n(c)(3))). Further, the non-applicability of the comparability requirement is explicitly set forth in 42 CFR § 440.250(k), which provides that “[i]f the [state] has been granted a waiver of the requirements of Sec. 440.240 (Comparability of services) in order to provide for home or community-based services under Sec. 440.180 or 440.181, *the services provided under the waiver need not be comparable for all individuals within a group.*” (Emphasis added) Therefore, the trial court was incorrect in holding that the shared living rule violates the comparability provision.

**c. The amount, duration and scope of services available to COPES recipients are comparable.**

The shared living rule complies with the comparability requirement, as it is used to identify the extent of need for publicly paid

services that the recipient receives. It would be absurd to say that every recipient should receive the same benefit regardless of need. In basing its benefit determination on the CARE assessment the Department exercised its “broad discretion” to determine that Medicaid recipients who share a home and household responsibilities with their caregivers are not eligible for as many hours of paid services as those recipients who do not live with their caregivers. This determination is based on the reasonable premise that certain household services that benefit the entire living unit will be provided by the resident caregiver as part of his or her household responsibility, even if he or she is not paid to do so.

The shared living rule does not create a situation where “the same benefit is funded for some recipients but not others.” *Rodriguez v. City of New York*, 197 F.3d 611, 616 (2nd Cir. 1999). Rather, the rule reflects a judgment that a person who chooses someone with whom he lives as caregiver has a level of need for publicly paid services different from that of a person whose caregiver does not reside in the same household. Simply put, the former has at least one other person who resides in the home who will take care of at least some of the routine household maintenance tasks whether he is paid to do so or not. This does not result in a different *benefit* level to different categorical groups of recipients: all categorically needy recipients are treated the same; all medically needy

recipients are treated the same; and the medically needy do not receive greater services than do the categorically needy.

Courts have only found a comparability violation where states were providing different services to the same categories of recipients, based on factors other than need. For example, one state offered eyeglasses only to recipients who needed them for “pathology” reasons but not for recipients who needed them “because of eye defects[.]” *White v. Beal*, 555 F.2d 1146, 1150 (2nd Cir. 1977). The court held that the comparability rule was violated because the distinction was based not on medical necessity but on the cause of the necessity.

No such distinction occurs with the shared living rule. All recipients have the choice of whether to select a provider who does or will live with them. All recipients who choose to live with a provider will receive a slightly reduced number of hours of coverage. The reason for the recipient’s decision is irrelevant.

Unlike the plaintiffs in *White*, Mr. Jenkins has not been denied comparable benefits based on his medical conditions. On the contrary, as discussed above, his clinically complex medical conditions automatically qualify him for additional assistance with special care needs, including laundry and meal preparation activities.

In short, even if the comparability requirements do apply, the shared living rule does not violate them, and the superior court's contrary decision should be reversed.

**3. The Court Should Defer To The Interpretation Of Federal And State Law By The Agencies Responsible For Implementation Of The Medicaid Program**

CMS, the federal agency charged with overseeing Medicaid, can only approve a waiver application if it has determined that the waiver is authorized by law. 42 U.S.C. § 1396a(b). Thus, approval of the programs by the federal agency that administers Medicaid demonstrates that the rule complies with federal law. If CMS believed the rule or the programs violated federal law, it would so inform the state, and require a change or disapprove the state's plan or the waivers. It has done neither with respect to the shared living rule.<sup>35</sup> Because CMS's interpretations of Medicaid law are entitled to considerable deference, this Court should conclude that the rule does not violate the comparability requirements.

In a case dealing with interpretations of the Medicaid waiver provisions, the Second Circuit outlined the appropriate standard that should guide judicial oversight of an agency's actions:

An agency's interpretation of a statute that the agency administers is entitled to *considerable deference*; a court

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<sup>35</sup> In fact, as noted above at p. 15, a version of the shared living rule has been part of Washington's Medicaid Personal Care program since at least 1993, and CMS has never questioned the propriety of the rule.

may not substitute its own reading unless the agency's interpretation is unreasonable. When an agency construes its own regulations, such deference is particularly appropriate, and even more appropriate where, as here, we consider a *small corner of a labyrinthine statute*.

*Rowe*, 14 F.3d at 178 (emphasis added), citing *inter alia Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 844-45, 104 S. Ct. 2778, 81 L. Ed. 2d 694 (1984)); *accord, Ahern v. Thomas*, 248 Conn. 708, 719-20, 733 A.2d 756 (1999) (“Deference [to an agency’s interpretation] is particularly warranted in cases in which we are required to interpret the Medicaid Act, a statutory scheme that is among the most intricate ever drafted by Congress” (internal quotation marks and citations omitted)).

In *Rowe*, the Court rejected the argument that the state was required to offer home-care services to the medically needy (in addition to the categorically needy). *Rowe*, 14 F.3d at 179. Like COPES, the home-care services were part of a CMS-approved waiver, and the federal agency’s conclusion that the program complied with federal law was entitled to deference. *Id.* CMS’s interpretation was “reasonable when considered in terms of the Act’s language and overall design, and in terms of the economic policy choices underlying the [state’s] home care waiver program.” *Id.* at 180-81.

The same result should obtain here. CMS has approved the State Plan and the waivers, and has not objected to the shared living rule. CMS's actions are "reasonable when considered in terms of the Act's language and overall design, and in terms of the economic policy choices underlying the" affected programs." *Id.* Further, CMS's conclusions are entitled to "considerable deference," especially given that the issues concern the interpretation of "a small corner of a labyrinthine statute." *Id.* at 178.

Washington courts also give deference to a state agency's interpretation of both state and federal law that the agency administers. Thus, the Washington Supreme Court has instructed that when reviewing a state agency's construction of a federal law, the Court "must determine whether Congress has directly spoken on the question at issue and has clearly indicated its intent." *Skamania County v. Columbia River Gorge Commission*, 144 Wn.2d 30, 42-43, 26 P.3d 241 (2001). "If it has, then that is the end of the matter, and [the Court] must give effect to that intent." *Id.* at 43 (internal quotation marks omitted). The Court looks to the statute in its entirety and "not just at the particular language in isolation." *Id.*

If the statute is ambiguous, the Court determines whether the state agency's interpretation "is based on a permissible construction of the

statute.” *Id.* (internal quotation marks omitted). The agency’s interpretation “is generally entitled to deference, and to sustain it [the Court] need only find that the agency’s interpretation was sufficiently rational to preclude [the Court] from substituting [its] judgment for that of the agency.” *Id.* Washington courts give weight to the Department’s interpretations of Medicaid law. *Burnham*, 115 Wn. App. 438.

The approach taken by Washington’s courts is essentially the same as the *Chevron* standard used by federal courts. *Puget Soundkeeper Alliance v. Dep’t of Ecology*, 102 Wn. App. 783, 787 n.4, 9 P.3d 892 (2000) (citing *Chevron*, 467 U.S. at 843-45):

When Congress has ‘explicitly left a gap for an agency to fill, there is an express delegation of authority to the agency to elucidate a specific provision of the statute by regulation,’ and any ensuing regulation is binding in the courts unless procedurally defective, arbitrary or capricious in substance, or manifestly contrary to the statute.

*United States v. Mead Corp.*, 533 U.S. 218, 227, 121 S. Ct. 2164, 150 L. Ed. 2d 292 (2001) (quoting *Chevron*, 467 U.S. at 843-44).

By issuing the shared living rule and applying it to the three Medicaid programs, the Department determined that the rule complied with federal Medicaid law, including the comparability provision rule, and the Department’s interpretation is entitled to deference. *Skamania County*, 144 Wn.2d at 43; *Burnham*, 115 Wn. App. 438.

Furthermore, the Legislature delegated to the Department the authority to supply the details of the programs. RCW 74.08.090 (“The department is hereby authorized to make rules and regulations . . . to the end that [Title 74 RCW] shall be administered uniformly throughout the state, and that the spirit and purpose of this title may be complied with.”); RCW 74.09.520(3) (“The department shall adopt, amend, or rescind such administrative rules as are necessary to ensure that Title XIX personal care services are provided to eligible persons in conformance with federal regulations.”); RCW 74.09.520(4) (“The department shall design and implement a means to assess the level of functional disability of persons eligible for personal care services under this section. The personal care services benefit shall be provided to the extent funding is available according to the assessed level of functional disability. Any reduction in services made necessary for funding reasons should be accomplished in a manner that assures that priority for maintaining services is given to persons with the greatest need as determined by the assessment of functional disability.”)

The Court should uphold the shared living rule because it is not “procedurally defective, arbitrary or capricious in substance, or manifestly contrary to the statute.” *Mead*, 533 U.S. at 227.<sup>36</sup>

In short, the shared living rule has been promulgated by the state agency responsible for administration of the Medicaid program in Washington, and has been applied to programs that have been approved by the federal agency responsible for administration of Medicaid programs across the nation. This represents a determination that the rule does not violate the comparability provisions of Medicaid law, and the trial court’s contrary conclusion should be reversed.

**B. The Shared Living Rule Does Not Violate The Americans With Disabilities Act.**

The superior court held that application of the shared living rule to Respondent violated the Americans with Disabilities Act, 42 U.S.C. § 12101, *et seq.* (the ADA), by discriminating against him based on his disability. COL 2.6, 2.9 and 2.10, CP 1190-91, App. A3-4; Order ¶ 3.4, CP 1192, App. A5. That ruling was incorrect, and should be reversed.

The ADA prohibits a public agency from discriminating against disabled persons “by reason of such disability.” 42 U.S.C. § 12132. Respondent argued, and the court below agreed, that by providing fewer

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<sup>36</sup> The Legislature also indicated its intention that home and community-based services would “support and enhance”—but not supplant—informal supports naturally provided by caring friends and family. RCW 74.39A.005.

hours of paid services for individuals who choose providers who live with them than provided to those who choose to receive personal care services from caregivers who live outside of the recipients' household, the Department violates the ADA by discriminating based on disability. In fact, the shared living rule differentiates among recipients based on their residential status and their unmet need for program services, not their disabilities. The rule does not, therefore, violate the ADA.

The case of *Weinreich v. Los Angeles Cy. Metro. Transp. Auth.*, 114 F.3d 976 (9th Cir. 1997), *cert. denied*, 522 U.S. 971 (1997) illustrates the point. Mr. Weinreich challenged a transit agency's requirement that persons seeking a reduced fare because of their disability must provide periodic medical reports to substantiate their ongoing eligibility. The Ninth Circuit rejected his claim:

Weinreich's inability to provide updated certification was due to his financial circumstances, not to his medical disability. Thus, the [transit agency]'s recertification policy did not discriminate against Weinreich on the basis of disability, and the [agency] is not required under the ADA or Rehabilitation Act to make reasonable modifications to the Program's eligibility requirements for Weinreich.

*Id.* at 979.

The same is true here: the shared living rule differentiates individuals such as Mr. Jenkins based on their living arrangement and

choice of provider, and not on the basis of their disability. The superior court's holding was incorrect, and should be reversed.

**C. The Shared Living Rule Does Not Violate The Equal Protection Clause of the U.S. Constitution Or The Privileges And Immunities Clause Of The Washington Constitution.**

The superior court held that the shared living rule violates the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution and article I, section 12 of the Washington Constitution, the Privileges and Immunities Clause. COL 2.7, 2.8, 2.9, 2.10, CP 1190-91, App. A3-4; Order ¶¶ 3.2 and 3.3, CP 1192, App. A-5. The shared living rule violates neither constitutional provision and the trial court's holding should be reversed.

**1. The Equal Protection Clause**

The Fourteenth Amendment to the Constitution of the United States provides, *inter alia* that:

No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state . . . deny to any person within its jurisdiction the equal protection of the laws.

Under the Equal Protection Clause, government classifications that do not implicate fundamental rights or suspect classifications are subject to rational basis review. *City of Cleburne v. Cleburne Living Center*, 473 U.S. 432, 440, 105 S. Ct. 3249, 87 L. Ed. 2d 313 (1985). Classifications

subject to rational basis review do not violate the Equal Protection Clause if they are rationally related to a legitimate government interest. *Id.* The shared living rule implicates neither fundamental rights nor suspect classifications and thus is subject to rational basis review.

The shared living rule is but one part of a multi-faceted system that classifies long-term care recipients based on their different levels of need for paid assistance, a mechanism that creates a classification of recipients that is rationally related to the state's legitimate interest in making a need-based allocation of its scarce resources.

In making its allocation of long-term care benefits, the Department assesses individuals to determine the number of paid long-term care hours that they need based on several factors: their ability to perform certain daily living tasks; their medical condition; their cognitive and behavioral functioning; and the availability of informal supports. Taken together, these factors determine both the amount of assistance that recipients need and the amount of paid assistance that the Department will provide to cover the gaps left by informal supports.

The shared living rule recognizes that certain tasks, which benefit a household generally, are informal supports that obviate the need for paid assistance. This classification is rationally related to the state's legitimate interest in making need-based resource allocation decisions. Because

there is a rational basis for the shared living rule, it does not violate the Equal Protection Clause.

## **2. The Privileges And Immunities Clause**

Article I, sec. 12 of the Washington Constitution provides that:

No law shall be passed granting to any citizen, class of citizens, or corporation other than municipal, privileges or immunities which upon the same terms shall not equally belong to all citizens, or corporations.

The Washington Supreme Court has historically analyzed claims arising under this provision using the principles of the Equal Protection Clause of the United States Constitution. *See, e.g., Seeley v. State*, 132 Wn.2d 776, 788, 940 P.2d 604 (1997).

However, in *Grant Cy. Fire Protection Dist. No. 5 v. City of Moses Lake*, 145 Wn.2d 702, 725-31, 42 P.3d 394 (2002) (*Grant County I*) and *Grant Cy. Fire Protection Dist. No. 5 v. City of Moses Lake*, 150 Wn.2d 791, 812-13, 83 P.3d 419 (2004) (*Grant County II*), the Washington Supreme Court held that in some instances the Privileges and Immunities clause provides protections distinct from, and greater than, the Equal Protection Clause of the United States Constitution and that separate analysis of the validity of a government classification under each provision is necessary.

However, the Supreme Court limited the application of article I, section 12, to “those fundamental rights which belong to citizens of the state *by reason of such citizenship.*” *Grant County II* at 812-13 (emphasis added). The Court went on to state that where “no privilege, i.e., fundamental right of state citizenship [is] at issue . . . the claim of a violation of article I, section 12 fails . . .” *Id.* at 814.

Public assistance recipients have a right -- which they enjoy by reason of statutory grant, not by reason of citizenship -- to benefits *only* if they legally qualify for medical benefits *and only* to the extent authorized based on their particular circumstances. There is no fundamental right to public assistance benefits, whether medical assistance or otherwise, that citizens possess by virtue of state citizenship. Because the shared living rule does not implicate a fundamental right enjoyed by virtue of citizenship, it does not violate article I, section 12.

