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No. 57411-6-I

COURT OF APPEALS
DIVISION I
OF THE STATE OF WASHINGTON

DAVID J. JENKINS
Respondent,

v.

DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Appellant.

BRIEF OF RESPONDENT

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I. INTRODUCTION

This case involves the validity of an agency rule promulgated by Appellant that *eliminates* payment for laundry, housekeeping, shopping, meal preparation, and wood supply services for Medicaid recipients with substantial illnesses and disabilities who rely upon these services for their day-to-day sustenance - commonly referred to as the Shared Living Rule. The Shared Living Rule requires live-in care providers to provide these services for free or quit. David's care provider is not willing to provide these extensive services for free, and, as such, David has two options: (1) find someone willing to work for free; or (2) be forced into a nursing home, which will cost the state even more money.

In a recent case, the Washington State, Division II Court of Appeals found this exact same rule invalid under the Medicaid Comparability Statute. *Myers v. Department of Social and Health Services*, Docket No. 33088-1-II, slip op. (March 7, 2006). The case is instructive because it is on all fours with the present case, where the trial court invalidated the agency rule on the exact same grounds.

The Shared Living Rule is disparately applied only to recipients requiring live-in care providers. It does not provide the same treatment to recipients who have care providers living outside of the home. David Jenkins needs a care provider in order to stay out of a nursing home. The

services are significantly more extensive than the types of services routinely provided by persons living together. The agency rule leaves the care provider with two choices: (1) perform the services for free or (2) terminate the care provider arrangement with the recipient.

This case also involves another agency rule, WAC 388-02-0225. This agency rule prohibits an administrative law judge (ALJ) from declaring an agency rule invalid even when he or she knows that it is patently unconstitutional or statutorily infirm. This rule has placed a significant hardship on David Jenkins, depriving him of his constitutionally protected due-process rights for a pre-deprivation hearing and requiring him to seek resolution of his dispute in two separate judicial/quasi-judicial forums. David initially filed his appeal in June 2004, and a decision was not rendered until October 2005, over 16 months after the initial filing. The process is abundantly cumbersome, extremely time consuming, expensive, and presents an extreme hardship, particularly for vulnerable Medicaid public benefit recipients like David Jenkins.

II. ASSIGNMENTS OF ERROR

1. The trial court should have invalidated the Shared Living Rule under 42 U.S.C. § 1396a(a)(23) and 42 C.F.R. § 431.51(a)(1), the Free Choice of Provider Statute and Agency Rule.
2. Should David Jenkins be awarded attorneys' fees and costs of co-counsel for David Jenkins pursuant to RCW 74.08.080(3).

III. ISSUES

1. Was the trial court correct in concluding that the Department is not entitled to deference in interpreting governing statutes that are plain and unambiguous, consistent with the *Myers* court ruling?
2. Was the trial court correct when it invalidated the Shared Living Rule under the Federal Medicaid Comparability Statute and Agency Rules when it disparately allocates benefits to similarly situated recipients within the same classification in violation of state and federal laws?
3. Was the trial court correct when it determined that the Medicaid Comparability Waiver did not apply when the Department acknowledges that it had not disclosed any details of the Shared Living Rule to the federal government, and the waiver language explicitly states that the purpose for the waiver is to “expand” benefits for recipients?
4. Did the trial court err when it found that the Shared Living Rule did not violate the Federal Choice of Provider Statute and Agency Rule when it forces a recipient to find a provider that will perform services for free or quit, and, it will force some recipients into a nursing home? This issue pertains to assignment of error No. 1.
5. Was the trial court correct when it invalidated the Shared Living Rule under the State and Federal Due Process Clauses because it imposes an irrebuttable presumption that are disfavored in Washington?
6. Was the trial court correct when it invalidated the Shared Living Rule under the Washington State Privileges and Immunities Clause when it disparately allocates benefits to similarly situated state citizens?
7. Was the trial court correct when it invalidated the Shared Living Rule under the Federal Equal Protection Clause when the operation of the rule does not rationally relate to a “need-based” resource allocation?
8. Was the trial court correct when it invalidated the Shared Living Rule under the Americans with Disabilities Act?
9. Was the trial court correct when it invalidated WAC 388-02-0225 on arbitrary and capricious grounds because it forces an Administrative Law Judge, **without exception**, to blindly apply an agency rule that is patently inconsistent with a statute or constitutional provision?

10. Was the trial court correct when it invalidated WAC 388-02-0225 for exceeding the scope of its authority under the Washington and Federal Administrative Procedures Act and state and federal law?
11. Was the trial court correct when it invalidated WAC 388-02-0225 under State and Federal Due Process when the agency rule prevents a public benefit recipient from receiving a pre or post deprivation hearing?
12. Was the trial court authorized to order back benefit payments, and costs with pre and post judgment interest to David Jenkins under the Administrative Procedures Act and RCW 74.08.080(3)?
13. Did the trial court err when it failed to award attorneys' fees for David's co-counsel pursuant to RCW 74.08.080(3)? This issue pertains to assignment of error No. 2.
14. Under RAP 14.2 and RAP 18.1, should this Court award David Jenkins attorneys' fees and costs to mitigate the impact on his limited financial resources?

III. PROCEDURAL HISTORY

In June 2004, David Jenkins filed an agency appeal of his elimination of benefits under the Shared Living Rule.¹ In November 2004, The Department dismissed David Jenkins' appeal. In December 2004, David filed a petition for judicial review in King County Superior Court. In August 2005, the trial court issued its decision. In September 2005, the Department filed a motion for reconsideration. In October 2005, the trial court denied in part and affirmed in part the Department's request

¹ The initial appeal included issues of law and fact. The issues of fact were subsequently resolved.

for reconsideration and issued the judgment for continuing and retroactive benefits, attorneys' fees and costs. This appeal followed.

IV. STATEMENT OF THE CASE

Respondent agrees with much of the Department's Statement of the Case as presented in Brief of Appellant, Section IV (pp. 7 – 22). But, the assessment process has nothing to do with the present appeal.

David Jenkins. David Jenkins is chronically ill with severe physical and mental disabilities. His mobility and dexterity is significantly impaired. CP at 205-06, 213-14, and 221-222. He has chronic pain, frequent incontinence and takes strong medications. *Id.* His condition *requires* him to have a live-in caregiver. *Id.* Among many other things, he simply cannot perform the functions of laundry, housekeeping, shopping, or meal preparation. *Id.* Although he qualifies for nursing home care, he participates in the state's Medicaid Community Options Program Entry System (COPES) program. *Id.*

The COPES program is governed under Title XIX of the Social Security Act and administered by the Department. It provides in-home services to persons like David who otherwise would require nursing home care. The COPES program provides a win-win situation because the state avoids paying for the escalating costs of nursing home care and the patient is able to continue living at home.

WAC 388-106-0130(b)(3). This case arises from an agency rule promulgated in August of 2003 that **completely eliminates** payment for shopping, housekeeping, laundry, meal preparation, or wood supply services, **but only when** the patient has a live-in care provider. AR at 4.

The original agency rule stated:

The department *will not pay* for shopping, housework, laundry, meal preparation, or wood supply when you and your individual provider, agency provider, or personal aide live in the same household.

WAC 388-71-0460(3) (emphasis added). This agency rule was applied under WAC 388-72A-0095(1)(c). Both of these rules were later repealed and superseded by WAC 388-106-0130(b)(3). The Department refers to WAC 388-106-0130(b)(3) as the “Shared Living Rule.”

The naming, however, is misleading because it operates to affect much more than “shared services” in the home; it is only applied in the not-uncommon instance when a recipient chooses to receive personal care services from a provider with whom the recipient lives.²

The Shared Living Rule is disparately applied. A patient who has a care provider who lives outside of the home and has a demonstrated need for shopping, housework, laundry, meal preparation, or wood supply

services will receive benefits to pay for the services. This is the case even if the patient has the exact same debilitating condition as the person with an in-home care provider.

If, like in the case of David Jenkins, the patient's medical condition requires a live-in care provider, then the patient will *automatically* lose benefits for payment of these services. But, if the patient's medical condition is not significant enough to require a live-in care provider, then the patient can receive the benefits by having his or her care provider live outside the home.

Furthermore, like in the case of David Jenkins, if the Department's assessment of a patient indicates that the patient needs substantial assistance with shopping, laundry, housekeeping, meal preparation, or wood supply, the patient's care provider is given two options: (1) provide the services for free; or (2) quit. This significantly interferes with the patient's right to choose the provider of his or her choice. The patient is forced to choose a provider who will provide services for free, which, in the case of David Jenkins, would force him into a nursing home situation. David simply cannot live at home without these essential services.

² The Department's brief at page 2 states: "The Department makes a *modest reduction* in the number of paid hours available to individuals" This is a callous statement for a person, like David Jenkins, who relies upon these personal care services for daily sustenance. The eliminated benefits represent a significant amount of money to care providers who receive just a few dollars above minimum wage for the services.

The Department seeks to justify the agency rule by asserting that live-in care providers should not be compensated for services that would be “naturally performed” in the home based upon a common living arrangement (i.e. services that roommates naturally perform for each other). David is not asking the Department to pay for services that benefit anyone other than himself. David agrees that a caregiver should not be paid for work that benefits the caregiver. The record, however, establishes the not-uncommon situation where the personal care services that he needs far exceed the housekeeping, meal preparation, laundry and shopping that his care provider would otherwise perform.

The Department cites a study it conducted whose purpose was to “measure the time spent performing caregiver tasks.”³ SHS-0001. The Draft Study is lacking in the usual indicators normally relied upon to determine the validity of a study, such as a description of the study’s methodology, margin of error, sampling criteria, and information regarding who performed the study under what conditions. It is clearly titled “Draft” and stamped as a “draft” on each page. SHS-0001–0004.

The Draft Study asserts that the percentage of time devoted by outside caregivers to household tasks ranged from a low of 26% to a high

³ The Time Study is not part of the record on review. The Department claims that it was part of the agency rule file, but Respondent received a full copy of the agency record from the Department, and the study is not in the agency file.

of 46%. SHS-0003. The range for caregivers who resided in the same household as their clients was narrower: 33% to 42%. SHS-0003. These figures include not only IADL services, but also “conferring with a client’s family, talking with other [sic] about the client’s needs, and reassuring or redirecting a client related to a specific behavior.” SHS-0002, last paragraph. The study does not report the actual number of hours it takes a caregiver to perform IADLs each month. The study does not provide data to distinguish clients who are clinically complex from clients who are not. There is no indication about whether the client is the only one who benefits from the work that was classified as “Household or Coordination” or “Household Without.” SHS-0001 through -0003. Although the study did not examine how much time a caregiver must spend on IADL services that benefit only the client, there is an assertion below the data table as follows:

Based on this data the group decided that the percentage reduction for shared living tasks should be approximately 15%, which appears from the time study data to be a reasonable deduction for meal preparation, shopping, and housekeeping activities.

SHS-0003.

The Department does not explain, in the study or elsewhere, how it arrived at the 15% figure. It does not relate to individual or even

generalized facts about time savings realized by recipients with live-in providers.

The services provided by David's care provider are way above and beyond services that would be "naturally performed" because of a common living arrangement. A live-in care provider should be compensated for the services he or she provides in the home on behalf of the patient, just as the Department compensates a care provider who lives outside of the home for providing the exact same services.

The services provided by David's care provider are much more extensive than services that would be "naturally performed" because of a common living arrangement. For example, David has a special medical diet, which requires shopping for specific dietary foods and requires separate meal preparation. CP at 205-06, 213-14, and 221-222. David has swallowing problems that makes meal preparation much more involved. David has incontinence at all hours of the day and night and frequent vomiting, creating a significant laundry workload. *Id.* The laundry room is also on a separate floor in the apartment building, which David cannot access due to his limited mobility. *Id.* David's physical mobility impairments also make it impossible for him to perform housekeeping or shopping duties. *Id.* This is clearly documented in David's assessment plan. CP at 342-45.

The Medicaid laws do not permit the Department to provide disparate services to like situated benefit recipients. Federal law requires that services be equal in amount, duration, and scope to all recipients within the categorically needy group (Medicaid Comparability Statute requirement). It also requires that each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose. Benefits based upon the live-in status of a care provider do not satisfy the federal law requirements for providing comparable services.

In a recent development, the Court of Appeals Division II of the State of Washington upheld another trial court's invalidation of WAC 388-106-0130(3)(b) because the court found it violated the Medicaid Comparability Statute. *See generally Myers*, Docket No. 33088-1-II, slip op. The case is instructive because it is on all fours with the present case, which invalidated the agency rule on the exact same grounds.

Furthermore, federal law requires that the states permit a patient to choose the care provider of his or her choice (Choice of Provider Statute). As indicated in the example above, forcing a live-in care provider to work for free or quit substantially interferes with the patient's right to choose a care provider. David Jenkins' care provider will leave him if he is not compensated for the services. David will then be forced into a nursing home if he cannot find a caregiver to provide the services for free.

In addition, several state and federal constitutional and statutory provisions prevent the state from discriminately applying benefits in an irrational manner as the Department does in this case. This includes the American with Disabilities Act, the Federal Equal Protection Clause, Due Process, and the Washington State Privileges and Immunities Clause. As indicated before, the Department does not have a rational basis, let alone a compelling reason, for the mandatory, automatic, and inflexible Shared Living Rule reduction in benefits.

WAC 388-02-0225. Under both state and federal due process, David Jenkins is entitled to an agency forum that affords him notice and opportunity to be heard *before* being deprived of his life-sustaining benefits. The Department stripped David Jenkins of his benefits without providing him with a notice and opportunity to be heard.

David Jenkins tried to be heard at the agency level. He filed a request for an agency hearing in June 2004. In November 2004, the Administrative Law Judge dismissed the case, indicating that she was handcuffed from ruling on the issues because WAC 388-02-0225 precluded her from ruling upon the validity of an agency rule. David Jenkins was then forced to file a petition for judicial review in December of 2004. The judgment rendered in October 2005, about **sixteen months** after his original appeal.

Making David Jenkins resolve some of his issues at the agency level and others at the Superior Court level does not further judicial economy. It is also an extremely burdensome and time consuming resolution process, which is exacerbated for a patient like David Jenkins who has limited financial means and serious health conditions. In addition, the agency rule deprives David Jenkins of his constitutionally protected due process rights. The Department should not have removed David Jenkins benefits until after a hearing, even if that means providing temporary benefits until the resolution of the dispute. WAC 388-02-0225 deprives David Jenkins of his constitutionally protected right. It strips him of a property interest without giving him a right to a hearing with notice and opportunity to be heard.

Agencies are vested with quasi-judicial authority and, as such, they are required to follow the law. If an agency concludes that a rule is not in accordance with a statute or is unconstitutional, it must follow the superior rather than subordinate law. WAC 388-02-0225, however, handcuffs an administrative law judge from declaring an agency rule invalid even if he or she knows that it is patently unlawful or unconstitutional. The agency rule also does not comport with state and federal law.

David Jenkins, therefore, requests that this Court invalidate WAC 388-02-0225 on statutory and/or unconstitutional grounds. It would be an

unnecessary limitation of the agency's role for it to blindly apply a rule inconsistent with a statute or constitutional provision. The agency must provide a hearing with notice and opportunity to be heard before stripping a patient of his or her essential benefits.

V. AUTHORITY

Issues of law involving the validity or invalidity of an agency rule are reviewed de novo. *Wenatchee Sportsmen Ass'n v. Chelan County*, 141 Wn.2d 169, 176, 4 P.3d 123 (2000). An agency rule shall be found invalid if (1) it violates the constitution, (2) it exceeds the agency's statutory authority; or (3) it is arbitrary and capricious. *Hoffman v. Regency Blue Shield*, 140 Wn.2d 121, 125, 991 P.2d 77 (2000). "Arbitrary and capricious" means a willful and unreasoned action taken without regard to or consideration of the facts and circumstances. *City of Redmond v. Cent. Puget Sound Growth Mgmt. Hearings Bd.*, 136 Wn.2d 38, 46-47, 959 P.2d 1091 (1998). A person challenging an agency rule has the burden of establishing its invalidity. *Port of Seattle v. Pollution Control Hearings Bd.*, 151 Wn.2d 568, 587, 90 P.3d 659 (2004).

1. **The Department is not entitled to deference.**

The Department is not entitled to deference because the statutes at issue are not ambiguous, and the agency has no special expertise to offer with respect to David Jenkins' constitutional claims. Although deference

is accorded to an agency's interpretation of an ambiguous statute, a reviewing court does not defer to an agency the power to determine the scope of its own authority. *U.S. West Communications, Inc. v. Utils. & Transp. Comm'n*, 134 Wn.2d 48, 56, 949 P.2d 1321 (1997).

In *Myers*, Appellant made the exact same claims that it should be entitled to deference. *Myers*, Docket No. 33088-1-II, slip op. at 8. The *Myers* court, however, held that the Department is not entitled to deference; the Medicaid Comparability Statute and Medicaid Freedom of Choice of Provider Statute are clear and unambiguous. *Id.*

Similarly, here, Appellant is not entitled to deference because the statutes are clear and unambiguous. *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 843-43 104 S.Ct. 2778, 81 L.Ed.2d 694 (1984). Furthermore, the agency has no special expertise to offer with respect to the constitutional issues.

Appellant asserts the federal government's approval of its Medicaid in-home care programs means the federal government has approved the Shared Living Rule. That approval, the argument goes, is then entitled to deference. There is no evidence in the record indicating that the Centers for Medicare and Medicaid Services (CMS) knows that the Shared Living Rule exists. An explanation about how the Shared Living Rule operates is not found in the Medicaid State Plan, which

covers the COPES Waiver Agreement between the Department and CMS. The rule-making file does not indicate that the proposed rule was ever distributed to CMS. *See* CP 260-289 and CP 300-340 (rule making file). For the reasons specified above, the trial court did not err in not giving the Department deference in this matter.

2. The Shared Living Rule violates the Comparability Laws.

The Shared Living Rule violates the Federal Medicaid Comparability Statute because it offers disparate benefits to recipients within the same classification by allocating benefits based upon the care provider's living status instead of on the medical need of the individual.

The Federal Medicaid Comparability Statute states:

(B) that the medical assistance made available to any individual described in subparagraph (A) –

(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to *any other such individual* not described in subparagraph (A);

42 U.S.C. § 1396a(a)(10)(B) (emphasis added).

The agency rule that interprets the Federal Medicaid Comparability Statute above states:

(b) The plan must provide that the services available to any individual in the following groups are equal in amount, duration, and scope *for all recipients within the group*:

- (1) The categorically needy [such as the COPES program].
- (2) A covered medically needy group.

42 C.F.R. § 440.240(b) (emphasis added).

In a recent development, a case that is on all fours with the present case, the State of Washington, Division II Court of Appeals found the Shared Living Rule invalid for violating the comparability laws. *Myers*, Docket No. 33088-1-II, slip op. The Medicaid recipients in *Myers* received benefits under the state's COPES and Medicaid Personal Care (MPC) Programs. *Myers*, Docket No. 33088-1-II, slip op. at 3. Both patients had significant debilitating conditions requiring them to have live-in care providers to perform shopping, laundry, housekeeping, and meal preparation services. *Myers*, Docket No. 33088-1-II, slip op. at 3.

The *Myers* court found that the comparability statute and agency rule was clear and unambiguous. *Myers*, Docket No. 33088-1-II, slip op. at 10. It held that the Shared Living Rule violated the comparability requirements because the Shared Living Rule reduced the recipient's benefits on considerations other than the recipient's actual need. *Myers*, Docket No. 33088-1-II, slip op. at 10. The court found that "to simply impose an automatic 15 percent reduction for all recipients ignores the realities of their individual situations." *Myers*, Docket No. 33088-1-II, slip op. at 10. The court stated, "DSHS has created a system in which

recipients like Gasper will have certain needs unmet while others with comparable disabilities will receive adequate services.” *Myers*, Docket No. 33088-1-II, slip op. at 10-11.

Other jurisdictions that have assessed the issue support this analysis. For example, in California, a state allocated disparate Methadone maintenance treatment services to Medicaid recipient’s in different counties in the state. *Sobky v. Smoley*, 855 F.Supp. 1123, 1126-28 (E.D.Cal. 1994). The disparate treatment arose because the state left it to each individual county to determine whether and in what amount of Methodone treatment services to provide. *Sobky*, 855 F.Supp. at 1128. The state alleged that that the comparability laws were not violated because those laws sought to ensure comparable services for distinct groups making up the categorically needy, not parity for individuals within those distinct groups. *Sobky*, 855 F.Supp. at 1140. The *Sobky* court, however, rejected the state’s argument based upon the plain language of the comparability statute. *Sobky*, 855 F.Supp. at 1140-41.

The *Sobky* court held that the comparability statute was plain and unambiguous and that the language of the comparability statute expressly requires that any categorically needy individual receive services not less in amount, duration, and scope than that received by “any other such individual.” *Sobky*, 855 F.Supp. at 1140-41 (quotes in original). Many

other courts have also found the comparability laws violated under similar factual scenarios. *See, e.g., Martin v. Taft*, 222 F.Supp.2d 940 (S.D. Ohio 2002) (holding that mentally and developmentally delayed individuals placed on waiting list to receive care violated the amount, duration, and scope provisions); *Schott v. Olszewski*, 401 F.3d 682 (6th Cir. 2005) (holding that failing to reimburse a Medicaid recipient who was wrongfully denied coverage violated the amount, duration, and scope provisions); *White v. Beal*, 555 F.2d 1146 (3rd Cir. 1977) (holding that providing glasses for persons with eye diseases, but not for persons with refractive error caused by poor eyesight, violated the amount, duration, and scope provisions.); *Becker v. Toia*, 439 F. Supp. 324, 333 (S.D.N.Y. 1977) (holding that the comparability provisions require that each categorically needy person “shall be eligible for the same ‘amount, duration, and scope’ of coverage as all the others in his or her group”); *Roe v. Casey*, 464 F.Supp. 487, 494 (E.D. Pa. 1978) (holding that the services available to a categorically needy person shall not be less in amount, duration, or scope, than the services made available to any other person in that particular category.).

