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CRIMINAL JUSTICE
JUL 14 2006
Crim NO. _____

SUPREME COURT OF THE STATE OF WASHINGTON

VENNETTA GASPER and TOMMYE MYERS,

Respondents,

v.

WASHINGTON STATE DEPARTMENT OF SOCIAL AND
HEALTH SERVICES,

Petitioner.

FILED
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CLERK OF SUPREME COURT
STATE OF WASHINGTON

PETITION FOR REVIEW
Court of Appeals No. 33088-1-II

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TABLE OF CONTENTS

I. IDENTITY OF PETITIONER1

II. COURT OF APPEALS’ DECISION1

III. ISSUES PRESENTED FOR REVIEW1

IV. STATEMENT OF THE CASE2

V. ARGUMENT WHY REVIEW SHOULD BE ACCEPTED6

 A. This Case Involves An Issue Of Substantial Public Interest That Should Be Determined By The Supreme Court6

 B. The Court of Appeals’ Decision Should Be Reversed.....8

 1. The Shared Living Rule Is Part Of The Determination Of Clients’ Need For Publicly Paid Services; The Comparability Requirement Applies Only To The Services That Are Provided Once The Level Of Need Is Determined.....10

 2. The Court Erred By Holding That The Comparability Provision Requires The Department To Make An Individualized Determination Of The Extent To Which A Client’s Needs Are Met By A Live-in Provider.....12

 3. The Court of Appeals’ Opinion Reflects A Misunderstanding Of Medicaid Waivers.....14

 4. The Court of Appeals’ Analysis Of Federal Medicaid Law Has No Application To The Chore Program.....18

VI. CONCLUSION19

APPENDICES

TABLE OF AUTHORITIES

Cases

<i>Beckwith v. Kizer</i> , 912 F.2d 1139 (9th Cir. 1990)	16
<i>Campbell v. Dep't of Soc. & Health Servs.</i> , 150 Wn.2d 881, 83 P.3d 999 (2004)	12
<i>Skandalis v. Rowe</i> , 14 F.3d 173 (2d Cir. 1994)	16, 18
<i>Weinberger v. Salfi</i> , 422 U.S. 749, 95 S. Ct. 2457, 45 L. Ed. 2d 522 (1975)	14

Statutes

42 U.S.C. § 1396a(a)(10)(B)	1, 5
42 U.S.C. § 1396a(a)(10)(B)(i)	1, 8
42 U.S.C. § 1396a(a)(23)	5
42 U.S.C. § 1396n(c)(1)	15
RCW 2.06.030(c)	6
RCW 2.06.030(d)	6
RCW 74.39A.100	18
RCW 74.39A.110	18

Regulations and Rules

42 C.F.R. § 440.180	16
42 C.F.R. § 440.181	16
42 C.F.R. § 440.250(k)	9, 15

WAC 388-106-0040(1)..... 2
WAC 388-106-0080 to -0140..... 3
WAC 388-106-0130(3)(b)..... 1, 3, 19
WAC 388-106-0600 to -0655..... 18
RAP 13.4(b)..... 6, 7
RAP 13.4(b)(4)..... 8

Other Authorities

Wash. St. Reg. 05-11-082..... 3

I. IDENTITY OF PETITIONER

The Washington State Department of Social and Health Services (Department or DSHS) asks this Court to accept review of the Court of Appeals' decision terminating review designated in Part II of this petition.

II. COURT OF APPEALS' DECISION

Petitioner seeks review of that part of the Court of Appeals' decision that affirmed the holding of the Thurston County Superior Court (1) that former WAC 388-72A-0095 (now WAC 388-106-0130(3)(b)) violates the requirements of 42 U.S.C. § 1396a(a)(10)(B), and (2) that the rule is invalid as applied to the state-funded Chore program. The Court of Appeals' opinion was filed on March 7, 2006, and Petitioner's motion for reconsideration was denied by order of June 9, 2006.¹

III. ISSUES PRESENTED FOR REVIEW

1. Did the trial court err as a matter of law by declaring that WAC 388-106-0130(3)(b) (former WAC 388-72A-0095(1)(c)) violates 42 U.S.C. § 1396a(a)(10)(B)(i)?

2. Did the trial court err as a matter of law by declaring WAC 388-106-0130(3)(b) (former WAC 388-72A-0095(1)(c)) invalid even as

¹ Pursuant to RAP 13.4, a copy of the decision is in the Appendix at pages A-1 through A-15; a copy of the order denying petitioner's motion for reconsideration is in the Appendix at page A-16; and copies of pertinent statutes are in the Appendix at pages A-28 through A-51.

used with respect to the state-funded Chore program that is not subject to the Medicaid Act?

The Court has accepted certification by Division One of the Court of Appeals of a case presenting issue (1) above, which is the core issue in both appeals. *See David J. Jenkins v. State of Washington, Department of Social and Health Services*, Washington Supreme Court Cause Number 78652-6. Shortly after this Petition is filed, the parties to the instant case intend to file a joint motion to consolidate this case with *Jenkins*.

III. STATEMENT OF THE CASE

This case involves a challenge to a rule used in administering four programs administered by DSHS under which the Department pays for in-home services for low-income disabled individuals to allow them to remain in their homes as an alternative to nursing homes or other institutions.² Three of the programs are Medicaid-funded, and the fourth (Chore) is wholly state-funded.

² The four programs potentially affected by the ultimate outcome of this case are Medicaid Personal Care (MPC), the Community Options Program Entry System (COPES) waiver program, the Medically Needy In-Home waiver program, and the Chore program. All four programs provide in-home assistance with personal care and household tasks furnished by a paid caregiver (referred to as an “individual provider”). WAC 388-106-0040(1). Services provided include assistance with activities of daily living such as bathing, dressing, food preparation, and house cleaning. Because the trial court’s order invalidating the shared living rule is not limited to the Respondents or the programs from which they receive benefits, the rule’s application as to all of the programs administered by the Department is at issue in this appeal.

The rule, the so-called “shared living” rule, WAC 388-106-0130(3)(b),³ adjusts the amount of publicly paid care for recipients whose caregiver lives with them. The adjustment is based on the premise that the need for publicly paid assistance in such situations is reduced because the live-in caregivers will be performing some tasks—such as housekeeping, shopping for food, and preparing meals—for the residential unit even if they were not being paid to provide services to the recipient(s) with whom they reside.

The shared living rule is a component of the Comprehensive Assessment and Reporting Evaluation (CARE), a multi-faceted tool developed by the Department to determine the level of need for publicly paid assistance to individuals enrolled in the four programs. The CARE assessment is designed to allocate limited public assistance resources on a consistent and equitable basis statewide. The mechanics of the CARE assessment system are delineated in WAC 388-106-0080 through 388-106-0140, and are described in detail in the Brief of Appellant at pages 7-16 (copy attached at A-17 through A-26).

Respondents Gasper and Myers are Medicaid recipients who receive publicly funded personal assistance under two of the Medicaid programs administered by the Department. Ms. Gasper receives benefits

³ The rule was formerly WAC 388-72A-0095 but was renumbered as part of a consolidation of DSHS rules relating to long-term care. *See* Wash. St. Reg. 05-11-082.

under the Medicaid Personal Care program, which is part of the state's basic Medicaid service package. Ms. Myers receives services under the Community Options Program Entry System (COPES) program, a Medicaid waiver program authorized under section 1915(c) of the Medicaid Act. Clerk's Papers (CP) at 24.⁴

Both respondents, Vennetta Gasper and Tommye Myers, were receiving state-paid in-home care prior to 2004. Each was assessed as part of an annual review of her continuing eligibility, using the CARE tool. Other than their objection to the shared living rule, both respondents agree that the individualized assessment of their functional capacity using the CARE tool accurately assessed their needs for services. *Gasper* AR at 44, ¶ 10; *Myers* AR at 50, ¶ 10.⁵

As noted, each respondent was satisfied with her CARE assessment, except for disputing the shared living rule. Rather than challenging the rule directly, however, each exercised the option given to them by the Department in former WAC 388-72A-0050 to request an adjudicative proceeding before an Administrative Law Judge (ALJ) to

⁴ States can provide Medicaid-funded services either under the state's basic Medicaid plan or under "waivers" approved by the federal government. The latter are referred to as "waiver programs" because the federal government typically waives some of the requirements applicable to the basic Medicaid program.

⁵ The clerk of the trial court transmitted the records of the administrative hearings relating to the two respondents, but did not paginate them as Clerk's Papers. Citation to those records is by name of the respondent and the relevant page number(s) in the administrative record (AR).

contest the reduction of authorized hours of paid in-home service. *Gasper* AR at 77; *Myers* AR at 90.

The respondents agreed that the ALJ did not have authority to invalidate the shared living rule. *Gasper* AR at 17, ¶ 3; *Myers* AR at 19, ¶ 3. In view of the respondents' acknowledgement that the CARE assessment was otherwise proper, the ALJs issued Initial Decisions affirming the reduction. *Gasper* AR at 17; *Myers* AR at 20. Respondents then appealed to the Department's Board of Appeals, which issued expedited decisions affirming the ALJs' decisions on June 30, 2004. *Gasper* AR at 7; *Myers* AR at 7.

The respondents then filed the instant actions in the Thurston County Superior Court, seeking both review of the administrative decisions and a declaratory judgment invalidating the shared living rule. CP at 6-22 (*Gasper* petition); CP at 280-301 (*Myers* petition). The two cases were consolidated pursuant to a stipulation and order entered on August 20, 2004. CP at 23-25.

The superior court invalidated the shared living rule on two bases: (1) that the rule denies Medicaid recipients a "choice of provider" contrary to 42 U.S.C. § 1396a(a)(23); and (2) that the rule violates the "comparability" requirement of 42 U.S.C. § 1396a(a)(10)(B). CP at 260, ¶ 4.1.

The Department appealed the superior court's ruling to the Court of Appeals, which stayed the effectiveness of the ruling below (except as applicable to Ms. Gasper and Ms. Myers) pending final resolution of the appeal.⁶ Following briefing and oral argument, the Court of Appeals rejected the first prong on the superior court's order but affirmed the second. The Department seeks review of this latter ruling.

