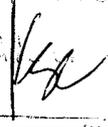


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STATE OF WASHINGTON

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NO. 33088-1-II

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

VENETTA GASPER and TOMMYE MYERS,

Respondents,

v.

DEPARTMENT OF SOCIAL AND HEALTH SERVICES,

Appellant.

APPELLANT'S REPLY BRIEF

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I. INTRODUCTION

The issue in this case is whether the Appellant, the Department of Social and Health Services (DSHS or the Department), has authority under federal and state law to adjust the level of paid in-home assistance it will provide to Medicaid recipients due to the recipient's living situation.

In the programs at issue, the Department provides in-home assistance to disabled individuals to allow them to avoid institutional care in a nursing home or hospital. As explained in the Department's opening brief, the services include assistance with what are known as "activities of daily living" (ADLs)—personal tasks such as bathing, getting dressed, and using the toilet—and "instrumental activities of daily living" (IADLs)—support tasks such as food preparation, shopping and housekeeping. Br. App. at 7-8.

The Department has developed a sophisticated formula, known as the Comprehensive Assessment Reporting Evaluation (CARE) system, to determine how many hours of assistance it will provide for eligible recipients. Under the formula built into the CARE system, the Department provides a higher level of paid in-home assistance to persons whose caregivers do not reside with them than to persons who live with their caregivers. The premise is that those who live with their caregivers have less need for the state to pay someone to perform common tasks that benefit the entire household, tasks such as housecleaning, food preparation, shopping and laundry.

Both of the Respondents are eligible recipients of in-home assistance. Because they live with their caregivers, they are eligible for fewer hours of paid assistance than they would receive if they did not live with their providers and had no other assistance available to them. This results from the application of the so-called “shared living rule.” Respondents assert that this rule violates federal and state statutes giving Medicaid recipients the choice of their provider and requiring that services available to Medicaid recipients be “comparable.” The trial court below agreed and invalidated the rule.

The Department’s opening brief demonstrated that the shared living rule complies with both the choice-of-provider and comparability provisions of federal Medicaid law, and that in any event the comparability rule has been waived and therefore does not apply to three of the four programs to which the rule applies. Respondents also pointed out that the state statute cited by the trial court—RCW 74.09.270—does not establish a choice-of-provider rule that differs from the federal rule.

In their reply, Respondents misconstrue the applicable statutes, misapply the principles articulated in the case law, and misunderstand both the shared living rule and the larger context in which it operates. As a result, their arguments lack merit.

II. ARGUMENT

A. The Shared Living Rule Does Not Violate Medicaid Law

The Department's opening brief explained that the shared living rule does not violate the federal "choice-of-provider" requirement (Br. App. at 32-35) or the comparability rule (*Id.* at 37-39 and 41-44) and that, in any event, the federal government has waived the latter requirement with respect to the Community Options Program Entry System (COPES) program in which Ms. Myers participates. *Id.* at 39-41.¹ Appellant's brief also observed that both federal and state courts routinely defer to the expertise of agencies such as the federal Centers for Medicare and Medicaid Services (CMS) and the Department with respect to the statutes they administer. Br. App. at 44-49. Respondents' attempts to refute these points are unconvincing.

1. Respondents Confirm That Their Providers Are Not "Willing" Providers As That Term Is Used In Medicaid Law

Under federal Medicaid law, participating states must assure that

any individual eligible for medical assistance . . . may obtain such assistance from any institution, agency, community pharmacy, or person, *qualified to perform* the service or services required . . . who *undertakes to provide* him such services[.]

See 42 U.S.C. § 1396a(a)(23)(A) (emphasis added); *see also* 42 C.F.R. § 431.51(b) (providers must be both "[q]ualified" and "[w]illing" to furnish Medicaid services).

¹ Respondents concede this latter point, although they dismiss the significance of the waiver. Br. Resp. at 27.

In their brief, the Respondents' confirmed that their providers are not willing to serve as caregivers if they are paid only for the hours that the Department's assessment determines are appropriate to their respective situations. Br. Resp. at 12. Accordingly, these caregivers should not be considered "willing providers" for purposes of the choice-of-provider requirement.