This Court should affirm the trial court’s decision and find that the Shared Living Rule violates the Comparability laws consistent with *Myers*, *Sobky*, and the litany of other cases that have decided the issue on

the exact same grounds. The plain language of the agency rule is clear and unambiguous. It requires that assistance made available to “any individual” in a classification shall not be less in amount, duration, and scope than the medical assistance made available to “any other such individual.” 42 U.S.C. § 1396a(a)(10)(B).

The Department states:

Respondent and the superior court misread the comparability requirement as applying between recipients instead of between categorical groups.

Appellant’s Brief at 33.

The Department appears to allege that the comparability laws do not apply to persons within a categorical group. But, the Department’s interpretation is completely counter to the plain language of the comparability statute and agency rule. The statute provides “that medical assistance made available *to any individual* . . . shall not be less in amount duration, or scope than the medical assistance made available *to any other individual*” 42 U.S.C. § 1396a(a)(10)(B)(i) (emphasis added). The agency rule says that the “plan must provide that the services available to *any individual* in the following groups [the categorically needy] are equal in amount, duration, and scope *for all recipients within the group*” 42 C.F.R. § 440.240(b) (emphasis added). The plain language and the

case law interpreting the comparability laws do not support the Department's position.

The Department's Supreme Court quote from *Schweiker v. Hogan* [Appellant Brief at 34] is taken out of context. The Court in *Schweiker* concerned an equal protection challenge to § 1903(f) of the Social Security Act. It had nothing to do with the comparability laws. The only reason for the quote is because the Court was making a distinction between the medically needy and categorically needy categories, which is not in dispute.

The Department also makes the claim that the amount, duration, and scope of services available to COPES recipients are comparable. As the *Myers* court recognized, "DSHS has created a system in which recipients . . . will have certain needs unmet while others with comparable disabilities will receive adequate services." *Myers*, Docket No. 33088-1-II, slip op. at 10-11. A mandatory, automatic, and inflexible elimination of services for persons with live-in care providers does not provide for comparable services to similarly situated persons who have care providers who live outside of the home. The Shared Living Rule fails to take into consideration the individual needs of the patient.

In addition, the other agency rule interpreting the Federal Comparability Statute imposes another obligation upon the state to ensure

that the medical assistance provided to recipients is “sufficient in amount, duration, and scope to reasonably achieve its purpose.” 42 C.F.R. § 440.230(b). Courts have held that this provision is violated when the state’s decision to deny services is made for reasons other than medical necessity. *See, e.g., Weaver v. Reagan*, 886 F.2d 194, 198 (8th Cir. 1989); *White v. Beal*, 555 F.2d 1146 (3rd Cir. 1977), 1151; *Allen v. Mansour*, 681 F.Supp. 1232, 1237 (E.D. Mich. 1986); *Ledet v. Fischer*, 638 F.Supp 1288, 1293 (M.D.La. 1986). Since the Shared Living Rule is based upon the live-in status of patient’s care provider and not on medical necessity, and it leads to services that are not sufficient for the purpose of maintaining a patient like David Jenkins in his or her home (the primary purpose of the COPES program), the Shared Living Rule should also be found to violate the sufficient in amount, duration, and scope provision of the Medicaid Act -- 42 C.F.R. § 440.230(b).

3. The Department’s Comparability Waiver does not apply to the elimination of benefits under the Shared Living Rule.

The CMS waiver of the comparability provisions does not apply to the Shared Living Rule because the waiver only applies to “expanded” services; and the Department failed to disclose the Shared Living Rule to

CMS in its waiver application.⁴ The *Myers* court agrees with this analysis by holding that the state's comparability Waiver did not apply to the Shared Living Rule. *Myers*, Docket No. 33088-1-II, slip op. at 12. The *Myers* court found that the state "must describe the waiver class by defining the target groups that will receive services under the waiver." *Myers*, Docket No. 33088-1-II, slip op. at 12. The court determined that the Department could not claim that CMS waived the comparability requirement for the Shared Living Rule unless it could show that the Shared Living Rule was incorporated into the waiver application. *Myers*, Docket No. 33088-1-II, slip op. at 12.

As the Appellant points out, the COPES waiver application includes language about waiving comparability requirements. But, the Appellant fails to place that language in context. This is the paragraph the Appellant claims waives comparability:

A waiver of the amount, duration and scope of services requirements . . . is requested, *in order that services not otherwise available under the approved Medicaid State plan may be provided to individuals served on the waiver.*

CP at 1057 (Appendix 1 at 4) (emphasis added).

⁴ For the Court's convenience, Respondent has included a full copy of the waiver application in Appendix 1. The clerk's paper paginations are included in the lower right hand corner of the document. It is important to read the application for waiver as a whole to understand exactly what has been waived.

This language does not restrict waiver services; it expands them. The purpose of this provision is to permit the State to provide *additional* services that it cannot provide under the Medicaid State Plan.

Medicaid requirements apply to waiver programs unless they are specifically waived. *See, e.g., McMillan v. McCrimon*, 807 F.Supp. 475, 482 (C.D. Ill. 1992) (holding that although 42 U.S.C. §1396n(c)(3) allows the federal government to waive comparability, the statute does not allow a waiver of other Medicaid requirements set out in 42 U.S.C. §1396a(a)(8)). Furthermore, to obtain a specific waiver of a Medicaid requirement, the state's request needs to actually *mention* what it was the state desired to waive. *McMillan*, 807 F.Supp. at 482.

Appellant includes a couple excerpts from the Centers for Medicare and Medicaid Services, Instructions, Technical Guide and Review Criteria (Federal Guidance Document) in its brief. Appellant, however, conveniently fails to point out the most relevant information from the Federal Guidance Document. It states:

Services Offered Under a Waiver

A state must specify the services that are furnished through the waiver Waiver services complement the services that a state offers under its State plan

In its application, a state must specify the scope and nature of each waiver service *and any limits on amount, frequency, and duration that the state elects to apply to a service*

Appendix 2 at 1. Federal law requires the state to “Describe [in the waiver] the group or groups of individuals to whom the services will be offered.” 42 C.F.R. § 441.301(b)(3). The waiver, however, contains no such description for the Shared Living Rule.

A review of the Waiver application, however, reveals that the State did not specify any limits on amount, frequency, and duration that the state plans to apply to the Shared Living Rule. The state does not dispute that they have not informed CMS of the specifics of the Shared Living Rule.

The COPES Waiver allows recipients to avoid nursing home placement. It provides more services than Medicaid would otherwise provide in order to prevent nursing home placement. For example, the Appellant can pay for “environmental modifications” such as a wheelchair ramp at a recipient’s home under the COPES program, but not otherwise under Medicaid. The COPES Waiver allows the State to use federal Medicaid funding to pay for services to individuals that would not otherwise be paid for under Medicaid when:

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

42 U.S.C. § 1396n(c)(1).

The COPES Waiver Agreement provision regarding comparability is explicitly limited; comparability is waived only to allow provision of

services to waiver recipients not available under the State Plan. The Waiver provides COPEs recipients with all the personal care services available under the State Plan and more. For example, here is another excerpt from the Department's waiver application:

Relationship to State Plan service (Check one):

Personal care services are included in the State plan, but with limitations. *The waived service will serve as an extension of the State plan service* in accordance with documentation provided in Appendix G of this waiver request.

CP at 1069 (Appendix 1 at 16) (emphasis added).

In addition, Appendix G to the Department's COPEs Waiver application states that, "[c]lients who are institutionally eligible and receive services under the COPEs waiver *receive a full package of personal care services under the waiver including personal care and are CN medically eligible*. CP at 1150 (Appendix 1 at 97). Refusing to cover needed personal care services under the Shared Living Rule violates the State's promise to provide at least the services available under the State plan, and to provide a "full package" of personal care services to COPEs waiver recipients. This is exactly what the *Myers* court found.

4. The shared living rule is invalid because it violates State and Federal laws guaranteeing freedom of choice of provider.

A. Federal Medicaid law guarantees free provider choice.

The Shared Living Rule materially interferes with David Jenkins' right under federal law to choose any qualified provider of his choosing. Under federal law, a state must permit a patient to choose any qualified Medicaid provider of his or her choosing. 42 U.S.C. § 1396a(a)(23); 42 C.F.R. § 431.51(a)(1). The Department waiver application reiterates the right to free choice of provider:

The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers *of each service* included in his or her written plan of care.

CP at 1093 (Appendix 1 at 40).

The significance of the distinction is shown in the following example. A woman eligible for 100 hours of COPES care services has two daughters, one who lives with her and one who lives next door. If the mother chooses the daughter who lives next door as her caregiver, she gets 100 hours of services paid for by the program. If she chooses the daughter who lives with her, there is a 15% "shared living" reduction, and she gets 85 hours of paid services. In both cases, she is sharing a home with the same person. The cases are distinguished not by her living situation, but by her choice of provider.

Put another way, to get 100 hours of paid care, and in particular to get the last 15 hours of paid care, the mother must choose a provider other than the daughter who lives with her.

The shared living rule denies David Jenkins the choice guaranteed by the Social Security Act, the Code of Federal Regulations, the COPES Waiver Agreement and the Medicaid State Plan. It bars him from receiving the IADL services to which he is entitled from the qualified providers of his choice.

B. David Jenkins' care provider is a qualified, willing provider.

David Jenkins' care provider, Paul Racchetta, is an appropriate and qualified provider. The Department's contract with Mr. Racchetta indicates that he is a qualified provider. CP at 216 ("the Contractor certifies and assures DSHS that the Contractor meets the minimum qualifications for care providers in home settings")

The record in this case establishes that Paul Racchetta is qualified and willing to provide the services without the 15% shared living reduction. Although Appellant characterizes this as a "modest reduction," the amount is material to a care provider who makes just above minimum wage to perform the extensive service. CP at 219 (showing Paul Racchetta's hourly pay at \$7.18 per hour).

Appellant will contend that if the provider is unwilling to provide the last 15 percent of the hours without compensation, then he or she is not willing to be a provider. But, the issue here involves the freedom of choice of a provider for Medicaid (i.e., paid) services. What if the Appellant proposed to reduce the hours by 99% or 100% instead of 15%? Appellant could make the same argument that free choice of provider is not implicated because the client can still choose the same provider if the provider is willing to work for 1% of the prior rate, or for free. This argument, however, fails for the same reason, namely, it fails to provide the recipient with the freedom to choose a provider of *paid* care.

In its waiver application, the Department asserts that it will provide housework, laundry, meal preparation, and wood supply services on a “*fee for service basis.*” CP at 1139 (Appendix 1 at 86). The care provider should not be required to render services for free.

Appellant reduced David Jenkins’ hours of paid care based solely on its choice of providers. The Shared Living Rule requires an automatic and inflexible reduction whenever a recipient lives with his or her provider; there is no examination of need. Absent the Shared Living Rule, David Jenkins would receive 185 hours per month of care. CP at 252. The Shared Living Rule then reduces his benefits to 153 hours per month or approximately 17%. CP at 252.

The Shared Living Rule mandates a finding that IADL needs are “fully met” on an informal (unpaid) basis, even if those needs are not met. WAC 388-72A-0095(1)(c). In the shared living situation, the provider must decide whether he or she will provide some amount of personal care services for free if the recipient’s care needs with meal preparation, housekeeping, shopping, or wood supply exceed what the provider would ordinarily do for themselves or their family. David Jenkins has an individualized service plan as required by the Appellant’s agency rules and his caregiver must agree to provide the services set out in the service plan. WAC 388-71-0515. The service plan written by the Appellant for David Jenkins requires the caregiver to perform work set out in the plan; it just will not pay him for doing it.

The Appellant will cite *Antrican v. Buell*, 158 F. Supp. 2d 663 (E.D.N.C. 2001), in which the court considered a claim that the rates paid for dental care were so low that few dentists were willing to participate. *Buell* held that comparability was not necessarily violated if dental reimbursement rates were low; but the *Buell* court did not consider a requirement that dentists perform certain services for free if they agreed to provide other services paid for at the Medicaid rate. More significantly for purposes of this case, the reimbursement in *Buell* applied to all

participating dentists; here the challenged rule applies only to recipients who live in the same home as the provider.

C. The Shared Living Rule is based on provider choice.

The Shared Living Rule requires recipients to choose someone other than a live-in provider as a condition of getting services they need for meal preparation, housekeeping, shopping, laundry or wood supply. The shared living situation to which the rule applies is *defined by* an individual's choice of provider. The rule does not apply to all individuals in shared living situations, but only to individuals who live with their providers. WAC 388-72A-0095(1)(c). The shared living reduction is the direct result of a choice of provider.

D. The Shared Living Rule overshoots its alleged purpose of avoiding payment for services that benefit caregivers.

The Appellant defends the Shared Living Rule on the ground that living with a caregiver necessarily results in the caregiver's ability to perform a large part of the IADLs a recipient needs along with the caregiver's own without expending additional time. This assumption is not always true. In particular, it is not true for David Jenkins. This case is not about normal cleaning of common areas and family shopping, or about throwing an extra handful of noodles in the pot. The records in this case demonstrate IADL needs far exceeding what the caregivers perform for their own households.

Although certain household tasks must be done regardless of how many people live in the home, there is extra work when one household member is incontinent, requires a special diet, or requires extraordinary clean-up after each meal because of lower mental or physical functioning, and it takes extra time to do it. To claim otherwise is like saying it takes someone no more time to do housekeeping, shopping and meal preparation when he is single than when he has an infant or a toddler, an assertion that would amuse anyone who has lived with children.

Appellant will argue that David Jenkins' clinically complex medical conditions automatically qualify him for additional assistance with special care needs. This assertion is unsupported by the record. There is nothing in the Appellant's rules that indicates that hours are awarded to recipients, including those who are classified as clinically complex, in order to address any particular personal care need, including IADLs. A clinically complex recipient who needs no help at all with IADLs receives the *same number of hours* as a clinically complex recipient who in all other respects is identical to the first, but needs total assistance with IADLs. WAC 388-72A-0087.⁵

⁵The base rate for the clinically complex groups, such as Group C, is based on the existence of at least one clinically complex medical condition + an "ADL score" which does not consider whether the recipient does or does not need IADL assistance.

E. The shared living reduction results in loss of provider choice.

The record establishes that application of the Shared Living Rule in the case here would result in David Jenkins losing his provider of choice even for the reduced hours awarded. David Jenkins will have to ask Paul Racchetta to leave because Paul cannot provide for free a significant portion of services for which he was formerly paid. David Jenkins will also lose his provider of choice because Paul will have to seek work outside the home.

F. State law guarantees free provider choice.

Under RCW 74.39A.270(4), and consistent with the federal law requirements discussed above, home care clients (including COPES) are guaranteed “the right to select . . . any individual provider providing services to them.”⁶ Until it adopted the Shared Living Rule, Appellant’s rules were generally consistent with this strong mandate. Other Appellant rules provide that the recipient has “primary responsibility for locating, screening, hiring, supervising, and terminating an individual provider,”⁷ and that the recipient’s choice of provider can only be overridden on the

⁶ This provision codifies Initiative 775, Section 6(4). RCW 74.39A.270(4) is not ambiguous. If a statute’s meaning is plain, courts give effect to the plain meaning. *Campbell v. Department of Social and Health Services*, 150 Wn.2d 881, 894, 83 P.3d 999 (2004). If the statutory language is ambiguous, the statute’s legislative history, including legislative bill reports, may be reviewed to help determine a statute’s intent. *Greenen v. Washington State Bd. of Accountancy*, 110 P.3d 224, 227 (2005).

⁷ WAC 388-71-0505(1).

basis of a “reasonable, good faith belief that the person will be unable to appropriately meet the client’s needs.”⁸

Free choice of provider is an explicitly stated value of Washington’s long term care statutory scheme and is protected by RCW 74.39A.270(4). Provider choice is a key part of the statutory scheme designed to enable people to receive care at home. *See* RCW 74.39.001, RCW 74.39.005, RCW 74.39A.005, RCW 74.39A.007, RCW 74.39A.009(5), RCW 74.39A.050, RCW 74.39A.095(7) and (8). These last two sections, by providing hearing rights, make clear the recipient’s stake in having his or her caregiver of choice.

The Shared Living Rule cannot be reconciled with “the right to select” one’s caregiver. In effect, Appellant has amended the statutory guarantee by establishing an irrebuttable presumption that *all* recipients in shared living situations have *all* of their IADL needs met *all* the time simply because they reside with a paid caregiver.

5. The Shared Living Rule violates Due Process.

The Shared Living Rule violates the Due Process Clause of the Fourteenth Amendment of the United States Constitution because it is not rationally related to a legitimate legislative goal. The law does not permit the Department to impose *irrebuttable presumptions* bearing no rational

⁸ WAC 388-71-0546.

relation to a legitimate legislative goal. *Weinberger v. Salfi*, 422 U.S. 749, 772, 95 S. Ct. 2457, 45 L. Ed. 2d 522(1975).

To the extent that the Department appears to be saying that public assistance programs are completely immune or shielded from Due Process challenges, this is incorrect. The *Salfi* Court clearly and unequivocally said that states cannot impose laws “on the basis of criteria which bear no rational relation to a legitimate legislative goal.” *Salfi*, 422 U.S. at 772. The *Salfi* Court identified both *Jiminez v. Weinberger*, 417 U.S. 628, 94 S. Ct. 2496, 41 L. Ed. 2d 363 (1974) and *U.S. Dept. of Agriculture v. Murry*, 413 U.S. 628, 93 S. Ct. 2832, 37 L. Ed. 2d 767 (1974) as two such cases where the law was not rationally related to a legitimate legislative goal.

In *Jiminez v. Weinberger*, a father was denied Social Security benefits for his two of his nonlegitimated illegitimate children who were born after the onset of his disability. *Jiminez*, 417 U.S. at 630. The benefits were denied on the ground that the children did not meet the requirements of 42 U.S.C. § 416(h)(3), which required the childrens’ paternity to be acknowledged or affirmed through evidence of domicile and support before the onset of the father's disability. *Jiminez*, 417 U.S. at 631. The Secretary indicated that a primary purpose of the law was to prevent spurious claims and to ensure that those persons who are entitled to benefits receive payment. *Jiminez*, 417 U.S. at 634.

Although acknowledging the prevention of spurious claims was a legitimate governmental interest, the *Jiminez* Court held that it did not follow that a blanket exclusion of illegitimates was reasonably related to the prevention of spurious claims. *Jiminez*, 417 U.S. at 634. The court found that the Secretary failed to produce any evidence in the record to show that allowing illegitimates to receive benefits would significantly impair the federal Social Security trust fund and necessitate a reduction in the scope of persons benefited by the Act. *Jiminez*, 417 U.S. at 634.

Similarly, in *U.S. Dept. of Agriculture v. Murry*, a due process challenge was made against a statute under the Food Stamp Act that excluded benefits for families with a member who had reached 18 years of age and claimed as a dependent child for federal income tax purposes by another person outside of the family -- i.e. an ex-husband, missing husband, etc. *Murry*, 413 U.S. at 511. The plaintiffs all had children over the age of eighteen that had been claimed on the federal income tax of a family member who lived outside of the home, and, therefore, were denied benefits under the Food Stamp Act. *Murry*, 413 U.S. at 509-11.

The *Murry* Court found that the legislative purpose of the statute was to prevent non-needy households from participating in the food stamp program, and particularly abuses of the program by college students and wealthy parents. *Murry*, 413 U.S. at 512-13. The Court held that the

deduction taken for the benefit in the prior year was an irrational measure of the need of a different household with which the child of the tax-deducting parent lives and rested on an irrebuttable presumption often contrary to fact. *Murry*, 413 U.S. at 514.

As indicated by the above cases and as plainly stated by the *Salfi* Court, a law may be held invalid under due process grounds if it creates an irrebuttable presumption bearing no rational relation to a legitimate legislative goal. *Salfi*, 422 U.S. 772. To the extent that the Department believes that public assistance programs have complete immunity to due process challenges, it should be disregarded.

The Shared Living Rule should be invalidated because it creates an irrebuttable presumption that is not rationally related to a legitimate legislative goal. Similar to the statutes in *Murry* and *Jiminez*, the operation of the Shared Living Rule is not rationally related to ensuring that care providers are not paid for services that would be “naturally performed” in the home based upon a common living arrangement. This is because the Shared Living Rule is based upon the living arrangement of the care provider and not the patient’s actual needs.

As shown with David Jenkins and also in the recent *Myers* case discussed above, the living arrangement of the care provider has little to

do with the amount of services that the patient requires.⁹ David Jenkins is not asking for the Department to provide benefits that benefit the entire household; he is only asking the Department to provide benefits to his care provider for the services that benefit himself.

Furthermore, like the court found in *Jiminez*, the Department has failed to provide even a scintilla of evidence in the record to demonstrate how paying care providers at just above minimum wage for the services they perform would have any effect whatsoever COPES fund and necessitate a reduction in the scope of persons benefited by it.

The only state interest identified by the Department was the state's interest in making "need-based" resource allocation decisions. Appellant Brief at 48. The Shared Living Rule, however, does not operate on a "need-based" premise; rather, it operates solely on the living arrangement of the care provider. This is completely irrational. The Department claims that this was based upon a "judgement" that persons living within the household will "naturally" perform services for each other. While this may be the case in some circumstances, it is certainly not the case for David Jenkins or the patients discussed in the *Myers* decision.

⁹ As discussed more thoroughly in the Statement of the Case above, the Department provided a "DRAFT" time study that failed to explain, in the study or elsewhere, how it arrived at its 15% figure. The Draft Study does not relate to individual or even generalized facts about time savings realized by recipients with live-in providers performing the services affected by the Shared Living Rule.

In addition, the Shared Living Rule is not rationally related to a legitimate legislative goal because it requires care providers to either perform the services for free or quit. If David Jenkins cannot find another care provider to perform these services for free, he will be forced into a nursing home, like the patients in *Myers*, which is completely contrary to the legislative goal behind the COPES program.