IV. ARGUMENT WHY REVIEW SHOULD BE ACCEPTED

A. This Case Involves An Issue Of Substantial Public Interest That Should Be Determined By The Supreme Court

RAP 13.4(b) outlines the circumstances under which this Court will accept review of a Court of Appeals' decision:

A petition for review will be accepted by the Supreme Court only: (1) If the decision of the Court of Appeals is in conflict with a decision of the Supreme Court; or (2) If the decision of the Court of Appeals is in conflict with another decision of the Court of Appeals; or (3) If a significant question of law under the Constitution of the State of Washington or of the United States is involved; or (4) If the petition involves an issue of substantial public interest that should be determined by the Supreme Court.

Subsections (3) and (4) of this rule parallel the provisions of RCW 2.06.030(c) and (d) outlining the jurisdiction of this Court. In accepting certification in the *Jenkins* case, this Court's Commissioner stated his agreement with Division One that the issues presented in that case—which

⁶ That stay by its terms will expire on July 9, 2006. Shortly after filing this Petition for Review, the parties anticipate filing a joint motion asking the Supreme Court to extend the stay pending resolution of this case and *Jenkins*.

include the issue presented here—“warrant[] direct review under the cited statute.” Ruling Accepting Certification dated May 5, 2006 (copy attached as A-27). Thus, this Court has already recognized that this case is appropriate for discretionary review under RAP 13.4(b).

In addition, however, there are differences between this case and *Jenkins* such that this case meets the standards for review on its own merits. First, while the core issue presented in this case and *Jenkins* is the same, the superior court’s ruling under review in *Jenkins* was limited by its terms to Mr. Jenkins. Second, Mr. Jenkins receives services under the COPES program, a Medicaid waiver program. A decision in that case will not necessarily address the extent to which the shared living rule may be applied with respect to the other personal care programs administered by the Department, all of which are implicated in this case.

Because the scope of the lower court’s decision is much broader than that involved in *Jenkins*, the ultimate decision in this case is likely to have a far greater impact. The shared living rule applies to approximately 40 percent of the approximately 25,000 clients who receive publicly funded in-home personal care services. Elimination of the shared living rule will result in an increase in the costs of affected programs estimated to be between \$20 and \$30 million, an increase that will have to be

addressed either by adjusting eligibility requirements (resulting in some current clients losing benefits) or by shifting funds from other worthwhile programs. Implementation of the Court of Appeals' approach requiring individualized assessments will divert some funds that are now used to pay for services to the increased administrative costs inherent in the kind of individualized assessments contemplated by the Court of Appeals' opinion. In short, there is little doubt that this case "involves an issue of substantial public interest that should be determined by the Supreme Court." RAP 13.4(b)(4).

B. The Court of Appeals' Decision Should Be Reversed

There are four bases for asking this Court to reverse the holding of the Court of Appeals. First, the Court of Appeals' opinion recognizes that "[h]aving a live-in provider certainly may affect a recipient's need [because p]roviders will do things for themselves that reduce the needs of their clients." Slip Op. at 10. In other words, recipients who live with their caregivers as a general rule have less need for publicly paid services than those who do not. But 42 U.S.C. § 1396a(a)(10)(B)(i) (the Medicaid comparability provision) does not require that recipients be provided the same level of services if their needs are in fact different; it only requires that services provided to similarly situated clients be comparable. The Court of Appeals' opinion, by applying the comparability requirement to a

rule used in determining the *need* for publicly paid services, appears to confuse the need of the clients, as determined by the CARE tool, with the services paid for from public funds to meet that need.

Second, the Court of Appeals recognized that the Department “may use a reasonable method (such as the CARE assessment program) to determine a recipient’s true need.” Slip Op. at 10. However, by requiring an individualized determination of recipients’ “actual need,” the Court of Appeals’ opinion reflects a misunderstanding of the Medicaid comparability requirement. Further, the Court of Appeals’ opinion appears to overlook the holding of the U.S. Supreme Court that public assistance benefits need not be based on individualized determinations.

Third, as to the COPES program from which Ms. Myers receives services and other Medicaid programs, the Court of Appeals’ opinion recognizes that the federal government has waived the comparability requirement, but fails to recognize that once such a waiver for home and community-based services has been granted, “*the services provided under the waiver need not be comparable for all individuals within a group.*” 42 C.F.R. § 440.250(k) (emphasis added). Rather, the Court of Appeals’ opinion appears to be predicated on the understanding that the waiver was somehow limited, a concept that finds no support or recognition in either

the Medicaid statutes and regulations or in the case law on which the Court relies.

Finally, the Court affirmed the trial court's ruling that invalidated the shared living rule in its entirety, even though one of the programs to which it applies, the Chore program, is wholly state-funded. There is no basis on which to invalidate the rule as applied to the Chore program.

1. The Shared Living Rule Is Part Of The Determination Of Clients' Need For Publicly Paid Services; The Comparability Requirement Applies Only To The Services That Are Provided Once The Level Of Need Is Determined

The Court of Appeals' opinion acknowledges that the CARE assessment tool is a reasonable means to determine the "true need" of in-home care recipients, and that the Department's assessment "process is entirely consistent with the Medicaid program's purposes." Slip Op. at 10. The Court of Appeals' opinion also acknowledges that "[h]aving a live-in provider certainly may affect a recipient's need [because p]roviders will do things for themselves that reduce the needs of their clients (such as clean the house)." *Id.*

However, the Court of Appeals' holding that the Medicaid comparability provision requires an assessment of the recipient's "individual situations" is not accurate. What the Court of Appeals' opinion overlooks is that the shared living rule functions as part of the

CARE assessment in determining the level of need for publicly paid assistance.

The Court of Appeals' statement that "DSHS has created a system in which recipients like Ms. Gasper will have certain needs unmet while others with comparable disabilities will receive adequate services" (slip op. at 10-11), demonstrates that the Court has confused the determination of need with the provision of services. It is not that Ms. Gasper has needs that are unmet; rather, the shared living rule reflects an expectation that at least some of her needs for assistance will be met—as the Court recognizes—through activities that a live-in caregiver would perform even if not being paid by the Department for doing so. The combination of these informal supports, plus the paid assistance, fully meets her needs, and the Court of Appeals' statement to the contrary is not accurate.⁷

In short, the Court of Appeals' opinion views the shared living rule as a separate calculation of service level once the need determination has been made. Instead, the shared living rule is correctly viewed as an integral part of the need determination itself. Medicaid law does not require that needs that are in fact different be treated as the same; yet that

⁷ The Court may be confusing the level of services received by the client with the efficacy of those services. If Ms. Gasper believes that relying on her in-home provider will not be efficacious, the Department will pay for an outside provider for her.

is the effect of the Court of Appeals' opinion. Accordingly, the Court of Appeals' opinion should be reversed.

2. The Court Erred By Holding That The Comparability Provision Requires The Department To Make An Individualized Determination Of The Extent To Which A Client's Needs Are Met By A Live-in Provider

The Court of Appeals' opinion correctly recognizes that using a "reasonable method (such as the CARE assessment program) to determine a recipient's true need . . . is entirely consistent with the Medicaid program's purposes." Slip Op. at 10. This statement is in accord with the general rule that "[a]dministrative rules adopted pursuant to a legislative grant of authority are presumed to be valid and should be upheld on judicial review if they are reasonably consistent with the statute being implemented." *Campbell v. Dep't of Soc. & Health Servs.*, 150 Wn.2d 881, 892, 83 P.3d 999 (2004) (quotation marks omitted).

Yet the Court departs from this well-settled rule by requiring that the Department base its need determinations on "the realities of [recipients'] individual situations." Slip Op. at 10. Significantly, the Court of Appeals' opinion cites no authority for this proposition, and no such authority exists.

Just as it is reasonable for the Department to determine that a recipient who depends on some assistance with most activities of daily

living and has a clinically complex medical condition and significant cognitive impairment will have a base-line need of 190 hours per month,⁸ it is equally reasonable for the Department to base its final need determination on the premise that a fixed percentage of those hours will be provided by a live-in caregiver whether paid for by the Department or not, and that the need for publicly paid services is less for those whose caregivers reside with them than for those whose caregivers live elsewhere.

There is no provision of Medicaid law requiring an individualized determination of public assistance benefits. Moreover, the U.S. Supreme Court has recognized that, in the public assistance context,

[t]he administrative difficulties of individual . . . determinations are without doubt matters which [policy makers] may consider when determining whether to rely on rules which sweep more broadly than the evils with which they seek to deal. In this sense, [a bright line rule] represents not merely a substantive policy determination [as to the benefits at issue] but also a substantive policy determination that limited resources would not be well spent in making individual determinations. It is [a] policy choice that the [beneficiaries] would be best served by a [firm] rule . . . which is also objective and easily administered.

⁸ This describes hypothetical client 3 in Brief of Appellant at 15.

Weinberger v. Salfi, 422 U.S. 749, 784-85, 95 S. Ct. 2457, 45 L. Ed. 2d 522 (1975).⁹

There is no basis for the Court of Appeals' conclusion that the Department must make individual determinations of the "actual needs" of recipients.

3. The Court of Appeals' Opinion Reflects A Misunderstanding Of Medicaid Waivers

The discussion above demonstrates that the shared living rule is part of the mechanism for determining the level of publicly paid services needed for a client receiving services under the home and community-based service programs administered by the Department, and that accordingly the Medicaid provision requiring services to be comparable is not implicated by the rule. However, assuming *arguendo* that the rule is subject to the comparability provision, the Court of Appeals' opinion understates the effect that the waiver of that requirement has with respect to all of the Medicaid home and community-based programs administered by the Department except for Medicaid Personal Care.¹⁰

⁹ The administrative costs of conducting the kind of individual assessments called for by the Court of Appeals' opinion would be significant, given that more than 10,500 recipients are affected by the shared living rule. Moreover, such evaluations are inherently subjective and more difficult to calibrate to assure consistency across the state. These realities are sufficient in and of themselves to justify the Department's policy decision to adopt the fixed percentage approach reflected in the shared living rule.