**D. The Shared Living Rule Does Not Violate Mr. Jenkins’ Due Process Rights.**

The superior court ruled that the shared living rule “creates an irrebuttable presumption [of the type that are] disfavored in Washington [and] therefore[] violates [Mr. Jenkins’] due process rights.” COL 2.2, CP 1189, App. A2, and therefore could not be applied to Mr. Jenkins.<sup>37</sup> COL

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<sup>37</sup> The court below did not specify whether the due process rights allegedly violated arise under the state or federal constitution. However, the Washington Supreme

2.9 and 2.10, CP 1190-91, App. A3-4. This holding reflects a misunderstanding of both the shared living rule and the case law applicable to the public assistance benefit context.

In certain circumstances, irrebuttable or conclusive presumptions are, as the superior court stated, “disfavored in the law.” *Id.* For example, in the context of a criminal trial, an irrebuttable presumption may not operate to ultimately establish an element of a crime in a criminal trial. *See e.g., State v. Savage*, 94 Wn.2d 569, 572-73, 618 P.2d 82 (1980). (“Due process prohibits the use of a conclusive or irrebuttable presumption to find an element of a criminal offense, because such use of a conclusive presumption would conflict with the overriding presumption of innocence with which the law endows the accused and which extends to every element of the crime, and would invade [the] fact-finding function’ which in a criminal case the law assigns solely to the jury.” (internal quotation marks and citation omitted.))

In the civil context, irrebuttable presumptions have sometimes been found to violate due process guarantees. For example, in *Stanley v. Illinois*, 405 U.S. 645, 92 S. Ct. 1208, 31 L. Ed. 2d. 551 (1972), the U. S. Supreme Court concluded that an Illinois statute establishing a

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Court has held that the state provision does not provide greater protection than its identical federal counterpart. *See, e.g., State v. Manussier*, 129 Wn.2d 652, 679-80, 921 P.2d 473 (1996).

presumption of unfitness for unwed fathers in child dependency proceedings violated the Due Process Clause of the federal constitution. *See also Vlandis v. Kline*, 412 U.S. 441, 93 S. Ct. 2230, 37 L. Ed. 2d 63 (1973) (invalidating state statute providing that for purpose of paying tuition at a state funded college or university, the student's out-of-state residence status continued throughout the student's time at the college); *Cleveland Board of Education v. LaFleur*, 414 U.S. 632, 94 S. Ct. 791, 39 L. Ed. 2d 52 (1974) (invalidating school district policy requiring pregnant teachers to take leave at least four months prior to expected delivery date and remain on leave until child was three months old).

However, shortly after *Stanley*, *Vlandis* and *LaFleur* were decided, the Supreme Court declined to apply their holdings in the context of public assistance benefits, observing that “[u]nlike the claims involved in *Stanley* and *LeFleur*, a noncontractual claim to receive funds from the public treasury enjoys no constitutionally protected status.” *Weinberger v. Salfi*, 422 U.S. 749, 772, 95 S. Ct. 2457, 45 L. Ed. 2d 522 (1975).

*Salfi* involved a challenge to a provision of the Social Security Act that withheld benefits to a surviving spouse of a covered worker unless the marriage had taken place at least nine months prior to the worker's death. While acknowledging that the rule had a reasonable goal—to prevent the use of sham marriages to obtain Social Security benefits—the lower court,

relying on *Stanley, Lefleur, and Vlandis*, had invalidated the nine month requirement “because it presumed a fact which was not necessarily or universally true” (*Id.* at 768), *i.e.*, that any marriage occurring less than nine months before the worker’s death was a sham.

The Supreme Court reversed, and based its decision on a long line of cases articulating the constitutional standard for statutes and regulations establishing requirements for receipt of social welfare benefits. The *Salfi* Court began its analysis with the observation that

[t]he standard for testing the validity of Congress’ Social Security classification was clearly stated in *Flemming v. Nestor*, 363 U.S., at 611, 80 S. Ct. 1367, 1373, 4 L. Ed. 2d 1435 [1960]

‘Particularly when we deal with a withholding of a noncontractual benefit under a social welfare program such as (Social Security), we must recognize that the Due Process Clause can be thought to interpose a bar only if the statute manifests a patently arbitrary classification, utterly lacking in rational justification.’

*Id.* at 768. The Court also noted that in *Richardson v. Belcher*, 404 U.S. 78, 92 S. Ct. 254, 30 L. Ed. 2d 231 (1971), it had upheld a provision of the Social Security Act that required an offset against disability benefits of state-paid workers’ compensation payments but did not require a similar offset of payments under private disability insurance, stating the governing principle as follows:

If the goals sought are legitimate, and the classification adopted is rationally related to the achievement of those goals, then the action of Congress is not so arbitrary as to violate the Due Process Clause of the Fifth Amendment.

*Id.* at 769 (quotation marks and citation omitted). Further, the *Salfi* Court re-iterated with approval the following statement from *Dandridge v. Williams*, 397 U.S. 471, 90 S. Ct. 1153, 25 L. Ed. 2d 491 (1970), where the Supreme Court rejected a claim that Maryland welfare legislation violated the Equal Protection Clause:

In the area of economics and social welfare, a State does not violate the Equal Protection Clause merely because the classifications made by its laws are imperfect. If the classification has some 'reasonable basis', it does not offend the Constitution simply because the classification is not made with mathematical nicety or because in practice it results in some inequality.

*Salfi*, 422 U.S. at 769. (quotation marks and citation omitted)

Finally, the *Salfi* Court rejected the suggestion that the Constitution requires an individualized determination as to the validity of marriages, rather than the bright line nine-month rule in the Act:

Nor is it at all clear that individual determinations could effectively filter out sham arrangements, since neither marital intent, life expectancy, nor knowledge of terminal illness has been shown by appellees to be reliably determinable. The administrative difficulties of individual eligibility determinations are without doubt matters which Congress may consider when determining whether to rely on rules which sweep more broadly than the evils with which they seek to deal. In this sense, the duration-of-relationship requirement represents not merely a

substantive policy determination that benefits should be awarded only on the basis of genuine marital relationships, but also a substantive policy determination that limited resources would not be well spent in making individual determinations.

*Id.* at 782-84. The *Salfi* Court concluded that “[t]he Constitution does not preclude such policy choices as a price for conducting programs for the distribution of social insurance benefits.” *Id.* at 785.

The situation in this case is exactly that presented in *Salfi*: Mr. Jenkins seeks public assistance benefits and argues that an eligibility standard violates due process because it allegedly does not meet his individual situation. Just as the U.S. Supreme Court did in *Salfi*, this Court should reject this argument and reverse the ruling below.

**E. WAC 388-02-0225 Is Valid And Consistent With RCW 34.05, The Washington Administrative Procedure Act. Further, The Federal Administrative Procedure Act Has No Application To State Agencies.**

The Washington Administrative Procedure Act (the APA), RCW 34.05, authorizes state agencies to “adopt rules governing the formal and informal procedures prescribed or authorized by [the APA] and rules of practice before the agency.” RCW 34.05.220(1). DSHS has adopted rules governing administrative hearings relating, *inter alia*, to challenges to agency determinations as to eligibility for and extent of public assistance

benefits such as those at issue in this case. See, generally, WAC 388-02.

One of the DSHS hearings rules reads as follows:

**WAC 388-02-0225 May an ALJ or review judge decide that a DSHS rule is invalid?**

(1) Neither an ALJ nor a review judge may decide that a DSHS rule is invalid or unenforceable. Only a court may decide this issue.

(2) If the validity of a DSHS rule is raised during the hearing, the ALJ or review judge may allow argument for court review.<sup>38</sup>

The trial court ruled that in adopting WAC 388-02-0225, the Department acted “arbitrarily and capriciously . . . because administrative agencies, like other judicial tribunals, are required to follow the law.” COL 2.11, CP 1191, App. A4. The trial court also ruled that the Department “exceeded the scope of its authority in applying WAC 388-02-0225 to [Mr. Jenkins] because it fails to comport with the spirit of the Washington Administrative Procedure Act, RCW 34.05, and it is inconsistent with the Federal Administrative Procedure Act, U.S.C. Title 5.” COL 2.12, CP 1191, App. A4. Finally the trial court ruled that “[a]pplication of WAC 388-02-0225 to [Mr. Jenkins] is unconstitutional under the state and federal Due Process clauses.” COL 2.13, CP 1191,

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<sup>38</sup> Initial hearings are conducted by an ALJ employed by the Office of Administrative Hearings, a separate state agency. RCW 34.12.040. Under the DSHS rules, the ALJ’s decision in certain categories of cases is final while in other categories the ALJ’s decision is subject to review by a DSHS review judge. See WAC 388-02-0215(4) and (5); WAC 388-02-0560 through -600.

App. A4. These rulings reflect a fundamental misunderstanding of administrative law, the separate roles of administrative agencies and the judiciary, and constitutional jurisprudence.

**1. WAC 388-02-0225 Is A Long-Standing Provision That Facilitates Uniform Administration Of DSHS's Multiple Responsibilities.**

The substance of WAC 388-02-0225 has been in effect since at least 1981.<sup>39</sup> It implements a statutory direction “to make rules and regulations not inconsistent with the provisions of [RCW Title 74] to the end that [RCW Title 74] shall be administered uniformly throughout the state, and that the spirit and purpose of this title may be complied with.” RCW 74.08.090. This legislative direction has been in effect since at least 1949. *See* Laws of 1949, ch. 6, § 10. Invalidation of the rule would have far-reaching, negative impacts on the administration of public assistance programs in the state.

The Department is charged with an extraordinary breadth of responsibilities, from the establishment and distribution of public

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<sup>39</sup>The rule was adopted under the Department’s authority in RCW 34.05.020 and its predecessor, RCW 34.04.020. *See* Wash. St. Reg. 81-12-015, adopting former WAC 388-08-00401, subsection (3) of which provided, in relevant part, that “[t]he hearing examiner shall not have the power to declare invalid any section of the Washington Administrative Code.” Petitioner expressed concern at the minimal attention WAC 388-02-0225 received during the 2000 rule-making process. CP 198-99 (Petitioner’s Trial Brief at 33-34.) The explanation is simple: the current version, adopted in 2000, is virtually identical to its predecessors, including WAC 388-08-425(2)(d), adopted at Wash. St. Reg. 90-04-076, effective March 1, 1990 (“The ALJ shall . . . [n]ot declare any department rule invalid”), and the language from former WAC 388-08-00401 quoted above.

assistance benefits, issuance and revocation of variety of licenses, the protection of children and vulnerable adults and resolution of child support issues between divorced and separated parents. These services must be provided consistently throughout the state, in accordance with state and federal law, and within available resources. The Office of Administrative Hearings (OAH) processed more than 23,000 DSHS-related administrative appeals during calendar year 2003, the latest year for which data is publicly available. Office of Administrative Hearings, Preliminary Strategic Plan for 2005-07, at 2, available at <http://www.oah.wa.gov/2005-07StratPlan.pdf> (visited Jan. 23, 2006). OAH employs 103 ALJs to handle hearings on behalf of state agencies. *Id.* at 5. If each of those 103 ALJs had plenary power to adjudicate the constitutionality or appropriateness of individual agency rules, the system of uniform administration of public assistance statutes contemplated by RCW 74.08.090 would be impossible to achieve.

**2. WAC 388-02-0225 Is Consistent With The Principles of Administrative Law.**

The traditional view is that the role of administrative adjudicators is that of fact finders, not policy makers, who are bound by the agency's rules just as is the agency. As one treatise puts it:

Rules and policy statements issued by the policymaking agency are binding on the adjudicating

agency. Adjudicating officials should not see themselves as courts. They are bound by rules as if they were part of the rulemaking agency . . . .

1 Charles H. Koch, Jr., *Administrative Law and Practice* § 4.22[5], at 371-72 (2d ed. 1997).

Although some may have a different view, the more common and traditional view is that administrative law judges and review judges are bound by properly adopted agency rules.

Where the court cannot say that the presiding official applied the agency's rules, the decision will not stand even if the agency later tries to link the presiding official's finding to its rules.

On the other [hand], the presiding officials are generally bound by the agency's rules. A rule or statement should have equal effect on all of the agency's decision makers . . . . An argument could be made that presiding officials should apply rules in the manner of a court rather than as part of the agency. *A better view, however, is that presiding officials, as well as other administrative adjudicators, must be considered part of the agency for the purposes of determining what law applies to their decisions. Under that approach, a rule that is binding on the agency is binding on its adjudicators.*

2 Charles H. Koch, Jr., *Administrative Law and Practice* § 5.68[2], at 262 (2d ed. 1997) (emphasis added). This approach recognizes the reality that a decision by an ALJ, if not subjected to further review, becomes in fact the decision of the agency itself.

**3. WAC 388-02-0225 Is Consistent With Washington Law.**

Washington courts have consistently recognized that administrative agencies have no authority to invalidate the statutes or rules under which they operate. The issue arises most frequently in the context of an argument that the party challenging a rule is required to exhaust administrative remedies before invoking the jurisdiction of the courts. Where the sole issue is one of the validity of a statute or regulation adopted by another agency, the uniform response of Washington courts has been that exhaustion is not required because the agency cannot grant the relief sought. *See, e.g., Bare v. Gorton*, 84 Wn.2d 380, 383, 526 P.2d 379 (1974) (Exhaustion “is unnecessary where the issue raised is the constitutionality of the very law sought to be enforced. An administrative body does not have authority to determine the constitutionality of the law it administers; only the courts have that power.”); *Yakima Clean Air Authority v. Glascam Builders, Inc.*, 85 Wn.2d 255, 257, 534 P.2d 33 (1975). (“An administrative tribunal is without authority to determine the constitutionality of a statute, and, therefore, there is no administrative remedy to exhaust.”); *City of Seattle v. Dept. of Ecology*, 37 Wn.2d 819, 821, 683 P.2d 244 (1984) (Under former Administrative Procedure Act, RCW 34.04, superior court had exclusive jurisdiction to challenge the validity of an agency rule and Pollution Control Hearings Board had no jurisdiction to determine validity of Ecology rule); *Snohomish County v.*

*State*, 69 Wn. App. 655, 664, 850 P.2d 546 (1993) (Under current Administrative Procedure Act, RCW 34.05, Forest Practices Appeals Board did not have authority to invalidate rule adopted by the Forest Practices Board).