The fact that Respondents' providers apparently *would* be willing to provide care *if* more hours were authorized no more makes them willing providers than if they conditioned their willingness on being compensated at a higher rate. As explained in Appellant's opening brief, the fact that the payment rate is allegedly too low to attract providers does not violate the choice-of-provider requirement. *Antrican v. Buell*, 158 F. Supp. 2d 663, 671 (E.D.N.C. 2001), *partially aff'd on other grounds sub. nom. Antrican v. Odom*, 290 F.3d 178 (4th Cir. 2002), *cert. denied*, 537 U.S. 973 (2002), discussed in Br. App. at 34.

Respondents discount *Antrican* by attempting to distinguish it factually from the instant case. Br. Resp. at 20. But they miss the essential point, i.e., that the level of Medicaid payment is a separate issue from the recipient's choice of provider. The unwillingness of the dentists in *Antrican* to provide services for the compensation offered did not amount to a denial of free choice, and neither does the now-confirmed unwillingness of Respondents' providers to furnish services for the compensation they have been offered.

2. State Law Does Not Add To The Federal Choice-Of-Provider Rule

The trial court found the shared living rule to be violative of RCW 74.39A.270(4), which provides that even though the state bargains collectively with in-home health care workers, “consumers *retain* the right to select, hire, supervise the work of, and terminate” providers. CP 259, ¶ 3.1 (emphasis added). Appellant’s opening brief pointed out that the statutory language relied on by the trial court was added in 2001 as part of Initiative 775, and that the use of the word “retain” is a strong indication that the drafters of the initiative did not intend to create any “choice of provider” rule different from what existed at the time of the enactment. Br. App. at 35-6.

Respondents attempt to counter this point by identifying several other state statutes relating to long-term care. Br. Resp. at 25, listing RCW 74.39.001, 74.39.005, 74.39A.005, 74.39A.007, 74.39A.009(5), 74.39A.050, and 74.39A.095(7) and (8). The trial court did not rely on any of these statutes; moreover, while some of the listed statutes include hortatory statements about the social and economic value of a variety of options in long-term care, none of them contains even an indirect reference to a state choice-of-provider rule. In fact, the thrust of at least one of the statutes is to the contrary. RCW 74.39A.050(13) provides:

[DSHS] shall establish, by rule, training, background checks, and other quality assurance requirements for personal aides who provide in-home services funded by Medicaid personal care as described in RCW 74.09.520, community options program entry system waiver services

as described in RCW 74.39A.030, or chore services as described in RCW 74.39A.110 that are equivalent to requirements for individual providers.

It is axiomatic that this legislative directive necessarily means that some clients' choices will be limited because not every provider will be able to meet the minimum qualifications established pursuant to the statute.

Similarly, Respondents' reliance on RCW 74.39A.095(7) and (8) is misplaced. RCW 74.39A.095 sets forth the expectations for case management oversight by staff from DSHS or area agencies on aging (AAAs)² with respect to in-home care service, including monitoring of provider qualifications and performance. RCW 74.39A.095(1)(a) and (e). The statute further authorizes either DSHS or the local AAA to take steps to cancel a provider contract under certain conditions, or reject a particular provider because he or she does not meet the qualifications. RCW 74.39A.095 (7) and (8).

These latter two provisions also direct that when a provider is disallowed, the client or would-be client has a right to request a hearing under the Administrative Procedure Act (APA), RCW 34.05. Without this language, recipients would have no mechanism to protect whatever interest they may have in determining who their providers would be, because the Department's arrangements with providers are contractual in nature and not subject to the APA. RCW 34.05.010(3).

² As explained in Appellant's opening brief, much of the administration of DSHS programs for the aged and disabled is performed through regional AAAs, pursuant to RCW 74.38.030. *See* Br. App. at 7, n.10.

Nonetheless, Respondents assert that the creation of a hearing right “make[s] clear the recipient’s stake in having his or her caregiver of choice.” Br. Resp. at 25. The Department agrees that clients have a “stake” in determining their provider, but having a “stake” in the outcome is far different from the kind of absolute right to choose a provider—regardless of the provider’s willingness to provide services at the compensation level offered—that Respondents assert.

Respondents’ argument that state law creates an additional choice-of-provider rule that differs from federal Medicaid law is simply not supported by the statutes they cite.