¹⁰ Medicaid Personal Care is part of Washington's basic Medicaid plan, and thus not under a waiver.

The COPES program, through which Ms. Myers receives services, is a home and community-based services program operating under a waiver granted by the federal Centers for Medicare and Medicaid Services (CMS) pursuant to the authority of section 1915(c) of the Social Security Act (42 U.S.C. § 1396n(c)(1)). The Court of Appeals’ opinion acknowledges that the Department applied for a waiver of the Medicaid comparability requirement and appears to acknowledge that a comparability waiver was granted.

However, the Court of Appeals missed the mark when it stated that “[w]ithout showing that it somehow incorporated the shared living rule into its waiver request, DSHS cannot claim that the Secretary waived the comparability requirements for those who live with their caregivers.” Slip Op. at 12. Also incorrect is the assertion that “[a] general waiver of the comparability requirement does not suffice” to authorize “varying levels of service” under the waiver. Slip Op. at 13. These statements misconstrue the requirements of the statute authorizing waiver programs and understate the effect of the waiver that was granted

First, these statements completely disregard a CMS rule that in fact does authorize states to differentiate the services offered under a home and community-based waiver. 42 C.F.R. § 440.250(k) specifically provides that:

If the [state Medicaid] agency has been granted a waiver of the requirements of § 440.240 (Comparability of services) in order to provide for home or community-based services under §§ 440.180 or 440.181, *the services provided under the waiver need not be comparable for all individuals within a group.*

(Emphasis added.) Because the two C.F.R. sections cited in this rule (42 C.F.R. §§ 440.180 and 440.181) are the authority for the kind of home and community-based waiver programs at issue here, this language explicitly refutes the above-quoted statements from the Court of Appeals' opinion.

Further, neither of the two cases cited by the Court—*Beckwith v. Kizer*, 912 F.2d 1139, 1141 (9th Cir. 1990), and *Skandalis v. Rowe*, 14 F.3d 173, 176 (2d Cir. 1994)—as support for the first statement quoted, actually stands for the proposition for which it is cited.

Beckwith involved a challenge to an eligibility requirement under a waiver program administered by the State of California, a challenge the Ninth Circuit rejected in part because the eligibility provision had been clearly spelled out in the waiver application. Unlike *Beckwith*, this case has nothing to do with eligibility for the programs at issue, nor has the eligibility of either Respondent ever been questioned. *Beckwith* simply has no application to the instant case.

Even more curious is the Court of Appeals' citation to *Skandalis*, which, like *Beckwith*, also involved a challenge to an eligibility

requirement—Connecticut’s exclusion from coverage under a home and community-based waiver of those individuals whose income exceeded a specific limit even though those same persons would nonetheless be eligible for nursing home care under the state’s basic Medicaid plan. The Second Circuit rejected the claims of those excluded from coverage that the income limitation was not authorized under the Medicaid Act, and its language describing the purpose behind the statute authorizing Medicaid waiver programs is instructive:

The Act is designed to encourage states to participate in Medicaid by freeing them to adapt their programs to local conditions, and to develop effective approaches to health care through innovation and experiment. The Secretary has been careful not to impose too many restrictions on a state’s ability to adopt waiver programs, since the Department of Health and Human Services “believe[s] *that Congress intended to give the States maximum flexibility in operating their waiver programs.* We expect this flexibility to foster initiative and to encourage States to administer cost-effective programs that meet specific local needs.” . . . Unlike the Medicaid program itself, which requires participating states to provide certain services to “all individuals” who fall into the group of the mandatory categorically needy, 42 U.S.C. § 1396a(a)(10)(A)(i), *the waiver program expressly contemplates a waiver of the “comparability” requirement so that individuals within the program may receive varying levels of service,* 42 U.S.C. § 1396n(c)(3) However appalling the consequences may be to particular Medicaid claimants, *the Act authorizes a variety of harsh distinctions, which may result in disparate treatment of individuals having similar or identical needs.*

Skandalis, 14 F.3d at 181 (emphasis added) (citations omitted) (some internal punctuation omitted). Thus, not only does the *Skandalis* opinion focus on an eligibility requirement, and not a level of service issue such as present here, but its description of the Medicaid waiver statute demonstrates that this Court of Appeals' reading of the waiver of comparability granted to the Department is far too narrow.

The Court of Appeals' holding that the comparability of services requirement applies to Medicaid waiver programs should be reversed.

4. The Court of Appeals' Analysis Of Federal Medicaid Law Has No Application To The Chore Program

The trial court invalidated the shared living rule in all of its applications, and the Court of Appeals' opinion appears to do the same. Both of these decisions are predicated upon provisions of federal Medicaid law. Yet one of the programs to which the rule applies is the Chore program, which is totally state-funded. RCW 74.39A.100, .110; WAC 388-106-0600 through -0655. At the risk of stating the obvious, federal Medicaid law imposes no limitations on a state's program that it funds solely from its own resources. At a minimum, the Court of Appeals' decision should be vacated as it applies to programs that are not Medicaid-funded.

VI. CONCLUSION

For the foregoing reasons, the Department respectfully requests that the Court grant review, vacate those parts of the decisions below that invalidated WAC 388-106-0130(3)(b), and affirm the decisions of the Department.

RESPECTFULLY SUBMITTED this 6th day of July, 2006.

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

DATED this 6th day of July, 2006, at Lacey, WA.

Sharon Paakkonen
Sharon Paakkonen, Legal Assistant

APPENDICES

Gasper/Myers v. DSHS Published Opinion A-1

Gasper/Myers v. DSHS Order Denying Motions to
Reconsider and Motion to Stay..... A-16

Gasper/Myers v. DSHS Brief of Appellant, pp. 7-16 A-17

Jenkins v. DSHS Ruling Accepting Certification A-27

Federal Statutes

42 U.S.C. § 1396a(a)(10)..... A-28

42 U.S.C. § 1396a(a)(10)(B)..... A-30

42 U.S.C. § 1396a(a)(10)(B)(i)..... A-30

42 U.S.C. § 1396a(a)(10)(B)(ii)..... A-30

42 U.S.C. § 1396a(a)(10)(C)(i)..... A-30

42 U.S.C. § 1396a(a)(23)(A) A-30

42 U.S.C. § 1396a(b) A-30

42 U.S.C. § 1396d(a)(24)..... A-32

42 U.S.C. § 1396n(c) A-33

42 U.S.C. § 1396n(c)(1)..... A-33

42 U.S.C. § 1396n(f)(1) A-33

State Statutes

RCW 43.88.290 A-34

RCW 74.09.520(2), (3), (4) A-35

RCW 74.09.700(2)(a)(i).....	A-36
RCW 74.38.030	A-37
RCW 74.39.001	A-38
RCW 74.39.005(5).....	A-39
RCW 74.39.041(1).....	A-40
RCW 74.39A.005.....	A-41
RCW 74.39A.007(1), (2), (3).....	A-42
RCW 74.39A.009(5).....	A-43
RCW 74.39A.030(2).....	A-44
RCW 74.39A.050(13).....	A-45
RCW 74.39A.095(1)(a) & (e), (7), (8).....	A-47
RCW 74.39A.100.....	A-49
RCW 74.39A.110.....	A-50
RCW 74.39A.270(4).....	A-51

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IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON

DIVISION II

VENETTA GASPER and TOMMYE MYERS,

Respondents.

v.

DEPARTMENT OF SOCIAL AND HEALTH
SERVICES,

Appellants.

No. 33088-1-II

PUBLISHED OPINION

PENOYAR, J. — The Department of Social and Health Services (DSHS) recently implemented the “shared living rule,”¹ which reduces the number of home care hours it will fund for clients who live with their paid caregivers. DSHS believed this rule was consistent with the policies of not paying for services that benefit the entire household and of not paying for services that other support mechanisms already provide. Venetta Gasper and Tommye Myers, disabled Medicaid recipients living with their paid caregivers, challenged the reduction in their care hours. The trial court invalidated the shared living rule, finding it violated federal choice of provider and comparability requirements. Agreeing that the shared living rule violates federal comparability requirements, we affirm.

¹ WAC 388-106-0130(3)(b), formerly WAC 388-72A-0095.

FACTS

This case involves the legality of one provision in DSHS's Comprehensive Assessment Reporting Evaluation (CARE) assessment tool². DSHS uses the CARE tool to evaluate the number of hours it will pay a caregiver to assist disabled clients in four different Medicaid programs. WAC 388-106-0050, -0055, -0070.

In a CARE evaluation, the evaluator scores the client on factors such as the client's ability to perform daily activities and the client's mental status. WAC 388-106-0085 through -0115. These numerical scores are put into a formula that calculates the client's "base" assistance level in hours of care. WAC 388-106-0080, -0125. If DSHS determines that informal supports like friends or family members are already helping the recipient meet certain needs, DSHS will apply a second formula to reduce the number of care hours for which the client qualifies. WAC 388-106-0130. The shared living rule at issue here automatically reduces the allowed care hours by approximately 15 percent if the caregiver resides with the client. WAC 388-106-0130(3)(b).

DSHS implemented the shared living rule on the theory that live-in caregivers must clean their own houses, go shopping, and cook meals for their own benefit, and that the state should not pay for tasks that benefit the entire household. Through a study, DSHS determined that caregivers spend between 26 and 46 percent of their time on household tasks like cleaning and shopping. Citing RCW 74.39A.005, DSHS claims the shared living rule furthers the legislative policy of not using public funds to displace a client's naturally occurring informal support.

Gasper and Myers live with their caregivers and receive Medicaid-funded home health care. Gasper is severely developmentally disabled and lives with Linda Green, an unrelated paid caregiver. Before the recent changes, Gasper was receiving funding for 184 hours of care per month. Under the CARE assessment, her base hours are 190, but are reduced to 152 through the shared living rule. Green states that she already spends more than 184 hours per month caring for Gasper and that she is unwilling to provide additional unpaid care. Green estimates she spends approximately 14 hours per week in extra cleanup and laundry for Gasper, beyond what she performs for herself and her family (Green's husband and teenage son also live in the house). She also estimates an extra 75 hours per month in food preparation time because Gasper's eating schedule and diet differ from the family's.