6. The Shared Living Rule violates the Privileges and Immunities Clause of the Washington State Constitution.

The Shared Living Rule should be invalidated because it provides citizens without live-in care providers with privileges that are not afforded to individuals with live-in care providers. The Washington State Supreme Court has already held that Article I, Section 12, of the Washington State Privileges and Immunities Clause, provides greater protection than the Equal Protection Clause of the United States Constitution. *Grant County Fire Protection District No. 5 v. City of Moses Lake*, 150 Wn.2d 791, 805, 83 P.3d 419 (2004). Once the court has found that a state constitutional provision provides greater protection than its federal counterpart, parties are not obligated to perform a subsequent *Gumwall* analysis. *State v. Boland*, 115 Wn.2d 571, 800 P.2d 1112 (1990). Nevertheless, a review of

some of some of the *Gunwall* factors, however, is instructional because it demonstrates how the law has historically been applied.

A. Gunwall Analysis

In order to determine whether our state constitutional provision requires a separate and independent constitutional analysis from the United States Constitution, the court considers six nonexclusive neutral criteria: (1) the textual language of the state constitution; (2) differences in the texts of parallel provisions of the federal and state constitutions; (3) state constitutional and common law history; (4) preexisting state law; (5) structural differences between the federal and state constitutions; and (6) matters of particular state or local concern. *State v. Gunwall*, 106 Wn.2d 54, 58, 720 P.2d 808 (1986).

Gunwall Factors 1 and 2. The first and second *Gunwall* factors focus on the textual language of the state constitution and the extent of the textual differences between the federal and state constitutions. *Gunwall*, 106 Wn.2d at 58. The privileges and immunities clause of the Washington State Constitution states:

“No law shall be passed granting to any citizen, [or] class of citizens . . . privileges or immunities which upon the same terms shall not equally belong to all citizens . . .”

CONST. Article I, § 12.

In contrast, the textual language of the equal protection clause of the United States Constitution states:

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.

U.S. CONST. AMEND. XIV, § 1

The text of the constitutional provisions address different types of discrimination. *Grant County*, 150 Wn.2d at 806-07. The federal provision is “concerned with majoritarian threats of invidious discrimination against nonmajorities, whereas the state constitution protects as well against laws serving the interest of special classes of citizens to the detriment of the interests of all citizens.”¹⁰ *Grant County*, 150 Wn.2d at 806-07. The *Grant County* court said that “one might expect that the state provision would have a harder ‘bite’ where a small class is given a special benefit, with the burden spread among the majority.” *Grant County*, 150 Wn.2d at 807 (quotes in original).

¹⁰ Article I, § 12 of the Washington State Constitution was adopted from Article I, Section 20 of the Oregon State Constitution. *The Journal of the Washington State Constitutional Convention*, 1889, at 501 n.20 (Beverly Paulik Rosenow ed., 1999). The Oregon Supreme Court's comments on the differences between the languages of the two provisions, therefore, are illustrative. See *State v. Smith*, 117 Wn.2d 263, 285, 814 P.2d 652 (1991) (Utter, J., concurring). The Oregon Supreme Court has stated: “The provisions of the state Constitution are the antithesis of the fourteenth amendment in that they prevent the enlargement of the rights of some in discrimination against the rights of others, while the fourteenth amendment prevents the curtailment of rights.” *State v. Clark*, 291 Or. 231, 236 n. 8, 630 P.2d 810 (1981) (quoting *State v. Savage*, 96 Or. 53, 59, 184 P. 567 (1919)).

Furthermore, “the difference in emphasis between the two constitutional provisions suggests that it is necessary to analyze the state provision separate from the federal provision.” *Grant County*, 150 Wn.2d at 807. In sum, *Gunwall* factors 1 and 2 support an independent analysis of the constitutional provision.

Gunwall Factor Three. Factor three considers the constitutional history of the provision to determine whether the framers of the Washington constitution intended to confer different protection than is offered by the federal constitution. *Gunwall*, 106 Wn.2d at 61. Washington modeled its constitutional provision after Oregon. *Grant County*, 150 Wn.2d at 807 (citing THE JOURNAL OF THE WASHINGTON STATE CONSTITUTIONAL CONVENTION, 1889, at 501 n.20 (Beverly Paulik Rosenow ed., 1999)). Oregon interprets its privileges and immunities clause independently from the federal constitution. *Grant County*, 150 Wn.2d at 808. In Oregon, the state provision is triggered whenever a person is denied a privilege to which he would be entitled but for government interference. *State v. Freeland*, 295 Or. 367, 369-70, 667 P.2d 509 (1983).

The only difference between the Oregon and Washington clauses is that the Washington provision added a reference to corporations, which our framers perceived as manipulating the lawmaking process. *Grant*

County, 150 Wn.2d at 808 (citing Thompson, 69 TEMP. L.REV. at 1253). As indicated in *Grant County*, the privilege and immunities clause is designed to prevent people from obtaining certain privileges or benefits from the state to the disadvantage of others.

The Fourteenth Amendment was enacted after the Civil War and its purpose was to eliminate the effects of slavery. It was intended to guarantee that certain classes of people (blacks) were not denied the benefits bestowed on other classes (whites), thereby granting equal treatment to all persons. Enacted after the Fourteenth Amendment, *state privileges and immunities clauses were intended to prevent people from seeking certain privileges or benefits to the disadvantage of others*. The concern was prevention of favoritism and special treatment for a few, rather than prevention of discrimination against disfavored individuals or groups.

Grant County, 150 Wn.2d at 808-09 (citing *State v. Smith*, 117 Wn.2d 263, 383, 814 P.2d 652 (1991) (Utter, J., concurring)). In sum, the historical context and the linguistic differences indicate that the Washington State Privileges and Immunities Clause requires independent analysis from the federal provision. *Grant County*, 150 Wn.2d at 809.

Gunwall Factor Four. Factor four evaluates preexisting state law, which "may be responsive to concerns of its citizens long before they are addressed by analogous constitutional claims." *Gunwall*, 106 Wn.2d at 62. This factor requires a consideration of the degree of protection that Washington State has historically given in similar situations. *Gunwall*, 106 Wn.2d at 61-62.

Prior to the adoption of the Washington Constitution in 1889, the limitation on government to grant special privileges to certain individuals or groups was recognized. *Grant County*, 150 Wn.2d at 810. The Organic Act as revised provided that "legislative assemblies of the several Territories shall not grant private charters or especial privileges." *Grant County*, 150 Wn.2d at 809-10 (citing U.S.REV.STAT. tit. 23, § 1889, at 333 (2d ed. 1878) (enacted by 43d Cong., 1st Sess. 1873-74)). The Washington Territorial Court upheld a statute that restricted hunting in five counties against an attack under the Organic Act provision because the statute "[fell] without distinction upon all inhabitants of the Territory." *Grant County*, 150 Wn.2d at 810 (citing *Hays v. Territory of Wash.*, 2 Wash. Terr. 286, 288, 5 P. 927 (1884)).

Several earlier cases also interpreted Article I, Section 12 independently from the federal provision and in a manner that focused on the award of special privileges rather than the denial of equal protection. *See, e.g., N. Springs Water Co. v. City of Tacoma*, 21 Wash. 517, 58 P. 773 (1899) (holding that franchise agreement between water utility and city council did not prevent city from building its own waterworks); *In re Application of Camp*, 38 Wash. 393, 80 P. 547 (1905) (invalidating ordinance that exempted farmers from ordinance forbidding anyone from peddling fruits and vegetables within city). The courts have also

distinguished between the prohibition of "undue favor" (drawn from the state provision) and "hostile discrimination" (drawn from the Fourteenth Amendment):

The aim and purpose of the special privileges and immunities provision of Art. I, § 12 of the state constitution and of the equal protection clause of the fourteenth amendment of the Federal constitution is *to secure equality of treatment of all persons*, without undue favor on the one hand or hostile discrimination on the other.

State ex rel. Bacich v. Huse, 187 Wash. 75, 80, 59 P.2d 1101 (1936). *See also Cotton v. Wilson*, 27 Wn.2d 314, 178 P.2d 287 (1947) (following *Huse* when invalidating law that required plaintiff to prove gross rather than ordinary negligence against owner or operator of "victory motor vehicle"). Preexisting law, therefore, supports a separate analysis of Article I, Section 12. *Grant County*, 150 Wn.2d at 811.

Gunwall Factors Five and Six. Factor five examines the structural difference between the federal and state constitutions. *Gunwall*, 106 Wn.2d at 62. Structural differences will always support an independent analysis. *See Seeley*, 132 Wn.2d at 790. *See also Smith*, 117 Wn.2d at 286 (listing several state constitutional protections not afforded to citizens by the federal constitution). Where the federal constitution is a grant of enumerated powers, the state constitution serves to limit the sovereign power, which directly lies with the residents and indirectly lies with the elected representatives. *Gunwall*, 106 Wn.2d at 62. Therefore, structural

differences also support an independent analysis.

Finally, *Gunwall* factor six favors independent analysis if the matters at issue are of particular state interest or local concern. *Gunwall*, 106 Wn.2d at 62. It is well settled that the state has a specific interest promotion of health among its residents. The COPES program was specifically designed to encourage assisted living so that the State would not have to incur the expense of more costly health care at higher level facilities such as nursing homes. The sixth factor, therefore, undisputedly supports an independent analysis.

B. Privileges and Immunities Clause Analysis

For a violation of Article I, Section 12, the law, or its application, must confer an “undue privilege” to a class of citizens. The threshold issue is whether the Department is providing an undue privilege to Medicaid recipients with care providers who live outside of the home as compared to similarly situated patients who have live in care providers.

To the extent that the Appellant believes that the Medicaid program, a long-standing and fundamental aspect of our society for the poor and medically needy, receives special immunity from a privileges and immunities challenges, this should be disregarded. David Jenkins does not dispute that the Department has the right to adjust public assistance benefit programs consistent with state and federal law. But, the

Privileges and Immunities Clause does not permit the Department to allocate life sustaining resources under one of the most fundamental health care systems in our society to citizens of the State of Washington in a completely disparate and irrational manner.

Appellant contends, without providing any rationale, that a fundamental right of a Washington State citizen cannot be created under one of the most long standing and fundamental health care programs in the history of our country, namely, the Medicaid program. Appellant's crabbed distinction between fundamental rights that arise by reason of state citizenship and longstanding fundamental rights that arise by operation of law is a distinction without substance. This reasoning is significantly flawed because it completely fails to understand the underpinnings of the Privileges and Immunities Clause and the *Grant County* case, a fundamental principle of fairness. This principle attaches to fundamental rights created by any law, whether those rights are created by the constitution, statute, or otherwise.¹¹

For a violation of Article I, Section 12, the law, or its application, must confer a privilege to a class of citizens. The terms "privileges and

¹¹ Taken to its logical conclusion, Appellant's position would exclude fundamental rights created by federal law or constitutional jurisprudence, and limit the Privileges and Immunities Clause to only those fundamental rights created by the Washington State Constitution. The Framers did not intend such a limitation. If the Framers meant to limit fundamental rights in this manner, they would have said so.

immunities" means:

those fundamental rights which belong to the citizens of the state by reason of such citizenship. These terms, as they are used in the constitution of the United States, secure in each state to the citizens of all states the right to remove to and carry on business therein; the right, by usual modes, to acquire and hold property, and to protect and defend the same in the law; the rights to the usual remedies to collect debts, *and to enforce other personal rights*; and the right to be exempt, in property or persons, from taxes or burdens which the property or persons of citizens of some other state are exempt from.

Cooley, Constitutional Limitations (6th ed.) 597 (emphasis added).

In *Grant County*, the court held that this definition did not apply to the annexation of land because “the legislature enjoys plenary power to adjust the boundaries of municipal corporations and may authorize annexation without the consent of the residents and even over their express protest.” *Grant County*, 150 Wn.2d at 813. In other words, the state retained the right to permit a certain class of citizens to establish boundaries for annexation because it had absolute and plenary right to delegate this authority. The right of annexation was the state’s privilege, not the citizens.

Unlike *Grant County*, however, the state does not have plenary power to adjust the state Medicaid Program benefits in any way that it sees fit. The Medicaid program is a statutory entitlement program *held by all the citizens of the state*. Unlike *Grant County*, the COPES privilege is not an entitlement for the state; it is an entitlement held by the citizens. For

example, the states cannot say that it will provide Medicaid program benefits to certain persons within the city of Bellevue, but not Seattle.

The state must provide Medicaid benefits *to all citizens* within the state who qualify. It is a long-standing and fundamental right everyone in this state enjoys just by being a citizen of this state. In other words, unlike *Grant County* where the state retained plenary power to apply the annexation to certain citizens, federal laws require that the Medicaid program be provided to all eligible state citizens. Even under the state waiver for COPES benefits, it specifically states that, “Clients who are institutionally eligible to receive services under COPES waiver *receive a full package of personal care services* under the waiver including personal care and are CN medically eligible.” CP at 1150 (Appendix 1 at 97).

Appellant is correct in that it may establish certain “classifications” within the Medicaid system. What it fails to point out, however, is that the classifications must be offered to all citizens within the state. Setting up classifications applying to all citizens in the state is different than disparately treating citizens within the same classification. The laws are designed to protect the citizens of this state from disparate treatment within classifications (i.e. the Federal Medicaid Comparability Statute and Agency Rules). For example, the Respondent would be precluded from offering COPES benefits to only people with red hair or only citizens that

own a blue Mercedes.

The common thread in the privileges and immunities law cases is the fact that it is a long standing entitlement that is provided *to all citizens* in the state without reservation and that it is a fundamental entitlement that is firmly established by reason of state citizenship. That is what *Grant County* stands for and it applies to the Medicaid COPES program.

In other words, the state cannot disparately allocate a certain fundamental privilege -- provide to some citizens but not others -- when the fundamental privilege belongs to the citizens of the entire state. *See, e.g., State v. Robinson Co.*, 84 Wash. 246, 249-50, 146 P. 628 (1915) (invalidating statute that exempted cereal and flouring mills from act imposing onerous conditions on other similarly situated persons and corporations); *In re Application of Camp*, 38 Wash. 393, 397, 80 P. 547 (1905) (holding that city ordinance prohibiting any one from peddling fruits and vegetables within city, but exempting farmers who grew produce themselves violated Article I, Section 12 as granting privilege to class of citizens); *City of Spokane v. Macho*, 51 Wash. 322, 323-26, 98 P. 755 (1909) (holding Spokane ordinance regulating employment agencies unconstitutional because it imposed criminal penalties upon one party, but imposed no penalties for others in like circumstances); *City of Seattle v. Dencker*, 58 Wash. 501, 504, 108 P. 1086 (1910) (invalidating Seattle

ordinance as unconstitutional under Article I, Section 12 because it imposed tax upon sale of goods by automatic devices that was not imposed upon merchants selling same class of goods). But, if the law did not favor a particular person or class, the state law was upheld. *See State v. Carey*, 4 Wash. 424, 427, 30 P. 729 (1982) (refusing to invalidate statute that respondent argued granted physicians on state examining board immunity from general physician licensing requirements because there was no basis for concluding that board members were in fact exempt). These cases invoke a fairness principle that the state cannot arbitrarily treat similarly situated citizens unfairly with respect to a fundamental right that all the citizens enjoy.

But, this is exactly what the Department does with the Shared Living Rule. Given two patients receiving benefits under the COPES program with the exact same health conditions, one with a live-in caregiver and the other without, the state confers a special privilege on the person without a live-in caregiver. Both of the patients should be entitled to the same level of benefits. Like all the other Privileges and Immunities law cases cited above, there is no compelling reason for the state making such a distinction – the Department failed to provide even a scintilla of evidence to demonstrate that denying services under the Shared Living Rule will protect the state treasury, particularly when it will act to force

the patients into nursing homes.

David Jenkins is a Washington State citizen. He is entitled to receive the benefits that he qualifies for as a Washington State citizen. He is just as entitled to the benefits as the citizen next door who does not have a live-in caregiver. This is exactly what the Washington State Privileges and Immunities Clause was designed to protect against.

7. The Shared Living Rule violates Equal Protection.

Respondent concedes that this case does not fall within any of the identified suspect classifications that require the strict or intermediate scrutiny classifications of the Equal Protection Clause. Respondent also understands that most Equal Protection cases are struck down under rational basis review. Nevertheless, Respondent believes that the Shared Living Rule violates the Equal Protection Clause even under a “rational basis” review. The Supreme Court has acknowledged on several occasions that “rational basis” review does not mean no review at all.

Appellant alleges that the Shared Living Rule “is rationally related to the state’s legitimate interest in making **need-based** resource allocation decisions. Appellant’s Brief at 48 (emphasis added). The Shared Living Rule, however, has nothing to do with “need-based” resource allocations. The Shared Living Rule does not take into consideration the “need” of the patient. It makes an automatic, inflexible, and mandatory elimination of

essential services based solely on whether or not the patient has a live-in care provider. The plain language and operation of the Shared Living Rule demonstrates that it is not a “need” based decision at all. The decision is completely based upon the location where the care provider resides, which is clearly not rationally related to the state’s interest in conducting “need-based” resource allocation decisions.

To the extent that Appellant contends that the Shared Living Rule provides equal treatment for persons with live-in and live-out care providers, this understanding fails to reflect reality.

Under the Shared Living Rule, persons with live-in caregivers receive less benefit hours than other persons in the “exact same classification” who have a care provider who lives outside of the home. This is not equal treatment. If patient’s illness, like in the case of David Jenkins, *requires* in-home care provider services for the provision of ADLs and IADLs, including, but not limited to, laundry, shopping, housework and meal preparation, then that patient is penalized by the Shared Living Rule. On the other hand, if a patient in the “exact same classification” has a care provider who does not live in the home, then that person will receive additional benefits for services. It is unbelievable that the Appellant can find that this constitutes equal treatment.

David Jenkins does not dispute that there may be situations where a care provider may perform tasks that result in a mutual benefit to the caregiver and recipient. But, this is simply not true for many of the COPES recipients like David Jenkins. The Shared Living Rule lays down a bright-line, automatic, and inflexible rule that completely rejects payment for essential shopping, laundry, housekeeping, and meal preparation services *regardless* of the needs of the specific individual.

As trial court judge indicated in *Myers*, the disparate impact may have been eliminated had the Appellant implemented some type of appeal procedure for the recipients. Or, if the Appellant would have based the rule on specific assessments permitting the case-workers to provide exceptions in certain cases.

The Appellant, however, failed to provide any exceptions to its bright line rule. It is completely based upon the live-in status of the care provider and not the need of the patient. The Shared Living Rule is not rationally related to the state's interest in making **need-based** resource allocation decisions, and, therefore, it should be invalidated under Equal Protection jurisprudence.

8. The Shared Living Rule violates the Americans with Disabilities Act.

A. Requirements to establish violation of Title II of the ADA.

Violation of *Title II of the Americans with Disabilities Act* (hereinafter the ADA) has been analyzed by this court in *Townsend v. Quasim*, 328 F.3d 511, 2003 U.S. App. LEXIS 8282 (9th Cir. 2003). There, this court stated that to prove that a public service or program violates *Title II of the ADA*, a plaintiff must show:

- (1) he is a 'qualified individual with a disability';
- (2) he was either excluded from participation in or denied the benefits of a public entity's services, programs, or activities or was otherwise discriminated against by the public entity;
- (3) such exclusion, denial of benefits, or discrimination was by reason of his disability.

Townsend, 328 F.3d at 517, quoting *Duvall v. County of Kitsap*, 260 F.3d 1124, 1135 (9th Cir. 2001).

Without analyzing these elements, the State claims that it did not violate *Title II of the ADA*, even though it first assessed Mr. Jenkins as being eligible for 184 hours per month of services and then reduced the number of hours to 153 hours per month (about a 17% reduction) because Mr. Jenkins has a live-in care provider. The State cites *Weinreich v. Los Angeles Cy. Metro. Transp. Auth.*, 114 F.3d 976 (9th Cir. 1997) as its authority to validate its action denying Mr. Jenkins the services it offers others who do not have live-in care providers.

B. Weinreich is not analogous to case at bar.

Even a casual scrutiny of the case reveals that *Weinreich* is not analogous to the case at bar in either facts or policy. The facts in *Weinreich* were as follows. The Metro Transit Authority (hereinafter MTA) of Los Angeles, a regional public transit system, offered a Reduced Fare Program for the elderly and for eligible disabled patrons. In 1982, Mr. Weinreich (hereinafter Weinreich), appellant in the case, qualified for the Program after a doctor certified that he was permanently disabled due to severe chronic back problems. In 1992, the MTA promulgated a new rule requiring disabled Program participants to provide updated medical information every three years re-certifying that they are disabled. In 1993, Weinreich sought an exemption from the new rules' recertification requirement on the grounds that he was indigent and could not afford to pay a private doctor to recertify his disability. The MTA refused to exempt Weinreich from the recertification requirement and, without recertification, refused to renew his eligibility for the Program. Weinreich appealed the denial, claiming that it was a violation of the Americans with Disabilities Act for the Authority not to exempt him from the requirement of having to provide the requested medical report. The appeal was denied. These facts in no way support the State's argument that where they provide services to others with a disability similar to that of Mr. Jenkins,

they are somehow entitled to deny Mr. Jenkins the same benefits under *Weinreich*. Mr. Jenkins has in no way refused to provide the State any information it has requested, nor has Mr. Jenkins failed to cooperate with the State in any manner. Under the circumstances, *Weinreich* is little more than a red herring.

C. Rationale behind the Americans with Disabilities Act and its adoption by the Department of Justice and the State of Washington.