3. The Shared Living Rule Does Not Violate Federal Comparability Requirements

The trial court held that the shared living rule “exceeds the statutory authority of [DSHS] by violating [Medicaid] comparability requirements.” CP 259, ¶ 3.4. The trial court did not identify either the specific requirement or why the rule was in violation. Appellant’s opening brief pointed out that under federal law, states have broad discretion to structure their Medicaid programs, and that the purpose of the comparability requirement is to prevent similarly situated recipients from being treated differently, either because of the basis for their eligibility or the reason for their need for a particular kind of care. *See generally* Br. App. at 37-39, 41-44. Appellant also pointed out that the federal government waived the comparability requirements with respect to certain Medicaid programs. Br. App. at 39-41.

Respondents counter with arguments premised on the incorrect assumption that compliance with the comparability requirement focuses on whether the “needs” of clients—presumably as they assess them—are adequately addressed. Br. Resp. at 30-31. However, they do not provide any authority for the proposition that Medicaid law prohibits a state from differentiating the level of assistance based on whether or not the clients have live-in assistance available to them.³

The Ninth Circuit Court of Appeals rejected arguments similar to those advanced by Respondents in *Beckwith v. Kizer*, 912 F.2d 1139 (9th Cir. 1990). *Beckwith* involved a California Medicaid waiver program that limited state-paid home-based care to those individuals who had been hospitalized for at least 90 days. 912 F.2d at 1141. A class of individuals who sought such services to avoid hospitalization sued, claiming *inter alia* that the 90-day restriction was barred by then-recent amendments to the Medicaid statute, and that the requirement violated equal protection. *Id.*

³ Washington is not alone in differentiating among providers of in-home health care. Some examples: Maine pays live-in providers a flat weekly fee, while live-out providers are paid by the half hour. Code of Maine Regulations 10-144, Chapter 101, Maine Cares Benefits Manual, Chap. III, Section 19, available on line at <http://www.maine.gov/sos/cec/rules/10/ch101.htm> (visited July 5, 2005). Unlike Washington (see discussion below at pp. 19-21), California calculates the need for assistance with IADL activities separately from that for ADLs. California also provides that “[t]he need for services in common living areas shall be prorated to all the housemates, the recipient’s need being his/her prorated share.” California Dept. of Social Services Manual of Policies and Procedures, Section 30-763.3.311, available on line at: <http://www.dss.cahwnet.gov/getinfo/pdf/ss2.pdf> (visited July 5, 2005). New York will not pay spouses or children, including sons and daughters-in-law, for providing in-home care (18 NYCRR 505.14(h)(2)), while Oregon limits payments to spouses (ORS 411.803 and OAR 411-030-080), and Michigan denies payment to a client’s “responsible relative or legal dependent.” Michigan Family Independence Agency, Adult Services Manual (ASM), part 363, page 16 of 26, available online at: <http://www.mfia.state.mi.us/olmweb/ex/asm/363.pdf> (visited July 5, 2005).

While much of the *Beckwith* opinion focuses on other issues, the Ninth Circuit ultimately upheld the California program, and the concluding paragraph of its opinion is instructive:

Definition of any waiver class necessarily involves *difficult policy judgments* concerning where the services would most efficiently be used. We lack the qualifications or the authority to pass upon the fiscal responsibility of California's waiver program in the manner plaintiffs request. . . . We are here faced with a situation in which the state has defined the class in material part upon the length of acute hospital care individuals would require if they were not provided home care services. . . . The state's program makes home care waiver services available in cases where the program will enable the recipient to leave an institution and return to a home environment. *We cannot say that this decision is irrational. The statute is intended to alleviate the problem of unnecessary institutionalization, but does not purport to solve it altogether.*

912 F.2d at 1143 (emphasis added).

The same may be said for the shared living rule. The state has made a “difficult policy judgment” to limit its assistance by not paying in-home providers for performing household tasks that benefit all residents and not just the recipient. Moreover, unlike the 90-day hospitalization requirement in *Beckwith*, the shared living rule does not result in any client actually being denied care.

Further, as pointed out in Appellant's opening brief, recipients who *truly are* similarly situated—i.e., those with live-in providers—are in fact treated similarly under the shared living rule. Br. App. at 43, n.30. The fact that they are treated differently from those who are in fact differently

situated, i.e., those who don't share living quarters with their providers, does not mean that the comparability requirements are violated.