Although there are no Washington cases precisely addressing the role of an individual ALJ,<sup>40</sup> as opposed to the authority of the agency whose hearings the ALJ conducts, it is axiomatic that the agency can (and perhaps should) at least limit the role of the ALJ to the same extent that the agency itself is limited. Administrative agencies, such as the Department and the Office of Administrative Hearings, are created by statute, and as such, their powers are limited to those expressly granted by statute or by implication. *Taylor v. Morris*, 88 Wn.2d 586, 588, 564 P.2d 795 (1977). This limitation also applies to administrative appeals conducted by state agencies. *Citizens v. Mercer Island*, 106 Wn. App. 461, 471, 24 P.3d 1079 (2001); *Messer v. Snohomish Cy. Bd. of Adjustment*, 19 Wn. App. 780, 787, 578 P.2d 50 (1978) (“The scope and nature of an administrative appeal or review must be determined by the provisions of the statutes and ordinances which authorize them.”). The

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<sup>40</sup> At least one state supreme court has addressed the issue squarely: “ALJs are an agency of the executive branch of government and must follow the law as written until its constitutionality is judicially determined; ALJs have no authority to pass upon the constitutionality of a statute or regulation.” *Video Gaming Consultants, Inc. v. South Carolina Dept. of Revenue*, 342 S.C. 34, 38, 535 S.E.2d 642 (2000).

state Administrative Procedure Act requires the administrative law judges to comply with rules properly adopted by state agencies: “The presiding officer shall regulate the course of the proceedings, *in conformity with applicable rules . . .*” RCW 34.05.449(1) (emphasis added).

WAC 388-02-0225 is consistent with Washington case law and the controlling statutes, and the court below committed error in concluding otherwise.

**4. WAC 388-02-0225 Is Consistent With Federal Law, And In Any Event The Federal APA Does Not Apply To State Agencies.**

The limited role of administrative adjudicators has been recognized by the federal courts as well. In *Iran Air v. Kugelman*, 996 F.2d 1253 (D.C. Cir. 1993), then Circuit Judge Ruth Bader Ginsberg noted that “[i]t is commonly recognized that ALJs ‘are entirely subject to the agency on matters of law.’” 996 F.2d at 1260 (quoting both Antonin Scalia, *The ALJ Fiasco--A Reprise*, 47 U. Chi. L. Rev. 57, 62 (1979), and Joseph Zwerdling, *Reflections on the Role of an Administrative Law Judge*, 25 Admin. L. Rev. 9 (1973)).<sup>41</sup>

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<sup>41</sup> Then Chief Administrative Law Judge of the Federal Power Commission, Judge Zwerdling, wrote that “[t]he basic concept of the independent administrative law judge requires that he conduct the cases over which he presides with complete objectivity and independence. In so operating, however, he is governed, as in the case of any trial court, by the applicable and controlling precedents. *These precedents include the applicable statutes and agency regulations*, the agency’s policies as laid down in its *published* opinions, and applicable court decisions.” 25 Admin. L. Rev. at 12 (first emphasis added; second emphasis in original).

Consistent with that view, and like Washington courts, federal courts have held that the federal Administrative Procedure Act does not require an appellant to exhaust his administrative remedies because an ALJ is precluded from ruling upon the constitutionality of the procedures he administers. *See, e.g. Frost v. Weinberger*, 375 F. Supp. 1312, 1320 (E.D.N.Y. 1974) (“an Administrative Law Judge is precluded from passing upon the constitutionality of the very procedures he is called upon to administer”), *rev’d on other grounds*, 515 F. 2d 57 (2nd Cir. 1975), *cert. denied sub nom. Frost v. Matthews*, 424 U.S. 958, 96 S. Ct. 1435, 47 L. Ed. 2d 364 (1976); *Gilbert v. Natl. Transp. Safety Board*, 80 F.3d 364, 366-67 (9th Cir. 1996) (“Generally, challenges to the constitutionality of a statute or a regulation promulgated by an agency are beyond the power or the jurisdiction of an agency” citing *Reid v. Engen*, 765 F.2d 1457, 1461 (9th Cir. 1985) and *Liu v. Waters*, 55 F.3d 421, 425 (9th Cir. 1995)); *Robinson v. U.S.*, 718 F.2d 336, 338 (10<sup>th</sup> Cir. 1983) (rejecting claim that ALJ improperly refused to hear constitutional challenge because “[t]he agency is an inappropriate forum for determining whether its governing statute is constitutional [because] the agency may not declare the statute unconstitutional.”)

Finally, the federal Administrative Procedure Act applies to adjudications conducted by “agencies” which are defined by 5 U.S.C. §

551 as “authorit[ies] of the Government of the United States.” The federal act simply has no application to state agency determinations such as that at issue here. The ruling of the court below that WAC 388-02-0225 violates the federal Administrative Procedure Act was simply wrong.

**5. WAC 388-02-0225 Is Consistent With Due Process**

Due process does not require that a person challenging an administrative decision have an adjudication of constitutional claims available at every step in the administrative hearing process. Indeed, as discussed above, Respondent could have had an expeditious resolution of his constitutional claim, had he chosen to do so, by filing a declaratory judgment action and bypassing the administrative proceedings altogether.<sup>42</sup> *See* cases discussed above at pp. 60-61. By choosing instead to invoke the administrative procedures available to him, Respondent should not be heard to complain that they did not provide him the adjudication that he wanted, when he wanted it.

In short, the superior court’s ruling that invalidated WAC 388-02-0225 was incorrect, and should be reversed.

**F. The Superior Court Erred By Awarding Back Benefits And Interest.**

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<sup>42</sup> Of course, had he done so, he would not have been able to invoke the attorneys’ fee provisions of RCW 74.08.080, because the statute by its terms applies only to judicial review of an administrative decision denying benefits.

By order of October 25, 2005 the superior court awarded back benefits of \$2,294.72 plus interest at the rate of 12 percent per annum, for a total of \$2,393.56. Judgment, p. 2, CP 1163, App. A10. The court also awarded attorneys fees of \$33, 654.00, and costs in the amount of \$1551.92, and provided that postjudgment interest was payable on all amounts awarded pursuant to RCW 4.56.110(4). *Id.*

By ordering back benefits, the court below exceeded its authority under the judicial review provisions of the APA, RCW 34.05.574. Further, because the state has not waived sovereign immunity with respect to interest on public assistance benefit awards, awarding prejudgment or postjudgment interest was improper.

**1. There Is No Authority Under The APA To Award Back Benefits Of The Type At Issue Here.**

RCW 34.05.574 outlines the relief that a court may award in a judicial review proceeding. As pertinent to this case, the statute provides:

(1) In a review under RCW 34.05.570, the court may (a) affirm the agency action or (b) order an agency to take action required by law, order an agency to exercise discretion required by law, set aside agency action, enjoin or stay the agency action, remand the matter for further proceedings, or enter a declaratory judgment order . . . . In reviewing matters within agency discretion, *the court shall limit its function to assuring that the agency has exercised its discretion in accordance with law, and shall not itself undertake to exercise the discretion that the legislature has placed in the agency.* The court shall remand to the agency

for modification of agency action, unless remand is impracticable or would cause unnecessary delay.

...

(3) The court may award damages, compensation, or ancillary relief *only to the extent expressly authorized by another provision of law.*

(Emphasis added.)

Nothing in the foregoing language authorizes the court to determine an amount of “back benefits”, especially where, as here, the benefits consist not of cash payments but of services. At most the Court should have remanded the matter to the Department to determine the extent to which services had been provided and make any payments that were warranted, consistent with the court’s ruling on the merits.

**2. No Provision Of State Law Authorizes Interest On Public Assistance Benefit Or Attorneys’ Fees And Cost Awards.**

Assuming, *arguendo*, that the superior court did have authority to make an award of back benefits in form of a money judgment, awarding interest on the amount so awarded or on the attorney’s fee award was improper. The same is true with respect to that part of the order imposing interest on the attorneys’ fee award.

Washington Courts have routinely held that RCW 4.56.110, which provides that judgments shall bear interest from the date of entry, does not apply to public agencies absent a clear waiver of sovereign immunity.

The general rule is that as a matter of sovereign immunity, the state cannot, without its consent, be held to interest on its debts. This rule is followed despite the fact that RCW 4.56.110 does not expressly exempt the state or its political subdivisions from its operation.

*Our Lady of Lourdes Hospital v. Franklin Cy.*, 120 Wn.2d 439, 455-456, 842 P.2d 956 (1993) (internal citations omitted).

In *Our Lady of Lourdes*, a hospital sued Franklin County for the cost of medical care for two inmates. The County, in turn, sued DSHS as a third-party defendant for reimbursement of the liability to the hospital. Although liability for the cost of care was upheld, the Supreme Court reversed the superior court decision awarding postjudgment interest because no statute or contract expressly or impliedly waived sovereign immunity against either the county or the state. *Id.*<sup>43</sup>

Similarly, in *State v. Thiessen*, 88 Wn. App. 827, 946 P.2d 1207 (1997), a defendant who successfully defended against an assault charge on the basis of self-defense, was awarded reimbursement of his defense costs pursuant to RCW 9A.16.110(2), as well as postjudgment interest. The Court of Appeals reversed the superior court's award of interest, and followed the holding of *Our Lady of Lourdes*:

A statutory waiver of sovereign immunity as to interest will apply only in those circumstances specifically delineated

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<sup>43</sup> The *Our Lady of Lourdes* case did not involve a claim for prejudgment interest.

by statute. We do not read into a statute provisions that are not there; nor do we modify a statute by construction.

*Id.*, 88 Wn. App. 829.

Nothing in RCW 74.39A (the statute that authorizes the COPES program), RCW 74.08.080 (the statute authorizing attorneys' fees awards) or the APA suggest that the State has waived sovereign immunity as to public assistance benefits or attorneys fees incurred in obtaining such benefits. Indeed the APA provides explicitly that a court reviewing an administrative decision "may award damages, compensation, or ancillary relief *only to the extent expressly authorized by another provision of law.*" RCW 34.05.574(3) (emphasis added).

The rule is different in the context of contracts between a state agency and a private entity. In *Architectural Woods, Inc., v. State*, 92 Wn.2d 521, 598 P.2d 1372 (1979), the Washington Supreme Court held that when the state does business with private entities, or assumes duties ordinarily undertaken by private business, it should be held to the same rights and responsibilities as would a private entity, including the duty to pay interest on contract damages, stating that

It is our further opinion that by the act of entering into an authorized contract *with a private party*, the State, absent a contractual provision to the contrary, thereby waives its sovereign immunity in regard to the transaction and impliedly consents to the same responsibilities and

liabilities as a the private party, including liability for interest.

*Architectural Woods*, 92 Wn.2d at 526-527 (emphasis added). This ruling was codified two years later by the adoption of RCW 39.76, governing interest on payments under contracts with private parties.

Courts have refused to imply a waiver of sovereign immunity where the state agency role is not similar to that of a private entity. For example, in *Shum v. Dep't of Labor and Indus.*, 63 Wn. App. 405 (1991), the court declined to find a waiver of sovereign immunity for a claim to interest in a Title 51 workers compensation case:

*Architectural Woods* does not apply here because the Department is not acting as a private insurer. Title 51 is an exercise of the police power that uses public funds and administers governmental functions under a statute whose terms and requirements are non-negotiable.

*Shum*, 63 Wn. App. 411.

Like *Shum*, this case does not involve a private party or an ordinary business contract but a claim for public assistance benefits. Because no statute authorizes payment of interest on such claims, the superior court's ruling that Mr. Jenkins was entitled to interest should be reversed.

**G. The Superior Court Erred In Including Items In Its Cost Award That Are Not Recoverable Under RCW 4.84.010.**

The court below awarded attorneys fees and costs pursuant to RCW 74.08.080, which provides, in relevant part, that when a public assistance recipient prevails upon judicial review of a denial of benefits, “said [recipient] shall be entitled to reasonable attorneys’ fees and costs.” The trial court did not limit its award of costs to the items authorized under RCW 4.84.010, but instead awarded a total of \$1512.92 that included such items as “photocopying, postage, telecommunication, and ‘other’”. CP 900, 1162. This was error, and should be reversed.

RCW 4.84.010 specifies the categories of costs that may be awarded to a prevailing party:

[T] there shall be allowed to the prevailing party upon the judgment certain sums by way of indemnity for the prevailing party’s expenses in the action, which allowances are termed costs, including, in addition to costs otherwise authorized by law, the following expenses:

- (1) Filing fees;
- (2) Fees for the service of process. . . ;
- (3) Fees for service by publication;
- (4) Notary fees, [to] the extent the fees . . . are expressly required by law and . . . represent actual costs;
- (5) Reasonable expenses . . . incurred in obtaining reports and records [used at trial or mandatory arbitration]
- (6) Statutory attorney and witness fees; and

(7) [Under some circumstances] the reasonable expense of the transcription of depositions used at trial or at the mandatory arbitration hearing . . . .

Although there are no cases precisely on point, Washington courts have consistently limited cost awards, whether under RCW 4.84.010 or another statutory provision, to those items specifically recoverable under RCW 4.84.010. *See e.g., Gerken v. Mutual of Omaha*, 74 Wn. App. 220, 231, 872 P.2d 1008 (1994) (Limiting costs under RCW 4.84.010 to “filing fees, costs of service of process, notary fees, costs of reports and records as evidence, statutory attorney and witness fees, costs of transcription of depositions used at trial or arbitration and ‘costs otherwise authorized by law . . . .’”); *Nordstrom v. Tampourlos*, 107 Wn.2d 735, 743, 733 P.2d 208 (1987) (The “costs of suit” recoverable under the Consumer Protection Act, RCW 19.86.090, are limited because “[c]osts have historically been very narrowly defined, and RCW 4.84.010, which statutorily defines costs, limits that recovery to a narrow range of expenses such as filing fees, witness fees, and service of process expenses.”)

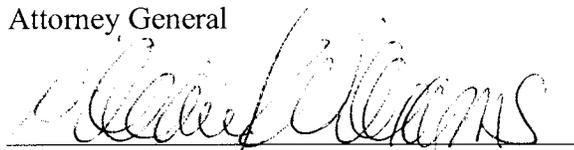
The same analysis applies here. There is no basis in logic or law to apply a different standard in determining what costs are recoverable under RCW 74.08.080 than under the more specific provisions of RCW 4.84.010. Accordingly, the superior court’s cost award should be vacated.

### VIII. CONCLUSION

For the reasons set forth above, this Court should vacate the decision below, and remand the matter to the superior court with instructions to affirm the Department's administrative decision.

RESPECTFULLY SUBMITTED this 21st day of February, 2006.

ROB MCKENNA  
Attorney General

A handwritten signature in cursive script, appearing to read "William L. Williams", written over a horizontal line.