The roots of the ADA can be traced back to the Congressional recognition that “historically society has tended to isolate and segregate individuals with disabilities and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem” and that “individuals with disabilities continually encounter various forms of discrimination, including outright intentional exclusion, ... failure to make modifications to existing facilities and practices, ...[and] segregation.” *Townsend*, 328 F.3d at 515, *citing* 42 U.S.C. §§ 12101(a)(2), (5). By enacting the American with Disabilities Act, Congress intended to end “this unjustified isolation and segregation of disabled people.” *Townsend*, 328 F.3d at 516. The goal Congress had in mind was that “no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs,

activities of a public entity, or be subjected to discrimination by any such entity.” *Townsend*, 328 F.3d 511 (*citing* 42 U.S.C. § 12132).

In implementing this Congressional mandate under Title II, the Department of Justice promulgated “integration regulations” which, among other provisions, state, “[a] public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified persons with disabilities.” *Townsend*, 328 F.3d at 516 (*citing* 28 C.F.R. § 35.130(d)). They also state, “[a] public entity shall make reasonable modifications in policies, practices or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.” *Townsend*, 328 F.3d at 516 (*citing* 28 C.F.R. § 35.130(b)).

In keeping with this national policy, the Washington State Legislature has itself declared, “the public interest would be best served by a broad array of long-term care services that support persons who need such services at home or in the community whenever practicable and that promote individual autonomy, dignity, and choice.” RCW 74.39A.005.

D. U.S. Supreme Court’s analysis of the ADA.

Common law precedence exists at both the Federal and State levels which supports a finding that services already being provided by a public entity cannot be denied to people with disabilities. *See, e.g. Olmstead v. L.C.*, 527 U.S. 581, 119 S. Ct. 2176 (1999). In *Olmstead*, the United States Supreme Court held that where the State of Georgia was already providing mental health treatment in a community setting, it was a violation of *Title II of the ADA* to deny some persons that benefit outside of an institutional (nursing home) setting. The court came to this conclusion by applying the integration and anti-isolation principles and interpreting discrimination forbidden under *Title II of the ADA* to include “[u]njustified isolation of the disabled.” *Townsend*, 328 F.3d at 516.

E. Application of *Olmstead* in Washington.

Applying *Olmstead*, the 9th Circuit in *Townsend*, 328 F.3d 511, adopted the “integration and anti-isolation” principles of that case to pronounce that the Department had violated the ADA Title II mandate when it refused services to a group of disabled clients qualified as Medically Needy, but allowed the same benefits to other clients qualified as Categorically Needy. *See gen. Townsend*, 328 F.3d 511¹².

¹² The distinction between Medically Needy and Categorically Needy clients is based on a factor unrelated to a client’s disability – the factor being the client’s income. Clients with incomes below a statutorily set threshold are categorized as Categorically

The *Townsend* case dealt with a DSHS client who had been initially qualified as a Categorically Needy client and afforded medical services outside of a nursing home setting. Subsequently, the client's income increased above the threshold limit and DSHS re-categorized the client as Medically Needy. After so re-categorizing the client, DSHS denied the client outside services, but offered to continue to provide the services in a nursing home setting.

The client bought suit against the State of Washington alleging violation of *Title II of the ADA*. Ruling in favor of the client, the Court of Appeals ruled as follows:

After considering the language of the statute and of the integration regulation and the Supreme Court's mandate and reasoning in *Olmstead*, we conclude that DSHS is in violation of *Title II of the ADA* by failing to provide long term care services it currently provides to medically needy disabled persons in integrated settings, ...

Townsend, 328 F.3d at 517-18.

F. Mr. Jenkins meets all three requirements of *Townsend*.

1. Mr. Jenkins is a qualified individual with disability. Section 12131(2) defines a qualified individual with a disability as "an individual with a disability who, with or without reasonable modifications to rules, policies, or practices ... meets the essential eligibility requirements for the

Needy whereas clients whose income exceeds the threshold are categorized as Medically Needy. For COPES purposes the threshold in Washington State is \$1,809 (effective January 1, 2006).

receipt of services or the participation in programs or activities provided by a public entity.” Title II, § 12131(2). The State has made no argument that Mr. Jenkins does not meet this requirement. Indeed, DSHS assessed Mr. Jenkins’ needs and found that he qualified for services for the maximum number of hours allowed under the COPES program.

2. David was denied the benefits of a public entity under the COPES program. Although DSHS assessed David as eligible for receiving 184 hours of care each month, it denied those benefits by reducing the number to 153 hours (a 17% reduction). This reduction is a denial of benefits the State affords others with similar disabilities.

3. The denial of benefits is based on David’s disability. The State contends that the reduction takes into account common chores performed by the live-in care provider which benefit not only Mr. Jenkins, but the care provider as well. This reasoning does not hold water under *Olmstead* and *Townsend*. The State points to chores including housework, laundry, meal preparation or wood supply (*See* WAC 388-71-0460(3)) as being services that the care provider would be expected to perform which benefit both the care provider and David. The plaintiffs in *Townsend* were denied benefits because they had too much income compared to the

income of DSHS clients who were allowed the same services.¹³ Clearly, the income factor had nothing to do with the disability of the plaintiffs in *Townsend*. The *Townsend* court rejected the State's argument, holding that where the denial was based on something other than the disability (income of clients), *Title II of the ADA* had been violated. The State essentially was suggesting that the income did not preclude the plaintiffs in *Townsend* to the services, only that they could not access the services outside a nursing home. To this, the court said, "[i]f the services were determined to constitute distinct programs based solely on the location in which they were provided, *Olmstead* and the integration regulation would be effectively gutted." *Townsend*, 328 F.3d at 517. The court also clarified that where the issue is the location of services, not whether the services will be provided, *Olmstead* controls. *Townsend*, 328 F.3d at 517 (based on which the *Townsend* court found the State had violated *Title II of the ADA*).

¹³ In *Townsend*, the plaintiff was receiving care services in a community setting under the "Categorically Needy" program. The program requirements included that Mr. Townsend have income and resources below a statutorily set limit in addition to being disabled. After being on the program for a few years, Mr. Townsend's income increased and exceeded the income threshold set by the State based on which DSHS denied further services to Mr. Townsend. DSHS did, however, leave open the door to provide the same services under the "Medically Needy" program if Mr. Townsend chose to move to a skilled nursing facility, which Mr. Townsend declined to do. Mr. Townsend bought suit where the Court of Appeals, based on *Olmstead*, found that where the State was providing the services to others, denial of these services to Mr. Townsend was in abrogation of ADA, even though the State argued that the denial had nothing to do with the disability status of Mr. Townsend.

The case at bar almost mirrors the facts of *Townsend*. As argued by the State in *Townsend*, the State denies David's benefits ostensibly not because of his disability, but because David has a live-in care provider. There is also no denying that should David agree to live alone without a live-in care provider, he will receive the full benefits he is entitled to under the assessment performed by the State. However, because David has a live-in care provider, the State has arbitrarily refused to provide David some of the services it provides others with similar disabilities who live without a live-in care provider. The fact that David has a live-in care provider has nothing to do with his disability, which is analogous to the situation in *Olmstead* and *Townsend*. In *Townsend* the income of the plaintiffs had nothing to do with their disabilities, and in *Olmstead* the denial of the mental health services outside of an institutional setting had nothing to do with the disability status of the plaintiffs. Similarly, David having a live-in care provider has nothing to do with his disability. It reasons, therefore, that the State violates *Title II of the ADA* under *Olmstead* and *Townsend* when it denies David benefits it allows others with similar disabilities.

Further, as in *Townsend*, the State keeps open the offer to move David to a nursing home without denying David the services needed to keep him safe and alive, but refuses the same services in a community

setting. Under the reasoning of *Olmstead* and *Townsend*, the State is clearly in violation of *Title II of the ADA*.

9. **WAC 388-02-0225 should be invalidated on arbitrary and capricious grounds because it forces Administrative Law Judges, without exception, to blindly apply an agency rule even when it is patently unconstitutional or statutorily infirm.**

WAC 388-02-0225 states that “Neither an ALJ [Administrative Law Judge] nor a review judge may decide that a DSHS rule is invalid or unenforceable” The threshold issue is whether an agency should be required to follow the law blindly when faced with a patently unconstitutional or statutorily infirm agency rule. This is a matter of first impression in the State of Washington.¹⁴ Other states, however, have ruled that an agency cannot force an ALJ, who is supposed to be an impartial and independent decision maker, to blindly follow the law.¹⁵

For example, in an Oregon worker’s compensation case, an ALJ struck down a statute because the agency exceeded its statutory authority in the promulgation of a discriminatory rule. *Schultz v. Springfield Forest*

¹⁴ Appellant cites only cases applying the exhaustion of administrative remedies, not the power of an administrative law judge to follow the law. As stated in the Oregon Supreme Court case in *Cooper* below, denying agency power only as an explanation for dispensing with the normal exhaustion requirement is weak authority for requiring an agency to look the other way when faced with a patently unlawful agency rule. Appellant concedes on page 61 of its brief that there are no cases on point in Washington.

¹⁵ Appellant states that it follows the “common and traditional” view and backs this contention up with very little authority. It is clear, however, that our neighbors in Oregon do not espouse this view and they have backed it up with a very detailed and reasoned analysis, unlike the authorities cited by Appellant. It defies logic to entrust our

Products, 151 Or. App. 727, 730, 951 P.2d 169 (1997). Relying on three other similar Oregon Supreme Court rulings, the *Schultz* court stated:

Although it is an authority to be exercised infrequently, and always with care, Oregon administrative agencies have the power to declare statutes and rules unconstitutional.

Schultz, 151 Or. App. at 730 (citing *Nutbrown v. Munn*, 311 Or. 328, 346, 811 P.2d 131 (1919). See also *Employment Div. v. Rogue Valley Youth for Christ*, 307 Or. 490, 770 P.2d 588 (1989) (“The Division must administer the law in accordance with constitutional principles, and must enforce its statutory obligations. If a statute tells an agency to do something that a constitution forbids, the agency should not do it.”); Florida Statute, Title X, Ch. 120.56 (a citizen may seek an administrative determination of the invalidity of an agency rule on the ground that it is an invalid exercise of the delegated legislative authority).¹⁶

Although the *Schultz* court was not deciding a constitutional issue like the other Oregon cases, it found that the same principles applied.

Schultz, 151 Or. App. at 730-31. The *Schultz* court declared that:

Administrative agencies, including those with quasi-judicial power, are required to follow the law. If the agency concludes that an administrative rule that it must apply is not in accordance with a statute or is unconstitutional it must follow the superior rather than the subordinate law. It would

neutral and impartial decision makers to look the other way when it comes to statutorily infirm and unconstitutional rules.

¹⁶ For a discussion of the role of an ALJ, see *The Authority of Administrative Agencies to Consider the Constitutionality of Statutes*, 90 Harv L Rev 1682 (1977).

be an unnecessary limitation of the agency's role for it blindly to apply a rule that is inconsistent with a statute or constitutional provision.

Schultz, 151 Or. App. at 731. The court further stated:

It would be pointless to reverse an agency for correctly deciding a legal question on the ground that the agency should have waited for the reviewing court to decide the question.

Schultz, 151 Or. App. at 731. (citing *Cooper v. Eugene Sch. Dist. No. 4J*, 301 Or. 358, 364, 723 P2d 298 (1986)).

Similarly, in *Cooper*, the Oregon Supreme Court was deciding whether an agency had to follow an unconstitutional statute. *Cooper*, 301 Or. at 362-63. The Oregon Supreme Court in *Cooper* stated:

Opinions denying agency power in constitutional cases only as an explanation for dispensing with the normal exhaustion requirement are weak authority for holding that an agency should not consider a constitutional claim when a party chooses to exhaust that process, or that the agency errs if it does decide the issue. If an agency decides a constitutional issue, though needlessly, the only result is that it will be affirmed on judicial review if the decision was right and reversed if the decision was wrong. It would be pointless to reverse an agency for correctly deciding a legal question on the ground that the agency should have waited for the reviewing court to decide the question.

Long familiarity with the institution of judicial review sometimes leads to the misconception that constitutional law is exclusively a matter for the courts. To the contrary, when a court sets aside government action on constitutional grounds, it necessarily holds that legislators or officials attentive to a proper understanding of the constitution would or should have acted differently. Doubt of an agency's obligation to decide constitutional challenges to its

governing statute is itself a question of interpreting the agency's statutory duties. The agency's duty to decide such challenges would not be doubted if the legislature provided for it expressly rather than doing so implicitly under the general term "law" in the Administrative Procedure Act provisions that require a final order in a contested case to include the agency's conclusions of law, ORS 183.470(2), and subject the order to reversal if it violates a constitutional provision, ORS 183.482(8)(b)(C), *see also* ORS 183.484(4)(b)(C).

An agency ordinarily can interpret a statute so as to exclude unconstitutional applications before it is forced to question the statute's validity. An agency also should consider whether anyone can obtain higher executive or judicial review if the agency erroneously concludes that the statute contravenes the constitution . . .

the constitution does not contemplate that legislators and officials will act as they think best and leave the constitutionality of their acts to the courts. Courts may have the last word in interpreting the constitution, but Chief Justice Marshall's defense of "the province and duty of the judicial department to say what the law is," *Marbury v. Madison*, 5 US (1 Cranch) 137, 177 (1803), did not imply that constitutional law is the province and duty *only* of the judicial department, leaving Congress and executive officials unconstrained to pursue their ends subject only to judicial review

Cooper, 301 Or. at 364-65, n.7 (emphasis in original).

Deciding issues of law is not new to ALJs. It is well settled that ALJs are free to announce new principles of law during an adjudication so long as it is not an abuse of discretion or circumvent the requirements under the Washington Administrative Procedures Act (APA). *Budget Rent A Car Corp. v. Washington State Dept. of Licensing*, 100 Wn. App.

381, 997 P.2d 420 (2000). Furthermore, courts frequently defer to the agency to resolve ambiguous agency rules. *See, e.g., Citizens for a Safe Neighborhood v. Seattle*, 67 Wn. App. 436, 442, 836 P.2d 235 (1992) (deferring to a agency’s hearing examiner on the interpretation of an ambiguous agency rule).

If an ALJ is permitted to enunciate new issues of law during an adjudication or decide issues of law involving ambiguous statutes, it is reasonable to permit an ALJ to rule on a patently unconstitutional or statutorily infirm agency rule. This is not to say, as the Department suggests, that an ALJ would have to rule upon every challenge. As the *Schultz* court indicated, the agencies power “is an authority to be exercised infrequently, and always with care.” *Schultz*, 151 Or. App. at 730. The problem with WAC 388-02-225, however, is that it creates a bright line, inflexible, mandatory rule that always requires an ALJ to follow a clearly unconstitutional or statutorily infirm agency rule.

Moreover, the APA and case law requires that adjudications be conducted by independent and impartial decision makers. The Washington State Supreme Court has stated:

The Due Process Clause entitles a person to an impartial and disinterested tribunal in both civil and criminal cases. This requirement of neutrality in adjudicative proceedings safeguards the two central concerns of procedural due process, the prevention of unjustified or mistaken

deprivations and the promotion of participation and dialogue by affected individuals in the decision making process.

Nguyen v. State, Dept. of Health Medical Quality Assurance, 144 Wn.2d 516, 544, 29 P.3d 689 (2001) (emphasis added). Requiring an ALJ to follow the law blindly interferes with this independence.

In addition, the oath of office states for the executive branch states, “I will support the Constitution of the United States and the Constitution and laws of the state of Washington, and that I will faithfully discharge the duties of the office of (name of office) to the best of my ability.” RCW 43.01.020. Anyone within an agency blindly applying a patently unconstitutional or infirm statute would not be fulfilling this promise.

As recognized by the *Schultz* court, “[i]t would be an unnecessary limitation of the agency’s role for it blindly to apply a rule that is inconsistent with a statute or constitutional provision.” *Schultz*, 151 Or. App. at 731. As the *Schultz* court recognized, administrative bodies are bound to follow the superior rather than the subordinate law. *Schultz*, 151 Or. App. at 731. WAC 388-02-0225 subverts this mandate by inflexibly requiring ALJs to blindly follow the law, **without exception**. As such, it is arbitrary and capricious and, the trial court properly invalidated it.

10. WAC 388-02-0225 should be invalidated because it exceeds the scope of its authority under the Washington Administrative Procedures Act and state and federal law.

The threshold question is whether WAC 388-02-0225 is invalid exercise of the delegated legislative authority to the Department.

Department Record. The statutory authority for the agency rule is “RCW 34.05.020. 00-18-059, S 388-02-0225, filed 9/1/00, effective 10/2/00.” WAC 388-71-0225. A review in these sections, however, provides no basis in law for the agency rule. *See generally* CP 258-265 and CP 342-519 (for the complete agency record on the rule).

RCW 34.05.020 states that the Department does not have the authority to limit a person’s rights with respect to the constitution or other statutes, which is exactly what the agency rule does. RCW 34.05.020 (“Nothing in this chapter may be held to diminish the constitutional rights of any person or to limit or repeal additional requirements imposed by statute or otherwise recognized by law.”).

The only thing in the agency file that pertains to WAC 388-02-0225 is a response to a comment where the Department said, “Language was added to emphasize that only a court may decide if a DSHS rule is invalid. Due to RCW 34.05.554 the other language was not added.” CP at 511. This statement by the Department reflects that, prior to the

promulgation of WAC 388-02-0225, it was unclear whether the agency rules permitted an ALJ to consider the validity of an agency rule.

No Constitutional or APA Limitations. Neither the Constitution nor the APA forecloses review at the agency level. Although an aggrieved party may challenge an agency rule at the judicial level pursuant to RCW 34.05.570, this does not foreclose review at the agency level. As indicated by the Oregon Supreme Court in Cooper, “Courts may have the last word in interpreting the constitution, but Chief Justice Marshall's defense of “the province and duty of the judicial department to say what the law is,” *Marbury v. Madison*, 5 US (1 Cranch) 137, 177 (1803), did not imply that constitutional law is the province and duty *only* of the judicial department.” *Cooper*, 301 Or. at n.7 (emphasis in original).

Moreover, although the APA provides flexibility for when an agency may commence an adjudicative proceeding, it *requires* that the Department commence an adjudicative proceeding when required by statute or constitutional right. RCW 34.05.413(2) (“When required by law or constitutional right, and upon the timely application of any person, *an agency shall commence an adjudicative proceeding.*”).

In addition, the APA says that initial and final orders “shall include a statement of findings and conclusions, and the reasons and basis therefor, on all the material issues of fact, *law* or discretion presented on

the record.” RCW 34.05.461 (emphasis added). This statement contemplates issues of law being resolved by the agency.

Constitutional and Statutory Rights to a Hearing. David Jenkins has (1) a constitutional due process right to a pre-deprivation hearing as discussed in Section 11 below; (2) state and federal statutory rights to a pre-deprivation hearing; and (3) a right to a pre-deprivation hearing under the Medicaid state plan.

State and federal statutes and agency rules that require that the Department provide a due-process hearing for benefits denied or reduced under the COPES program. These laws include:

- RCW 74.08.080(1)(a) (“A public assistance applicant or recipient who is *aggrieved by a decision of the department* or an authorized agency of the department has the right to an adjudicative proceeding”).
- RCW 34.05.413(2) (“When required by law or constitutional right, and upon the timely application of any person, an agency *shall* commence an adjudicative proceeding.”).
- Federal Guidance Document on Waivers (“A state *must* provide that individuals have the opportunity to request a Fair Hearing when they are not given the choice to receive waiver services, are denied waiver services or providers of their choice, *or their waiver services are denied, suspended, reduced or terminated.*”) Appendix 3 at 1.

In addition, the Department’s Medicaid Waiver application states, **in at least two places**, that “the Department will provide an opportunity for a fair hearing . . . to *persons who are denied the service(s) of their choice, or the provider(s) of their choice.*” CP at 1061 (Appendix 1 at 8) and CP at 1115 (Appendix 1 at 62).

The plain language of the laws and the promise under the Medicaid Waiver application requires the Department to provide an adjudicative hearing when requested by an aggrieved public assistance recipient denied the services(s) of their choice under the COPEs program. It does not limit the types of issues that can be presented by the aggrieved party. WAC 388-02-0225, therefore, exceeds its statutory authority because it provides no exceptions, even when the law says otherwise.

In sum, a review of the agency file does not offer support for the inflexible mandate of WAC 388-02-0225. RCW 34.05.020 specifically states that the Department does not have the authority to interfere with a person's statutory or constitutional rights, which is exactly what the agency rule does. Moreover, David Jenkins has constitutional and statutory rights to an adjudicative proceeding when benefits are being eliminated, which are explicitly stated in state and federal laws, and the Department's Medicaid Waiver application. As such, WAC 388-02-0225 exceeds the scope of its authority under the Washington Administrative Procedures Act, and the trial court did not err in its invalidation.

11. WAC 388-02-0225 is unconstitutional because it violates David Jenkins' due process rights.

Procedural Due Process. The federal due process clause requires that "deprivation of life, liberty or property by adjudication be preceded by notice and opportunity for hearing appropriate to the nature of the case."

Mullane v. Cent. Hanover Bank & Trust Co., 339 U.S. 306, 313, 70 S.Ct. 652, 94 L.Ed. 865 (1950); U.S. Const. Amend. XIV, § 1. Notice must be " 'reasonably calculated . . . to apprise interested parties of the pendency of the action and afford them an opportunity to present their objections.' " *Olympic Forest Prods., Inc. v. Chausee Corp.*, 82 Wn.2d 418, 422, 511 P.2d 1002 (1973) (*quoting Mullane*, 339 U.S. at 314). The form of due process may vary and the court should use a balancing test to decide if procedures are sufficient to satisfy due process. *Mathews v. Eldridge*, 424 U.S. 319, 334-35, 96 S.Ct. 893, 47 L.Ed.2d 18 (1976). The court must balance three factors: (1) the private interest affected by the action, (2) the risk of erroneous deprivation of such interest through the procedures used and the value of additional procedural safeguards, and (3) the governmental interest, including the cost and administrative burden of additional procedures. *Mathews*, 424 U.S. at 335.