Myers is an elderly woman who lives with her disabled son Ricky, her son John, and John's wife. John is Myers's paid caregiver. Myers is diabetic and requires kidney dialysis three times per week. Under the previous assessment, she was receiving 184 hours of paid care. The CARE assessment set her base hours at 190, but reduced them to 153 after applying the shared living rule.

Like Green, John estimates that he spends more than 184 hours per month on his mother's care. In addition to the chores he performs for himself and his wife, John estimates he spends an extra eight hours per month shopping for his mother's special diet, 100 hours per month extra on housekeeping, and 45 hours per month extra on meal preparation.

Gasper and Myers challenge the shared living rule, asserting that it does not take into account the additional hours their caregivers provide that do not benefit the caregivers or the household in general. They claim their actual need for help with certain household tasks should have been evaluated and not automatically deemed met by their shared living situations.

DSHS claims that the shared living rule must be considered in the context of the entire CARE assessment. The assessment does not break down each task by hours needed to perform it but, rather, pays the caregiver for the extra time spent on household tasks for severely impaired persons by allotting more hours to those clients with more serious disabilities. DSHS argues that the shared living rule takes into account only that portion of the housework benefiting the entire household and that the caregivers are still being paid for work that benefits only the recipient.

Gasper and Myers requested hearings before administrative law judges (ALJs) to challenge the reductions in paid hours. The ALJs, who lacked the power to invalidate a department rule, affirmed the reduction. DSHS's Board of Appeals issued expedited decisions affirming the ALJs' decisions.

Gasper and Myers (hereafter Gasper) then filed actions in Thurston County Superior Court seeking both review of the administrative decisions and a declaratory judgment invalidating the shared living rule. The two cases were consolidated.

DSHS responded to both petitions. Appended to the response was the declaration of Penny Black, director of the Home and Community Services Division of the DSHS Aging and Disability Services Administration. Black explained the background and design of the CARE assessment tool and, in particular, the shared living rule. The trial court granted Gasper's motion to strike Black's declaration, but it allowed DSHS to supplement the record with the rule making file relating to the adoption and implementation of the CARE assessment tool.

After hearing arguments, the trial court invalidated the shared living rule and reversed the two administrative decisions. Specifically, the trial court ruled that DSHS exceeded its statutory authority by violating federal choice of provider protections³ and comparability requirements.⁴

ANALYSIS

I. Excluded declaration

Peggy Black's declaration explained the CARE assessment tool and DSHS's justification for the shared living rule. Excluding this declaration limited the record to the agency rule making file and the records from the parties' administrative proceedings. DSHS claims that the trial court abused its discretion by limiting the information it considered on review.

Under the Administrative Procedure Act (APA), judicial review is limited to the agency record. RCW 34.05.558; *Motley-Motley, Inc. v. Pollution Control Hearings Bd.*, 127 Wn. App. 62, 76, 110 P.3d 812 (2005), *review denied*, 2006 Wash. LEXIS 15 (citing *Wash. Indep. Tel. Ass'n v. Wash. Utils. & Transp. Comm'n*, 110 Wn. App. 498, 518, 41 P.3d 1212 (2002), *aff'd*, 149 Wn.2d 17 (2003)). A court may consider additional evidence only to resolve certain legal issues, not one of which is raised here. RCW 34.05.562(1).

The trial court has the discretion to limit its review to the administrative record before it. *Wash. Independent Tel.*, 110 Wn. App. at 518. A trial court abuses its discretion when its decision is manifestly unreasonable, is exercised on untenable grounds, or is based on untenable

³ 42 U.S.C. § 1396a(a)(23) allows "any individual eligible for medical assistance [to] . . . obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform . . . the service or services required."

⁴ 42 USC § 1396a(a)(10)(B)(i) states that the medical assistance a state provides for any categorically needy individual "shall not be less in amount, duration, or scope" than the assistance provided to any other categorically needy individual.

reasons. *In the Matter of the Personal Restraint of Davis*, 152 Wn.2d 647, 691, 101 P.3d 1 (2004).

In this case, the court struck Black's declaration but ordered that the rule making file, in its entirety, be admitted into the record. The rule making file is required to have all the information the agency gathered in formulating and adopting the rule. RCW 34.05.370; *Wash. Indep. Tel. Ass'n v. Wash. Utils. & Transp. Comm'n*, 148 Wn.2d 887, 906, 64 P.3d 606 (2003). The trial court had no obligation to supplement the administrative record. Because the trial court could presume that it had all relevant information in the record already through the rule making file, we hold that the trial court did not abuse its discretion by striking Black's declaration.

II. The Medicaid program

Medicaid is a program that provides medical assistance to financially needy individuals. *Rodriguez v. City of New York*, 197 F.3d 611, 613 (2nd Cir. 1999), *cert. denied*, 531 U.S. 864 (2000). Federal and state governments fund and run it jointly, with the federal government reimbursing the state for a portion of the state's expenditures. *Rodriguez*, 197 F.3d at 613; *Skandalis v. Rowe*, 14 F.3d 173, 174-75 (2nd Cir. 1994). State participation in the program is optional. If a state chooses to participate, it must formulate a plan (state plan) that includes certain federally mandated forms of medical assistance, including nursing home care. 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(4); *Rodriguez*, 197 F.3d at 613.

States also have the option of providing in-home care services instead of nursing home care for those who would otherwise qualify for a nursing home. 42 U.S.C. § 1396n(c). In order to get federal reimbursement for this in-home care, states must receive a waiver from the Secretary of Health and Human Services (Secretary). 42 U.S.C. § 1396n(c)(1). This case involves these "waivered" Medicaid home care services.

III. Standard of review for agency decisions

A. Scope

Here we review an administrative rule's validity.

In a proceeding involving review of a rule, the court shall declare the rule invalid only if it finds that: The rule violates constitutional provisions; the rule exceeds the statutory authority of the agency; the rule was adopted without compliance with statutory rule-making procedures; or the rule is arbitrary and capricious.

RCW 34.05.570(2)(c); *Devine v. Dep't of Licensing*, 126 Wn. App. 941, 956, 110 P.3d 237 (2005) (a rule that conflicts with a statute is beyond an agency's authority). In its conclusions of law, the trial court declared the shared living rule invalid because the agency exceeded its statutory authority by promulgating a rule that conflicted with federal law. Specifically, the trial court concluded as a matter of law that the rule violated "state and federal laws regarding freedom of choice of provider and comparability requirements." Clerk's Papers (CP) at 259. Because this is an issue of law, we review the trial court's conclusion de novo. *Sunnyside Valley Irrigation Dist. v. Dickie*, 149 Wn.2d 873, 880, 73 P.3d 369 (2003).

B. Deference to agency determinations

When a court reviews an agency's construction of a statute that the agency administers, the court must first ask whether Congress has directly spoken to the precise question at issue. *Chevron, U.S.A., Inc. v. Natural Res. Defense Council, Inc.*, 467 U.S. 837, 842, 104 S. Ct. 2778, 81 L. Ed. 2d 694 (1984). If Congress's intent is clear, the court, as well as the agency, must give effect to Congress's unambiguously expressed intent. *Chevron*, 467 U.S. at 842-43; *Edelman v. State ex rel. Pub. Disclosure Comm'n*, 152 Wn.2d 584, 590, 99 P.3d 386 (2004). If, however, the court determines that Congress has not directly addressed the precise question at issue, and

the statute is silent or ambiguous, the question for the court is whether the agency's answer is based on a permissible statutory construction. *Chevron*, 467 U.S. at 843.

Here, DSHS urges us to defer to its interpretation of the Medicaid statute because of its expertise in administering that law. Furthermore, DSHS argues that the provider choice and comparability provisions do not directly address the shared living rule, so we should defer to DSHS. Gasper argues that the provider choice and comparability provisions are not ambiguous and, therefore, no deference is warranted.

The comparability provision clearly demonstrates Congress's intent to provide comparable services to similarly situated recipients. 42 USC § 1396a(a)(10)(B); *Martin v. Taft*, 222 F. Supp. 2d 940, 977 (S.D. Ohio 2002) (finding the concepts of comparability and equality are neither vague nor ambiguous). The provider choice provision is equally straightforward and demonstrates Congress's intent to allow a recipient to choose a qualified and willing provider. 42 U.S.C. § 1396a(a)(23). Therefore, we need not defer to DSHS's interpretations of these two provisions.

IV. Comparability

Analyzing whether the shared living rule meets federal comparability requirements entails a factual inquiry as well as a legal inquiry. *Martin*, 222 F. Supp. 2d at 977. The trial court's finding of facts determined:

- 2.3 The Department automatically reduces by 15% the personal care hours of recipients who live with their paid care providers. An automatic reduction is also applied to recipients who live in the same household as another recipient.
- 2.4 This shared living reduction is applied regardless of whether a recipient's needs for assistance with meal preparation, housekeeping, shopping, and wood supply are actually met by the shared living situation.

- 2.5 The shared living reduction is not applied to recipients who live with someone other than the recipient's paid care provider or another recipient. ...
- 2.8 Petitioners' needs for assistance with housekeeping, shopping and meal preparation are not fully met by their shared living situation.

CP at 258.

We review findings of fact under a substantial evidence standard, which is a quantum of evidence sufficient to persuade a rational, fair-minded person the finding is true. *Wenatchee Sportsmen Ass'n v. Chelan County*, 141 Wn.2d 169, 176, 4 P.3d 123 (2000). DSHS assigned error to each of these findings. It disputes the findings by attempting to demonstrate that recipients with live-in caregivers will always have certain needs met.

Based on a fair reading of chapter 388-106 WAC and the administrative records for Gasper and Myers, we hold that substantial evidence supports the trial court's findings of fact.

The trial court found that the shared living rule violates Medicaid's "comparability" requirement. CP at 259. That requirement states that the medical assistance a state provides for any categorically-needy individual "shall not be less in amount, duration, or scope" than the assistance provided to any other categorically needy individual. 42 USC § 1396a(a)(10)(B)(i).