Finally, as pointed out in Appellant's opening brief, a state's federal application for Medicaid funding for in-home services necessarily involves a request that certain Medicaid requirements, including comparability, be waived. Br. App. at 39-41. Respondents acknowledge this fact, Br. Resp. at 27, but assert that the waiver only applies to the extent that "additional services" are provided. *Id.*

It is true that the standard waiver application includes language stating that the purpose for requesting the comparability waiver is "in order that services not otherwise available under the approved Medicaid state plan may be provided and individuals served on the waiver." Br. App. at 40, quoting the standard application form from the CMS web site: <http://www.cms.hhs.gov/medicaid/1915c/cwaiverapp.pdf> (visited May 9, 2005, and again on July 2, 2005). And in fact, waiver programs do provide services under the waiver that are not provided under the state's Medicaid Plan. However, that does not change the fact that DSHS requested and CMS granted a waiver, with the result that the comparability requirement does not apply to the state's Medicaid waiver programs. The case relied on by Respondents, *McMillan v. McCrimmon*, 807 F. Supp. 475 (C.D. Ill. 1992), does not support a contrary conclusion. In *McMillan* the plaintiffs claimed that Illinois was not permitting already enrolled Medicaid recipients to apply for a waiver program that provided home and community-based care, contrary to 42

U.S.C. § 1396a(a)(8). 807 F. Supp. at 477. That statute requires states to allow all persons to apply for assistance, and to process applications for Medicaid programs with “reasonable promptness.” The court rejected the state’s argument that the “reasonable promptness” requirement had been waived, and observed as follows:

[S]ection 1396n(c)(3) allows [CMS] to waive certain uniform requirements of the Medicaid Act, such as the requirements relating to statewideness, comparability, and income. 42 U.S.C. Section 1396n(c)(3); . . . This section does not allow a waiver of the requirements of section 1396a(a)(8) [the reasonable promptness requirement], however. In addition, the State waiver request to the Secretary did not mention limiting applications for the [program at issue].

807 F. Supp at 482 (citation omitted). Here, the state’s application specifically requested and, as respondents acknowledge, CMS granted, a waiver of 42 U.S.C. §1396a(a)(10)(B)—the comparability requirement—with respect to all three of the waiver programs in which the shared living rule is used in allocating hours. Washington did not request a waiver of the “reasonable promptness” requirement, nor is that requirement at issue here. *McMillan* simply has no application to the instant case.

Respondents also miss the point of *Rodriguez v. City of New York*, 197 F.3d 611 (2nd Cir. 1999) and *Alexander v. Choate*, 469 U.S. 287, 105 S. Ct. 712, 83 L. Ed. 2d 661 (1985) by focusing on the particular services at issue in those cases. Br. Resp. at 33-35. The larger point overlooked by

Respondents is that these cases demonstrate the broad discretion that states have in structuring Medicaid programs, whether under a state plan or pursuant to a waiver.

The main thrust of Respondents' comparability argument appears to be that all clients should be treated the same, regardless of the resources that they should be able to call upon to assist them. A state Medicaid program is not expected to pay for a service that is not medically necessary or that would be provided to an ineligible person. Similarly, a state should be able to presume that a live-in caregiver or others living in the residence will provide certain in-home services that benefit the entire household. Further, a state can choose not to pay for services that benefit the provider and other ineligible persons who reside with the recipient. These principles are built into the CARE assessment tool through the shared living rule, and it does not violate Medicaid comparability requirements.⁴

⁴ Respondents assert that the shared living rule is the kind of "irrebuttable presumption" which they state is "disfavored in the law." Br. Resp. at 25-6, n. 17. (citing *Vlandis v. Kline*, 412 U.S. 441, 452, 93 S. Ct. 2230, 37 L. Ed. 2d 63 (1973) and *Cleveland Bd. of Education v. LaFleur*, 414 U.S. 632, 646, 94 S. Ct. 791, 39 L. Ed. 2d 52 (1974)) However, shortly after these two cases were decided, the U.S. Supreme Court declined to apply their holding to "a noncontractual claim to receive funds from the public treasury", i.e., precisely the kind of claim involved in this case. See *Weinberger v. Salfi*, 422 U.S. 749, 772 95 S. Ct. 2457, 45 L. Ed. 2d 522 (1975). The *Salfi* Court noted that Congress had conditioned eligibility for the Social Security benefits at issue there "upon compliance with an objective criterion, one which the Legislature considered to bear a sufficiently close nexus with underlying policy objectives to be used as the test for eligibility" and that adopting the reasoning of *Vlandis* and *LaFleur* to the public