The "right to be heard before being condemned to suffer grievous loss of any kind, even though it may not involve the stigma and hardships of a criminal conviction, is a principle basic to our society." *Mathews*, 424 U.S. at 333. (*quoting Joint Anti-Fascist Comm. V. McGrath*, 341 U.S. 123, 168, 71 S.Ct. 624, 646, 95 L.Ed. 817 (1951) (Frankfurter, J., concurring)). The fundamental requirement of due process is the opportunity to be heard "at a meaningful time and in a meaningful

manner." *Mathews*, 424 U.S. at 333 (quoting *Armstrong v. Manzo*, 380 U.S. 545, 552, 85 S.Ct. 1187, 1191, 14 L.Ed.2d 62 (1965)).

Because David Jenkins was denied a right to a pre or post deprivation hearing on the deprivation of his COPES benefits, he was deprived of his right to have an opportunity to be heard at a meaningful time and in a meaningful manner. *Mathews*, 424 U.S. at 333. Even in *Mathews*, the Court found that a disability recipient was entitled to at least a post-deprivation hearing. *Mathews*, 424 U.S. at 334-35. In *Goldberg*, the Court held that a welfare recipient was entitled to a pre-deprivation hearing. *Goldberg v. Kelly*, 397 U.S. 254, 90 S.Ct. 1011, 25 L.Ed.2d 287 (1987). In *Mathews*, the Court recognized that the distinguishing factor in *Goldberg* was the fact that the termination of aid would deprive the recipient of the very means by which the person sustained himself or herself. *Mathews*, 424 U.S. at 340.

As such, the deprivation of benefits to David Jenkins is much more similar to the welfare recipient in *Goldberg*. The private interest affected by the Department's action is the reduction of the very means by which David Jenkins sustains himself. The risk of erroneous deprivation means that, if he cannot provide a care provider to perform the services for free, David Jenkins will be forced into a nursing home. The burden of

providing a pre-deprivation hearing to David Jenkins is minimal as the Department already has the hearing process defined.

To completely deprive David Jenkins of any opportunity to address the deprivation of his benefits in a hearing undisputedly violates his constitutional rights to procedural due process under the Fourteenth Amendment of the United States Constitution. As such, the trial court did not err in finding that WAC 388-02-0225 invalid for violating the procedural due process rights for public assistance recipients.

It is unfair to make a public welfare recipient, who stands to lose essential benefits, address factual issues and mixed questions of law and fact in one forum, and issues of law in another.¹⁷ David Jenkins was not able to obtain a hearing until over **16 months** after he initially filed his appeal. Appellant says that “Respondent [David Jenkins] should not be heard to complain that they did not provide the adjudication that he wanted, when he wanted it.” Appellant Brief at 64. By this statement, Appellant shows his complete lack of understanding of the essential needs of COPEs recipients.

¹⁷ To the extent Appellant suggests there were never issues of fact involved in this case, the assertion is not correct. When the case was originally filed, it contained both issues of fact and law. The issues of fact involved the cognitive score for David Jenkins, which were resolved after the Department agreed to do a second assessment. The issues of fact were resolved just prior to the case dismissal.

To a public assistance recipient who completely relies upon the Shared Living Services for daily sustenance, like David Jenkins and the patients in *Myers*, and for care providers who rely on just above minimum wage payment for the services provided, the impact of the elimination of services is substantial. A timely resolution of the issues is essential. Making an indigent, nursing home eligible, public assistance recipient resolve his issues in multiple forums is nonsensical, time consuming, and induces a substantial burden on the public assistance recipient.

David Jenkins was entitled to a pre-deprivation fair hearing, as required by statute and constitutional law, just as the court found in *Goldberg*. The trial court was correct, therefore, in invalidating WAC 388-02-0225 because it violates a public assistance recipients' rights to due process under the law.

12. The trial court properly assessed back benefits and costs, including pre and post judgment interest, pursuant to RCW 74.08.080(3) and the Administrative Procedures Act.

Appellant makes some additional allegations against the trial court's award of benefits and costs. The amount of costs awarded by a trial court is reviewed under the abuse of discretion standard. *Schmidt v. Cornerstone Invs., Inc.*, 115 Wn.2d 148, 169, 795 P.2d 1143 (1990). The same standard is used to review the court's determination of the applicable

interest to apply on a judgment entered by the trial court. *Curtis v. Security Bank*, 69 Wn. App. 12, 20, 847 P.2d 507 (1993).

First, the trial court was completely correct in awarding back benefits. Although Appellant claims that this is against RCW 34.05.574, this is a wholly incorrect reading and application of the statute. RCW 34.05.574 permits a trial court to award “damages, compensation, or ancillary relief only *to the extent authorized by another provision of law.*” The other provision of law is RCW 74.08.080(3), which expressly states “If a decision of the court is made in favor of the appellant, assistance shall be *paid . . .* in the case of a recipient, from the effective date of the local community services office decision.”

Second, Appellant claims that the trial court is precluded from awarding pre and post judgment interest on the benefits. The general rule is that the state cannot, without its consent, be held to interest on a judgment. *Our Lady of Lourdes Hosp. v. Franklin County*, 120 Wn.2d 439, 455-56, 455-56, 842 P.2d 956 (1993). The State, however, may waive sovereign immunity by contract in an individual situation. *Bond v. State*, 70 Wn.2d 746, 748, 425 P.2d 10 (1967). Respondent agrees with Appellant that the State is generally immune from pre and post judgment interest. In this case, however, there was a contract between David Jenkins’ care provider and the Department that provides for interest to be

applied in overpayment situations. CP at 218. It would follow from general principles of contractual fairness and equity that the parties intended the same to apply in underpayment situations. The fact that the state drafted the contract and had the negotiating power over the care provider should be a substantial factor for applying interest here.

Third, Appellant alleges that David Jenkins is not entitled to full reimbursement of his costs under RCW 74.08.080(3); rather, it claims that the costs should be limited to RCW 4.84.010. RCW 74.08.080(3), however, specifically awards costs, without restriction, to a prevailing public assistance recipient. RCW 4.84.010 expressly states that the identified statutory costs are “*in addition to* costs otherwise authorized by law.” (emphasis added). The Legislature could have defaulted to the costs and attorneys fees under RCW 4.84.010, but decided to include a separate section on costs and attorney fees that provided no restrictions on the types of recoverable costs for public assistance recipients. The Legislature is presumed to have knowledge of existing statutes relevant to the subject upon which it is acting. *Health Ins. Pool v. Health Care Authority*, 129 Wn.2d 504, 510, 919 P.2d 62 (1996). This is consistent with the policy of encouraging public assistance recipients to act upon their legal rights and acknowledges the limited financial status of these persons.

Based upon the above, the trial court did not abuse his discretion with respect to awarding back benefits, costs, and interest.

13. The trial court should have awarded attorneys' fees and costs for co-counsel.

In the Judgment for David Jenkins Awarding Retroactive and Continuing Benefits, Attorneys' Fees and Costs, the trial court denied attorneys' fees for co-counsel, Mr. Nagaich. CP at 1164. The trial court's indicated there was no justification for two law firms, no apparent division of labor, and some individual billing items were not reasonable ("i.e. 6.0 hours for lengthy discussion and review; 6.0 hours for a [] atty to appear in court etc.)" CP at 1164.

Mr. Nagaich was retained by David Jenkins for his expertise involving the American with Disabilities Act. Mr. Nagaich conducted the analytical research and briefing with respect to the Americans with Disabilities Act. He attended all meetings. Mr. Nagaich attended and presented argument at the agency and court appearances in this matter. Mr. Nagaich submitted an itemized invoice of his time spent. CP at 958-59. David Jenkins requests that he be awarded attorneys' fees for his co-counsel consistent with public assistance under RCW 74.08.080(3).

14. Under RCW 74.08.080(3), RAP 14.2, and RAP 18.1, attorneys' fees and costs should be awarded.

David Jenkins requests attorneys' fees and costs pursuant to RCW

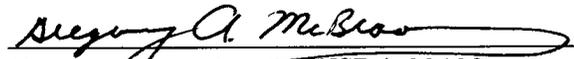
74.08.080(3), RAP 14.2, and RAP 18.1.

VI. CONCLUSION

The judgment of the trial court should be affirmed.

RESPECTFULLY SUBMITTED this 7th day of April, 2006.

ATTORNEYS FOR RESPONDENT:



Gregory A. McBroom, WSBA 33133

Rajiv Nagaich, WSBA 32991

Attorneys for Respondent, David Jenkins

Gregory A. McBroom declares that:

I am a permanent resident of the United States, over the age of 18 years, and competent to testify as a witness. On April 7, 2006, I caused the Respondent's Renewed Motion to File Over-Length Brief to be served on Appellant via First Class Mail to:

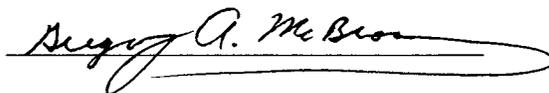
William L. Williams
Senior Assistant Attorney General
Michael M. Young, WSBA No. 35562
Attorney General of Washington
670 Woodland Square Loop SE
PO Box 40124
Olympia, WA 98504 -0124
Facsimile: (360) 438-7400

And to be filed with the Court of Appeals via hand delivery to:

Clerk of the Court of Appeals
One Union Square
600 University St
Seattle, WA 98101-1176
Facsimile: (206) 389-2613

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct to the best of my knowledge.

Executed at Seattle, Washington this 7th day of April, 2006.

A handwritten signature in black ink that reads "Gregory A. McBroom". The signature is written in a cursive style and is underlined with a long, horizontal stroke that extends to the right.

Gregory A. McBroom

3. A waiver of section 1902(a)(10)(B) of the Act is requested to target waiver services to one of the select group(s) of individuals who would be otherwise eligible for waiver services:

- a. ___ aged (age 65 and older)
- b. ___ disabled
- c. X aged and/or disabled
- d. ___ mentally retarded
- e. ___ developmentally disabled
- f. ___ mentally retarded and/or developmentally disabled
- g. ___ chronically mentally ill

4. A waiver of section 1902(a)(10)(B) of the Act is also requested to impose the following additional targeting restrictions (specify):

- a. ___ Waiver services are limited to the following age groups (specify):
- b. ___ Waiver services are limited to individuals with the following disease(s) or condition(s) (specify):
- c. ___ Waiver services are limited to individuals who are mentally retarded or developmentally disabled, who currently reside in general NFs, but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by P.L. 100-203 to require active treatment at the level of an ICF/MR.
- d. ___ Other criteria. (Specify):
- e. ___ Not applicable.

STATE: Washington

DATE: December 2003

9. A waiver of the "statewideness" requirements set forth in section 1902(a)(1) of the Act is requested.

- a. Yes
- b. No

If yes, waiver services will be furnished only to individuals in the following geographic areas or political subdivisions of the State (Specify):

10. A waiver of the amount, duration and scope of services requirements contained in section 1902(a)(10)(B) of the Act is requested, in order that services not otherwise available under the approved Medicaid State plan may be provided to individuals served on the waiver. ←

11. The State requests that the following home and community-based services, as described and defined in Appendix B.1 of this request, be included under this waiver:

- a. Case management
- b. Homemaker
- c. Home health aide services
- d. Personal care services
- e. Respite care
- f. Adult day health
- g. Habilitation
 - Residential habilitation
 - Day habilitation
 - Prevocational services
 - Supported employment services
 - Educational services

STATE: Washington

DATE: December 2003

- h. X Environmental accessibility adaptations
- i. X Skilled nursing
- j. X Transportation
- k. X Specialized medical equipment and supplies
- l. _____ Chore services
- m. X Personal Emergency Response Systems
- n. _____ Companion services
- o. _____ Private duty nursing
- p. _____ Family training
- q. _____ Attendant care
- r. X Adult Residential Care
 - X Adult family home care
 - X Assisted living

STATE: Washington

DATE: December 2003

s. Extended State plan services (Check all that apply):

- Physician services
- Home health care services
- Physical therapy services
- Occupational therapy services
- Speech, hearing and language services
- Prescribed drugs
- Other (specify):

t. Other services (specify):

- (1) Adult Day Care (2) Caregiver/Recipient Training Services (3) Home-delivered Meals

u. The following services will be provided to individuals with chronic mental illness:

- Day treatment/Partial hospitalization
- Psychosocial rehabilitation
- Clinic services (whether or not furnished in a facility)

12. The state assures that adequate standards exist for each provider of services under the waiver. The State further assures that all provider standards will be met.
13. An individual written plan of care will be developed by qualified individuals for each individual under this waiver. This plan of care will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written plan of care. The plan of care will be subject to the approval of the Medicaid agency. FFP will not be claimed for waiver services furnished prior to the development of the plan of care. FFP will not be claimed for waiver services which are not included in the individual written plan of care.

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- 14. Waiver services will not be furnished to individuals who are inpatients of a hospital, NF, or ICF/MR.

- 15. FFP will not be claimed in expenditures for the cost of room and board, with the following exception(s) (Check all that apply):
 - a. When provided as part of respite care in a facility approved by the State that is not a private residence (hospital, NF, foster home, or community residential facility).
 - b. Meals furnished as part of a program of adult day health services.
 - c. When a live-in personal caregiver (who is unrelated to the individual receiving care) provides approved waiver services, a portion of the rent and food that may be reasonably attributed to the caregiver who resides in the same household with the waiver recipient. FFP for rent and food for a live-in caregiver is not available if the recipient lives in the caregiver's home, or in a residence that is owned or leased by the provider of Medicaid services. An explanation of the method by which room and board costs are computed is included in Appendix G-3.

For purposes of this provision, "board" means 3 meals a day, or any other full nutritional regimen.

- 16. The Medicaid agency provides the following assurances to HCFA:
 - a. Necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. Those safeguards include:
 - 1. Adequate standards for all types of providers that furnish services under the waiver (see Appendix B);
 - 2. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver (see Appendix B). The State assures that these requirements will be met on the date that the services are furnished; and

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3. Assurance that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.
- b. The agency will provide for an evaluation (and periodic reevaluations, at least annually) of the need for a level of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future (one month or less), but for the availability of home and community-based services. The requirements for such evaluations and reevaluations are detailed in Appendix D.
 - c. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, and is included in the targeting criteria included in items 3 and 4 of this request, the individual or his or her legal representative will be:
 1. Informed of any feasible alternatives under the waiver; and
 2. Given the choice of either institutional or home and community-based services.
 - d. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to persons who are not given the choice of home or community-based services as an alternative to institutional care indicated in item 2 of this request, or who are denied the service(s) of their choice, or the provider(s) of their choice.
 - e. The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care indicated in item 2 of this request under the State plan that would have been made in that fiscal year had the waiver not been granted.
 - f. The agency's actual total expenditure for home and community-based and other Medicaid services under the waiver and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals in the institutional setting(s) indicated in item 2 of this request in the absence of the waiver.
 - g. Absent the waiver, persons served in the waiver would receive the appropriate type of Medicaid-funded institutional care that they require, as indicated in item 2 of this request.

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- h. The agency will provide HCFA annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of the persons served on the waiver. The information will be consistent with a data collection plan designed by HCFA.
- i. The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as HCFA may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

The State conducts a single audit in conformance with the Single Audit Act of 1984, P.L. 98-502.

a. X Yes b. No

- 17. The State will provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-neutrality. The results of the assessment will be submitted to HCFA at least 90 days prior to the expiration of the approved waiver period and cover the first 24 months (new waivers) or 48 months (renewal waivers) of the waiver.

a. Yes b. X No

- 18. The State assures that it will have in place a formal system by which it ensures the health and welfare of the individuals served on the waiver, through monitoring of the quality control procedures described in this waiver document (including Appendices). Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that plans of care are periodically reviewed to ensure that the services furnished are consistent with the identified needs of the individuals. Through these procedures, the State will ensure the quality of services furnished under the waiver and the State plan to waiver persons served on the waiver. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

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19. An effective date of April 1, 2004 is requested.
20. The State contact person for this request is Marrienne Backous, who can be reached by telephone at (360) 725-2535.
21. This document, together with Appendices A through G, and all attachments, constitutes the State's request for a home and community-based services waiver under section 1915(c) of the Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver (including Appendices and attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid agency. Upon approval by HCFA, this waiver request will serve as the State's authority to provide home and community services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid agency.

Signature: _____
 Print Name: Dennis Braddock
 Title: Secretary
 Date: December 22, 2003

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449. The time required to complete this information collection is estimated to average 160 hours for each new and renewed waiver request and an average of 30 hours for each amendment, including the time to review instructions, searching existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to: HCFA, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

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APPENDIX A - ADMINISTRATION

LINE OF AUTHORITY FOR WAIVER OPERATION

CHECK ONE:

- _____ The waiver will be operated directly by the Medical Assistance Unit of the Medicaid agency.
- _____ The waiver will be operated by _____, a separate agency of the State, under the supervision of the Medicaid agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.
- X The waiver will be operated by Aging and Disability Services Administration (ADSA), a separate division within the Single State agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

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APPENDIX B - SERVICES AND PROVIDER STANDARDS

APPENDIX B-1: DEFINITION OF SERVICES

The State requests that the following home and community-based services, as described and defined herein, be included under this waiver. Provider qualifications/standards for each service are set forth in Appendix B-2.

a. Case Management

 Services which will assist individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

Case managers shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care.

1. Yes 2. No

Case managers shall initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of plans of care at such intervals as are specified in Appendices C & D of this request.

1. Yes 2. No

 Other Service Definition (Specify):

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b. Homemaker:

 Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.

 Other Service Definition (Specify):

c. X Home Health Aide services:

 X Services defined in 42 CFR 440.70, with the exception that limitations on the amount, duration and scope of such services imposed by the State's approved Medicaid plan shall not be applicable. The amount, duration and scope of these services shall instead be in accordance with the estimates given in Appendix G of this waiver request. Services provided under the waiver shall be in addition to any available under the approved State plan.

 Other Service Definition (Specify):

d. X Personal care services:

 X Assistance with eating, bathing, dressing, personal hygiene, and activities of daily living. These services may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the plan of care, this service may also include such housekeeping chores as bed making, laundry, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. Personal care providers must meet State standards for this service.

Nursing tasks, such as administration of medication, blood glucose monitoring, ostomy care, simple wound care or straight catheterization, may be delegated under the direction of a licensed, registered nurse if the provider meets the requirements of a nursing assistance certified and/or registered in the State of Washington. The following tasks CAN NOT be

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delegated: Injections, Central Lines, Sterile procedures, and tasks that require nursing judgment.

1. Services provided by family members (Check one):

Payment will not be made for personal care services furnished by a member of the individual's family.

Personal care providers may be members of the individual's family. Payment will not be made for services furnished to a minor by the child's parent (or step-parent), or to an individual by that person's spouse.

Justification attached. (Check one):

Family members who provide personal care services must meet the same standards as providers who are unrelated to the individual.

Standards for family members providing personal care services differ from those for other providers of this service. The different standards are indicated in Appendix B-2.

2. Supervision of personal care providers will be furnished by (Check all that apply):

A registered nurse, licensed to practice nursing in the State.

A licensed practical or vocational nurse, under the supervision of a registered nurse, as provided under State law.

Case managers

Other (Specify):

The waiver recipient or the recipient's representative (as long as the representative is not the paid provider) or as specified in the service plan.

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3. Frequency or intensity of supervision (Check one):

As indicated in the plan of care

Other (Specify):

The waiver recipient or the recipient's representative will supervise the personal care provider on a day-to-day basis. The recipients hire, train and supervise qualified providers of the recipients' choice. The recipients are free to terminate the providers' employment and select new qualified providers. Additional provider instruction and care coordination is given as outlined in the client's service plan.

4. Relationship to State plan services (Check one):

Personal care services are not provided under the approved State plan.

Personal care services are included in the State plan, but with limitations. The waived service will serve as an extension of the State plan service, in accordance with documentation provided in Appendix G of this waiver request.

Personal care services under the State plan differ in service definition or provider type from the services to be offered under the waiver.

Other service definition (Specify):

e. Respite care:

Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

Other service definition (Specify):

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FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Respite care will be provided in the following location(s) (Check all that apply):

- Individual's home or place of residence
- Foster home
- Medicaid certified Hospital
- Medicaid certified NF
- Medicaid certified ICF/MR
- Group home
- Licensed respite care facility
- Other community care residential facility approved by the State that its not a private residence (Specify type):

Other service definition (Specify):

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f. Adult day health:

Services furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Physical, occupational and speech therapies indicated in the individual's plan of care will be furnished as component parts of this service.

Transportation between the individual's place of residence and the adult day health center will be provided as a component part of adult day health services. The cost of this transportation is included in the rate paid to providers of adult day health services. (Check one):

1. Yes 2. No

Other service definition (Specify):

Qualifications of the providers of adult day health services are contained in Appendix B-2.

g. Habilitation:

Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. This service includes:

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____ Residential habilitation: assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code. Payment for residential habilitation does not include payments made, directly or indirectly, to members of the individual's immediate family. Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid. Documentation which shows that Medicaid payment does not cover these components is attached to Appendix G.

____ Day habilitation: assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the individual resides. Services shall normally be furnished 4 or more hours per day on a regularly scheduled basis, for 1 or more days per week unless provided as an adjunct to other day activities included in an individual's plan of care.

Day habilitation services shall focus on enabling the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

____ Prevocational services not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs). Prevocational services are available only to individuals who have previously been discharged from a SNF, ICF, NF or ICF/MR.

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Check one:

- Individuals will not be compensated for prevocational services.
- When compensated, individuals are paid at less than 50 percent of the minimum wage.

Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the individual's plan of care as directed to habilitative, rather than explicit employment objectives.

Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and
2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

Educational services, which consist of special education and related services as defined in section s (15) and (17) of the Individuals with Disabilities Education Act, to the extent to which they are not available under a program funded by IDEA. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and
2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

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Supported employment services, which consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and
2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

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FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Payments for vocational training that is not directly related to an individual's supported employment program.

Transportation will be provided between the individual's place of residence and the site of the habilitation services, or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

1. Yes 2. No

Other service definition (Specify):

The State requests the authority to provide the following additional services, not specified in the statute. The State assures that each service is cost-effective and necessary to prevent institutionalization. The cost neutrality of each service is demonstrated in Appendix G. Qualifications of providers are found in Appendix B-2.