The comparability requirement grew out of Congress's concern about previous disparities in servicing the medical needs of various needy groups. *Schweiker v. Hogan*, 457 U.S. 569, 573 n.6, 102 S. Ct. 2597, 73 L. Ed. 2d 227 (1982). For example, Congress wanted the amount, duration, and scope of assistance provided to an individual receiving assistance for the aged to be the same as the amount, duration, and scope of benefits provided to an individual receiving assistance for the blind. *Schweiker*, 457 U.S. at 573 n.6.

Courts have found that states violated the comparability requirement when they treated some recipients differently from other recipients with a similar level of need. *Schott v.*

Olszewski, 401 F.3d 682, 688-89 (6th Cir. 2005) (finding treatment was not comparable when Medicaid did not reimburse recipient for medical expenses she paid out of pocket after she was wrongfully denied coverage); *White v. Beal*, 555 F.2d 1146, 1151-52 (3rd Cir. 1977) (finding statute was illegal when it covered eyeglasses for those suffering from eye diseases but did not cover glasses for patients when refractive error caused poor eyesight).

Because Medicaid's overarching purpose is to provide for an individual recipient's needs, the comparability provision requires comparable services when individuals have comparable needs. See 42 U.S.C. § 1396a(a)(10). The question in this case is whether Gasper was offered the same amount of medical assistance available to "any other such individual." 42 U.S.C. § 1396a(a)(10)(B).

DSHS may use a reasonable method (such as the CARE assessment program) to determine a recipient's true need. This process is entirely consistent with the Medicaid program's purposes. However, DSHS violates the comparability requirement if it reduces a recipient's benefits based on a consideration other than the recipient's actual need. *White*, 555 F.2d at 1151. Having a live-in provider certainly may affect a recipient's need. Providers will do things for themselves that reduce the needs of their clients (such as clean the house). However, to simply impose an automatic 15 percent reduction for all recipients ignores the realities of their individual situations.

Clearly, each household differs in both the total number of hours spent on chores and in each household member's ability to do the work. However, without an evaluation to determine which needs live-in providers meet when they work on their own behalf, DSHS has created a system in which recipients like Gasper will have certain needs unmet while others with

comparable disabilities will receive adequate services. Therefore, the shared living rule as applied here violates the comparability requirement.

V. Waiver of the Comparability Requirement

We next consider DSHS's argument that it obtained a waiver of the comparability requirement.

A. Medicaid waiver rules

In order to obtain any reimbursement for home health care services, a state must apply for a waiver from the Secretary under 42 U.S.C. § 1396n(c); *McMillan v. McCrimon*, 807 F. Supp. 475, 481 (C.D. Ill. 1992). State participation in the section 1396n(c) waiver program is entirely voluntary. *Skandalis*, 14 F.3d at 181. Unlike the Medicaid program itself, which requires participating states to provide certain services to all categorically needy individuals, the waiver program expressly allows states to request a waiver of the "comparability" requirement so that individuals within the program may receive varying levels of service. 42 U.S.C. § 1396n(c)(3), (c)(10); *Skandalis*, 14 F.3d at 181.

Under these provisions, states may target patients in a waiver class defined by a specific illness or by other circumstances. *See Skandalis*, 14 F.3d at 183 (upholding a state waiver plan that provided home care only to the categorically needy); *Beckwith v. Kizer*, 912 F.2d 1139, 1140 (9th Cir. 1990) (upholding a waiver program targeting those hospitalized for more than 90 days). Defining a waiver class sometimes involves difficult policy judgments concerning where services would be used most efficiently. *Beckwith*, 912 F.2d at 1141.

B. DSHS's waiver application

DSHS claims that, in its waiver application to the Secretary, it specifically requested a waiver of the Medicaid Act's comparability requirement. In applying for the waiver, DSHS used

a boilerplate application form available through the Center for Medicare and Medicaid Services (CMS).⁵ The boilerplate form does indeed contain standardized language about waiving comparability requirements. Centers For Medicare & Medicaid Services, Section 1915(c) Home And Community-Based Services Waiver Application (Version 06-95) at 4.

However, the boilerplate language waiving comparability does not give states complete freedom to provide different services to different people. States still must describe the waiver class by defining the target groups that will receive services under the waiver. *Skandalis*, 14 F.3d at 181; 42 C.F.R. § 441.301(b)(3).

According to the statutory language, the Secretary, not the state, grants the waiver. 42 U.S.C. § 1396n(c)(1),⁶ (c)(3).⁷ Without showing that it somehow incorporated the shared living rule into its waiver request, DSHS cannot claim that the Secretary waived the comparability requirements for those who live with their caregivers. *See Skandalis*, 14 F.3d at 176; *Beckwith*, 912 F.2d at 1141 (upholding states' limits on services under the waiver where the states had described in the waiver how they intended to limit services).

⁵ CMS is the federal agency that administers the Medicare program and works with the states to administer Medicaid. It approves Medicaid waivers and State Medicaid Plans.

⁶ "The Secretary may by waiver provide that a State plan approved under this subchapter may include as 'medical assistance' under such plan payment for part or all of the cost of home or community-based services." 42 U.S.C. § 1396n(c)(1).

⁷ "A waiver granted under this subsection may include a waiver of the requirements of section 1396a(a)(1) of this title (relating to statewideness), section 1396a(a)(10)(B) of this title (relating to comparability), and section 1396a(a)(10)(C)(i)(III) of this title (relating to income and resource rules applicable in the community)." 42 U.S.C. § 1396n(c)(3).

C. CMS approval

DSHS claims that CMS authorized the shared living rule because CMS authorized its Medicaid plan. Gasper claims that CMS was not aware of the shared living rule because the rule was not described in any materials given to it. Furthermore, Gasper claims that CMS does not have the authority to waive federal Medicaid laws.

There is no proof that a specific waiver was sought or obtained for so that varying levels of service could be given under the shared living rule. A general waiver of the comparability requirement does not suffice.

VI. Provider choice

Even though we have determined that the shared living rule is invalid, DSHS may nonetheless reduce the care hours of those who live with their paid caregivers *after* it has found that a client's needs are actually met through his or her shared living situation. Because the issue of provider choice could still arise in this context, we address it below.

The federal Medicaid Act says that a state plan must:

provide that (A) any individual eligible for medical assistance (including drugs) 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.

42 U.S.C. § 1396a(a)(23).

Gasper claims state law also guarantees provider choice under RCW 74.39A.270(4), which states, "Consumers and prospective consumers retain the right to select, hire, supervise the work of, and terminate any individual provider providing services to them." However, this section does not create an independent choice of provider rule that is different from federal law.

Gasper argues that the shared living rule interferes with her right to choose a provider because her benefit reduction was based solely on her choice of provider, i.e., Gasper must choose someone other than her preferred provider in order to obtain the level of service she needs.

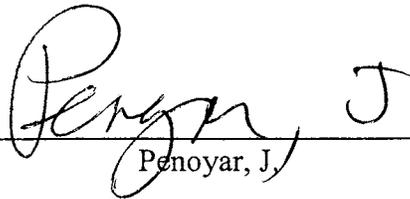
Medicaid recipients do not have an absolute right to receive continued service from their preferred providers. *O'Bannon v. Town Court Nursing Ctr.*, 447 U.S. 773, 785, 100 S. Ct. 2467, 65 L. Ed. 2d 506 (1980). For example, recipients cannot claim a state has violated their right to the provider of choice when providers refuse or discontinue service because of low rates. *Antrican v. Buell*, 158 F. Supp. 2d 663, 671 (E.D.N.C. 2001), *aff'd*, 290 F.3d 178 (4th Cir. 2002).

Furthermore, forcing a recipient to change caregivers or to physically relocate when the current care provider is no longer willing or qualified does not violate the choice of provider rules. *O'Bannon*, 447 U.S. at 785; *Kelly Kare, Ltd. v. O'Rourke*, 930 F.2d 170, 178 (2nd Cir. 1991). Therefore, although the shared living rule violates comparability requirements, it does not violate the choice of provider rules. No provider or recipient may demand additional hours or greater pay than DSHS guidelines allow. *Antrican*, 158 F. Supp. 2d at 671.

VII. Attorney fees

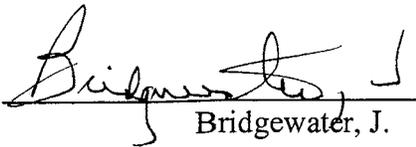
Gasper requests attorney fees on appeal under RCW 74.08.080(3).⁸ Because she prevails, we grant her request upon compliance with RAP 18.1.

Affirmed.

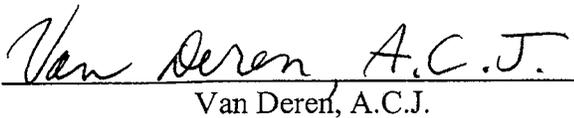


Penoyar, J.

We concur:



Bridgewater, J.



Van Deren, A.C.J.

⁸ RCW 74.08.080(3) states: When a person files a petition for judicial review . . . of an adjudicative order entered in a public assistance program, no filing fee shall be collected. . . . In the event that the superior court, the court of appeals, or the supreme court renders a decision in favor of the appellant, said appellant shall be entitled to reasonable attorneys' fees and costs.

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON

Office of the
Clerk of the Court
Olympia Social & Health Services, et al.

RECEIVED

DIVISION II

JUN 12 2006

VENETTA GASPER and
TOMMIE MYERS,

Respondents,

v.

WASHINGTON STATE
DEPARTMENT OF SOCIAL
AND HEALTH SERVICES,

Appellant.

No. 33088-1-II

ORDER DENYING MOTIONS TO
RECONSIDER AND MOTION TO STAY

STATE OF WASHINGTON
DEPUTY
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COURT OF APPEALS
DIVISION II

Appellant and Respondent move for reconsideration of the court's decision

terminating review, filed **March 7, 2006**. Upon consideration, the Court denies the motion.