4. Respondents Understate The Deference Due To Administrative Agencies

Appellant's opening brief pointed out that federal and state courts have historically deferred to agencies' interpretation of the statutes they are charged with administering. Br. App. at 44-49, citing *inter alia*, *Skandalis v. Rowe*, 14 F.3d 173, 178 (2nd Cir. 1994) ("An agency's interpretation of a statute that the agency administers is entitled to considerable deference; a court may not substitute its own reading unless the agency's interpretation is unreasonable. . . . When an agency construes its own regulations, such deference is particularly appropriate, and even more appropriate [when] we consider a small corner of a labyrinthine statute." (citations omitted) and *Puget Soundkeeper Alliance v. Dep't of Ecology*, 102 Wn. App. 783, 786-7, 9 P.3d 892 (2000) ("We review [agencies'] legal decisions de novo, giving substantial weight to the agency's interpretation of the statutes it administers. An agency's interpretation of a statute is not binding on the court, but we will uphold it if it is a plausible construction." (footnotes omitted)).

Respondents do not challenge that basic proposition, but assert that the deference is limited and that "[a] state agency's interpretation of federal law requirements is not entitled to the same deference that would

assistance context "would turn the doctrine of those cases into a virtual engine of destruction for countless legislative judgments." 442 U.S. at 772.

be accorded to a federal agency's interpretation." Br. Resp. at 40 (citations omitted). Once again, Respondents miss the mark.

At issue in this case is a program that is funded in part with federal money and closely monitored by a federal agency, the Centers for Medicare and Medicaid Services (CMS). The precise issue is whether the state's program violates federal statutes and their implementing regulations requiring "choice-of-provider" and "comparability." As the U.S. Supreme Court recently observed, it is a "settled principle of administrative law that an open-ended and potentially vague term is highly susceptible to administrative interpretation subject to judicial deference." *Washington Dep't of Social & Health Servs. v. Estate of Keffeler*, 537 U.S. 371, 389, 123 S. Ct. 1017, 154 L. Ed. 2d 972 (2003).

The shared living rule is consistent with the direction given by CMS that "[c]onsideration may also be given to the kinds of household tasks family members typically expect to share or to do for one another when they live in the same household—as opposed to intimate personal tasks that individuals normally do for themselves." SHS-0006.⁵ Further, a version of the shared living rule has been part of Washington's Medicaid plan since 1993, with no objection from CMS. Br. App. at 11, n.13. Thus, not only is DSHS's interpretation of federal and state law entitled to

⁵ As explained in the Department's opening brief, this citation is to the rule-making file which was considered by the trial court. Br. App. at 11, n.14.

deference, the administration of federal Medicaid programs on a national basis by CMS is also entitled to deference.

Federal courts have also recognized that programs enacted under the Spending Clause of the U.S. Constitution,⁶ such as the Medicaid program, should not be read as creating privately enforceable rights absent explicit “rights creating language”. *Gonzaga v. Doe*, 536 U.S. 273, 290, 122 S. Ct. 2268, 153 L. Ed. 2d 309 (2002); *see also Long Term Care Pharm. Alliance v. Ferguson*, 362 F.3d 50, 58 (1st Cir. 2004) (applying *Gonzaga* in a Medicaid context and concluding that “the generality of the goals [outlined in the Medicaid provision at issue] and the structure for implementing them suggests that [state Medicaid] plan review by the Secretary is the central means of enforcement intended by Congress.”)

There is no question but that RCW 34.05.570(2) vests this Court with jurisdiction to determine the validity of agency rules and that, although not explicitly stated, such review may include the rule’s compliance with federal law. Given that “[t]he burden of demonstrating the invalidity of agency action is on the party asserting invalidity” (RCW

⁶ U.S. Const., art. I, § 8, cl. 1 provides that “[t]he Congress shall have Power To lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and general Welfare of the United States.” Legislation enacted under Congress’ spending power is “in the nature of a contract: in return for federal funds, the States agree to comply with federally imposed conditions.” *Pennhurst State School & Hosp. v. Halderman*, 451 U.S. 1, 17, 101 S. Ct. 1531, 67 L. Ed. 2d 694 (1981).