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h. X Environmental accessibility adaptations:

X Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home, which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations, which add to the total square footage of the home, are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

___ Other service definition (Specify):

i. X Skilled nursing:

X Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

___ Other service definition (Specify):

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j. X Transportation:

X Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the individual's plan of care. Whenever possible, family, neighbors, friends, or community agencies, which can provide this service without charge, will be utilized.

___ Other service definition (Specify):

k. X Specialized Medical Equipment and Supplies:

X Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items, which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

___ Other service definition (Specify):

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l. Chore services:

 Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress. These services will be provided only in cases where neither the individual, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

 Other service definition (Specify):

m. X Personal Emergency Response Systems (PERS)

X PERS is an electronic device, which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified in Appendix B-2. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

 Other service definition (Specify):

n. Adult companion services:

 Non-medical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but

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do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the plan of care, and is not purely diversional in nature.

___ Other service definition (Specify):

o. ___ Private duty nursing:

___ Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of State law. These services are provided to an individual at home.

___ Other service definition (Specify):

p. ___ Family training:

___ Training and counseling services for the families of individuals served on this waiver. For purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, children, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the consumer. Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as necessary to safely maintain the individual at home. All family training must be included in the individual's written plan of care.

___ Other service definition (Specify):

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q. Attendant care services:

Hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically handicapped individual. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. this service may include skilled or nursing care to the extent permitted by State law. Housekeeping activities which are incidental to the performance of care may also be furnished as part of this activity.

Supervision (Check all that apply):

Supervision will be provided by a Registered Nurse, licensed to practice in the State. The frequency and intensity of supervision will be specified in the individual's written plan of care.

Supervision may be furnished directly by the individual, when the person has been trained to perform this function, and when the safety and efficacy of consumer-provided supervision has been certified in writing by a registered nurse or otherwise as provided in State law. This certification must be based on direct observation of the consumer and the specific attendant care provider, during the actual provision of care. Documentation of this certification will be maintained in the consumer's individual plan of care.

Other supervisory arrangements (Specify):

Other service definition (Specify):

r. Adult Residential Care (Check all that apply):

Adult Family home care: Personal care and services, homemaker, chore, attendant care and companion services medication oversight (to the extent permitted under State law) provided in a licensed (where applicable) private home by a principal care provider who lives in the home. Adult family home care is furnished to adults who receive these services in conjunction with residing in the home. the total number of individuals (including persons served in the waiver) living in the home, who are

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unrelated to the principal care provider, cannot exceed (6). Separate payment will not be made for homemaker or chore services furnished to an individual receiving adult family home care services, since these services are integral to and inherent in the provision of adult family home care services.

X **Assisted living/Enhanced Adult Residential Care:** Enhanced Adult Residential care facilities provide care to waiver eligible clients. Such facilities have shared rooms and shared bathrooms for the residents. Assisted living facilities are required by contract to provide a private room, private bathroom and limited cooking facilities for each resident. Both facilities provide personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed (where applicable) community care facility, in conjunction with residing in the facility. This service includes 24 hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility, but the care provided by these other entities supplements that provided by the community care facility and does not supplant it.

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The consumer has a right to privacy. Living units may be locked at the discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms). The consumer retains the right to assume risk, tempered only by the individual's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each consumer to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect.

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Assisted living services may also include (Check all that apply):

- Home health care
- Physical therapy
- Occupational therapy
- Speech therapy
- Medication administration
- Intermittent skilled nursing services
- Transportation specified in the plan of care
- Periodic nursing evaluations
- Other (Specify)

However, nursing and skilled therapy services (except periodic nursing evaluations if specified above) are incidental, rather than integral to the provision of assisted living services. Payment will not be made for 24-hour skilled care or supervision. FFP is not available in the cost of room and board furnished in conjunction with residing in an assisted living facility.

Other service definition (Specify):

Payments for adult residential care services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Payment for adult residential care services does not include payments made, directly or indirectly, to members of the consumer's immediate family. The methodology by which payments are calculated and made is described in Appendix G.

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s. X Other waiver services which are cost-effective and necessary to prevent institutionalization (Specify):

(1) Adult Day Care: Adult Day Care Services provided in an adult day care center include provision of personal care; routine health monitoring with consultation from a registered nurse; general therapeutic activities; general health education; and supervision and/or protection for at least four hours a day but less than twenty-four hours a day in a group setting on a continuing, regularly scheduled basis.

Services also include: provision of recipient meals as long as meals do not replace nor be a substitute for a full day's nutritional regimen; and, programming and activities designed to meet clients' physical, social and emotional needs. Transportation to and from the program will be obtained through the Title XIX transportation brokers in the areas served by the adult day care.

Adult day care shall be included in a recipient's approved plan of care only when the recipient is; ineligible for adult day health services (Medicaid State Plan covered services); has mild to moderate dementia and/or is chronically ill or disabled; is socially isolated and/or confused; is unable/unsafe to be left alone during the day; needs assistance with personal care; and will benefit from an enriched socially supportive experience.

(2) Caregiver/Recipient Training Services: Training services are mandated for each COPES paid caregiver and provide instruction in either a one-to-one situation or in a group setting. Each caregiver shall receive a two (2) hour orientation and additional twenty eight (28) hours basic training, and ten (10) hours continuing education. Residential providers receive an additional twenty (20) hours training in caring for specialized populations (e.g. Alzheimer's, mental illness or developmental disabilities.)

The caregiver training curriculum includes: use of special or adaptive equipment or medically related procedures required to maintain the recipient in the home or community-based setting; and, activities of daily living. In addition, caregiver training teaches critical care giving skills including: client rights and abuse reporting; observation and reporting changes in client condition; infection control, accident prevention, food handling and other tips on providing a safe environment; emergency procedures and problem solving.

Recipient training needs are identified in the comprehensive assessment or in a professional evaluation. This service is provided in accordance with a therapeutic goal in the plan of care and includes e.g., adjustment to serious impairment; maintenance or restoration of physical functioning and management of personal

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care needs, i.e., the development of skills to deal with care providers.

(3) Home-Delivered Meals: Home-delivered meal services provide nutritional balanced meals delivered to the recipient's homes when meal provision is more cost effective than having a personal care provider prepare the meal. These meals shall not replace nor be a substitute for a full day's nutritional regimen but shall provide at least one-third (1/3) of the current recommended dietary allowance as established by the Food and Nutrition Board of the National Academy of Sciences, National research Council. A unit of service equals one (1) meal. No more than one meal per day will be reimbursed under the waiver.

Home-delivered meals are provided to an individual at home and included in the approved plan of care only when the recipient is homebound, unable to prepare the meal and there is no other person, paid or unpaid, to prepare the meal. When a client's needs cannot be met by a Title III provider due to geographic inaccessibility, special dietary needs, the time of day or week the meal is needed, or existing Title III provider waiting lists, a meal may be provided by restaurants, cafeterias or caterers who comply with Washington State Department of health and local board of health regulations for food service establishments.

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t. Extended State plan services:

The following services, available through the approved State plan, will be provided, except that the limitations on amount, duration and scope specified in the plan will not apply. Services will be as defined and described in the approved State plan. The provider qualifications listed in the plan will apply, and are hereby incorporated into this waiver request by reference. These services will be provided under the State plan until the plan limitations have been reached. Documentation of the extent of services and cost-effectiveness are demonstrated in Appendix G. (Check all that apply):

- Physician services
- Home health care services
- Physical therapy services
- Occupational therapy services
- Speech, hearing and language services
- Prescribed drugs
- Other State plan services (Specify):

u. Services for individuals with chronic mental illness, consisting of (Check one):

- Day treatment or other partial hospitalization services (Check one):
 - Services that are necessary for the diagnosis or treatment of the individual's mental illness. These services consist of the following elements:
 - a. individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law),
 - b. occupational therapy, requiring the skills of a qualified occupational therapist,
 - c. services of social workers, trained psychiatric

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nurses, and other staff trained to work with individuals with psychiatric illness,

- d. drugs and biologicals furnished for therapeutic purposes,
- e. individual activity therapies that are not primarily recreational or diversionary,
- f. family counseling (the primary purpose of which is treatment of the individual's condition),
- g. training and education of the individual (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment), and
- h. diagnostic services.

Meals and transportation are excluded from reimbursement under this service. The purpose of this service is to maintain the individual's condition and functional level and to prevent relapse or hospitalization.

___ Other service definition (Specify):

___ Psychosocial rehabilitation services (Check one):

___ Medical or remedial services recommended by a physician or other licensed practitioner under State law, for the maximum reduction of physical or mental disability and the restoration of maximum functional level. Specific services include the following:

- a. restoration and maintenance of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management, money management and maintenance of the living environment);

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- b. social skills training in appropriate use of community services;
- c. development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion); and
- d. telephone monitoring and counseling services.

The following are specifically excluded from Medicaid payment for psychosocial rehabilitation services:

- a. vocational services,
- b. prevocational services,
- c. supported employment services, and
- d. room and board.

___ Other service definition (Specify):

___ Clinic services (whether or not furnished in a facility) are services defined in 42 CFR 440.90.

Check one:

___ This service is furnished only on the premises of a clinic.

___ Clinic services provided under this waiver may be furnished outside the clinic facility. Services may be furnished in the following locations (Specify):

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- b. social skills training in appropriate use of community services;
- c. development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion); and
- d. telephone monitoring and counseling services.

The following are specifically excluded from Medicaid payment for psychosocial rehabilitation services:

- a. vocational services,
- b. prevocational services,
- c. supported employment services, and
- d. room and board.

___ Other service definition (Specify):

___ Clinic services (whether or not furnished in a facility) are services defined in 42 CFR 440.90.

Check one:

___ This service is furnished only on the premises of a clinic.

___ Clinic services provided under this waiver may be furnished outside the clinic facility. Services may be furnished in the following locations (Specify):

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APPENDIX B-2

PROVIDER QUALIFICATIONS

A. LICENSURE AND CERTIFICATION CHART

The following chart indicates the requirements for the provision of each service under the waiver. Licensure, Regulation, State Administrative Code are referenced by citation. Standards not addressed under uniform State citation are attached.

Service	Provider	License	Certification	Other Standard
1. Personal Care	Individual Providers		Must be a registered or certified nursing assistant in the State of WA to provide delegated nursing tasks	Meet the requirements of WAC 388-71-0500 through 399-71-05952
	Agency Providers	Home Care Agency License under Chapter 70.127 RCW and Chapter 246-336 WAC; or Home Health Agency License under Chapter 70.127 RCW		
2. Assisted Living/Enhanced Adult Residential Care	Boarding Home	BH License under Chapter 18.20 RCW, Chapter 388-110 WAC		
3. Adult Family Home Care	Adult Family Home	AFH License under Chapter 70.128 RCW and 388-76 WAC		
4. Personal Emergency Response	Electronic Communication Equipment and Monitoring Agency			See attachment B-2a

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Service	Provider	License	Certification	Other Standard
5. Environmental Modifications	Contractor Volunteer			Meet the requirements of Chapter 18.27 RCW
6. Skilled Nursing	Licensed Practical Nurse (LPN)	LPN License under Chapter 18.79 RCW and Chapter 246-840 WAC RN License under Chapter 18.79 RCW and Chapter 246-840		
7. Transportation	Taxicab Public Transit Volunteer			Standards are the same as those applied to vendors who provide access to state plan medical services.
8. Home Health	Nursing Assistant Certified		Nursing Assistant Certified (and registered) under Chapter 18.88A RCW and WAC 246-841	
9. Adult Day Care	Adult Day Care Center		Certified as Title XIX Provider	Meet the requirements Of WAC 388-71-0702 through WAC 388-71-0776
10. Caregiver/ Recipient Training/ Support	Licensed Practical Nurse (LPN); and Registered Nurse (RN)	LPN license under RCW 18.79 and WAC 246-840 RN license under RCW 18.79 and WAC 246-840		

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	<p>Certified Dietician/ Nutritionist</p> <p>Physical Therapist (PT)</p> <p>Occupational Therapist (OT)</p> <p>Home Health Agencies</p> <p>Home Care Agencies</p> <p>Community Colleges</p> <p>Independent Living Provider</p>	<p>PT license under Chapter 18.74 RCW</p> <p>OT license under Chapter 18.59 RCW</p> <p>Home Health Agency license under Chapter 70.127 RCW and WAC 246-327</p> <p>Home Care Agency license under Chapter 70.127 RCW and Chapter 246-336 WAC</p>	<p>Dietician and Nutritionist Certificate under 18.138 RCW</p>	<p>Higher education institutions conducting programs under RCW 28B.50.020</p> <p>A Bachelor's degree in social work or psychology with two years experience in the coordination or provision of Independent Living Services; or, Two years experience in the coordination or provision of Independent Living Services (e.g. housing, personal assistance services recruitment and/or management, IL skills training) social service setting under qualified supervision; or, Four years personal experience with a disability, two years experience in the coordination or provision of IL services in a social service setting under qualified supervision.</p>
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11. Home Delivered Meals	Food Service Vendor			Title III: Home Delivered Nutrition Program Standards Chapter 246-215 WAC: Food Service Vendor
12. Specialized Medical Equipment & Supplies	Contractor			Have a state contract as A Title XIX Vendor
13. In home Nurse Delegation	RN Registered Nurse	RN licensed under Chapter RCW 18.79.040		

B. ASSURANCE THAT REQUIREMENTS ARE MET

The State assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services provided under the waiver.

C. PROVIDER REQUIREMENTS APPLICABLE TO EACH SERVICE

For each service for which standards other than, or in addition to State licensure or certification must be met by providers, the applicable educational, professional, or other standards for service provision or for service providers are attached to this Appendix, tabbed and labeled with the name of the service(s) to which they apply.

When the qualifications of providers are set forth in State or Federal law or regulation, it is not necessary to provide copies of the applicable documents. However, the documents must be on file with the State Medicaid agency, and the licensure and certification chart at the head of this Appendix must contain the precise citation indicating where the standards may be found.

D. FREEDOM OF CHOICE

The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

ATTACHMENT B-2

Minimum Standards for PERS Equipment Vendors and Monitoring Agencies

1. All PERS equipment vendors must provide equipment approved by the Federal Communications Commission and the equipment must meet the Underwriters Laboratories, Inc., (UL) standard for home health care signaling equipment. The UL listing mark on the equipment will be accepted as evidence of the equipment's compliance with such standard.
2. The emergency response activator must be able to be activated by breath, by touch, or some other means and must be usable by persons who are visually or hearing impaired or physically disabled.
3. The emergency response communicator must be attached to the PERS client's telephone line and must not interfere with normal telephone use. The communicator must be capable of operating without external power during a power failure at the recipient's home in accordance with UL requirements for home health care signaling equipment with stand-by capability.
4. The monitoring agency must be capable of simultaneously responding to multiple signals for help from clients' PERS equipment. The monitoring agency's equipment must include a primary receiver, a stand-by information retrieval system and a separate telephone service, a stand-by receiver, a stand-by back up power supply, and a telephone line monitor. The primary receiver and back-up receiver must be independent and interchangeable. The clock printer must print out the time and date of the emergency signal, the PERS client's Medical identification code (PIC) and the emergency code that indicates whether the signal is active, passive, or a responder test. The telephone line monitor must give visual and audible signals when an incoming telephone line is disconnected for more than 10 seconds. The monitoring agency must maintain detailed technical and operations manuals that describe PERS elements including PERS equipment installation, functioning and testing; emergency response protocols; and record keeping and reporting procedures.

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APPENDIX B-3

KEYS AMENDMENT STANDARDS FOR BOARD AND CARE FACILITIES

KEYS AMENDMENT ASSURANCE:

The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

APPLICABILITY OF KEYS AMENDMENT STANDARDS:

Check one:

Home and community-base services will not be provided in facilities covered by section 1616(e) of the Social Security Act. Therefore, no standards are provided.

A copy of the standards applicable to each type of facility identified above is maintained by the Medicaid agency.

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APPENDIX C-Eligibility and Post-Eligibility

Appendix C-1--Eligibility

MEDICAID ELIGIBILITY GROUPS SERVED

Individuals receiving services under this waiver are eligible under the following eligibility group(s) in your State plan. The State will apply all applicable FFP limits under the plan. (Check all that apply.)

1. Low income families with children as described in section 1931 of the Social Security Act.
2. SSI recipients (SSI Criteria States and 1634 States).
3. Aged, blind or disabled in 209(b) States who are eligible under 435.121 (aged, blind or disabled who meet requirements that are more restrictive than those of the SSI program).
4. Optional State supplement recipients
5. Optional categorically needy aged and disabled who have income at (Check one):
 - a. 100% of the Federal poverty level (FPL)
 - b. % Percent of FPL which is lower than 100%.
6. The special home and community-based waiver group under 42 CFR 435.217 (Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based services in order to remain in the community, and who are covered under the terms of this waiver).

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Spousal impoverishment rules are used in determining eligibility for the special home and community-based waiver group at 42 CFR 435.217.

A. Yes B. No

Check one:

a. The waiver covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community; or

b. Only the following groups of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community are included in this waiver: (check all that apply):

(1) A special income level equal to:

300% of the SSI Federal benefit (FBR)

% of FBR, which is lower than 300% (42 CFR 435.236)

\$ which is lower than 300%

(2) Aged, blind and disabled who meet requirements that are more restrictive than those of the SSI program. (42 CFR 435.121)

(3) Medically needy without spenddown in States which also provide Medicaid to recipients of SSI. (42 CFR 435.320, 435.322, and 435.324.)

(4) Medically needy without spenddown in 209(b) States.
(42 CFR 435.330)

(5) Aged and disabled who have income at:

a. 100% of the FPL

b. % which is lower than 100%.

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(6)___ Other (Include statutory reference only to reflect additional groups included under the State plan.)

7. ___ Medically needy (42 CFR 435.320, 435.322, 435.324 and 435.330)

8. ___ Other (Include only statutory reference to reflect additional groups under your plan that you wish to include under this waiver.)

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Appendix C-2--Post-Eligibility

GENERAL INSTRUCTIONS

ALL Home and Community-Based waiver recipients found eligible under 435.217 are subject to post-eligibility calculations.

Eligibility and post-eligibility are two separate processes with two separate calculations. Eligibility determines whether a person may be served on the waiver. Post-eligibility determines the amount (if any) by which Medicaid reduces its payment for services furnished to a particular individual. By doing so, post-eligibility determines the amount (if any) for which an individual is liable to pay for the cost of waiver services.

An eligibility determination (and periodic redetermination) must be made for each person served on the waiver.

Post-eligibility calculations are made ONLY for persons found eligible under 435.217.

Post-eligibility determinations must be made for all groups of individuals who would be eligible for Medicaid if they were in a medical institution and need home and community-based services in order to remain in the community (435.217). For individuals whose eligibility is not determined under the spousal rules (1924 of the Social Security Act), the State must use the regular post-eligibility rules at 435.726 and 435.735. However, for persons found eligible for Medicaid using the spousal impoverishment rules, the State has two options concerning the application of post-eligibility rules:

OPTION 1: The State may use the post-eligibility (PE) rules under 42 CFR 435.726 and 435.735 just as it does for other individuals found eligible under 435.217 or;

OPTION 2: it may use the spousal post-eligibility rules under 1924.

REGULAR POST-ELIGIBILITY RULES--435.726 and 435.735

- o The State must provide an amount for the maintenance needs of the individual. This amount must be based upon a reasonable assessment of the individual's needs in the community.
- o If the individual is living with his or her spouse, or if the individual is living in the community and the spouse is living at home, the State must protect an additional amount for the spouse's maintenance. This amount is limited by the highest appropriate income standard for cash assistance, or the medically needy standard. The State may choose which standard to apply.

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- o If the individual's spouse is not living in the individual's home, no maintenance amount is protected for that spouse's needs.
- o If other family members are living with the individual, an additional amount is protected for their needs. This amount is limited by the AFDC need standard for a family of the same size or by the appropriate medically needy standard for a family of the same size. The State may choose which standard to apply.

SPOUSAL POST-ELIGIBILITY--1924

When a person who is eligible as a member of a 42 CFR 435.217 group has a community spouse, the State may treat the individual as if he or she is institutionalized and apply the post-eligibility rules of 1924 of the Act (protection against spousal impoverishment) instead of the post-eligibility rules under 42 CFR 435.726 and 435.735. The 1924 post-eligibility rules provide for a more generous community spouse and family allowance than the rules under 42 CFR 435.726 and 435.735. Spousal impoverishment post-eligibility rules can only be used if the State is using spousal impoverishment eligibility rules.

The spousal protection rules also provide for protecting a personal needs allowance (PNA) "described in 1902(q)(1)" for the needs of the institutionalized individual. This is an allowance which is reasonable in amount for clothing and other personal needs of the individual . . . while in an institution." For institutionalized individuals this amount could be as low as \$30 per month. Unlike institutionalized individuals whose room and board are covered by Medicaid, the personal needs of the home and community-based services recipient must include a reasonable amount for food and shelter as well as for clothing. The \$30 PNA is not a sufficient amount for these needs when the individual is living in the community.

Therefore, States which elect to treat home and community-based services waiver participants with community spouses under the 1924 spousal impoverishment post-eligibility rules must use as the personal needs allowance either the maintenance amount which the State has elected under 42 CFR 435.726 or 42 CFR 435.735, or an amount that the State can demonstrate is a reasonable amount to cover the individual's maintenance needs in the community.

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POST ELIGIBILITY

REGULAR POST ELIGIBILITY

1. X **SSI State.** The State is using the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

A. . 435.726--States which **do not use more restrictive** eligibility requirements than SSI.

a. Allowances for the needs of the

1. individual: (Check one):

A. The following standard included under the State plan (check one):

(1) SSI

(2) Medically needy

(3) The special income level for the institutionalized

(4) The following percent of the Federal poverty level): %

(5) Other (specify):

B. The following dollar amount:
\$ *

* If this amount changes, this item will be revised.