Appellant moves to stay further proceedings in this appeal. Upon consideration, the Court denies the motion.

Accordingly, it is

SO ORDERED.

PANEL: Jj. Penoyar, Bridgewater, Van Deren

DATED this 9th day of June, 2006.

FOR THE COURT:

Van Deren, A.C.J.
ACTING CHIEF JUDGE

Department has developed a tool known as the Comprehensive Assessment Reporting Evaluation (“CARE”). *See generally* chapter 388-72A WAC.⁹

The CARE assessment process consists of three parts—gathering information about the client’s individual capabilities; application of an algorithm to classify the client according to level of assistance needed; and adjustment of authorized hours based on certain specified circumstances.

1. Information Gathering

The CARE process begins with an interview by a Department staff or designee¹⁰ who interviews the client (or prospective client) in his or her residence. WAC 388-72A-0025. The assessor also gathers information from “caregivers, family members, and other sources to determine how much assistance [the recipient] needs with personal care services.” WAC 388-72A-0036.

The assessment covers the client’s ability to perform two categories of activities. The first are referred to as “activities of daily living” (ADLs) and include such personal tasks as bathing, dressing,

⁹ The current CARE assessment was put in place in place in 2003 (WSR 03-05-097), and the details of the assessment process were adopted into rule in 2004 (WSR 04-19-103). The assessment process used prior to CARE was similar, but less sophisticated; for example, it placed clients into one of four classifications, rather than the fourteen different levels of assistance identified using the CARE tool. *See* former WAC 388-71-203.

¹⁰ The Department administers many of its community based programs for the aged and disabled through regional area agencies on aging. RCW 74.38.030.

eating, mobility (at home and elsewhere), medication management, toilet use, and personal hygiene. WAC 388-72A-0035(1) The second category consists of activities of a less personal nature that must be performed for the recipient to maintain a level of independence. This category of activities, referred to as “instrumental activities of daily living” (IADLs), includes such tasks as food preparation, ordinary housework, shopping for essentials, and, for those who use wood as the sole source of heat or cooking, wood supply. WAC 388-72A-0035(2).

The assessor determines the level of assistance, if any, that the client used in the preceding seven days in performing specific ADLs (WAC 388-72A-0036 through 0041) and codes each activity, which in turn generates a numbered score. (WAC 388-72A-0084). In addition, the information gathered by the assessor generates a cognitive performance score (WAC 388-72A-0081), determines whether his or her clinical needs are complex (WAC 388-72A-0082), whether he or she requires exceptional care (WAC 388-72A-0085), and whether the client’s mood and behavior—as reflected in current behavior or manifested within the previous five years—affects the care assessment (WAC 388-72A-0083).

2. Calculation And Classification

The scores assigned to the ADLs by the assessment process through this process are totaled, and depending on whether the client has a

clinically complex medical condition, is cognitively impaired, or exhibits certain behavior/mood characteristics, the client is assigned to one of fourteen “care groups” using a formula specified in the regulation. CARE classification groups range from Group A Low (level 1) to Group E High (level 14). WAC 388-72A-0087. Two CARE classification groups are identified as demonstrating exceptional care needs. WAC 388-72A-0085. The other twelve reflect different combinations of the client’s scores on the ADL portion of the assessment and the client’s cognitive performance, the clinical complexity of the client’s medical condition and/or the client’s mood and behavior assessment. WAC 388-72A-0086.

3. Adjustment For Specific Circumstances

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

- The availability of informal supports (i.e., friends, family or others not paid by DSHS) (WAC 388-72A-0095(1)(a));
- The client’s distance from essential facilities, such as laundry or stores (WAC 388-72A-0095(1)(b));
- Whether the client relies on wood exclusively for heat (WAC 388-72A-0095(1)(b)); and

- The client's living arrangements, i.e., whether the client resides with another eligible client or receives (or proposes to receive) the program-funded services from someone living in the same residential unit where the client will receive the services (WAC 388-72A-0095(1)(c)). This latter adjustment is the shared living rule that is the focus of this litigation.

This results in a final number of hours that will be paid for through public assistances. WAC 388-72A-0095(2). The client may be reassessed and the number of hours changed if there is a changes in any of the relevant factors. WAC 388-72A-105.

4. The Shared Living Rule

The Department applies the shared living rule, WAC 388-72A-0095(1)(c), when a recipient of home and community services lives in the same household as the recipient's paid caregiver, by reducing a client's base hours of support by approximately 15 percent. The rule serves to limit the use of public funds paid for certain household tasks (such as meal preparation, housekeeping, and shopping) that benefit the entire living unit, and not just the client. The rule furthers the legislative policy of not using public funds to displace naturally occurring informal support provided by family and other household members. *See* RCW 74.39A.005

(the purpose of home and community programs is to support and complement informal services provided by family and friends).¹¹

Rules similar to the shared living rule have been applicable to Washington public assistance programs since at least 1977 with the adoption of former WAC 388-15-215(3) (“Chore services [are] provided for the person needing the service, not for other household members unless they are part of the total chore service plan which includes them as eligible service clients.”)¹² The rule has been part of the Medicaid Personal Care program—and thus has been part of the state’s Medicaid Plan—since at least 1993.¹³

Part of the development of the CARE assessment tool included a time study of caregivers in a variety of settings. SHS-0001-4¹⁴. The study

¹¹ The rule also implements the legislative direction to “maximize the use of financial resources in directly meeting the needs of persons with functional limitations.” RCW 74.39.005(5).

¹² See DSHS Administrative Order 1238, filed with the Code Reviser on August 31, 1977 under Docket No. 8438, File No. 41. No Washington State Reference citation is available because the act creating the Washington State Register did not take effect until January 1, 1978. Laws of 1977 1st Ex. Sess., ch. 240 § 16.

¹³ See former WAC 388-15-890, WSR 93-10-023, effective May 29, 1993; repealed by WSR 00-04-056, effective February 28, 2000 and replaced in that same action by WAC 388-71-0465, which was repealed and replaced when the CARE tool was adopted. WSR 04-19-023.

¹⁴ As discussed more fully below at p. 17, the trial court allowed the Department to supplement the record with a copy of the file relating to the Department’s adoption of the rules implementing the CARE assessment. The individual pages of the rule-making file were numbered consecutively in the lower right corner with SHS- and a four digit number starting with 0001. The clerk of the trial court included the rule-making file when filing the Clerk’s Papers with this Court, but did not paginate them in the same manner as the other Clerk’s Papers. Accordingly, references in this brief to the rule-making file are to the numbers placed on them in the trial court.

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

5. Examples Illustrate How The CARE Assessment Works

Attached in the appendix (pages A7-A10) are four examples of how the CARE assessment works with respect to hypothetical clients whose situations are similar, but not identical, and all of whom reside with their caregivers.

For Client 1, the total of the ADL scores is 17. The client's condition is not clinically complex, and the client does not have significant cognitive impairment or mood issues. This combination places Client 1 in Care Group A (high), which has a base allotment of 78 hours. WAC 388-72A-087. Because the client lives with the caregiver, and no other

adjustment factors apply, the number of hours authorized is 85% of the base, or 66 hours.¹⁵

Client 2's situation is identical to that of Client 1, except that Client 2's medical condition is clinically complex. With a total ADL score of 17 and no other relevant factors, this places Client 2 in Care Group C (Medium), with a base hour allocation of 140 hours. When adjusted per the shared living rule, the allocation is 85% of the base, or 119 hours.

Client 3's situation is the same as that of Client 2, except that Client 3 also has significant cognitive impairment. Because Client 3's medical condition is, like that of Client 2, also clinically complex, Client 3 is placed in Care Group D (medium), with a base allocation of 190 hours. When adjusted per the shared living rule, the allocation is 85% of the base, or 162 hours.

Client 4's situation is the same as that of Client 3, except that Client 4 can perform some ADLs on his or her own. This results in a somewhat lower ADL score of 13, but Client 4 is also placed in Group D (Medium). In addition to the adjustment for the shared living rule, Client 4's base hours are reduced because of the ability to perform certain tasks

¹⁵ The actual mathematical computation with respect to Client 1 yields a result of 66.3 hours, but the Department rounds to the nearest whole hour.

independently.¹⁶ As a result, Client 4 is allocated 80% of the base hours, or 152 hours.

These examples are not exhaustive illustrations of the thousands of circumstances that exist among the more than 25,000 Washington residents who receive publicly funded in-home long-term care.¹⁷ However, they do illustrate how the CARE assessment tool recognizes variations among clients, and how it addresses those variations.

C. The Respondents Were Properly Assessed

Both respondents, Venetta Gasper and Tommye Myers, were receiving state-paid in-home care prior to 2004. Each was assessed as part of an annual review of her continuing eligibility, using the CARE tool. Other than their objection to the shared living rule, both respondents agree that the individualized assessment of their functional capacity using the CARE tool accurately assessed their needs for services. Gasper AR 44, ¶ 10, Myers AR 50, ¶ 10.¹⁸ Ms. Gasper was assessed in May 2004 and assigned to Group D Medium, for which the base level of service is 190 hours. Gasper AR 74, WAC 388-72A-087. She was determined to be

¹⁶ The calculation reflects the fact that under WAC 388-72A-095(1)(a)(ii), ADLs or IADLs that are assessed as independent are not included in the denominator of the calculation that results in Value A.

¹⁷ The number of clients is expected to increase. See Caseload Forecast Council reports available at <http://www.cfc.wa.gov/Monitoring/HCS-In-Home-Services.html>.