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**CERTIFICATE OF SERVICE**

*Judy Halla*, states and declares as follows:

On February 21, 2006, I served a true and correct copy of this BRIEF OF APPELLANT on each of the parties to this action, as indicated below:

Rajiv Nagaich  
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- By United States Mail
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- By Facsimile
- By Legal Messenger
- By Overnight Mail
- By Hand Delivery

I certify under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

Dated this 21<sup>st</sup> day of February, 2006, at Olympia, Washington.



---

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# APPENDICES

## APPENDIX

<b>Respondent's Documents</b>	<b>Date</b>	<b>Description</b>
A1	November 14, 2005	First Amended Findings of Fact, Conclusions of Law, and Order on Petition for Judicial Review
A9	October 21, 2005	(Proposed) Judgment for David Jenkins Awarding Retroactive and Continuing Benefits, Attorneys' Fees and Costs
A14		WAC 388-106
A37		Hypothetical Clients
A40	November 2005	Instructions, Technical Guide and Review Criteria

NOV 16 2005

**ORIGINAL**

SUPERIOR COURT OF WASHINGTON IN AND FOR KING COUNTY

DAVID J. JENKINS,  
an individual,  
  
Petitioner,  
  
v.  
  
DEPARTMENT OF SOCIAL AND  
HEALTH SERVICES OF THE STATE  
OF WASHINGTON,  
  
Respondent.

The Honorable Judge Bruce Hilyer -  
No. 04-2-40867-9 SEA

**FIRST AMENDED FINDINGS OF FACT,  
CONCLUSIONS OF LAW, AND ORDER  
ON PETITION FOR JUDICIAL REVIEW**

**I. HISTORY OF PROCEEDING**

1.1 This matter was heard on August 22, 2005, before the Honorable Bruce Hilyer. Petitioner, David Jenkins (Petitioner), appeared by and through his attorneys of record, Gregory A. McBroom, Foster Pepper & Shefelman, PLLC, and Rajiv Nagaich, Johnson & Nagaich, PS. Respondent, the Department of Social and Health Services (Respondent), appeared by and through Rob McKenna, Attorney General, and Jonathan Milstein, Assistant Attorney General.

1.2 At the conclusion of the hearing on August 22, 2005, the Court signed Findings of Fact, Conclusions of Law; Declaratory Judgment and Order Granting Relief from Administrative Orders (Order). On September 1, 2005, pursuant to CR 59, Respondent filed a timely motion for clarification, reconsideration and stay of the Order.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND  
ORDER - 1

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1 not based upon Petitioner's need; rather, it is only based on the living situation of the care  
2 provider.

3 2.5 The comparability of service requirement is not met under the particular factual  
4 situation with respect to Petitioner. The COPES waiver expands services available to recipients,  
5 it does not restrict them.

6 2.6 Respondent acted arbitrarily and capriciously and exceeded the scope of its  
7 authority by applying the Shared Living Rule to Petitioner because it violates the Americans  
8 with Disabilities Act by discriminating on the basis of health issues. There is sufficient showing  
9 that the discrimination here stems from Petitioner's disability. 42 U.S.C. §12101 *et seq.*

10 2.7 Respondent's application of the Shared Living Rule to Petitioner is  
11 unconstitutional under the Privileges and Immunities Clause of the Washington State  
12 Constitution because it grants citizens without live-in caregivers benefits unavailable to those  
13 with live-in caregivers. Wash. Const. Art. I, §12. There is no rational basis for the distinction  
14 Respondent makes between Petitioner, who has a live-in caregiver, and citizens without live-in  
15 caregivers.

16 2.8 Respondent's application of the Shared Living Rule to Petitioner violates the  
17 Equal Protection Clause of the United States Constitution by providing more benefits to other  
18 similarly situated patients without live-in caregivers compared to those provided to Petitioner,  
19 who has a live-in caregiver. U.S. Const. Art. XIV. There is no rational basis for the distinction  
20 Respondent makes between Petitioner who has a live-in caregivers and citizens without live-in  
21 caregivers.

22 2.9 Respondent should not automatically deem as met, in shared living situations,  
23 Petitioner's need for assistance with housekeeping, laundry, shopping, meal preparation and  
24 wood supply. Respondent should assess Petitioner's needs in the same way and to the same  
25 extent and should provide services to meet those assessed needs in the same way and to the  
26

FINDINGS OF FACT, CONCLUSIONS OF LAW AND  
ORDER - 3

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1 same extent as services are provided to meet the needs of other Medicaid recipients who do not  
2 live in a shared living situation.

3 2.10 Petitioner should receive personal care hours consistent with his unmet needs for  
4 assistance with housekeeping, laundry, shopping, and meal preparation services as determined  
5 by the assessment conducted by Respondent on February 25, 2004, or such later assessment  
6 conducted while this order is in effect, but without application of the Shared Living Rule to him.  
7 The application of retroactive and continuing benefits shall be consistent with the requirements  
8 set forth in the Court's October 21, 2005 Judgment for David Jenkins Awarding Retroactive and  
9 Continuing Benefits, Attorneys Fees and Costs.

10 2.11 Respondent acted arbitrarily and capriciously when it applied WAC 388-02-0225  
11 to Petitioner because administrative agencies, like other judicial tribunals, are required to follow  
12 the law. The agency rule leaves no alternatives for an administrative law judge when faced with  
13 a patently unconstitutional or illegal agency rule other than to dismiss the case.

14 2.12 Respondent exceeded the scope of its authority in applying WAC 388-02-0225 to  
15 Petitioner, because it fails to comport with the spirit of the Washington Administrative  
16 Procedures Act, RCW 34.05, and it is inconsistent with the Federal Administrative Procedures  
17 Act, U.S.C. Title 5. Petitioner never had the opportunity to be heard, and he was entitled to that  
18 opportunity before his benefits were reduced by about fifteen percent. Petitioner and people  
19 similarly situated should have the opportunity to establish, prior to the termination of benefits,  
20 that the agency rule does not fit them and that they should have relief from the rule. The  
21 opportunity to come into court 14 or 16 months after the fact is an insufficient remedy.

22 2.13 Application of WAC 388-02-0225 to Petitioner is unconstitutional under the  
23 state and federal Due Process clauses because it precludes Petitioner from receiving a pre or  
24 post deprivation hearing without a notice and opportunity to be heard. It is constitutionally  
25 deficient for Respondent to purport not to allow this sort of relief at the agency level, when the  
26 Constitution supersedes the promulgation of administrative agency rules.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND  
ORDER - 4

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1 rule to him. Benefits will be retroactive to December 2004, the date the Shared Living Rule was  
2 applied to Petitioner's case. The application of retroactive and continuing benefits shall be  
3 consistent with the requirements set forth in the Court's October 21, 2005 Judgment for David  
4 Jenkins Awarding Retroactive and Continuing Benefits, Attorneys Fees and Costs.

5 3.6 So long as this order is in effect, Respondent shall not automatically deem as  
6 met, in shared living situations, Petitioner's need for assistance with housekeeping, shopping,  
7 laundry, meal preparation and wood supply, but shall assess those needs in the same way and to  
8 the same extent and shall provide services to meet those assessed needs in the same way and to  
9 the same extent as services are provided to meet the needs of other Medicaid recipients who do  
10 not live in a shared living situation.

11 3.7 Application of WAC 388-02-0225 to Petitioner is declared invalid on  
12 constitutional grounds.

13 3.8 Application of WAC 388-02-0225 to Petitioner is declared invalid because it  
14 deprives Petitioner of his constitutionally protected right under state and federal Due Process to  
15 a forum that affords him notice and opportunity to be heard *before* being deprived of his life-  
16 sustaining benefits. Respondent should not have removed Petitioner's benefits until after a full  
17 hearing on the matter. Wash. Const. Art. I, §3; U.S. Const. Art. XIV.

18 3.9 Application of WAC 388-02-0225 to Petitioner is invalid on the grounds that it  
19 prevents administrative law judges from following the law by preventing them from declaring  
20 application of an administrative rule to Petitioner is invalid even when faced with a patently  
21 unlawful or unconstitutional rule.

22 3.10 Application of WAC 388-02-0225 to Petitioner is invalid as exceeding the scope  
23 of Respondent's authority because the agency rule fails to comport with the spirit of the  
24 Washington Administrative Procedures Act, RCW 34.05, and it is inconsistent with the Federal  
25 Administrative Procedures Act, U.S.C. Title 5.

26  
FINDINGS OF FACT, CONCLUSIONS OF LAW AND  
ORDER - 6

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1           3.11 Application of WAC 388-02-0225 to Petitioner is invalid because it does not  
2 further judicial economy when it forces patients like Petitioner to resolve some of his issues at  
3 the agency level and others at the Superior Court level; it is an extremely burdensome resolution  
4 process which is exacerbated for a COPEs beneficiary like Petitioner, who has limited financial  
5 means and serious health conditions.

6           3.12 Petitioner shall be entitled to reasonable attorneys' fees and costs as set forth in  
7 the Court's October 21, 2005 Judgment for David Jenkins Awarding Retroactive and  
8 Continuing Benefits, Attorneys Fees and Costs.

9           3.13 The application of this order shall apply only to the benefit of Petitioner as  
10 required for an invalidation of an agency rule arising from an agency order.

11           3.14 The administrative order applying the Share Living Rule and WAC 388-02-0225  
12 to Petitioner's case is reversed.

13  
14 Dated this 14 day of Nov, 2005.

15  
16  
17   
18 JUDGE COURT COMMISSIONER

19 Presented by:

20 FOSTER PEPPER & SHEFELMAN PLLC

21   
22 Gregory K. McBroom, WSBA No. 35155  
23 Rajiv Nagaich, WSBA No. 32991  
24 Attorneys for Petitioner, David J. Jenkins

25 JUDGE BRUCE HILYER

26  
FINDINGS OF FACT, CONCLUSIONS OF LAW AND  
ORDER - 7

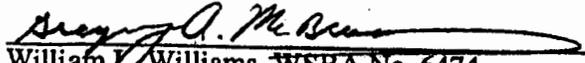
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Approved as to form;  
notice of presentation waived:

ATTORNEY GENERAL'S OFFICE

*SIGNATURE AUTHORITY BY EMALC.*



William E. Williams, WSBA No. 6474  
Donna Turner Cobb, WSBA No. 11201  
Assistant Attorney General  
Attorney for Respondent, DSHS

FINDINGS OF FACT, CONCLUSIONS OF LAW AND  
ORDER - 8

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OCT 25 2005

OFFICE OF THE ATTORNEY GENERAL  
SOCIAL & HEALTH SERVICES DIV  
OLYMPIA

SUPERIOR COURT OF WASHINGTON IN AND FOR KING COUNTY

DAVID J. JENKINS

Petitioner,

v.

WASHINGTON STATE DEPARTMENT OF  
SOCIAL AND HEALTH SERVICES,

Respondent.

THE HONORABLE JUDGE  
BRUCE HILYER

Docket No. 04-2-40867-9 SEA

(PROPOSED) JUDGMENT FOR  
DAVID JENKINS AWARDED  
RETROACTIVE AND CONTINUING  
BENEFITS, ATTORNEYS' FEES AND  
COSTS

(Clerk's Action Required)

JUDGMENT SUMMARY

Respondent/Judgment Debtor: Department of Social and Health Services

Jonathan W. Milstein  
900 Fourth Avenue, Suite 200  
Seattle, WA 98164  
(206) 464-7744

Donna Turner Cobb  
William L. Williams  
670 Woodland Square Loop SE  
Olympia, WA 98504-0124  
(360) 459-6558

Petitioner/Judgment Creditor: David Jenkins

Gregory A. McBroom  
Foster Pepper & Shefelman PLLC

JUDGMENT FOR DAVID JENKINS - 1

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1 1111 Third Ave. Ste 3400  
2 Seattle, WA 98101  
206-447-8916

3 Rajiv Nagaich  
4 31919 Sixth Avenue South, Suite A-100  
5 Federal Way, WA 98003  
Phone: (253) 838-3454

6 Retroactive Benefits (thru 8/22/05): \$2,393.56\*  
7 Attorneys' Fees: ~~\$57,142.50~~ \$ 33,659.00  
8 Costs: \$1,551.92  
9 Total ~~\$61,087.98~~ \$ 35,166.92 + Post Judgment Interest\*\*  
10

11 \* Includes pre-judgment interest of \$98.84 (12/31/04 through 8/22/05).

12 \*\* RCW 4.56.110(4) specifies requirements for post judgment interest.

13 PROCEDURAL FINDINGS BACK GROUND

14 This matter was heard on August 22, 2005 before the Honorable Judge Bruce Hilyer.  
15 Petitioner, David Jenkins, appeared by and through his attorneys of record, Gregory A.  
16 McBroom, Foster Pepper & Shefelman, PLLC, and Rajiv Nagaich, Johnson & Nagaich, PS.  
17 Respondent, the Department of Social and Health Services, appeared by and through its attorney  
18 of record, Jonathan Milstein, Assistant Attorney General.

19 The court received evidence offered by the parties, considered the pleadings filed in the  
20 action and heard oral argument of the parties' counsel. At the conclusion of the hearing, the  
21 court rendered an oral decision in favor of Petitioner and entered the Findings of Fact,  
22 Conclusions of Law; Declaratory Judgment and Order Granting Relief from Administrative  
23 Orders (hereinafter "FF&CL"). A copy of oral decision and FF&CL is attached as Exhibit A  
24 and B, respectively. The court invalidated the shared living rule, currently embodied in WAC  
25 388-106-0130(3)(b) and previously embodied in WAC 388-71-0460(3) and WAC 388-72A-  
26 0095(1)(c). It also invalidated WAC 388-02-0225.

JUDGMENT FOR DAVID JENKINS - 2

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1 In addition to invalidating the agency rules, the court awarded David Jenkins retroactive  
2 benefits, which were to be calculated without the automatic shared living rule reduction. It also  
3 awarded David Jenkins attorneys' fees and costs consistent with RCW 74.08.080(3).

4 Retroactive Benefits. The Respondent terminated David Jenkins' benefits as a result of  
5 the shared living rule at the end of November 2005 (after the Administrative Law Judge  
6 dismissed the case without hearing the matter because of WAC 388-02-0225). The retroactive  
7 benefits calculation runs through the date of ~~judgment~~, August 22, 2005, and it does not include  
8 benefits for the month of August (since benefits are not paid until the end of the month), *SEPT OR OCTUBER*  
9 *2005.*

10 The retroactive benefits account for the eight-month period running from December  
11 2004 through the end of July. In November 2005, David Jenkins received 185 benefit hours per  
12 month. As a result of the shared living rule adjustment, his benefits were reduced to 153 hours  
13 per month beginning in December 2004 – a difference of 32 hours per month. Paul Racchetta,  
14 David Jenkin's caregiver is paid \$9.20 per benefit hour.