C. X The following formula is used to determine the needs allowance:

a) 100% of Federal Poverty

b) An allowance for the payment of guardianship fees of

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an individual under a Superior Court order of guardianship as allowed under Washington Administrative Code (WAC).

- c) Earned income: the first \$65 plus one-half of the remaining earned income.
- d) total needs allowance will not exceed SIL

Note: If the amount protected for waiver recipients in item 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under 42 CFR 435.217, **enter NA in items 2. and 3.** following.

2. spouse only (check one):

- A. ___ SSI standard
- B. ___ Optional State supplement standard
- C. ___ Medically needy income standard
- D. ___ The following dollar amount:
\$ ___ *

* If this amount changes, this item will be revised.

- E. ___ The following percentage of the following standard that is not greater than the standards above: ___ % of standard.
- F. ___ The amount is determined using the following formula:

G. X Not applicable (N/A)

3. Family (check one):

- A. ___ AFDC need standard
- B. X Medically needy income standard

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The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C. ___ The following dollar amount:
\$ ___ *

*If this amount changes, this item will be revised.

D. ___ The following percentage of the following standard that is not greater than the standards above: % ___ of standard.

E. ___ The amount is determined using the following formula:

F. ___ Other

G. ___ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.726.

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POST-ELIGIBILITY

REGULAR POST ELIGIBILITY

1.(b) 209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 435.735. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

B. 42 CFR 435.735--States using more restrictive requirements than SSI.

(a) Allowances for the needs of the

1. individual: (check one):

A. ___ The following standard included under the State plan (check one):

(1)___ SSI

(2)___ Medically needy

(3)___ The special income level for the institutionalized

(4)___ The following percentage of the Federal poverty level: ___%

(5)___ Other (specify):

B. ___ The following dollar amount:
\$ ___*

* If this amount changes, this item will be revised.

C. ___ The following formula is used to determine the amount:

Note: If the amount protected for waiver recipients in 1. is equal to, or greater than the

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maximum amount of income a waiver recipient may have and be eligible under 435.217, enter NA in items 2. and 3. following.

2. spouse only (check one):

A. ___ The following standard under 42 CFR 435.121:

B. ___ The medically needy income standard _____;

C. ___ The following dollar amount:
\$ _____ *

* If this amount changes, this item will be revised.

D. ___ The following percentage of the following standard that is not greater than the standards above: _____ % of

E. ___ The following formula is used to determine the amount:

F. ___ Not applicable (N/A)

3. family (check one):

A. ___ AFDC need standard

B. ___ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C. ___ The following dollar amount:

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\$ _____ *

* If this amount changes, this item will be revised.

D. ___ The following percentage of the following standard that is not greater than the standards above: _____% of standard.

E. ___ The following formula is used to determine the amount:

F. ___ Other

G. ___ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.735.

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POST ELIGIBILITY

SPOUSAL POST ELIGIBILITY

2. X The State uses the post-eligibility rules of 1924(d) of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of home and community-based care if it determines the individual's eligibility under 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(A) Allowance for personal needs of the individual:
(check one)

(a) ___ SSI Standard

(b) X Medically Needy Standard

(c) ___ The special income level for the institutionalized

(d) ___ The following percent of the Federal poverty level:
___%

(e) ___ The following dollar amount
\$ ___ **

**If this amount changes, this item will be revised.

(f) The following formula is used to determine the needs allowance:

(g) X Other (specify): Waiver clients not living with CS will receive the same PNA as defined under regular post-eligibility on pp 47 & 48.

If this amount is different from the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is

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reasonable to meet the individual's maintenance needs in the community.

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APPENDIX D - ENTRANCE PROCEDURES AND REQUIREMENTS

APPENDIX D-1

a. EVALUATION OF LEVEL OF CARE

The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in the Executive Summary of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

b. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (check all that apply):

- Discharge planning team
- Physician (MD or DO)
- Registered nurse, licensed in the state
- Licensed social worker
- Qualified mental retardation professional, as defined in 42 CFR 483.430(a)
- Other (specify):
Social Workers, Case Managers

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APPENDIX D-2

a. REEVALUATIONS OF LEVEL OF CARE

Reevaluations of the level of care required by the individual will take place (at a minimum) according to the following schedule (specify):

_____ Every 3 months

_____ Every 6 months

X Every 12 months

X Other (specify):
As indicated by a significant change in the client's condition or situation

b. QUALIFICATIONS OF PERSONS PERFORMING REEVALUATIONS

Check one:

X The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.

_____ The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for all individuals performing reevaluations of level of care (specify):

_____ Physician (MD or DO)

_____ Registered nurse, licensed in the state

_____ Licensed social worker

_____ Qualified mental retardation professional, as defined in 42 CFR 483.430(a)

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_____ Other (specify):

c. PROCEDURES TO ENSURE TIMELY REEVALUATIONS

The state will employ the following procedures to ensure timely reevaluations of level of care (check below):

- _____ "Tickler" file
- _____ Edits in computer system
- _____ Component part of case management

 X Other (specify):
 Quality assurance monitoring staff from ADSA headquarters conducts annual reviews of case management services provided by the Home and Community Services Division (HCS) and Area Agencies on Aging (AAA). Each HCS region and AAA office is monitored. At the regional and local levels, HCS and AAA case management supervisors also conduct regular quality reviews of their case management staff.

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APPENDIX D-3

a. MAINTENANCE OF RECORDS

1. Records of evaluations and reevaluations of level of care will be maintained in the following location(s) (check all that apply):

- By the Medicaid Agency in its central office
- By the Medicaid Agency in district/local offices
- By the agency designated in Appendix A as having primary authority for the daily operation of the waiver program
- By the case managers
- By the persons or agencies designated as responsible for the performance of evaluations and reevaluations
- By service providers
- Other (specify):

2. Written documentation of all evaluations and reevaluations will be maintained as described in this Appendix for a minimum period of 3 years.

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b. COPIES OF FORMS AND CRITERIA FOR EVALUATION/ASSESSMENT

A copy of the written assessment instrument(s) to be used in the evaluation and reevaluation and screening procedures for individuals need for a level of care indicated in the Executive Summary of this request is attached to this Appendix.

For persons diverted rather than deinstitutionalized, the state's evaluation process must provide for a more detailed description of their evaluation and screening procedures for individuals to ensure that waiver services will be limited to persons who would otherwise receive the level of care specified in the Executive Summary of this request.

Check one:

The process for evaluating and screening diverted individuals is the same as that used for deinstitutionalized persons.

The process for evaluating and screening diverted individuals differs from that used for deinstitutionalized persons. Attached is a description of the process used for evaluating and screening diverted individuals.

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APPENDIX D-3

DOCUMENTATION OF EVALUATIONS/RE-EVALUATIONS

Documentation of all evaluations and reevaluations are maintained for a minimum of one year following the termination of waiver services in local offices of the agency designated in Appendix A as having primary authority for the daily operation of the waiver program. Area Agency on Aging direct service or contracted case management unit's may also maintain client case records. Clients' case records, which are repositories for the documents, are then sent to the state archives where they are maintained for another two years.

Records may be requested and recovered from the state archives during the retention period

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APPENDIX D-4

a. FREEDOM OF CHOICE AND FAIR HEARING

1. When an individual is determined to be likely to require a level of care indicated in the Executive Summary of this request, the individual or his or her legal representative will be:
 - a. Informed of any feasible alternatives under the waiver; and
 - b. Given the choice of either institutional or home and community-based services.
2. The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to the institutional care indicated in the Executive Summary of this request or who are denied the service(s) of their choice, or the provider(s) of their choice.
3. The following are attached to this Appendix:
 - a. A copy of the form(s) used to document freedom of choice and to offer a fair hearing:
 - b. A description of the agency's procedure(s) for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver;
 - c. A description of the State's procedures for allowing individuals to choose either institutional or home and community-based services; and
 - d. A description of how the individual (or legal representatives) is offered the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E.

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FREEDOM OF CHOICE DOCUMENT

Specify where copies of this form are maintained:

The attached form, DSHS 14-225, "Acknowledgement of Services", is used to document the applicant/recipient's freedom to choose between institutional and home and community-based services. The DSHS 14-225 is explained to the individual and a signature is obtained stating that the individual understands they have a choice in the type of services received, where the service is provided as well as the right to a fair hearing. The individual signs this form to designate the service choice.

Fair hearing information is contained on the DSHS 14-225, "Acknowledgement of Services" form. Rights to a fair hearing are explained to all clients during the Medicaid application process and again during the assessment process.

The client receives a signed copy of the DSHS 14-225 and a copy of the form is maintained in the applicant/recipients' case records, together with the applicant/recipient' evaluations and reevaluations.

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APPENDIX D-4

DESCRIPTION OF THE AGENCIES PROCEDURES FOR INFORMING RECIPIENTS OF CHOICE OF INSTITUTIONAL OR HOME & COMMUNITY-BASED CARE:

1. After performing a comprehensive assessment of the applicant/recipient the department will offer waiver services to financially eligible individuals when:
 - a. The applicant/recipient is found eligible for nursing facility care; and
 - b. A feasible home or community-based plan of care, which adequately meets the health, and personal needs of the applicant/recipient can be developed.
2. The applicant/recipient's choice will prevail as to whether to accept the offer of waiver services or be admitted to a nursing facility.

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APPENDIX D-4

Individual Right To A Fair Hearing

All individuals assessed for this waiver program have fair hearing rights as specified in the Medicaid State plan. When an individual requests a Medicaid application, a fair hearing pamphlet is included in the information. Rights to a fair hearing are explained to all clients during the Medicaid application process and again during the assessment process.

Fair Hearing information is contained on the DSHS document number 14-225, "Acknowledgement of Services" form. This form is explained to the individual during the assessment process and a signature is obtained stating that the individual understands they have a choice in the type of services received, where they will receive services as well as the right to a fair hearing. A signed copy of this document is left with the individual and a copy is filed in the record maintained by the case manager.

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AGING AND DISABILITY SERVICES ADMINISTRATION
Home and Community Based Waiver
ACKNOWLEDGMENT OF SERVICES

APPLICANT'S NAME		ACES CLIENT ID NUMBER	
<p>The Home and Community based waiver offers the opportunity for eligible persons to receive specific Medicaid services necessary to prevent institutionalization of the recipient. These services are provided under a Medicaid waiver approved by the Centers for Medicare and Medicaid Services. These services are offered to persons identified by the department as eligible for nursing home care but who prefer to live at home or in the community.</p> <p>I have been informed of the alternatives to Nursing Home care that are available to me and I choose to receive:</p> <p><input type="checkbox"/> COPES waiver services</p> <p><input type="checkbox"/> Medically Needy waiver services</p> <p><input type="checkbox"/> Nursing Home services</p> <p><input type="checkbox"/> I have refused waiver services.</p>			
APPLICANT'S SIGNATURE		DATE	
REPRESENTATIVE'S SIGNATURE	<input type="checkbox"/> Guardian <input type="checkbox"/> Representative	DATE	
SOCIAL WORKER/CASE MANAGER'S SIGNATURE		DATE	
AGENCY		TELEPHONE NUMBER (INCLUDE AREA CODES)	
<p>Below are your rights to a fair hearing:</p> <p>If you are denied waiver services, or if you are denied the waiver services of your choice, you have the right to request a Fair Hearing. You have 90 days from the date services are denied to request a hearing. You may request a Fair Hearing by writing to your local Home and Community Services Division office, local Area Agency on Aging, or by writing to: CHIEF, OFFICE OF ADMINISTRATIVE HEARINGS, MAIL STOP: 42489, DEPARTMENT OF SOCIAL AND HEALTH SERVICES, PO BOX 42489, OLYMPIA WA 98504-2489.</p>			

APPENDIX E - PLAN OF CARE

APPENDIX E-1

a. PLAN OF CARE DEVELOPMENT

1. The following individuals are responsible for the preparation of the plans of care:

- Registered nurse, licensed to practice in the State
- Licensed practical or vocational nurse, acting within the scope of practice under State law
- Physician (M.D. or D.O.) licensed to practice in the State
- Social Worker (qualifications attached to this Appendix)
- Case Manager
- Other (specify):

2. Copies of written plans of care will be maintained for a minimum period of 3 years. Specify each location where copies of the plans of care will be maintained.

- At the Medicaid agency central office
- At the Medicaid agency county/regional offices
- By case managers
- By the agency specified in Appendix A
- By consumers
- Other (specify):

3. The plan of care is the fundamental tool by which the State will ensure the health

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and welfare of the individuals served under this waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability. The minimum schedule under which these reviews will occur is:

- Every 3 months
- Every 6 months
- Every 12 months
- Other (specify):
As indicated by a significant change in the client's condition or situation.

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APPENDIX E-2

a. **MEDICAID AGENCY APPROVAL**

The following is a description of the process by which the plan of care is made subject to the approval of the Medicaid agency:

The waiver service plan of care development includes the nurse, social worker or case manager who may have completed the comprehensive assessment of client needs, the waiver client and also may include the waiver client representative, family members, service provider and any other individuals involved in the care of the waiver recipient. The assessor presents the proposed plan identifying the service. The final service plan is developed with the client and approved by the client and the Aging and Disability Services Administration staff or their designee.

b. **STATUTORY REQUIREMENTS AND COPY OF PLAN OF CARE**

1. The plan of care will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service.
2. A copy of the plan of care form to be utilized in this waiver is attached to this Appendix.

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APPENDIX F - AUDIT TRAIL

a. DESCRIPTION OF PROCESS

1. As required by sections 1905(a) and 1902(a)(32) of the Social Security Act, payments will be made by the Medicaid agency directly to the providers of waiver and State plan services.

2. As required by section 1902(a)(27) of the Social Security Act, there will be a provider agreement between the Medicaid agency and each provider of services under the waiver.

3. Method of payments (check one):

Payments for all waiver and other State plan services will be made through an approved Medicaid Management Information System (MMIS).

Payments for some, but not all, waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will maintain an audit trail for all State and Federal funds expended, and under which payments will be made to providers is attached to this Appendix.

Payment for waiver services will not be made through an approved MMIS. A description of the process by which payments are made is attached to this Appendix, with a description of the process by which the State will maintain an audit trail for all State and Federal funds expended.

Other (Describe in detail):

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b. BILLING AND PROCESS AND RECORDS RETENTION

1. Attached is a description of the billing process. This includes a description of the mechanism in place to assure that all claims for payment of waiver services are made only:

- a. When the individual was eligible for Medicaid waiver payment on the date of service;
- b. When the service was included in the approved plan of care;
- c. In the case of supported employment, prevocational or educational services included as part of habilitation services, when the individual was eligible to receive the services and the services were not available to the individual through a program funded under section 602(16) or (17) of the Individuals with Disabilities Education Act (P.L. 94-142) or section 110 of the Rehabilitation Act of 1973.

Yes

No. These services are not included in this waiver.

2. The following is a description of all records maintained in connection with an audit trail. Check one:

All claims are processed through an approved MMIS.

MMIS is not used to process all claims. Attached is a description of records maintained with an indication of where they are to be found.

3. Records documenting the audit trail will be maintained by the Medicaid agency, the agency specified in Appendix A (if applicable), and providers of waiver services for a minimum period of 3 years.

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c. PAYMENT ARRANGEMENTS

1. Check all that apply:

The Medicaid agency will make payments directly to providers of waiver services.

The Medicaid agency will pay providers through the same fiscal agent used in the rest of the Medicaid program.

The Medicaid agency will pay providers through the use of a limited fiscal agent who functions only to pay waiver claims.

Providers may *voluntarily* reassign their right to direct payments to the following governmental agencies (specify):

Providers who choose not to voluntarily reassign their right to direct payments will not be required to do so. Direct payments will be made using the following method:

2. Interagency agreement(s) reflecting the above arrangements are on file at the Medicaid agency.

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ATTACHMENT F-1a

DESCRIPTION OF THE BILLING PROCESS

Washington utilizes two computer systems to process claims pertaining to the services provided to waiver recipients. State plan services are processed through the Medicaid Management Information System (MMIS) and waiver services are processed through the Social Service Payment System (SSPS).

The SSPS maintains data on waiver recipients including recipient name, birth date, social security number and case number. The recipient data is associated with the provider name, provider payment identification number, waiver service begin and end dates, unit rate, authorized service charge code, amount paid, date paid, etc.

Aging and Disability Services Administration (ADSA) social workers, community nurse consultants and Area Agency on Aging direct service and contracted case managers authorize waiver service payments for applicant/recipients meeting financial and service eligibility factors using a DSHS 14-154, Service Authorization form. Information on the form is used to update the SSPS computer database. A copy of the completed form is retained in the recipient's case record and the service provider receives a notice of payment authorization from SSPS. The computer generates a Change of Service Authorization form (DSHS 14-159) after the first authorization is processed. ADSA and the Area Agency on Aging direct service and contracted case manager staff use this Change of Service form to add, change, or terminate services.

The Service Invoice is the basis for payment of authorized waiver services, which have been provided. Each service is shown on an invoice one time for each month it was authorized as that month ends. Even if a service has not been billed or paid for, it will not be shown on an invoice a second time unless ADSA or Area Agency on Aging direct service or contracted case manager staff re-authorize payment. The provider signs the invoice and returns it to the department. Payments are made directly to the service provider. Historical records of all payments are maintained.

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ATTACHMENT F-1b

DESCRIPTION OF MECHANISM FOR ASSURING PAYMENTS ARE MADE ONLY FOR ELIGIBLE SERVICE RECIPIENTS

Aging and Disability Services Administration social workers, community nurse consultants and Area Agency on Aging direct service and contracted case manager will authorize waiver program services (as listed on the individual service plan) effective on the date all the following program factors constituting Medicaid eligibility for waiver services are satisfied:

- (1) Categorical relatedness and financial eligibility are approved.
- (2) The assessed applicant/recipient is eligible for nursing facility level care and is, or likely to be, institutionalized.
- (3) The individual service plan is developed and approved by the Aging and Adult Services Administration social worker, community nurse consultant or the Area Agency on Aging direct service or contracted case manager.
- (4) The recipient has approved the service plan.
- (5) The provider is qualified for payment.

The provider contract procedures are completed.

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ATTACHMENT F-1c

DESCRIPTION OF MECHANISM FOR ASSURING PAYMENTS ARE MADE ONLY WHEN THE SERVICE IS INCLUDED IN THE APPROVED PLAN OF CARE

The services the COPES waiver offers are often the corner stone of the recipients' service plan. The waiver services in the approved plans are not authorized until steps in the description of mechanism for assuring payments are made only for eligible service recipients are completed. Claims for payments can be made only after Aging and Disability Services Administration staff or Area Agency on Aging direct service or contracted case managers have authorized the payment on the Social Service Payment System (SSPS) database. The only services authorized are those services listed in the client's plan of care.

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ATTACHMENT F-1d

DESCRIPTION OF ALL RECORDS MAINTAINED IN CONNECTION WITH AN AUDIT TRAIL
 Recipient case records retained in the Aging and Disability Services Administration (ADSA) and Area Agency on Aging direct service and contracted case managers local offices provide the necessary documentation to support the cost of provided waiver services. The case records contain recipient's eligibility documents, service plans, service authorization and change forms and other information regarding the recipients' needs. Key documents in the recipients' case records with regard to an audit trail are:

1. DSHS 14-154, SERVICE AUTHORIZATION

This form is completed by ADSA social workers, community nurse consultants and Area Agency on Aging direct service and contracted case managers to authorize payment for specific waiver services identified by a specific waiver service charge code in the Social Service Payment System (SSPS).

2. DSHS 14-159, SERVICE AUTHORIZATION CHANGE

This form is computer generated after the DSHS 14-154 is processed. The ADSA social workers, community nurse consultants and Area Agency on Aging direct service and contracted case manager staff use this Change of Service form to add, change or terminate waiver services.

WAIVER SERVICES PAYMENTS ARE MADE THROUGH SSPS. KEY DOCUMENTS ARE:

1. DSHS 08-141, SERVICE INVOICE

This form is the basis for payment for authorized waiver services. The information for the service invoice is taken directly from the Service Authorization and the Change of Service Authorization forms (DSHS 14-154/14-159). The Service Invoice lists all the clients and all the services for which a specific provider (denoted by name and SSPS Provider File number) was authorized payment, identifying each client's waiver service name and charge code and the associated service begin and end date for that particular payment period.

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ATTACHMENT F-1d, continued

2. WARRANTS

The SSPS maintains reports, which associate the Service Invoice number with the number of each payment, warrant.

3. DSHS 07-071, VENDOR REMITTANCE ADVICE

This form is a detailed statement of the individual services, which make up the total amount of the warrant. A Vendor Remittance Advice is included with each warrant.

Payments for state plan services are made by the MMIS.

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APPENDIX G - FINANCIAL DOCUMENTATION

APPENDIX G-1
COMPOSITE OVERVIEW
COST NEUTRALITY FORMULA

INSTRUCTIONS: Complete one copy of this Appendix for each level of care in the waiver. If there is more than one level (e.g. hospital and nursing facility), complete a Appendix reflecting the weighted average of each formula value and the total number of unduplicated individuals served.

LEVEL OF CARE:

YEAR	FACTOR D	FACTOR D'	FACTOR G	FACTOR G'
1	<u>\$9,943</u>	<u>\$ 8,913</u>	<u>\$26,546</u>	<u>\$4,922</u>
2	<u>\$10,037</u>	<u>\$ 9,466</u>	<u>\$27,342</u>	<u>\$5,227</u>
3	<u>\$10,132</u>	<u>\$10,053</u>	<u>\$28,162</u>	<u>\$5,551</u>
4	<u>\$10,229</u>	<u>\$10,676</u>	<u>\$29,007</u>	<u>\$5,895</u>
5	<u>\$10,326</u>	<u>\$11,338</u>	<u>\$29,877</u>	<u>\$6,260</u>

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FACTOR C: NUMBER OF UNDUPLICATED INDIVIDUALS SERVED

YEAR	UNDUPLICATED INDIVIDUALS
1	<u>31,450</u>
2	<u>31,884</u>
3	<u>32,325</u>
4	<u>32,772</u>
5	<u>33,226</u>

EXPLANATION OF FACTOR C:

Check one:

The State will make waiver services available to individuals in the target group up to the number indicated as factor C for the waiver year.