¹⁸ The clerk of the trial court transmitted the records of the administrative hearings relating to the two respondents, but did not paginate them as Clerk's Papers. Citation to those records is by name of the respondent and the relevant page number(s) in the administrative record (AR).

functionally eligible for Medicaid Personal Care services. Gasper AR 94. Because Ms. Gasper is independent with certain ADLs, her base hours were reduced by approximately 10 hours. WAC 388-72A-0095(1)(a). Gasper AR 61-63.¹⁹ Ms. Gasper lives with Linda Green, her paid service provider, along with Ms. Green's husband and son. Gasper AR 43. Accordingly, her base hours were further reduced by application of the shared living rule. As a result, she was determined to be eligible for 152 hours of paid services per month. Gasper AR 74.²⁰

Ms. Myers was assessed in February 2004 and assigned to Group C High, for which the base level of service is 180 hours a month.²¹ Myers AR 87; WAC 388-72A-087. Ms. Myers had no other applicable deductions or increases from her base hours under WAC 388-72A-0095. She was determined to be functionally eligible for COPES waiver services. Myers AR 87. She resides in the home of her son, John Myers, who is also her paid caregiver. Myers AR 57. Also living in the home is Ms. Myers' son, Richard ("Ricky) Myers, who is also an eligible COPES client, and for whom Mr. Myers is also the paid caregiver. *Id.* The base

¹⁹ This reduction has not been challenged by respondents.

²⁰ Base hours of 190, less approximately 10 hours deducted under WAC 388-72A-0095(1)(a), multiplied by 15 percent equals 152 hours. The 15 percent shared living deduction can be demonstrated by manually performing the calculations described under WAC 388-72A-0095(1)(a)(ii).

²¹ Finding of Fact 10 of the Review Decision incorrectly states that the Petitioner's base hours were 190. Myers AR 4, ¶ 10.

hours of 180 were then reduced 15 percent by application of the shared living rule, yielding 153 hours. Myer AR 87.

The hours authorized in 2004 for each of the respondents represented a reduction from the number of hours authorized following previous assessments.

D. Procedural History

As noted above, each respondent was satisfied with her care assessment, except for disputing the shared living rule. Rather than challenging the rule directly, however, each exercised the option given to them by the Department in WAC 388-72A-050 to request an adjudicative proceeding before an Administrative Law Judge (ALJ) to contest the reduction of authorized hours of paid in-home service. Gasper AR 77, Myers AR 90.

The respondents agreed that the ALJ did not have authority to invalidate the shared living rule. Gasper AR 17, ¶ 3; Myers AR 19, ¶ 3. In view of the respondents' acknowledgement that the CARE assessment was otherwise proper, the ALJs issued Initial Decisions affirming the reduction. Gasper AR 17; Myers AR 20. Respondents then appealed to the Department's Board of Appeals, which issued expedited decisions affirming the ALJs' decisions on June 30, 2004. Gasper AR 7; Myers AR 7.

THE SUPREME COURT OF WASHINGTON

FILED
SUPERIOR COURT
COUNTY OF WASHINGTON
2006 MAY -5 P 2:59
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DAVID J. JENKINS,

Respondent,

v.

DEPARTMENT OF SOCIAL AND
HEALTH SERVICES,

Appellant,

NO. 78652-6

RULING ACCEPTING
CERTIFICATION

By order dated May 3, 2006, this matter was certified to this court by Division One of the Court of Appeals pursuant to RCW 2.06.030. Having reviewed the Court of Appeals file, I agree that the case warrants direct review under the cited statute. Certification is therefore accepted. Court of Appeals Cause No. 57411-6-I, in its entirety, is hereby transferred to this court for determination on the merits.


COMMISSIONER

May 5, 2006

493/188

42 U.S.C. § 1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must -

...
(10) provide -

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5), (17) and (21) of section 1396d(a) of this title, to -

(i) all individuals -

(I) who are receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI of this chapter, or part A or part E of subchapter IV of this chapter (including individuals eligible under this title by reason of section 602(a)(37), 606(h), (673(b) of this title, or considered by the State to be receiving such aid as authorized under section (e)(6) of this title),

(II) with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter (or were being paid as of the date of the enactment section 211(a) of the Personal Responsibility and Work Reconciliation Act of 1996 (P.L. 104-193) and would continue to be paid but for the enactment of that section or who are qualified severely impaired individuals as defined in section 1396d(q) of this title),

(III) who are qualified pregnant women or children as defined in section 1396d(n) of this title,

(IV) who are described in subparagraph (A) or (B) of subsection (l)(1) of this section and whose family income does not exceed the minimum income level the State is required to establish under subsection (l)(2)(A) of this section for such a family;

(V) who are qualified family members as defined in section 1396d(m)(1) of this title,

(VI) who are described in subparagraph (C) of subsection (l)(1) of this section and whose family income does not exceed the income level the State is required to establish under subsection (l)(2)(B) of this section for such a family, or

(VII) who are described in subparagraph (D) of subsection (l)(1) of this section and whose family income does not exceed the income level the State is required to establish under subsection (l)(2)(C) of this section for such a family;

(ii) at the option of the State, to any group or groups of individuals described in section 1396d(a) of this section (or, in the case of individuals described in section 1396d(a)(i) of this title, to any reasonable categories of such individuals) who are not individuals described in clause (i) of this subparagraph but -

(I) who meet the income and resources requirements of the appropriate State plan described in clause (i) or the supplemental security income program (as the case may be),

(II) who would meet the income and resources requirements of the appropriate State plan described in clause (i) if work-related child care costs were paid from their earnings rather than by a State agency as a service expenditure,

(III) who would be eligible to receive aid under the appropriate State plan described in clause (i) if coverage such plan was as broad as allowed under Federal law,

(IV) with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, aid or assistance under the appropriate State plan described in clause (i), supplemental security income benefits under subchapter XVI of this chapter, or a State supplementary payment;

(V) who are in a medical institution for a period of not less than 30 consecutive days (with eligibility by reason of this subclause beginning on the first day of such period), who meet the resource requirements of the appropriate State plan described in clause (i) or the supplemental

security income program, and whose income does not exceed a separate income standard established by the State which is consistent with the limit established under section 1396b(f)(4)(C) of this title,

(VI) who would be eligible under the State plan under this subchapter if they were in a medical institution, with respect to whom there has been a determination that but for the provision of home or community-based services described in subsection (c), (d), or (e) of section 1396n of this title they would require the level of care provided in a hospital, nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan, and who will receive home or community-based services pursuant to a waiver granted by the Secretary under subsection (c), (d), or (e) of section 1396n of this title,

(VII) who would be eligible under the State plan under this subchapter if they were in a medical institution, who are terminally ill, and who will receive hospice care pursuant to a voluntary election described in section 1396d(o) of this title;

(VIII) who is a child described in section 1396d(a)(i) of this title -

(aa) for whom there is in effect an adoption assistance agreement (other than an agreement under part E of subchapter IV of this chapter) between the State and an adoptive parent or parents,

(bb) who the State agency responsible for adoption assistance has determined cannot be placed with adoptive parents without medical assistance because such child has special needs for medical or rehabilitative care, and

(cc) who was eligible for medical assistance under the State plan prior to the adoption assistance agreement being entered into, or who would have been eligible for medical assistance at such time if the eligibility standards and methodologies of the State's foster care program under part E of subchapter IV of this chapter were applied rather than the eligibility standards and methodologies of the State's aid to families with dependent children program under part A of subchapter IV of this chapter;

(IX) who are described in subsection (l)(1) of this section and are not described in clause (i)(IV), clause (i)(VI), or clause (i)(VII);

(X) who are described in subsection (m)(1) of this section;

(XI) who receive only an optional State supplementary payment based on need and paid on a regular basis, equal to the difference between the individual's countable income and the income standard used to determine eligibility for such supplementary payment (with countable income being the income remaining after deductions as established by the State pursuant to standards that may be more restrictive than the standards for supplementary security income benefits under subchapter XVI of this chapter), which are available to all individuals in the State (but which may be based on different income standards by political subdivision according to cost of living differences), and which are paid by a State that does not have an agreement with the Commissioner of Social Security under section 1382e or 1383c of this title;

(XII) who are described in subsection (z)(1) of this section (relating to certain TB-infected individuals);

(XIII) who are in families whose income is less than 250 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 9902(2) of this title) applicable to a family of the size involved, and who but for earnings in excess of the limit established under section 1396d(q)(2)(B) of this title, would be considered to be receiving supplemental security income (subject, notwithstanding section 1396o of this title, to payment of premiums or other cost-sharing charges (set on a sliding scale based on income) that the State may determine);

(XIV) who are optional targeted low-income children described in section 1396d(u)(2)(B) of this title;

(XV) who, but for earnings in excess of the limit established under section 1396d(q)(2)(B) of this title, would be considered to be receiving supplemental security income, who is at least 16, but less than 65, years of age, and whose assets, resources, and earned or unearned income (or both) do not exceed such limitations (if any) as the State may establish;

(XVI) who are employed individuals with a medically improved disability described in section 1396d(v)(1) of this title and whose assets, resources, and earned or unearned income (or both) do not exceed such limitations (if any) as the State may establish, but only if the State provides medical assistance to individuals described in subclause (XV);

(XVII) who are independent foster care adolescents (as defined in section 1396d(w)(1) of this title), or who are within any reasonable categories of such adolescents specified by the State; or

(XVIII) who are described in subsection (aa) of this section (relating to certain breast or cervical cancer patients);

(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 such individual, and

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

(C) that if medical assistance is included for any group of individuals described in section 1396d(a) of this title who are not described in subparagraph (A) or (E), then -

(i) the plan must include a description of (I) the criteria for determining eligibility of individuals in the group for such medical assistance, (II) the amount, duration, and scope of medical assistance made available to individuals in the group, and (III) the single standard to be employed in determining income and resource eligibility for all such groups, and the methodology to be employed in determining such eligibility, which shall be no more restrictive than the methodology which would be employed under the supplemental security income program in the case of groups consisting of aged, blind, or disabled individuals in a State in which such program is in effect, and which shall be no more restrictive than the methodology which would be employed under the appropriate State plan (described in subparagraph (A)(i)) to which such group is most closely categorically related in the case of other groups;

...

(23) provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services, and

...

(b) Approval by Secretary

The Secretary shall approve any plan which fulfills the conditions specified in subsection (a) of this section, except that he shall not approve any plan which imposes, as a condition of eligibility for medical assistance under the plan -

(1) an age requirement of more than 65 years; or

- 2) any residence requirement which excludes any individual who resides in the State, regardless of whether or not the residence is maintained permanently or at a fixed address; or
- (3) any citizenship requirement which excludes any citizen of the United States.