15 The total amount that David Jenkins should have received during this eight month period  
16 is (7 months x 32 hours per month x \$8.93 per benefit hour) + (1 month x 32 hours per month x  
17 \$9.20 per benefit hour) = \$2,294.72. In addition, pre-judgment interest applies to sum certain  
18 amounts. *Hansen v. Rothaus*, 107 Wn.2d 468, 472. The amount of pre-judgment interest is  
19 determined on the same basis as the entitlement for post-judgment interest. *Bailie*  
20 *Communications, Ltd., v. Trend Business Sys., Inc.*, 61 Wn. App. 151, 162, 810 P.2d 12 (1991)  
21 (“[a] claimant's entitlement to prejudgment interest in an appropriate case is of the same order as  
22 the same party's entitlement to post-judgment interest). Applying a 12% interest rate per annum  
23 to the \$2,294.72 over the eight-month period yields a total retroactive benefit amount of  
24 \$2,393.56.

25 Attorneys' fees and Costs. Petitioner has submitted a fee and cost report, concurrent  
26 with this filing, detailing reasonable attorneys' fees and costs and consistent with RCW

1 74.08.080(3) ("[i]n the event that the superior court . . . renders a decision in favor of the  
2 appellant, said appellant shall be entitled to reasonable attorneys' fees and costs").)

3 **JUDGMENT**

4 THIS MATTER came before the court on the Petitioner's Application for Retroactive  
5 Benefits, Attorneys' Fees and Costs. The court reviewed the materials submitted, including (1)  
6 the Findings of Fact, Conclusions of Law; Declaratory Judgment and Order Granting Relief  
7 from Administrative Orders; (2) the Petitioner's Application for Retroactive and Continuing  
8 Benefits, Attorneys' Fees and Costs, (3) the Declaration of Gregory A. McBroom in Support of  
9 Retroactive Benefits for David Jenkins, Attorneys' Fees, and Costs; (4) the Declaration of Rajiv  
10 Nagaich Regarding Attorney Fees; and (4) all the briefings and pleadings submitted in this  
11 matter. The court considered the factors set forth in *Absher Const. Co. v. Kent School Dist. No.*  
12 *415*, 79 Wn. App. 841(1995) and *Allard v. First Interstate Bank*, 112 Wn.2d 145, 149 (1989),  
13 and determined that the hourly rates of the attorneys and the time spent was reasonable. The  
14 court also considered RCW 74.08.080(3), and determined that the attorneys' fees and costs  
15 associated with the litigation were recoverable.

16 THE AMOUNT OF FEES INVOLVED HAVE BEEN DETERMINED BY  
17 THE COURT APPLYING THE RELEVANT FACTORS AND REFLECT  
18 (A) A REDUCTION OF APPROX \$ 596 + PER LEGAL  
19 WORK AT THE INDIVIDUAL LEVEL HOWEVER,  
20 (B) MOST OF THE LEGAL RESEARCH AT THE ADMINISTRATIVE  
21 LEVEL, WHICH WAS PRESUMABLY ALSO USED AT  
22 THE SUPERIOR COURT LEVEL, WAS NOT REDUCED  
23 (C) NO AWARD OF ATTORNEYS FEES FOR CO-COUNSEL  
24 BECAUSE THERE IS NO JUSTIFICATION FOR NEEDING  
25 2 LAW FIRMS, THERE IS NO APPARENT REASONABLE  
26 DIVISION OF LABOR AND SOME OF THE INDIVIDUAL  
BILLING ITEMS ARE NOT REASONABLE I.E. 6.0 HOURS  
FOR A LENGTHY DISCUSSION + REVIEW; 6.0 HOURS FOR A LTR  
ATTY TO ANOTHER COURT ETC.

JUDGMENT FOR DAVID JENKINS - 4  
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WITH THE 2000 FEE  
Allowed \$ 35166.92  
+ 2500.00  
50577588.1  
37666.92

(C) UNDER RCW 74.08.080(3)  
IS NOT LIMITED TO STATUTORY COSTS ALA RCW 48Y010  
BUT THE FULL AMOUNT OF \$ 1512.92 IS AWARD,



## SCOPE AND DEFINITIONS

388-106-0005 What is the purpose and scope of this chapter?

388-106-0010 What definitions apply to this chapter?

## SCOPE AND DEFINITIONS

**WAC 388-106-0005** What is the purpose and scope of this chapter? This chapter applies to applicants and recipients of long-term care services.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0005, filed 5/17/05, effective 6/17/05.]

**WAC 388-106-0010** What definitions apply to this chapter? "Ability to make self understood" means how you make yourself understood to those closest to you; express or communicate requests, needs, opinions, urgent problems and social conversations, whether in speech, writing, sign language, symbols, or a combination of these including use of a communication board or keyboard:

(a) Understood: You express ideas clearly;

(b) Usually understood: You have difficulty finding the right words or finishing thoughts, resulting in delayed responses; or requires some prompting to make self understood;

(c) Sometimes understood: You have limited ability, but are able;

(d) Rarely/never understood.

"Activities of daily living (ADL)" means the following:

(a) Bathing: How you take a full-body bath/shower, sponge bath, and transfer in/out of tub/shower.

(b) Bed mobility: How you move to and from a lying position, turn side to side, and position your body while in bed.

(c) Body care: How you perform with passive range of motion, applications of dressings and ointments or lotions to the body and pedicure to trim toenails and apply lotion to feet. In adult family homes, contracted assisted living, enhanced adult residential care, and enhanced adult residential care-specialized dementia care facilities, dressing changes using clean technique and topical ointments must be performed by a licensed nurse or through nurse delegation in accordance with chapter 246-840 WAC. Body care excludes:

(i) Foot care if you are diabetic or have poor circulation; or

(ii) Changing bandages or dressings when sterile procedures are required.

(d) Dressing: How you put on, fasten, and take off all items of clothing, including donning/removing prosthesis.

(e) Eating: How you eat and drink, regardless of skill. Eating includes any method of receiving nutrition, e.g., by mouth, tube or through a vein.

(f) Locomotion in room and immediate living environment: How you move between locations in your room and immediate living environment. If you are in a wheelchair, locomotion includes how self-sufficient you are once in your

wheelchair.

(g) Locomotion outside of immediate living environment including outdoors: How you move to and return from more distant areas. If you are living in a boarding home or nursing facility (NF), this includes areas set aside for dining, activities, etc. If you are living in your own home or in an adult family home, locomotion outside immediate living environment including outdoors, includes how you move to and return from a patio or porch, backyard, to the mailbox, to see the next-door neighbor, etc.

(h) Walk in room, hallway and rest of immediate living environment: How you walk between locations in your room and immediate living environment.

(i) Medication management: Describes the amount of assistance, if any, required to receive medications, over the counter preparations or herbal supplements.

(j) Toilet use: How you use the toilet room, commode, bedpan, or urinal, transfer on/off toilet, cleanse, change pad, manage ostomy or catheter, and adjust clothes.

(k) Transfer: How you move between surfaces, i.e., to/from bed, chair, wheelchair, standing position. Transfer does not include how you move to/from the bath, toilet, or vehicle.

(l) Personal hygiene: How you maintain personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands (including nail care), and perineum (menses care). Personal hygiene does not include hygiene in baths and showers.

**"Aged person"** means a person sixty-five years of age or older.

**"Agency provider"** means a licensed home care agency or a licensed home health agency having a contract to provide long-term care personal care services to you in your own home.

**"Application"** means a written request for medical assistance or long-term care services submitted to the department by the applicant, the applicant's authorized representative, or, if the applicant is incompetent or incapacitated, someone acting responsibly for the applicant. The applicant must submit the request on a form prescribed by the department.

**"Assessment details"** means a summary of information that the department entered into the CARE assessment describing your needs.

**"Assessment or reassessment"** means an inventory and evaluation of abilities and needs based on an in-person interview in your own home or your place of residence, using CARE.

**"Assistance available"** means the amount of informal support available if the need is partially met. The department determines the amount of the assistance available using one of four categories:

- (a) Less than one-fourth of the time;
- (b) One-fourth to one-half of the time;
- (c) Over one-half of the time to three-fourths of the time; or
- (d) Over three-fourths of the time.

**"Assistance with body care"** means you need assistance with:

- (a) Application of ointment or lotions;

- (b) Trimming of toenails;
- (c) Dry bandage changes; or
- (d) Passive range of motion treatment.

**"Assistance with medication management"** means you need assistance managing your medications. You are scored as:

(a) Independent if you remember to take medications as prescribed and manage your medications without assistance.

(b) Assistance required if you need assistance from a nonlicensed provider to facilitate your self-administration of a prescribed, over the counter, or herbal medication. Assistance required includes reminding or coaching you, handing you the medication container, opening the container, using an enabler to assist you in getting the medication into your mouth, and placing the medication in your hand. This does not include assistance with intravenous or injectable medications. You must be aware that you are taking medications.

(c) Self-directed medication assistance/administration if you are a person with a functional disability who is capable of and who chooses to self-direct your medication assistance/administration.

(d) Must be administered if you must have medications placed in your mouth or applied or instilled to your skin or mucus membrane. Administration must either be performed by a licensed professional or delegated by a registered nurse to a qualified caregiver (per chapter 246-840 WAC). Intravenous or injectable medications may never be delegated. Administration may also be performed by a family member or unpaid caregiver if facility licensing regulations allow.

**"Authorization"** means an official approval of a departmental action, for example, a determination of client eligibility for service or payment for a client's long-term care services.

**"Blind person"** means a person determined blind as described under WAC 388-511-1105 by the division of disability determination services of the medical assistance administration.

**"Categorically needy"** means the status of a person who is eligible for medical care under Title XIX of the Social Security Act.

**"Client"** means an applicant for service or a person currently receiving services from the department.

**"Current"** means a behavior occurred within seven days of the CARE assessment date, including the day of the assessment. Behaviors that the department designates as current must include information about:

- (a) Whether the behavior is easily altered or not easily altered; and
- (b) The frequency of the behavior.

**"Decision making"** means your ability and actual performance in making everyday decisions about tasks or activities of daily living. The department determines whether you are:

(a) Independent: Decisions about your daily routine are consistent and organized; reflecting your lifestyle, choices, culture, and values.

(b) Modified independence/difficulty in new situations: You have an organized daily routine, are able to make decisions in familiar situations, but experience some difficulty in decision making when faced with new tasks or

situations.

(c) Moderately impaired/poor decisions; unaware of consequences: Your decisions are poor and you require reminders, cues and supervision in planning, organizing and correcting daily routines. You attempt to make decisions, although poorly.

(d) Severely impaired/no or few decisions or preferences regarding ADLs: Decision making is severely impaired; you never/rarely make decisions.

**"Department"** means the state department of social and health services, aging and disability services administration or its designee.

**"Designee"** means area agency on aging.

**"Difficulty"** means how difficult it is or would be for you to perform an instrumental activity of daily living (IADL). This is assessed as:

(a) No difficulty in performing the activity;

(b) Some difficulty in performing the activity (e.g., you need some help, are very slow, or fatigue easily); or

(c) Great difficulty in performing the activity (e.g., little or no involvement in the activity is possible).

**"Disabling condition"** means you have a medical condition which prevents you from self performance of personal care tasks without assistance.

**"Estate recovery"** means after the client's death, the department's activity in recouping funds that were expended for long-term care services provided to the client during the client's lifetime, per WAC 388-527-2742.

**"Home health agency"** means a licensed:

(a) Agency or organization certified under Medicare to provide comprehensive health care on a part-time or intermittent basis to a patient in the patient's place of residence and reimbursed through the use of the client's medical identification card; or

(b) Home health agency, certified or not certified under Medicare, contracted and authorized to provide:

(i) Private duty nursing; or

(ii) Skilled nursing services under an approved Medicaid waiver program.

**"Income"** means income as defined under WAC 388-500-0005.

**"Individual provider"** means a person employed by you to provide personal care services in your own home. See WAC 388-71-0500 through 388-71-05909.

**"Disability"** is described under WAC 388-511-1105.

**"Informal support"** means a person or resource that is available to provide assistance without home and community program funding.

**"Institution"** means medical facilities, nursing facilities, and institutions for the mentally retarded. It does not include correctional institutions.

**"Instrumental activities of daily living (IADL)"** means routine activities performed around the home or in the community and includes the following:

(a) Meal preparation: How meals are prepared (e.g., planning meals, cooking, assembling ingredients, setting out food, utensils, and cleaning up after meals). NOTE: The department will not authorize this IADL to plan meals or clean up after meals. You must need assistance with actual meal preparation.

(b) Ordinary housework: How ordinary work around the house is performed (e.g., doing dishes, dusting, making bed, tidying up, laundry).

(c) Essential shopping: How shopping is completed to meet your health and nutritional needs (e.g., selecting items). Shopping is limited to brief, occasional trips in the local area to shop for food, medical necessities and household items required specifically for your health, maintenance or well-being. This includes shopping with or for you.

(d) Wood supply: How wood is supplied (e.g., splitting, stacking, or carrying wood) when you use wood as the sole source of fuel for heating and/or cooking.

(e) Travel to medical services: How you travel by vehicle to a physician's office or clinic in the local area to obtain medical diagnosis or treatment-includes driving vehicle yourself, traveling as a passenger in a car, bus, or taxi.

(f) Managing finances: How bills are paid, checkbook is balanced, household expenses are managed. The department cannot pay for any assistance with managing finances.

(g) Telephone use: How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed).

**"Long-term care services"** means the services administered directly or through contract by the aging and disability services administration and identified in WAC 388-106-0015.

**"Medicaid"** is defined under WAC 388-500-0005.

**"Medically necessary"** is defined under WAC 388-500-0005.

**"Medically needy (MN)"** means the status of a person who is eligible for a federally matched medical program under Title XIX of the Social Security Act, who, but for income above the categorically needy level, would be eligible as categorically needy. Effective January 1, 1996, an AFDC-related adult is not eligible for MN.

**"Own home"** means your present or intended place of residence:

(a) In a building that you rent and the rental is not contingent upon the purchase of personal care services as defined in this section;

(b) In a building that you own;

(c) In a relative's established residence; or

(d) In the home of another where rent is not charged and residence is not contingent upon the purchase of personal care services as defined in this section.

**"Past"** means the behavior occurred from eight days to five years of the assessment date. For behaviors indicated as past, the department determines whether the behavior is addressed with current interventions or whether no interventions are in place.

**"Personal aide"** is defined in RCW 74.39.007.

**"Personal care services"** means physical or verbal assistance with activities of daily living (ADL) and instrumental activities of daily living (IADL) due to your functional limitations. Assistance is evaluated with the use of assistive devices.