34.05.270(1)(a)), state courts should exercise at least the same degree of caution as exhibited by federal courts in making such determinations.

B. The Department Has Broad Discretion To Determine What Level Of Services Will Be Provided And To Consider Other Resources, Including Informal Supports, In Determining Need

There is an underlying assumption in Respondents' brief that the Department's programs are required to meet every conceivable need of every client and that, in addressing those needs, the Department should not be able to take into account other resources that the client may have available.⁷ This assumption is incorrect.

Medicaid is considered the "payor of last resort," i.e., it is to pay for needed medical care *only* when the care cannot be provided from another source. *Wilson v. Dep't of Social & Health Servs.*, 142 Wn.2d 40, 44, 10 P.3d 1061 (2000) (noting, albeit in a different context, that "Medicaid is to be the payment source of last resort; all other available resources must be used before Medicaid funds are made available to eligible recipients" and citing S. Rep. No. 146, 99th Cong., 1st Sess. 459 (1985), *reprinted in* 1986 U.S.C.C.A.N. 42); *see also Cordall v. State*, 96 Wn. App. 415, 424, 980 P.2d 253 (1999).⁸

⁷ *See, e.g.* Br. Resp. at 30 ("The Department [applied the shared living rule] without regard to [Respondents'] actual need for help with meal preparation, housekeeping or shopping."); and 31 ("A long term care recipient's need for personal care services is not limited to 'routine household maintenance tasks,' nor are his or her non-routine IADL needs always subsumed into the routine household tasks of a live-in caregiver.").

⁸ Both of these cited cases involved reimbursement for Medicaid-provided medical services from third party sources such as a tortfeasor (*Wilson*) and federal veterans benefits (*Cordall*). While that factually distinguishes those cases from the instant case, the underlying principle—that Medicaid steps in only when no other source is available—is the same one built into the CARE assessment tool.

Further, the Legislature has directed that community-based Medicaid waiver services be available “to the extent of available funds” and has vested in the Department broad authority “to establish eligibility criteria, applicable income standards, and the specific waiver services to be provided.” RCW 74.39.041. The Legislature has also instructed that the Department’s long-term care options provide a “balanced array” of long-term care services designed to “meet the needs of consumers and to maximize effective use of limited resources” and to provide services that are both “responsive and appropriate to individual need and also cost-effective for the state.” RCW 74.39A.007(1), (2) and (3). Finally, services must be made available based on “a uniform system for comprehensively assessing functional disability.” RCW 74.39.005.

The Legislature enacted similar directives when it authorized personal care services to be added to the state’s Medicaid plan. *See* RCW 74.09.520(2), (3), and (4), directing, *inter alia*, that the Department develop an assessment of the need for such services for persons covered under the plan, and that the “services . . . be provided to the extent funding is available according to the assessed level of functional disability.”

The combined effect of these directives is that the Department has broad discretion to develop a set of services, make them available to eligible clients based on a comprehensive assessment system, with the sometimes conflicting goals of (1) attempting to meet client needs (2) in a cost-effective manner while (3) maximizing the use of available resources. Given this legislative direction, and the broad discretion that states have

under Medicaid law to structure their programs (see Br. App. at 28-29), the suggestion implicit in Respondents' brief that the Department is obligated to meet all of their "needs"—as they perceive them—is unwarranted.

C. Respondents Analyze The Shared Living Rule In Isolation And Fail To Recognize That It Is An Integral Component Of A Comprehensive Assessment Formula

Respondents attack the shared living rule as though it were a stand-alone provision unrelated to the rest of the rules describing the CARE assessment.⁹ This is exactly the wrong approach.

The rules of statutory construction apply to administrative rules just as they do to statutes. *Dep't of Licensing v. Cannon*, 147 Wn.2d 41, 56, 50 P.3d 627 (2002); *City of Seattle v. Allison*, 148 Wn.2d 75, 88, 59 P.3d 85 (2002). Thus, like statutes, related administrative rules are to be read together as a whole so as to give effect to the intent underlying the entire regulatory scheme. *Judd v. Amer. Tel. & Tel. Co.*, 152 Wn.2d 195, 204, 95 P.3d 337 (2004).