The State will make waiver services available to individuals in the target group up to the lesser of the number of individuals indicated as factor C for the waiver year, or the number authorized by the State legislature for that time period.

The State will inform HCFA in writing of any limit, which is less than factor C for that waiver year.

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APPENDIX G-2
METHODOLOGY FOR DERIVATION OF FORMULA VALUES

FACTOR D

LOC: NE

The July 25, 1994 final regulation defines Factor D as:

"The estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program."

The demonstration of Factor D estimates is on the following page.

STATE: Washington

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APPENDIX G-2

FACTOR D

LOC: NF

Demonstration of Factor D estimates:

Waiver Year 1 X 2__ 3__ 4__ 5__

Waiver Year 4/01/04-3/31/05

Waiver Service Column A	#Undup. Recip. (users) Column B	Avg. # Annual Units/User Column C	Avg. Unit Cost Column D	Total Column E
1. Personal Care	19,500	290 Days	\$ 35.47	\$200,582,850
2. Enhanced Adult Residential Care	1,750	204 Days	\$ 36.10	\$ 12,887,700
3. Assisted Living	6,000	229 Days	\$ 38.11	\$ 52,363,140
4. Adult Family Home Care	4,200	223 Days	\$ 41.24	\$ 38,625,384
5. Personal Emergency Response	7,600	255	\$ 1.16	\$ 2,248,080
6. Environmental Modification	700	3 jobs	\$395.92	\$ 720,574
Skilled Nursing	175	80 visits	\$ 45.45	\$ 636,300
Transportation	230	12 trips	\$ 36.47	\$ 100,657
9. Home Health Aide Services	15	24 visits	\$ 18.28	\$ 6,581
10. Adult Day Care	205	192 days	\$ 9.52	\$ 374,707
11. Caregiver/Recipient Training Services	375	10 hours	\$ 45.45	\$ 170,438
12. Home Delivered Meals	3,200	206 meals	\$ 4.55	\$ 2,999,360
13. Assistive Technology Specialized Medical Equipment	1,630	2 items	\$252.50	\$ 823,150
14. In home Nurse Delegation	400	50	\$ 8.16	\$ 163,200
GRAND TOTAL (sum of Column E):			\$ 312,702,121	
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:				31,450
FACTOR D (Divide total by number of recipients):			\$ 9,943	
AVERAGE LENGTH OF STAY: 273 days				

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APPENDIX G-2
 ACTOR D
 DC: NF

Demonstration of Factor D estimates:

Waiver Year 1__ 2 X 3__ 4__ 5__

Waiver Year 4/01/05-3/31/06

Waiver Service Column A	#Undup. Recip. (users) Column B	Avg. # Annual Units/User Column C	Avg. Unit Cost Column D	Total Column E
1. Personal Care	19,695	290 Days	\$ 35.82	\$204,587,721
2. Enhanced Adult Residential Care	1,785	204 Days	\$ 36.46	\$ 13,276,544
3. Assisted Living	6,120	229 Days	\$ 38.49	\$ 53,942,965
4. Adult Family Home Care	4,284	223 Days	\$ 41.65	\$ 39,789,578
5. Personal Emergency Response	7,676	255	\$ 1.17	\$ 2,290,135
6. Environmental Modification	707	3 job	\$ 399.88	\$ 735,059
7. Skilled Nursing	177	80 visits	\$ 45.90	\$ 649,944
8. Transportation	232	12 trips	\$ 36.83	\$ 102,535
9. Home Health Aide Services	15	24 visits	\$ 18.46	\$ 6,646
10. Adult Day Care	207	192 days	\$ 9.62	\$ 382,337
11. Caregiver/Recipient Training Services	379 hours	10 hours	\$ 45.90	\$ 173,961
12. Home Delivered Meals	3,232	206 meals	\$ 4.60	\$ 3,062,643
13. Assistive Technology Specialized Medical Equipment	1,646	2 items	\$ 255.03	\$ 839,559
14. In home Nurse Delegation	404	50	\$ 8.24	\$ 166,448
GRAND TOTAL (sum of Column E):			\$	320,006,075
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:				31,884
FACTOR D (Divide total by number of recipients):			\$	10,037
AVERAGE LENGTH OF STAY: 273 days				

ATE: Washington

DATE: December 2003

APPENDIX G-2

ACTOR D

C: NF

Demonstration of Factor D estimates:

Waiver Year 1__ 2__ 3 X 4__ 5__

Waiver Year 4/01/06-3/31/07

Waiver Service Column A	#Undup. Recip. (users) Column B	Avg. # Annual Units/User Column C	Avg. Unit Cost Column D	Total Column E
1. Personal Care	19,892	290 Days	\$ 36.18	208,710,842
2. Enhanced Adult Residential Care	1,821	204 Days	\$ 36.82	13,678,041
3. Assisted Living	6,242	229 Days	\$ 38.87	\$55,561,478
4. Adult Family Home Care	4,370	223 Days	\$ 42.07	\$40,997,636
5. Personal Emergency Response	7,753	255	\$ 1.18	\$ 2,332,878
6. Environmental Modification	714	3 job	\$ 403.88	\$ 749,763
7. Skilled Nursing	179	80 visits	\$ 46.36	\$ 663,875
8. Transportation	234	12 trips	\$ 37.20	\$ 104,458
Home Health Aide Services	15	24 visits	\$ 18.64	\$ 6,710
10. Adult Day Care	209	192 days	\$ 9.72	\$ 390,044
11. Caregiver/Recipient Training Services	383 hours	10 hours	\$ 46.36	\$ 177,559
12. Home Delivered Meals	3,264	206 meals	\$ 4.65	\$ 3,126,586
13. Assistive Technology Specialized Medical Equipment	1,662	2 items	\$ 257.58	\$ 856,196
14. In home Nurse Delegation	408	50	\$ 8.32	\$ 169,728

GRAND TOTAL (sum of Column E):	<u>\$327,525,794</u>
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:	32,325
FACTOR D (Divide total by number of recipients):	\$10,132
AVERAGE LENGTH OF STAY: 273 days	

TE: WashingtonDATE: December 2003

APPENDIX G-2
 ACTOR D
 DC: NF

Demonstration of Factor D estimates:

Waiver Year 1__ 2__ 3__ 4 X 5__
 Waiver Year 4/01/07-3/31/08

Waiver Service Column A	#Undup. Recip. (users) Column B	Avg. # Annual Units/User Column C	Avg. Unit Cost Column D	Total Column E
1. Personal Care	20,091	290 Days	\$ 36.54	212,896,291
2. Enhanced Adult Residential Care	1,857	204 Days	\$ 37.19	14,088,613
3. Assisted Living	6,367	229 Days	\$ 39.26	\$57,242,768
4. Adult Family Home Care	4,457	223 Days	\$ 42.49	\$42,231,278
5. Personal Emergency Response	7,831	255	\$ 1.19	\$ 2,376,317
6. Environmental Modification	721	3 jobs	\$ 407.92	\$ 764,687
7. Skilled Nursing	181	80 visits	\$ 46.82	\$ 677,954
8. Transportation	236	12 trips	\$ 37.57	\$ 106,398
9. Home Health Aide Services	15	24 visits	\$ 18.83	\$ 6,779
10. Adult Day Care	211	192 days	\$ 9.82	\$ 397,828
11. Caregiver/Recipient Training Services	387	10 hours	\$ 46.82	\$ 181,193
12. Home Delivered Meals	3,297	206 meals	\$ 4.70	\$ 3,192,155
13. Assistive Technology Specialized Medical Equipment	1,679	2 items	\$ 260.16	\$ 873,617
14. In home Nurse Delegation	412	50	\$ 8.40	\$ 173,040
GRAND TOTAL (sum of Column E):				\$335,208,918
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:				32,772
FACTOR D (Divide total by number of recipients):				\$10,229
AVERAGE LENGTH OF STAY: 273 days				

ATE: Washington

DATE: December 2003

APPENDIX G-2

ACTOR D

C: NF

Demonstration of Factor D estimates:

Waiver Year 1__ 2__ 3__ 4__ 5_X

Waiver Year 4/01/08-3/31/09

Waiver Service Column A	#Undup. Recip. (users) Column B	Avg. # Annual Units/User Column C	Avg. Unit Cost Column D	Total Column E
1. Personal Care	20,292	290 Days	\$ 36.91	\$217,203,539
2. Enhanced Adult Residential Care	1,894	204 Days	\$ 37.56	\$14,512,283
3. Assisted Living	6,494	229 Days	\$ 39.65	\$58,964,546
4. Adult Family Home Care	4,546	223 Days	\$ 42.91	\$43,500,356
5. Personal Emergency Response	7,909	255	\$ 1.20	\$ 2,420,154
6. Environmental Modification	728	3 job	\$ 412.00	\$ 779,834
7. Skilled Nursing	183	80 visits	\$ 47.29	\$ 692,326
8. Transportation	238	12 trips	\$ 37.95	\$ 108,385
Home Health Aide Services	15	24 visits	\$ 19.02	\$ 6,847
10. Adult Day Care	213	192 days	\$ 9.92	\$ 405,688
11. Caregiver/Recipient Training Services	391	10 hours	\$ 47.29	\$ 184,904
12. Home Delivered Meals	3,330	206 meals	\$ 4.75	\$ 3,258,405
13. Assistive Technology Specialized Medical Equipment	1,696	2 items	\$ 262.76	\$ 891,282
14. In home Nurse Delegation	416	50	\$ 8.48	\$ 176,384

GRAND TOTAL (sum of Column E):	\$343,104,933
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:	33,226
FACTOR D (Divide total by number of recipients):	\$10,326
AVERAGE LENGTH OF STAY: 273 days	

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APPENDIX G-3

METHODS USED TO EXCLUDE PAYMENTS FOR ROOM AND BOARD

The purpose of this Appendix is to demonstrate that Medicaid does not pay the cost of room and board furnished to an individual under the waiver.

A. The following service(s), other than respite care*, are furnished in residential settings other than the natural home of the individual(e.g., foster homes, group homes, supervised living arrangements, assisted living facilities, personal care homes, or other types of congregate living arrangements). (Specify):

*NOTE: FFP may be claimed for the cost of room and board when provided as part of respite care in a Medicaid certified NF or ICF/MR, or when it is provided in a foster home or community residential facility that meets State standards specified in this waiver.)

B. The following service(s) are furnished in the home of a paid caregiver. (Specify):

Personal care services such as eating, toileting, ambulation, transferring, positioning, bathing and self-medication as well as skilled nursing visits, caregiver/client training, transportation and specialized medical equipment and supplies. Services may also include help with housework, laundry, meal preparation and wood supply.

The services cited above are paid on a fee for service basis. Room and board is not considered when determining the fees for services cited above.

Attached is an explanation of the method used by the State to exclude Medicaid payment for room and board.

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APPENDIX G-3 a

Method used by the State to exclude Medicaid payment for room and board:

Clients living in residential facilities (Adult Family Homes & Boarding Home Facilities) are required to pay for their room and board at a rate set by the state. For clients with insufficient income to meet their room and board obligations, state funding is used to supplement client payments up to the room and board standard amount.

Payments for client services are authorized on a DSHS form 14-154/14-159. The authorization includes the total cost of care for the individual for each month. This form includes an amount for client participation paid toward the cost of room and board.

When the SSPS system processes provider payments, any room and board costs listed on the SSPS form that are the responsibility of the client to pay to the provider are subtracted from the total amount owed for the month billed.

When the State submits for FFP, the amount billed is the actual amount paid by the State as reported by the SSPS payment system for the client's care in a residential setting

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APPENDIX G-4
METHODS USED TO MAKE PAYMENT FOR RENT AND FOOD EXPENSES OF AN UNRELATED
LIVE-IN CAREGIVER

Check one:

The State will not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who lives with the individual(s) served on the waiver.

The State will reimburse for the additional costs of rent and food attributable to an unrelated live-in personal caregiver who lives in the home or residence of the individual served on the waiver. The service cost of the live-in personal caregiver and the costs attributable to rent and food are reflected separately in the computation of factor D (cost of waiver services) in Appendix G-2 of this waiver request.

Attached is an explanation of the method used by the State to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver.

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APPENDIX G-5

FACTOR D'

LOC: NF

NOTICE: On July 25, 1994, HCFA published regulations which changed the definition of factor D'. The new definition is:

"The estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program."

Include in Factor D' the following:

The cost of all State plan services (including home health, personal care and adult day health care) furnished in addition to waiver services WHILE THE INDIVIDUAL WAS ON THE WAIVER.

The cost of short-term institutionalization (hospitalization, NF, or ICF/MR) which began AFTER the person's first day of waiver services and ended BEFORE the end of the waiver year IF the person returned to the waiver.

Do NOT include the following in the calculation of Factor D':

If the person did NOT return to the waiver following institutionalization, do NOT include the costs of institutional care.

Do NOT include institutional costs incurred BEFORE the person is first served under the waiver in this waiver year.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor D'.

TE: WashingtonDATE: December 2003

APPENDIX G-5

Factor D' (cont.)

LOC: NF

Factor D' is computed as follows (check one):

Based on HCFA Form 2082 (relevant pages attached).

Based on HCFA Form 372 for year 4 of waiver
0049.91.R3.02, which serves a similar target population.

Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

Other (specify):

ATE: Washington

DATE: December 2003

APPENDIX G-7

FACTOR G'

LOC: NF

Factor G' is computed as follows (check one):

Based on HCFA Form 2082 (relevant pages attached).

Based on HCFA Form 372 for year 4 of waiver
0049.91.R3.02, which serves a similar target population.

Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

Other (specify):

STATE: Washington

DATE: December 2003

APPENDIX G-7

FACTOR G'

LOC: NF

The July 25, 1994 final regulation defines Factor G' as:

"The estimated annual average per capita Medicaid costs for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted.

Include in Factor G' the following:

The cost of all State plan services furnished WHILE THE INDIVIDUAL WAS INSTITUTIONALIZED.

The cost of short-term hospitalization (furnished with the expectation that the person would return to the institution) which began AFTER the person's first day of institutional services.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G'.

STATE: Washington

DATE: December 2003

APPENDIX G-7

FACTOR G'

LOC: NF

Factor G' is computed as follows (check one):

Based on HCFA Form 2082 (relevant pages attached).

Based on HCFA Form 372 for year 4 of waiver
0049.91.R3.02, which serves a similar target population.

Based on a statistically valid sample of plans of care for individuals with the disease or
condition specified in item 3 of this request.

Other (specify):

STATE: Washington

DATE: December 2003

APPENDIX G-8

DEMONSTRATION OF COST NEUTRALITY

LOC: NF

YEAR 1

FACTOR D: <u>9,943</u>		FACTOR G: <u>26,546</u>
FACTOR D': <u>8,913</u>		FACTOR G': <u>4,922</u>
TOTAL: <u>18,856</u>	≤	TOTAL: <u>31,468</u>

YEAR 2

FACTOR D: <u>10,037</u>		FACTOR G: 27,342
FACTOR D': <u>9,466</u>		FACTOR G': <u>5,227</u>
TOTAL: <u>19,503</u>	≤	TOTAL: <u>32,569</u>

YEAR 3

FACTOR D: <u>10,132</u>		FACTOR G: <u>28,162</u>
FACTOR D': <u>10,053</u>		FACTOR G': <u>5,551</u>
TOTAL: <u>20,185</u>	≤	TOTAL: <u>33,713</u>

STATE: WashingtonDATE: December 2003

APPENDIX G-8

DEMONSTRATION OF COST NEUTRALITY (cont.)

LOC: NF

YEAR 4

FACTOR D:	<u>10,229</u>		FACTOR G:	<u>29,007</u>
FACTOR D':	<u>10,676</u>		FACTOR G':	<u>5,895</u>
TOTAL:	<u>20,905</u>	≤	TOTAL:	<u>34,902</u>

YEAR 5

FACTOR D:	<u>10,326</u>		FACTOR G:	<u>29,877</u>
FACTOR D':	<u>11,338</u>		FACTOR G':	<u>6,260</u>
TOTAL:	<u>21,664</u>	≤	TOTAL:	<u>36,137</u>

STATE: Washington

DATE: December 2003

APPENDIX G-3

Methodology for Determining Factors D, D', G, G'

Factor D is calculated by applying a 2% increase in cost per year and a 5% increase in population for all waiver services. The exception to this rule regarding population growth is personal care, enhanced adult residential care and assisted living. The population increase used for these services is 17% for personal care, 33% for assisted living and 4% for enhanced residential care.

Factor D' is calculated by applying a 10 % growth in medical expenses (based on historical data) to the data from the most recent HCFA 372 report for each waiver year.

Factor G is calculated by applying a 7% growth in nursing facility services costs to the data from the most recent HCFA 372 report for each waiver year.

Factor G' is calculated by applying a 10 % growth in medical expenses (based on historical data) to the most recent HCFA 372 report for each waiver year.

STATE: WashingtonDATE: December 2003

APPENDIX G-4

Description of COPES Personal Care waiver Service as Extension of State Plan Personal Care Services

State Plan personal care services are limited to the categorically needy. Persons whose incomes are within the special income level covered by the waiver are not included in the State Plan personal care services covered Medicaid eligibility group.

Clients who meet institutionally eligibility and are waiver eligible under the special income standard have income that exceeds the CN income standard for state plan personal care services. These clients would not be eligible for personal care under the state plan services. Clients who are institutionally eligible and receive services under the COPES waiver receive a full package of personal care services under the waiver including personal care and are CN medically eligible. ←

STATE: Washington

DATE: December 2003

Medicaid eligibility on the same footing as persons who elect to receive institutional services.

Waivers target many types of Medicaid beneficiaries, including older persons, individuals who have experienced a brain injury, children with serious emotional disturbances, children and adults with developmental disabilities, persons with physical and other disabilities, persons living with AIDS, and others.

Services Offered Under a Waiver

A state must specify the services that are furnished through the waiver. The state may include the services that are enumerated in §1915(c) of the Act and/or propose to offer other services that assist individuals to remain in the community and avoid institutionalization. Waiver services complement the services that a state offers under its State plan. Waiver participants must have full access to State plan services, including Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for children. A state may also furnish "extended State plan services" through its waiver that exceed the limits that apply under the State plan. There is no limit on the number of services that a state may offer in a waiver nor are states required to include specific services in the waiver.

→ In its application, a state must specify the scope and nature of each waiver service and any limits on amount, frequency and duration that the state elects to apply to a service. Also, the state must specify the qualifications of the individuals or agencies that furnish each waiver service.

Exclusion of Room and Board

Except in limited circumstances, a state may not claim federal financial participation (FFP) for the costs of room and board expenses of waiver participants. Room and board costs must be met from participant resources or through other sources.

Number of Waiver Participants

In its application, a state must specify the unduplicated number of individuals that the state intends to serve each year the waiver is in effect. It is up to the state to determine this number, based on the resources that the state has available to underwrite the costs of waiver services. As state resources permit, this number may be modified by amendment while the waiver is in effect.

Service Plan

The waiver services that an individual is authorized to receive must be incorporated into a written service plan (a.k.a., "plan of care"). A state may only claim FFP for the waiver services that have been included in the participant's service plan. The service plan must also include the non-waiver services and supports that are used to meet the needs of the participant in the community. In its application, the state must specify how the service plan is developed, including how the plan addresses potential risks to the individual. Effective service plan development processes are essential in order to ensure that waiver participants will receive the services and supports that they need in order to function successfully in the community and to assure their health and welfare. Monitoring the implementation of the service plan is also critical waiver operational activity.

Participant Direction of Waiver Services

A state may provide that the waiver participant (or the participant's representative) may direct and manage some or all of the waiver services included in the service plan.

Participant direction may take a variety of forms, including the participant's employing and directly supervising community support workers and exercising decision making authority over an amount of waiver funds (the participant-directed budget). When a waiver provides for participant direction, the state is expected to make supports available to the participant as necessary to facilitate participant direction. A state that makes a strong commitment to participant direction may request that CMS review the application for possible designation as an Independence Plus waiver (see Appendix E instructions).

Assuring Participant Health and Welfare

A waiver's design must provide for continuously and effectively assuring the health and welfare of waiver participants. Processes that are important for assuring participant health and welfare include (but are not necessarily limited to):

- Specifying the qualifications of waiver providers and verifying that providers continuously meet these qualifications;
- Periodic monitoring of the implementation of the service plan and participant health and welfare;
- Identifying and responding to alleged instances of abuse, neglect and exploitation that involve waiver participants; and,
- Instituting appropriate safeguards concerning practices that may cause harm to the participant or restrict participant rights.

The renewal of a waiver is contingent on CMS determining that the state has effectively assured the health and welfare of waiver participants during the period that the waiver has been in effect. In its application, the state must specify how it monitors performance in assuring health and welfare along with other waiver assurances by preparing and submitting a Quality Management Strategy.

Waiver Administration and Operation

A waiver may be operated directly by the Medicaid agency or by another state agency (termed the "operating agency") under an agreement with the Medicaid agency, so long as the Medicaid agency retains ultimate authority and responsibility for the waiver. In addition, a state may provide that local or regional non-state entities (e.g., county human services agencies) or contracted entities perform specified waiver administrative and operational tasks, so long as the authority of the Medicaid agency over the waiver is maintained.

Participant Rights

A state must provide that individuals have the opportunity to request a Fair Hearing when they are not given the choice to receive waiver services, are denied the waiver services or providers of their choice, or their waiver services are denied, suspended, reduced or terminated.

Cost Neutrality

In its application and each year during the period that the waiver is in operation, the state must demonstrate that the waiver is *cost neutral*. In particular, the average per participant expenditures for the waiver and non-waiver Medicaid services must be no more costly than the average per person costs of furnishing institutional (and other Medicaid state plan) services to persons who require the same level of care.