**"Physician"** is defined under WAC 388-500-0005.

**"Plan of care"** means assessment details and service summary generated by CARE.

**"Provider or provider of service"** means an institution, agency, or person:

- (a) Having a signed department contract to provide long-term care client services; and
- (b) Qualified and eligible to receive department payment.

**"Residential facility"** means a licensed adult family home under department contract or licensed boarding home under department contract to provide assisted living, adult residential care or enhanced adult residential care.

**"Self performance for ADLs"** means what you actually did in the last seven days before the assessment, not what you might be capable of doing. Coding is based on the level of performance that occurred three or more times in the seven-day period. Your self performance is scored as:

- (a) Independent if you received no help or oversight, or if you needed help or oversight only once or twice;
- (b) Supervision if you received oversight (monitoring or standby), encouragement, or cueing three or more times;
- (c) Limited assistance if you were highly involved in the activity and given physical help in guided maneuvering of limbs or other non-weight bearing assistance on three or more occasions. For bathing, limited assistance means physical help is limited to transfer only;
- (d) Extensive assistance if you performed part of the activity, but on three or more occasions, you needed weight bearing support or you received full performance of the activity during part, but not all, of the activity. For bathing, extensive assistance means you needed physical help with part of the activity (other than transfer);
- (e) Total dependence if you received full caregiver performance of the activity and all subtasks during the entire seven-day period from others. Total dependence means complete nonparticipation by you in all aspects of the ADL; or
- (f) Activity did not occur if you or others did not perform an ADL over the last seven days before your assessment. The activity may not have occurred because:
  - (i) You were not able (e.g., walking, if paralyzed);
  - (ii) No provider was available to assist; or
  - (iii) You declined assistance with the task.

**"Self performance for IADLs"** means what you actually did in the last seven days before the assessment, not what you might be capable of doing. Coding is based on the level of performance that occurred three or more times in the seven-day period. Your self performance is scored as:

- (a) Independent if you received no help, set-up help, or supervision;

- (b) Supervision if you received set-up help or arrangements only;
- (c) Limited assistance if you sometimes performed the activity yourself and other times needed assistance;
- (d) Extensive assistance if you were involved in performing the activity, but required cueing/supervision or partial assistance at all times;
- (e) Total dependence if you needed the activity fully performed by others; or
- (f) Activity did not occur if you or others did not perform the activity in the last seven days before the assessment.

**"Service summary"** is CARE information which includes: Contacts (e.g. emergency contact), services the client is eligible for, number of hours or residential rates, personal care needs, the list of formal and informal providers and what tasks they will provide, a provider schedule, referral needs/information, and dates and agreement to the services.

**"SSI-related"** is defined under WAC 388-500-0005.

**"Status"** means the amount of informal support available. The department determines whether the ADL or IADL is:

- (a) Met, which means the ADL or IADL will be fully provided by an informal support;
- (b) Unmet, which means an informal support will not be available to provide assistance with the identified ADL or IADL;
- (c) Partially met, which means an informal support will be available to provide some assistance, but not all, with the identified ADL or IADL; or
- (d) Client declines, which means you do not want assistance with the task.

**"Supplemental Security Income (SSI)"** means the federal program as described under WAC 388-500-0005.

**"Support provided"** means the highest level of support provided (to you) by others in the last seven days before the assessment, even if that level of support occurred only once.

- (a) No set-up or physical help provided by others;
- (b) Set-up help only provided, which is the type of help characterized by providing you with articles, devices, or preparation necessary for greater self performance of the activity (such as giving or holding out an item that you take from others);
- (c) One-person physical assist provided;
- (d) Two- or more person physical assist provided; or
- (e) Activity did not occur during entire seven-day period.

**"You/your"** means the client.

## COMPREHENSIVE ASSESSMENT REPORTING EVALUATION (CARE) ASSESSMENT

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### CARE CLASSIFICATION

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388-106-0120 What is the payment rate that the department will pay the provider if I receive personal care services in a residential facility?

388-106-0125 How does CARE use the criteria of cognitive performance as determined under WAC 388-106-0090, clinical complexity as determined under WAC 388-106-0095, mood/behaviors as determined under WAC 388-106-0100, ADLs as determined under WAC 388-106-0105, and exceptional care as determined under WAC 388-106-0110, to place me in a classification group for in-home care?

388-106-0130 How does the department determine the number of hours I may receive for in-home care?

388-106-0135 What are the maximum hours that I can receive for in-home services?

388-106-0140 What will change the maximum hours I can receive?

## COMPREHENSIVE ASSESSMENT REPORTING EVALUATION (CARE) ASSESSMENT

**WAC 388-106-0050** **What is an assessment?** An assessment is an inventory and evaluation of abilities and needs based on an in-person interview in your home or your place of residence.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0050, filed 5/17/05, effective 6/17/05.]

**WAC 388-106-0055** **What is the purpose of an assessment?** The purpose of an assessment is to:

- (1) Determine eligibility for long-term care programs;
- (2) Identify your strengths, limitations, and preferences;
- (3) Evaluate your living situation and environment;

- (4) Evaluate your physical health, functional and cognitive abilities;
- (5) Determine availability of informal supports and other nondepartment paid resources;
- (6) Determine need for intervention;
- (7) Determine need for case management activities;
- (8) Determine your classification group that will set your payment rate for residential care or number of hours of in-home care;
- (9) Determine need for referrals; and
- (10) Develop a plan of care, as defined in WAC 388-106-0010.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0055, filed 5/17/05, effective 6/17/05.]

**WAC 388-106-0060 Who must perform the assessment?** The assessment must be performed by the department.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0060, filed 5/17/05, effective 6/17/05.]

**WAC 388-106-0065 What is the process for conducting an assessment?** The department:

- (1) Will assess you using a department-prescribed assessment tool, titled the comprehensive assessment reporting evaluation (CARE).
- (2) May request the assessment be conducted in private. However, you have the right to request that third parties be present (e.g. a friend, a family member, or a legal representative).
- (3) Has the right to end the assessment if behaviors by any party are impeding the assessment process. If an assessment is terminated, the department will reschedule.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0065, filed 5/17/05, effective 6/17/05.]

**WAC 388-106-0070 Will I be assessed in CARE?** You will be assessed in CARE if you are applying for or receiving COPEs, MNIW, MNRW, MPC, chore, respite, adult day health, GAU-funded residential care, PACE, or Private Duty Nursing. You may not be assessed by forms previously used by the department once you have been assessed under CARE.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0070, filed 5/17/05, effective 6/17/05.]

**WAC 388-106-0075 How is my need for personal care services assessed in CARE?** To assess your need for personal care services, the department gathers information from you, your caregivers, family members, and other sources. The department will assess your ability to perform:

- (1) Activities of daily living (ADL) using self performance, support provided, status and assistance available, as defined in WAC 388-106-0010. Also, the department determines your need for "assistance with body care" and "assistance with medication management," as defined in WAC 388-106-0010; and
- (2) Instrumental activities of daily living (IADL) using self performance, difficulty, status and assistance available, as defined in WAC 388-106-0010.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0075, filed 5/17/05, effective 6/17/05.]

## CARE CLASSIFICATION

**WAC 388-106-0080** How is the amount of long-term care services I can receive in my own home or in a residential facility determined? The amount of long-term care services you can receive in your own home or in a residential facility is determined through a classification system. Twelve classifications apply to clients served in residential and in-home settings. Two additional exceptional care groups apply to clients served in in-home settings. The department has assigned each classification a residential facility rate or a base number of hours you can receive in your own home.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0080, filed 5/17/05, effective 6/17/05.]

**WAC 388-106-0085** What criteria does the CARE tool use to place me in one of the classification groups? The department uses CARE to assess your characteristics. Based on this assessment, the CARE tool uses the following criteria to place you in one of the classification groups:

- (1) Cognitive performance.
- (2) Clinical complexity.
- (3) Mood/behaviors symptoms.
- (4) Activities of daily living (ADLs).

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0085, filed 5/17/05, effective 6/17/05.]

**WAC 388-106-0090** How does the CARE tool measure cognitive performance? (1) The CARE tool uses a tool called the cognitive performance scale (CPS) to evaluate your cognitive impairment. The CPS results in a score that ranges from zero (intact) to six (very severe impairment). Your CPS score is based on:

- (a) Whether you are comatose.
  - (b) Your ability to make decisions, as defined in WAC 388-106-0010 "Decision making."
  - (c) Your ability to make yourself understood, as defined in WAC 388-106-0010 "Ability to make self understood."
  - (d) Whether you have short-term memory problem (e.g. can you remember recent events?) or whether you have delayed recall; and
  - (e) Whether you score as total dependence for self performance in eating, as defined in WAC 388-106-0010 "Self performance of ADLs."
- (2) You will receive a CPS score of:
- (a) **Zero** when you do not have problems with decision-making ability, making yourself understood, or recent memory.
  - (b) **One** when you meet one of the following:
    - (i) Your decision-making ability is scored as modified independence or moderately impaired;
    - (ii) Your ability to make yourself understood is usually, sometimes, or rarely/never understood; or
    - (iii) You have a recent memory problem.
  - (c) **Two** when you meet two of the following:

- (i) Your decision-making ability is scored as modified independence or moderately impaired;
- (ii) Your ability to make yourself understood is usually, sometimes, or rarely/never understood; and/or
- (iii) You have a short-term memory problem or delayed recall.

(d) **Three** when you meet at least two of the criteria listed in subsection (2)(b) of this section and one of the following applies:

- (i) Your decision making is moderately impaired; or
- (ii) Your ability to make yourself understood is sometimes or rarely/never understood.

(e) **Four** when both of the following criteria applies:

- (i) Your decision making is moderately impaired; and
- (ii) Your ability to make yourself understood is sometimes or rarely/never understood.

(f) **Five** when your ability to make decisions is scored as severely impaired.

(g) **Six** when one of the following applies:

- (i) Your ability to make decisions is severely impaired and you require total dependence in eating; or
- (ii) You are comatose.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0090, filed 5/17/05, effective 6/17/05.]

**WAC 388-106-0095 How does the CARE tool measure clinical complexity?** The CARE tool places you in the clinically complex classification group only when you have one or more of the following criteria and corresponding ADL scores:

Condition	AND an ADL Score of
ALS (Lou Gehrig's Disease)	>14
Aphasia (expressive and/or receptive)	>=2
Cerebral Palsy	>14
Diabetes Mellitus (insulin dependent)	>14
Diabetes Mellitus (noninsulin dependent)	>14
Emphysema & Shortness of Breath (at rest or exertion) or dizziness/vertigo	>10
COPD & Shortness of Breath (at rest or exertion) or dizziness/vertigo	>10
Explicit terminal prognosis	>14
Hemiplegia	>14
Multiple Sclerosis	>14
Parkinson Disease	>14
Pathological bone fracture	>14
Quadriplegia	>14
Rheumatoid Arthritis	>14
You have one or more of the following skin problems:	
▪ Pressure ulcers, with areas of persistent skin redness;	>=2
▪ Pressure ulcers with partial loss of skin layers;	
▪ Pressure ulcers, with a full thickness lost;	

- Skin desensitized to pain/pressure;
- Open lesions; and/or
- Stasis ulcers.

AND

You require one of the following types of assistance:

- Ulcer care;
- Pressure relieving device;
- Turning/reposition program;
- Application of dressing; or
- Wound/skin care.

You have a burn(s) and you need one of the following:

- Application of dressing; or >=2
- Wound/skin care

You have one or more of the following problems:

- You are frequently incontinent (bladder);
- You are incontinent all or most of the time (bladder);
- You are frequently incontinent (bowel); or
- You are incontinent all or most of the time (bowel).

AND

>10

One of the following applies:

- The status of your individual management of bowel bladder supplies is "Uses, has leakage, needs assistance";
- The status of your individual management of bowel bladder supplies is "Does not use, has leakage"; or
- You use any scheduled toileting plan.

You have a current swallowing problem, and you are not independent in eating. >10

You have Edema. >14

You have Pain daily. >14

You need and receive a Bowel program. >10

You need Dialysis. >10

You require IV nutritional support or tube feedings; and

Your total calories received per IV or tube was at least 25%; and >=2

Your fluid intake is greater than 2 cups. >14

You need Hospice care. >14

You need Injections.	>14
You need Intravenous medications.	>10
You need management of IV lines.	>10
You need Ostomy care.	>=2
You need Oxygen therapy.	>10
You need Radiation.	>10
You need and receive Passive range of motion.	>10
You need and receive Walking training.	>10
You need Suction treatment.	>=2
You need Tracheostomy care.	>10
You need a Ventilator/respirator	>10

Key:

>means greater than.

>= means greater than or equal to.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0095, filed 5/17/05, effective 6/17/05.]

**WAC 388-106-0100 How does the CARE tool measure mood and behaviors?** (1) When you do not meet the criteria for the clinically complex classification group, or the criteria for exceptional care, or for in-home only have a cognitive performance scale score of five or six, the mood and behavior criteria listed in subsection (3) below determines your classification group.

(2) For each behavior that the CARE tool has documented, the department will determine a status as "current" or "past" as defined in WAC 388-106-0010.

(3) CARE places you in the mood and behavior classification group only if you have one or more of the behavior/moods that also meets the listed status, frequency, and alterability as identified in the following chart. No other moods or behaviors documented by CARE will qualify you for the mood and behavior classification.

Behavior/Mood	AND Status, Frequency & Alterability
Assaultive	Current
Combative during personal care	Current
Combative during personal care	In past and addressed with current interventions
Crying tearfulness	Current, frequency 4 or more days per week
Delusions	In past, addressed with current interventions
Depression score >=14	N/A
Disrobes in public	Current and not easily altered
Easily irritable/agitated	Current and not easily altered
Eats nonedible substances	Current
Eats nonedible substances	In past, addressed with current interventions
Hallucinations	Current
Hiding items	In past, addressed with current interventions
Hoarding/collecting	In past, addressed with current interventions
Mental health therapy/program	Need
Repetitive complaints/questions	Current, daily
Repetitive complaints/questions	In past, addressed with current interventions
Repetitive movement/pacing	Current, daily
Resistive to care	Current

Resistive to care	In past, addressed with current interventions
Sexual acting out	Current
Sexual acting out	In past, addressed with current interventions
Spitting	Current and not easily altered
Spitting	In past, addressed with current interventions
Breaks/throws items	Current
Unsafe smoking	Current and not easily altered
Up at night and requires intervention	Current
Wanders exit seeking	Current
Wanders exit seeking	In past, addressed with current interventions
Wanders not exit seeking	Current
Wanders not exit seeking	In past, addressed with current interventions
Yelling/screaming	Current, frequency 4 or more days per week

Key:

> means greater than.