The shared living rule is only one part of a comprehensive information gathering and assessment system designed for consistent statewide use with a wide variety of clientele. It is used to determine, among other things, eligibility for and level of services to be provided to a

⁹ See, e.g., Br. Resp. at 4 (“[T]he assessment process has nothing to do with this appeal.”); and 5 (asserting that the portions of the Department’s brief “discussing the assessment system and describing how the system groups based on several factors . . . is irrelevant to the shared living rule.”) and (“The methodology of obtaining the base hours is irrelevant to this appeal.”).

significant category of applicants for public assistance.¹⁰ By focusing only on the shared living rule and labeling “irrelevant” the remainder of the entire CARE assessment process, respondents ignore the rules of statutory construction and give short shrift to the many benefits that clients receive under Medicaid.

For example, Respondents state that “[a]bsent the [shared living] rule, each [of them] would receive 190 hours per month of care.” Br. Resp. at 18. That may be true if the shared living rule did not apply and the rest of the CARE assessment remained unchanged. However, if the shared living rule is invalidated, the Department will likely have to adjust either eligibility requirements or the level of services—or both—in order to operate within its legislative appropriation.¹¹ Thus, contrary to Respondents’ glib assertion, “absent the rule” the number of hours for *all* recipients, including Respondents, might in fact be smaller than under the current version of the CARE assessment.

In addition to focusing their argument too narrowly—or perhaps because of that approach—Respondents also misapprehend the operation of the CARE assessment. The respondents appear to believe that the CARE assessment allots hours for instrumental activities of daily living (IADLs) separately from hours authorized for the more personal activities

¹⁰ Respondents correctly note, Br. Resp. at 4, that some information gathered during the CARE assessment process is used for purposes other than determining the number of authorized hours, such as case management or development of the client’s service plan. See WAC 388-72A-0069.

¹¹ See RCW 43.88.290 (“No state officer or employee shall intentionally or negligently [o]ver-expend or over-encumber any appropriation made by law.”).

of daily living (ADLs), and that the shared living rule results in a complete denial of payment for IADLs.¹² This reflects a flawed understanding of the CARE assessment process.

As described in Appellant's Opening Brief, at pp. 5-14 and A-7 through A-10, the CARE assessment develops the base number of hours of care that the Department will provide based on a combination of three factors: (1) the client's ability to perform certain personal self-care tasks without assistance (the activities of daily living, or ADLs); (2) the client's medical condition; and (3) the client's cognitive or behavioral functioning. Thus, the hours allotted for performance of IADLs by a state-paid provider are embedded in the base hours allotted. They are not, as Respondents appear to suppose, the result of a separate calculation.

One of Respondents' hypotheticals illustrates the point. They postulate the existence of "[a] clinically complex recipient who needs no help at all with IADLs [and who] 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." Br. Resp. at 23 (emphasis in the original). As Respondents note, "the base rate for the clinically complex groups . . . is based on the existence of at least one clinically complex medical condition [combined with] an 'ADL score' which does

¹² See, e.g., Br. Resp. at 5, ("The case manager may not award personal care hours for [special dietary] needs [when the CARE assessment system] "marks those needs as fully met."); and 14 (Under "[t]he shared living rule . . . a covered benefit – personal care services for assistance with IADLs – is provided to one class of recipients [and] the same benefit is denied to another.").

not consider whether the recipient does or does not need IADL assistance.” *Id. at n.13.*

Respondents omit the fact that any one of 35 different medical conditions can qualify a client as clinically complex, and that for all but a few of these conditions the client would need an ADL score of at least 10 to qualify as “clinically complex.” WAC 388-72A-0082, 388-72A-0084. This means the client would require at least “limited assistance” on at least 5 activities of daily living such as bathing, toilet use, or moving around, or “extensive assistance” on at least 3 such tasks.

The CARE formula allocates base hours at a high level for such an individual based on the reasonable premise that a person who needs assistance with such activities as bathing, moving around, getting dressed, and using the toilet would also require assistance with housework, meal preparation, and shopping.

Respondents are correct that *if* this premise is not accurate in an individual situation—one that is highly unlikely to exist in the real world—the result would be somewhat anomalous. Even so, the fact that the CARE assessment may not work perfectly in every hypothetical situation—especially one as inconceivable as that posited by Respondents—does not mean that the assessment should be abandoned or significantly altered.