>= means greater than or equal to.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0100, filed 5/17/05, effective 6/17/05.]

**WAC 388-106-0105 How does the CARE tool measure activities of daily living (ADLs)?** (1) CARE determines an ADL score ranging from zero to twenty-eight for each of the following ADLs.

- (a) Personal hygiene;
- (b) Bed mobility;
- (c) Transfers;
- (d) Eating;
- (e) Toilet use;
- (f) Dressing;
- (g) Locomotion in room;
- (h) Locomotion outside room; and
- (i) Walk in room.

(2) The department through the CARE tool determines the ADL score by using the definitions in WAC 388-106-0010 under "Self-performance for ADLs." The CARE tool assigns the following points to the level of self performance for each of the ADLs listed in subsection (1) of this section. For the locomotion in room, locomotion outside of room and walk in room, the department uses the highest score of the three in determining the total ADL score.

#### ADL Scoring Chart

If Self Performance is:	Score Equals
Independent	0
Supervision	1
Limited assistance	2
Extensive assistance	3

Total dependence	4
Did not occur/no provider	4
Did not occur/client not able	4
Did not occur/client declined	0

(3) Although assessed by CARE, the department does not score bathing and medication management to determine classification groups.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0105, filed 5/17/05, effective 6/17/05.]

**WAC 388-106-0110** How does the CARE tool evaluate me for the exceptional care classification of in-home care? CARE places you in the exceptional care classifications for the in-home setting when the following criteria are met in either diagram 1 or 2:

Diagram 1

You have one of the following diagnoses:

- Quadriplegia;
- Paraplegia;
- ALS (Amyotrophic Lateral Sclerosis);
- Parkinson's Disease;
- Multiple Sclerosis;
- Comatose;
- Muscular Dystrophy;
- Cerebral Palsy;
- Post Polio Syndrome; or
- TBI (traumatic brain injury).

AND

You have an ADL score of greater than or equal to 22.

AND

You need a Turning/repositioning program.

AND

You require at least one of the following:

- External catheter;
- Intermittent catheter;
- Indwelling catheter care;
- Bowel program; or
- Ostomy care

AND

You need one of the following services provided by an individual provider, agency provider, a private duty nurse, or through self-directed care:

- Active range of motion (AROM); or
- Passive range of motion (PROM).

Diagram 2

You have an ADL score of greater than or equal to 22.

AND

You need a Turning/repositioning program.

AND

You need one of the following services provided by an individual provider, agency provider, a private duty nurse, or through self-directed care:

- Active range of motion (AROM); or
- Passive range of motion (PROM).

AND

All of the following apply:

- You require IV nutrition support or tube feeding;
- Your total calories received per IV or tube was greater than 50%; and
- Your fluid intake is greater than 2 cups.

AND

You need assistance with one of the following, provided by an individual provider, agency provider, a private duty nurse, or through self-directed care:

- Dialysis; or
- Ventilator/respirator.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0110, filed 5/17/05, effective 6/17/05.]

**WAC 388-106-0115** How does CARE use the criteria of cognitive performance as determined under WAC 388-106-0090, clinical complexity as determined under WAC 388-106-0095, mood/behaviors as determined under WAC 388-106-0100, and ADLs as determined under WAC 388-106-0105 to place me in a classification group for residential facilities? The CARE tool uses the criteria of cognitive performance as determined under WAC 388-106-0090, clinical complexity as determined under WAC 388-106-0095, mood/behaviors as determined under WAC 388-106-0100, and ADLs as determined under WAC 388-106-0105 to place you into one of the following twelve residential classification groups:

Classification	ADL Score	Group
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<p style="text-align: center;"><b>Group D</b></p> <p>Cognitive performance score = 4-6</p> <p style="text-align: center;">and</p> <p>Clinically complex = yes</p> <p style="text-align: center;">and</p> <p>Mood/behavior = yes or no</p> <hr/>	<p>ADL Score 18-28</p> <p>ADL Score 13-17</p> <p>ADL Score 2-12</p>	<p>D High (12)</p> <p>D Med (11)</p> <p>D Low (10)</p>
<p style="text-align: center;"><b>Group C</b></p> <p>Cognitive performance score = 0-3</p> <p style="text-align: center;">and</p> <p>Clinically complex = yes</p> <p style="text-align: center;">and</p> <p>Mood/behavior = yes or no</p> <hr/>	<p>ADL Score 18-28</p> <p>ADL Score 9-17</p> <p>ADL Score 2-8</p>	<p>C High (9)</p> <p>C Med (8)</p> <p>C Low (7)</p>
<p style="text-align: center;"><b>Group B</b></p> <p>Mood &amp; behavior = Yes</p> <p style="text-align: center;">and</p> <p>Clinically complex = no</p> <p style="text-align: center;">and</p> <p>Cognitive performance score = 0-6</p> <hr/>	<p>ADL Score 15-28</p> <p>ADL Score 5-14</p> <p>ADL Score 0-4</p>	<p>B High (6)</p> <p>B Med (5)</p> <p>B Low (4)</p>
<p style="text-align: center;"><b>Group A</b></p> <p>Mood &amp; behavior = No</p> <p style="text-align: center;">and</p> <p>Clinically complex = No</p> <p style="text-align: center;">and</p> <p>Cognitive performance score = 0-6</p>	<p>ADL Score 10-28</p> <p>ADL Score 5-9</p> <p>ADL Score 0-4</p>	<p>A High (3)</p> <p>A Med (2)</p> <p>A Low (1)</p>

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0115, filed 5/17/05, effective 6/17/05.]

**WAC 388-106-0120** What is the payment rate that the department will pay the provider if I receive personal care services in a residential facility? The department publishes rates and/or adopts rules to establish how much

the department pays toward the cost of your care in a residential facility. The department assigns payment rates to the CARE classification groups. Payment for care in a residential facility corresponds to the payment rate assigned to the classification group in which the CARE tool has placed you.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0120, filed 5/17/05, effective 6/17/05.]

**WAC 388-106-0125** How does CARE use the criteria of cognitive performance as determined under WAC 388-106-0090, clinical complexity as determined under WAC 388-106-0095, mood/behaviors as determined under WAC 388-106-0100, ADLs as determined under WAC 388-106-0105, and exceptional care as determined under WAC 388-106-0110, to place me in a classification group for in-home care? CARE uses the criteria of cognitive performance as determined under WAC 388-106-0090, clinical complexity as determined under WAC 388-106-0095, mood/behavior as determined under WAC 388-106-0100, ADLS as determined under WAC 388-106-0105, and exceptional care as determined under WAC 388-106-0110 to place you into one of the following fourteen in-home groups.

Classification	ADL Score	Group	Base Hours of Group
<b>Group E</b>	ADL Score 26-28	E High (14)	420
Exceptional care = yes	ADL Score 22-25	E Med (13)	350
and			
Mood and behavior = yes or no			
and			
Cognitive performance score = 0-6			
<b>Group D</b>	ADL Score 18-28	D High (12)	240
Cognitive performance score = 4-6	ADL Score 13-17	D Med (11)	190
and	ADL Score 2-12	D Low (10)	145
Clinically complex = yes			
and			
Mood and behavior = yes or no			
<b>OR</b>			
Cognitive performance score = 5-6			
and			
Clinically complex = no			
and			
Mood and behavior = yes or no			

<b>Group C</b>	ADL Score 18-28	C High (9)	180
Cognitive performance score = 0-3	ADL Score 9-17	C Med (8)	140
	ADL Score 2-8	C Low (7)	83

and

Clinically complex = yes

and

Mood and behavior = yes or no

<b>Group B</b>	ADL Score 15-28	B High (6)	155
Mood and behavior = yes	ADL Score 5-14	B Med (5)	90
	ADL Score 0-4	B Low (4)	52

and

Clinically complex = no

and

Cognitive performance score = 0-4

<b>Group A</b>	ADL Score 10-28	A High (3)	78
Mood and behavior = no	ADL Score 5-9	A Med (2)	62
	ADL Score 0-4	A Low (1)	29

and

Clinically complex = no

and

Cognitive performance score = 0-4

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0125, filed 5/17/05, effective 6/17/05.]

**WAC 388-106-0130 How does the department determine the number of hours I may receive for in-home care?** (1) The department assigns a base number of hours to each classification group as described in WAC 388-106-0125.

(2) The department will deduct from the base hours to account for your informal supports, as defined in WAC 388-106-0010, as follows:

(a) The CARE tool determines the adjustment for informal supports by determining the amount of assistance available to meet your needs, assigns it a numeric percentage, and reduces the base hours assigned to the classification group by the numeric percentage. The department has assigned the following numeric values for the amount of assistance available for each ADL and IADL:

<u>Meds</u>	<u>Self Performance</u>	<u>Status</u>	<u>Assistance Available</u>	<u>Value</u>
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				Percentage
Self administration of medications	Rules for all codes apply except independent is not counted	Unmet	N/A	1
		Met	N/A	0
		Decline	N/A	0
		Partially met	<1/4 time	.9
			1/4 to 1/2 time	.7
			1/2 to 3/4 time	.5
			>3/4 time	.3

Value				
Unscheduled ADLs	Self Performance	Status	Assistance Available	Percentage
Bed mobility, transfer, walk in room, eating, toilet use	Rules apply for all codes except: Did not occur/client not able and Did not occur/no provider = 1;  Did not occur/client declined and independent are not counted.	Unmet	N/A	1
		Met	N/A	0
		Decline	N/A	0
		Partially met	<1/4 time	.9
			1/4 to 1/2 time	.7
			1/2 to 3/4 time	.5
			>3/4 time	.3

Value				
Scheduled ADLs	Self Performance	Status	Assistance Available	Percentage
Dressing, personal hygiene, bathing	Rules apply for all codes except: Did not occur/client not able and Did not occur/no provider = 1;  Did not occur/client declined and independent are not counted .	Unmet	N/A	1
		Met	N/A	0
		Decline	N/A	0
		Partially met	<1/4 time	.75
			1/4 to 1/2 time	.55
			1/2 to 3/4 time	.35
			>3/4 time	.15

Value				
IADLs	Self Performance	Status	Assistance Available	Percentage
Meal preparation, Ordinary housework, Essential shopping	Rules for all codes apply except independent is not counted.	Unmet	N/A	1
		Met	N/A	0
		Decline	N/A	0
		Partially met	<1/4 time	.3
			1/4 to 1/2 time	.2
			1/2 to 3/4 time	.1
			>3/4 time	.05

Value				
IADLs	Self Performance	Status	Assistance Available	Percentage
Travel to medical	Rules for all codes apply except independent is not counted.	Unmet	N/A	1
		Met	N/A	0
		Decline	N/A	0

Partially met	<1/4 time	.9
	1/4 to 1/2 time	.7
	1/2 to 3/4 time	.5
	>3/4 time	.3

**Key:**

> means greater than

< means less than

(b) To determine the amount of reduction for informal support, the value percentage is divided by the number of qualifying ADLs and IADLs needs. The result is value A. Value A is then subtracted from one. This is value B. Value B is divided by three. This is value C. Value A and Value C are summed. This is value D. Value D is multiplied by the "base hours" assigned to your classification group and the result is base in-home care hours reduced for informal supports.

(3) Also, the department will adjust in-home base hours for the following shared living circumstances:

(a) If there is more than one client living in the same household, the status under subsection (2)(a) of this section must be met or partially met for the following IADLs:

- (i) Meal preparation,
- (ii) Housekeeping,
- (iii) Shopping, and
- (iv) Wood supply.

(b) If you and your paid provider live in the same household, the status under subsection (2)(a) of this section must be met for the following IADLs:

- (i) Meal preparation,
- (ii) Housekeeping,
- (iii) Shopping, and
- (iv) Wood supply.

(c) When there is more than one client living in the same household and your paid provider lives in your household, the status under subsection (2)(a) of this section must be met for the following IADLs:

- (i) Meal preparation,
- (ii) Housekeeping,
- (iii) Shopping, and
- (iv) Wood supply.

(4) After deductions are made to your base hours, as described in subsections (2) and (3), the department may add on hours based on your living environment:

<u>Condition</u>	<u>Status</u>	<u>Assistance Available</u>	<u>Add On Hours</u>
<u>Offsite laundry facilities, which</u>	Unmet	N/A	8

means the client does not have facilities in own home and the caregiver is not available to perform any other personal or household tasks while laundry is done.

Client is >45 minutes from essential services (which means he/she lives more than 45 minutes one-way from a full-service market).	Unmet	N/A	5
	Met	N/A	0
	Partially met	<1/4 time	5
		between 1/4 to 1/2 time	4
		between 1/2 to 3/4 time	2
>3/4 time	2		
Wood supply used as sole source of heat.	Unmet	N/A	8
	Met	N/A	0
	Declines	N/A	0
	Partially met	<1/4 time	8
		between 1/4 to 1/2 time	6
		between 1/2 to 3/4 time	4
>3/4 time	2		

(5) The result of actions under subsections (2), (3), and (4) is the maximum number of hours that can be used to develop your plan of care. The department must take into account cost effectiveness, client health and safety, and program limits in determining how hours can be used to meet your identified needs.

(6) You and your case manager will work to determine what services you choose to receive if you are eligible. The hours may be used to authorize:

- (a) Personal care services from a home care agency provider and/or an individual provider.
- (b) Home delivered meals (i.e. a half hour from the available hours for each meal authorized).
- (c) Adult day care (i.e. a half hour from the available hours for each hour of day care authorized).
- (d) A home health aide.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0130, filed 5/17/05, effective 6/17/05.]

**WAC 388-106-0135** What are the maximum hours that I can receive for in-home services? The maximum hours that you may receive is the base hours assigned to your classification group and adjusted per WAC 388-106-0130. For chore program clients, the maximum personal care hours per month the department will pay is one hundred sixteen.

[Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-106-0135, filed 5/17/05, effective 6/17/05.]

**WAC 388-106-0140** What will change the maximum hours I can receive? When you have a change in any of the criteria listed in WAC 388-106-0125 and/or 388-106-0130, the maximum hours you can receive will change.

[Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-106-0140, filed 5/17/05, effective 6/17/05.]