The shared living rule presumes that activities such as shopping, housekeeping and preparing meals (the IADLs) will be performed by a live-in provider on behalf of the entire household, not just the client, and

reduces the base hours by 15 percent to avoid the use of Medicaid funds to pay for services that benefit non-eligible persons. This is a reasonable reduction in view the available data available to the Department indicates that on average providers devote between 26% and 42% of their paid time on such tasks. SHS 0003. It does not, contrary to Respondents' arguments, mean that their caregivers are not being paid for performing any IADLs for recipients.

Respondents' misunderstanding of the complexity of the shared living rule is also apparent in their other hypothetical situation—that of an eligible woman client with two daughters, one who lives with her mother and one who lives next door. Respondents observe that if the former is her caregiver, the number of hours paid by the Department would be 15% less than if the daughter next door were the caregiver. Br. Resp. at 2. Respondents overlook the fact that the mother would continue to receive assistance in the form of housekeeping, food preparation, and shopping as those tasks were performed on behalf of the entire household (i.e., that the mother would receive the same level of assistance in either situation). The difference is that the state would not be paying the daughter with whom the mother lived to perform tasks that benefit her entire household.¹³

Respondents also ignore the substantial possibility, if not likelihood, that a daughter who lives with (or, for that matter, next to) her ailing mother would provide some assistance even if she were not paid by

¹³ As noted above, p.8 n.3, New York state would not pay either daughter to perform personal care services, regardless of their living arrangement.

the state to do so. The CARE assessment addresses such situations by recognizing certain ADL and IADL needs as “met” or “partially met” under WAC 388-72A-0095. For that reason, Respondents’ assertion that the shared living rule “is not applied generally to recipients who share living situations with others” (Br. Resp. at 1) is not accurate. Of course, the state cannot force unwilling or unable family members or others living with a client to help with tasks necessary for the client to remain in the home. However, this does not mean that the state has to compensate live-in caregivers for tasks that benefit the caregiver and the rest of the household.

D. The Concessions Made By Respondents Demonstrate That The Trial Court Should Have Upheld The Rule Because Of Its General Validity

The trial court invalidated the shared living rule on its face, stating that it violated “state and federal laws regarding freedom of choice of provider and comparability requirements.” CP 259. Respondents acknowledge that the purpose of the rule is that “taxpayer money should be paid to live-in caregivers for tasks that benefit the caregiver,” Br. Resp. at 6, and further state that they agree with that proposition. *Id.* at 3.

Respondents’ criticism of the rule is based on their assertion that “the impact of the rule, *at least in some cases*, goes beyond the stated purpose.” *Id.* at 6 (emphasis added); *see also Id.* at 31, where Respondents state that the judgment underlying the shared living rule that the need of a person who lives with a caregiver is different from that of a

person who does not “is incorrect, *at least some of the time.*” (Emphasis added.)

These statements reflect an implicit acknowledgment by Respondents that the CARE assessment, including the shared living rule, does not violate even Respondents’ formulation of federal or state law as it is applied to many Department clients. It is unreasonable to believe that any system designed to cover a broad range of needs in a wide variety of circumstances could work perfectly in every conceivable situation. Respondents have provided no authority for the proposition that any state or federal law imposes a requirement that the Department’s assessment mechanism achieve such perfection.

At a minimum, Respondents’ recognition that the CARE assessment works well in many situations is an admission that the trial court’s ruling was overly broad. At most, the rule should be deemed valid absent compelling evidence in an individual case that the assessment produces an irrational result.

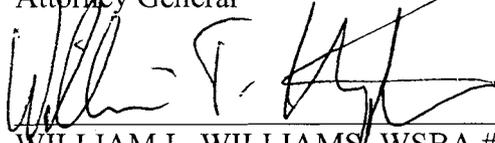
III. CONCLUSION

For the reasons set forth above and in the Brief of Appellant, the judgment below should be reversed, and the validity of the Department’s rule affirmed. In the alternative, the trial court’s determination that the rule is invalid on its face should be set aside, and the matter be remanded

for a determination of whether the rule is valid as applied to the two
Respondents.

RESPECTFULLY SUBMITTED this 15th day of July, 2005.

ROB MCKENNA
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A handwritten signature in black ink, appearing to read 'William L. Williams', written over a horizontal line.

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DATED this 15th day of July, 2005, at Lacey, WA.

Judith A. Hulla