**Client # 1**  
 (Not clinically complex, no cognitive impairment or mood or behavior issues )

ADL	Assistance Used In Previous 7 Days	Score
<b>Maintenance</b>		
Bathing		*
Bed Mobility	Extensive	3
Dressing	Extensive	3
Eating	Limited	2
<b>Mobility Section</b>		
Locomotion in room	Extensive	3
Locomotion outside of room	Limited	2
Walk in room	Extensive	3
<i>(Only Highest Score Counted)</i>	<b>Highest Score</b>	3
Medication management		*
Toilet use	Extensive	3
Transfer	Extensive	3
Personal hygiene	Extensive	3
<b>TOTAL ADL SCORE</b>		<b>20</b>

Not included in Calculation  
 Per WAC 388-106-105(1)

Use the Highest Score from this Group  
 Per WAC 388-106-105(2)

Not included in Calculation  
 Per WAC 388-106-105(1)

Clinically Complex	No	
Cognitive Performance Impaired	No	
Mood and Behavior	No	
Exceptional Care	No	

**Classification: ADL Score of 20 and No Other Factor = Care Group A (High)**

<b>BASE HOURS</b>		<b>78</b>
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ADL group	Status (see above)	Score
Self administration of medication	Unmet	1
<b>Scheduled ADLs</b>		
Bed mobility	Unmet	1
Transfer	Unmet	1
Walking in room	Unmet	1
Eating	Unmet	1
Toilet use	Unmet	1
<b>Scheduled ADLs</b>		
Dressing	Unmet	1
Personal hygiene	Unmet	1
Bathing	Unmet	1
<b>IADLs</b>		
Meal preparation	Met	0
Ordinary housework	Met	0
Essential shopping	Met	0
Wood supply	N/A	
Travel to Medical	Unmet	1
<b>TOTAL</b>		<b>10</b>
<b>Number of Qualifying ADLs/IADLs</b>		<b>13</b>

**CALCULATING ADJUSTMENT**

<b>TOTAL POINTS</b>		<b>10</b>
<b>Qualifying ADL/IADLS</b>		<b>13</b>
<b>VALUE "A"</b>	Total Points divided by Qual ADL	<b>0.77</b>
<b>VALUE "B"</b>	One minus Value A	<b>0.23</b>
<b>VALUE "C"</b>	Value B divided by 1/3	<b>0.08</b>
<b>VALUE "D"</b>	Value A plus Value C	<b>0.85</b>
<b>Hours of Care Auth Per-Month</b>	Base Hrs times Value D	<b>63.18</b>

which rounds to 63 hrs/mo authorized

Client # 2

(Not clinically complex and no cognitive performance problems, presents mood and behavior issues)

ADL	Assistance Used In Previous 7 Days	Score
<b>Maintenance</b>		
Bathing		*
Bed Mobility	Extensive	3
Dressing	Extensive	3
Eating	Limited	2
<b>Mobility Section</b>		
Locomotion in room	Extensive	3
Locomotion outside of room	Limited	2
Walk in room	Extensive	3
<i>(Only Highest Score Counted)</i>	<b>Highest Score</b>	3
Medication management		*
Toilet use	Extensive	3
Transfer	Extensive	3
Personal hygiene	Extensive	3
<b>TOTAL ADL SCORE</b>		<b>20</b>

Not included in Calculation  
Per WAC 388-106-105(1)

Use the Highest Score from this Group  
Per WAC 388-106-105(2)

Not included in Calculation  
Per WAC 388-106-105(1)

Clinically Complex	No	
Cognitive Performance Impaired	No	
Mood and Behavior	Yes	
Exceptional Care	No	

**Classification: ADL Score of 20 Plus Mood & Behavior = Care Group B (High)**

<b>BASE HOURS</b>		<b>155</b>
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ADL group	Status (see above)	Score
Self administration of medication	Unmet	1
<b>Scheduled ADLs</b>		
Bed mobility	Unmet	1
Transfer	Unmet	1
Walking in room	Unmet	1
Eating	Unmet	1
Toilet use	Unmet	1
<b>Scheduled ADLs</b>		
Dressing	Unmet	1
Personal hygiene	Unmet	1
Bathing	Unmet	1
<b>IADLs</b>		
Meal preparation	Met	0
Ordinary housework	Met	0
Essential shopping	Met	0
Wood supply	N/A	
Travel to Medical	Unmet	1
<b>TOTAL</b>		<b>10</b>
<b>Number of Qualifying ADLs/IADLs</b>		<b>13</b>

**CALCULATING ADJUSTMENT**

**TOTAL POINTS** 10

**Qualifying ADL/IADLS** 13

**VALUE "A"** Total Points divided by Qual ADL 0.77

**VALUE "B"** One minus Value A 0.23

**VALUE "C"** Value B divided by 1/3 0.08

**VALUE "D"** Value A plus Value C 0.85

**Hours of Care Auth Per-Month** Base Hrs times Value D 131.75 which rounds to 132 hrs/mo authorized

**Client # 3**  
**(Clinically complex and presents Mood and Behavior Issues)**

ADL	Assistance Used In Previous 7 Days	Score
<b>Maintenance</b>		
Bathing		*
Bed Mobility	Extensive	3
Dressing	Extensive	3
Eating	Limited	2
<b>Mobility Section</b>		
Locomotion in room	Extensive	3
Locomotion outside of room	Limited	2
Walk in room	Extensive	3
<i>(Only Highest Score Counted)</i>	<b>Highest Score</b>	3
Medication management		*
Toilet use	Extensive	3
Transfer	Extensive	3
Personal hygiene	Extensive	3
<b>TOTAL ADL SCORE</b>		<b>20</b>

Not included in Calculation  
Per WAC 388-106-105(1)

Use the Highest Score from this Group  
Per WAC 388-106-105(2)

Not included in Calculation  
Per WAC 388-106-105(1)

Clinically Complex	Yes
Cognitive Performance Impaired	No
Mood and Behavior	Yes
Exceptional Care	No

**Classification: ADL Score of 20, Clinically Complex Plus Mood & Behavior = Care Group C (High)**

<b>BASE HOURS</b>	<b>180</b>
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ADL group	Status (see above)	Score
Self administration of medication	Unmet	1
<b>Scheduled ADLs</b>		
Bed mobility	Unmet	1
Transfer	Unmet	1
Walking in room	Unmet	1
Eating	Unmet	1
Toilet use	Unmet	1
<b>Scheduled ADLs</b>		
Dressing	Unmet	1
Personal hygiene	Unmet	1
Bathing	Unmet	1
<b>IADLs</b>		
Meal preparation	Met	0
Ordinary housework	Met	0
Essential shopping	Met	0
Wood supply	N/A	
Travel to Medical	Unmet	1
<b>TOTAL</b>		<b>10</b>
<b>Number of Qualifying ADLs/IADLs</b>		<b>13</b>

**CALCULATING ADJUSTMENT**

<b>TOTAL POINTS</b>	<b>10</b>	
<b>Qualifying ADL/IADLS</b>	<b>13</b>	
<b>VALUE "A"</b>	Total Points divided by Qual ADL	<b>0.77</b>
<b>VALUE "B"</b>	One minus Value A	<b>0.23</b>
<b>VALUE "C"</b>	Value B divided by 1/3	<b>0.08</b>
<b>VALUE "D"</b>	Value A plus Value C	<b>0.85</b>
<b>Hours of Care Auth Per-Month</b>	Base Hrs times Value D	<b>153.00 hrs/mo authorized</b>

**Application for a §1915(c) Home and  
Community-Based Waiver [Version 3.3]**

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**Instructions, Technical Guide  
and Review Criteria**

**Release Date:  
November 2005**

***CMS***

***CENTERS for MEDICARE & MEDICAID SERVICES***

**Disabled and Elderly Health Programs Group  
Center for Medicaid and State Operations  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services**

submit a five-year waiver renewal application and a determination by CMS that, while the waiver has been in effect, the state has satisfactorily met the waiver assurances and other federal requirements, including the submission of mandatory annual waiver reports (the CMS-372(S) report). Each subsequent renewal of the waiver also requires the submission of a renewal application and a CMS determination that the state has continued to meet federal requirements.

The final approved waiver application specifies the operational features of the waiver. A state must implement the waiver as specified in the approved application. If the state wants to change a waiver while it is in effect, it must submit an amendment to CMS for its review and approval. All requests for new waivers, waiver renewals and amendments must be submitted by the state Medicaid agency. There is no limit on the number of HCBS waivers that a state may operate. In 2005, each state operated an average of six waivers. Arizona is the only state that does administer a §1915(c) HCBS waiver.

### **Waivers Granted**

§1915(c) of the Act permits the Secretary of Health and Human Services to grant waivers of three provisions of the Act so that a state may operate a HCBS waiver:

- **§1902(a)(10)(B) (Comparability).** The waiver of this provision of the Act permits a state to limit the provision of waiver services to Medicaid beneficiaries who require the level of care in an institutional setting, are in the target group(s) specified in the waiver, and offer services to waiver participants that are not provided to other Medicaid beneficiaries. All HCBS waivers operate under a waiver of this statutory provision;
- **§1902(a)(1) (Statewideness).** The Secretary may grant a waiver of this provision of the Act in order to permit a state to limit the operation of a waiver to specified geographic areas of the state; and,
- **§1902(a)(10)(C)(i)(III) (Income and Resources for the Medically Needy).** A state may request a waiver of this provision in order to apply institutional income and resources rules for the medically needy to persons in the community who otherwise qualify for waiver services.

§1915(c) of the Act does not give the Secretary the authority to waive any other additional provisions of the Act. Therefore, all other pertinent Medicaid statutory requirements apply to the operation of a waiver. By proposing to operate a HCBS waiver concurrently with a §1915(b) waiver, a state may obtain relief from certain other additional provisions of the Act.

### **Individuals Served by a Waiver**

In its application, a state must specify the group or groups of Medicaid beneficiaries who are served through the HCBS waiver. This specification has three dimensions. First, a state must specify the level or levels of institutional care that individuals must need in order to be considered for entrance into the waiver. For example, a waiver may target persons who require the nursing facility level of care. Second, a state must select the specific target group (e.g., the “aged”) that the waiver will serve from among the three basic groups that are specified in the waiver regulations. A state may further specify the waiver target group by age, condition and/or other factors. Lastly, a state must identify the Medicaid eligibility groups (e.g., Supplemental Security Income (SSI) recipients) to which waiver services are furnished. These groups may include some or all of the eligibility groups that are included in the Medicaid State plan. Also, a state may elect to apply more generous “institutional eligibility rules” to permit persons in the community to secure

### 3. Components of the Waiver Request

#### Instructions

Select whether the waiver provides for participant direction of services.

#### Technical Guidance

This part of the application summarizes the remaining components of the application. It is included to inform interested persons about the scope and contents of the application. Item E (Participant Direction of Services) is the only item in this section for which a response is required. It asks whether the waiver provides participants the opportunity to direct some or all of their waiver services. If the waiver does, then Appendix E must be completed. If not, Appendix E is not completed.

Before responding to this item, review Appendix E and its instructions. Appendix E revolves around two opportunities for participant-direction of waiver services: the participant-employer opportunity and the budget authority opportunity (these opportunities also may be combined). When a state currently does not provide for participant direction, CMS urges that serious consideration be given to affording waiver participants the opportunity to direct some or all of their waiver services. States that already provide one or both of these participant direction opportunities or want to expand the opportunities that are available to individuals must complete Appendix E.

### 4. Waiver(s) Requested

#### Overview

§1915(c) of the Act permits the Secretary to grant waivers of three specific provisions of the Act. As discussed below, all HCBS waiver programs operate under a waiver of §1902(a)(10)(B) of the Act (comparability). A state also may request waivers of two other provisions of the Act: statewideness and income/resources. Except for these waivers, HCBS waivers must comply with all other relevant provisions of the Act unless the waiver also operates concurrently with waivers granted under other authorities that permit the waiver of additional provisions of the Act. For example, under the provisions of §1902(a)(23) of the Act, waiver participants must be able to exercise free choice in selecting any willing and qualified provider of waiver services included in their service plan. Should a state wish to limit the number of providers, it must secure a waiver of §1902(a)(23) (e.g., by separately requesting a waiver under the provisions of §1915(b) of the Act).

#### Item 4-A: Comparability

##### Technical Guidance

§1902(a)(10)(B) of the Act provides that Medicaid services must be available to all categorically eligible individuals on a comparable basis (e.g., services available to adult beneficiaries with disabilities cannot be different in their amount, scope and duration from the services that are available to other adult beneficiaries). HCBS waivers target services only to specified groups of beneficiaries (e.g., persons with developmental disabilities or older persons) rather than making them available to all beneficiaries. Thus, a waiver of §1902(a)(10)(B) is an integral and necessary feature of all HCBS waivers. HCBS waivers also include services that are not otherwise available under the State plan and thus not available to

beneficiaries who do not participate in the waiver. In order to make those services available, a waiver of comparability also is necessary. The waiver application incorporates the request for a waiver of §1902(a)(10)(B). Submission of the application constitutes the state's request for this waiver.

#### **Item 4-B: Income and Resources for the Medically Needy**

##### **Instructions**

Select whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy

##### **Technical Guidance**

If the state elects to cover the medically needy under the waiver, it may request a waiver of §1902(a)(10)(C)(i)(III) of the Act so that it may waive the community income and resource rules that apply to the medically needy and, instead, apply institutional income and resource eligibility rules. Institutional income and resource rules are more generous than community rules. Application of institutional deeming rules means that income and resources are not deemed to the person from a spouse or parent; thus making an individual eligible for Medicaid who might not otherwise qualify. This permits covering under a waiver medically needy individuals who would not be eligible for waiver services under the community rules, but would be eligible under institutional rules. If the waiver serves the medically needy, indicate whether or not this section is waived. If the state does not serve the medically needy under its State plan, check "not applicable." It is important to point out that the waiver of this provision of the Act only applies to the medically needy and that population must be served under the State plan in order for a waiver of §1902(a)(10)(c)(i)(III) to be requested.

##### **CMS Review Criteria**

When a waiver of §1902(a)(10)(C)(i)(III) is requested:

- The state must cover the medically needy in the State plan
- The state must include the medically needy in the eligibility groups that may receive waiver services as provided in Appendix B-4 of the application

#### **Item 4-C: Statewide**

##### **Instructions**

Select whether a waiver of statewide is requested. If a waiver is requested, specify the type or types of waivers of statewide that are requested and provide the information that is specified.

##### **Technical Guidance**

§1902(a)(1) of the Act requires that the Medicaid State plan be in effect in all political subdivisions of the State. As provided in §1915(c)(3) of the Act, a state may request a waiver of §1902(a)(1) of the Act in order to operate a waiver on a less than statewide basis. The Version 3.3 HCBS waiver application provides for requesting two types of waivers of statewide:

- **Geographic Limitation.** A state may request a waiver of statewide in order to furnish waiver services only to eligible persons who reside in specific geographic areas (e.g., state planning regions or human services catchment areas) or political subdivisions (e.g., counties or municipalities) of the state. When the waiver is limited to specific *political*