42 U.S.C. § 1396d. Definitions

For purposes of this subchapter -

...

24) personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home or other location;

42 U.S.C. § 1396n. Compliance with State plan and payment provisions

...

(c) Waiver respecting medical assistance requirement in State plan; scope, etc.; "habilitation services" defined; imposition of certain regulatory limits prohibited; computation of expenditures for certain disabled patients; coordinated services; substitution of participants

(1) The Secretary may by waiver provide that a State plan approved under this subchapter may include as "medical assistance" under such plan payment for part or all of the cost of home or community-based services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan. For purposes of this subsection, the term "room and board" shall not include an amount established under a method determined by the State to reflect the portion of costs of rent and food attributable to an unrelated personal caregiver who is residing in the same household with an individual who, but for the assistance of such caregiver, would require admission to a hospital, nursing facility, or intermediate care facility for the mentally retarded.

...

(f) Monitor of implementation of waivers; termination of waiver for noncompliance; time limitation for action on requests for plan approval, amendments, or waivers

(1) The Secretary shall monitor the implementation of waivers granted under this section to assure that the requirements for such waiver are being met and shall, after notice and opportunity for a hearing, terminate any such waiver where he finds noncompliance has occurred.

(2) A request to the Secretary from a State for approval of a proposed State plan or plan amendment or a waiver of a requirement of this subchapter submitted by the State pursuant to a provision of this subchapter shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the State agency in writing with respect to any additional information which is needed in order to make a final determination with respect to the request. After the date the Secretary receives such additional information, the request shall be deemed granted unless the Secretary, within 90 days of such date, denies such request. After the date the Secretary receives such additional information, the request shall be deemed granted unless the Secretary, within 90 days of such date, denies such request.

RCW 43.88.290

Fiscal responsibilities of state officers and employees — Prohibitions relative to appropriations and expenditures.

No state officer or employee shall intentionally or negligently: Over-expend or over-encumber any appropriation made by law; fail to properly account for any expenditures by fund, program, or fiscal period; or expend funds contrary to the terms, limits, or conditions of any appropriation made by law.

[1981 c 270 § 13; 1977 ex.s. c 320 § 2.]

Notes:

Effective date -- Severability -- 1981 c 270: See notes following RCW 43.88.010.

Effective date -- 1977 ex.s. c 320: See note following RCW 43.88.280.

RCW 74.09.520**Medical assistance — Care and services included — Funding limitations.**

(1) The term "medical assistance" may include the following care and services: (a) inpatient hospital services; (b) outpatient hospital services; (c) other laboratory and x-ray services; (d) nursing facility services; (e) physicians' services, which shall include prescribed medication and instruction on birth control devices; (f) medical care, or any other type of remedial care as may be established by the secretary; (g) home health care services; (h) private duty nursing services; (i) dental services; (j) physical and occupational therapy and related services; (k) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select; (l) personal care services, as provided in this section; (m) hospice services; (n) other diagnostic, screening, preventive, and rehabilitative services; and (o) like services when furnished to a child by a school district in a manner consistent with the requirements of this chapter. For the purposes of this section, the department may not cut off any prescription medications, oxygen supplies, respiratory services, or other life-sustaining medical services or supplies.

"Medical assistance," notwithstanding any other provision of law, shall not include routine foot care, or dental services delivered by any health care provider, that are not mandated by Title XIX of the social security act unless there is a specific appropriation for these services.

(2) The department shall amend the state plan for medical assistance under Title XIX of the federal social security act to include personal care services, as defined in 42 C.F.R. 440.170(f), in the categorically needy program.

(3) The department shall adopt, amend, or rescind such administrative rules as are necessary to ensure that Title XIX personal care services are provided to eligible persons in conformance with federal regulations.

(a) These administrative rules shall include financial eligibility indexed according to the requirements of the social security act providing for medicaid eligibility.

(b) The rules shall require clients be assessed as having a medical condition requiring assistance with personal care tasks. Plans of care for clients requiring health-related consultation for assessment and service planning may be reviewed by a nurse.

(c) The department shall determine by rule which clients have a health-related assessment or service planning need requiring registered nurse consultation or review. This definition may include clients that meet indicators or protocols for review, consultation, or visit.

(4) The department shall design and implement a means to assess the level of functional disability of persons eligible for personal care services under this section. The personal care services benefit shall be provided to the extent funding is available according to the assessed level of functional disability. Any reductions in services made necessary for funding reasons should be accomplished in a manner that assures that priority for maintaining services is given to persons with the greatest need as determined by the assessment of functional disability.

(5) Effective July 1, 1989, the department shall offer hospice services in accordance with available funds.

(6) For Title XIX personal care services administered by aging and disability services administration of the department, the department shall contract with area agencies on aging:

(a) To provide case management services to individuals receiving Title XIX personal care services in their own home; and

(b) To reassess and reauthorize Title XIX personal care services or other home and community services as defined in RCW 74.39A.009 in home or in other settings for individuals consistent with the intent of this section:

(i) Who have been initially authorized by the department to receive Title XIX personal care services or other home and community services as defined in RCW 74.39A.009; and

(ii) Who, at the time of reassessment and reauthorization, are receiving such services in their own home.

(7) In the event that an area agency on aging is unwilling to enter into or satisfactorily fulfill a contract or an individual consumer's need for case management services will be met through an alternative delivery system, the department is authorized to:

(a) Obtain the services through competitive bid; and

(b) Provide the services directly until a qualified contractor can be found.

[2004 c 141 § 2; 2003 c 279 § 1; 1998 c 245 § 145; 1995 1st sp.s. c 18 § 39; 1994 c 21 § 4. Prior: 1993 c 149 § 10; 1993 c 57 § 1; 1991 sp.s. c 8 § 9; prior: 1991 c 233 § 1; 1991 c 119 § 1; prior: 1990 c 33 § 594; 1990 c 25 § 1; prior: 1989 c 427 § 10; 1989 c 400 § 3; 1985 c 5 § 3; 1982 1st ex.s. c 19 § 4; 1981 1st

RCW 74.09.700**Medical care — Limited casualty program.**

(1) To the extent of available funds and subject to any conditions placed on appropriations made for this purpose, medical care may be provided under the limited casualty program to persons not otherwise eligible for medical assistance or medical care services who are medically needy as defined in the social security Title XIX state plan and medical indigents in accordance with eligibility requirements established by the department. The eligibility requirements may include minimum levels of incurred medical expenses. This includes residents of nursing facilities, residents of intermediate care facilities for the mentally retarded, and individuals who are otherwise eligible for section 1915(c) of the federal social security act home and community-based waiver services, administered by the department of social and health services aging and adult services administration, who are aged, blind, or disabled as defined in Title XVI of the federal social security act and whose income exceeds three hundred percent of the federal supplement security income benefit level.

(2) Determination of the amount, scope, and duration of medical coverage under the limited casualty program shall be the responsibility of the department, subject to the following:

(a) Only the following services may be covered:

(i) For persons who are medically needy as defined in the social security Title XIX state plan: Inpatient and outpatient hospital services, and home and community-based waiver services;

(ii) For persons who are medically needy as defined in the social security Title XIX state plan, and for persons who are medical indigents under the eligibility requirements established by the department: Rural health clinic services; physicians' and clinic services; prescribed drugs, dentures, prosthetic devices, and eyeglasses; nursing facility services; and intermediate care facility services for the mentally retarded; home health services; hospice services; other laboratory and x-ray services; rehabilitative services, including occupational therapy; medically necessary transportation; and other services for which funds are specifically provided in the omnibus appropriations act;

(b) Medical care services provided to the medically indigent and received no more than seven days prior to the date of application shall be retroactively certified and approved for payment on behalf of a person who was otherwise eligible at the time the medical services were furnished: PROVIDED, That eligible persons who fail to apply within the seven-day time period for medical reasons or other good cause may be retroactively certified and approved for payment.

(3) The department shall establish standards of assistance and resource and income exemptions. All nonexempt income and resources of limited casualty program recipients shall be applied against the cost of their medical care services.

[2001 c 269 § 1; 1993 c 57 § 2. Prior: 1991 sp.s. c 9 § 7; 1991 sp.s. c 8 § 10; 1991 c 233 § 2; 1989 c 87 § 3; 1985 c 5 § 4; 1983 1st ex.s. c 43 § 1; 1982 1st ex.s. c 19 § 1; 1981 2nd ex.s. c 10 § 6; 1981 2nd ex.s. c 3 § 6; 1981 1st ex.s. c 6 § 22.]

Notes:

Effective dates -- 1991 sp.s. c 9: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and shall take effect on July 1, 1991, except sections 1 through 6 and 9 of this act which shall take effect on September 1, 1991." [1991 sp.s. c 9 § 11.]

Effective date -- 1991 sp.s. c 8: See note following RCW 18.51.050.

Effective dates -- 1989 c 87: See note following RCW 11.94.050.

Effective date -- 1983 1st ex.s. c 43: "This act is necessary for the immediate preservation of the public peace, health, and safety, the support of the state government and its existing public institutions, and shall take effect on July 1, 1983." [1983 1st ex.s. c 43 § 3.]

Effective date -- 1982 1st ex.s. c 19: See note following RCW 74.09.035.

Severability -- 1981 2nd ex.s. c 3: See note following RCW 74.09.510.

Effective date -- Severability -- 1981 1st ex.s. c 6: See notes following RCW 74.04.005.

RCW 74.38.030

Administration of community based services program — Area plans — Annual state plan — Determination of low income eligible persons.

(1) The program of community based services authorized under this chapter shall be administered by the department. Such services may be provided by the department or through purchase of service contracts, vendor payments or direct client grants.

The department shall, under stipend or grant programs provided under RCW 74.38.060, utilize, to the maximum staffing level possible, eligible persons in its administration, supervision, and operation.

(2) The department shall be responsible for planning, coordination, monitoring and evaluation of services provided under this chapter but shall avoid duplication of services.

(3) The department may designate area agencies in cities of not less than twenty thousand population or in regional areas within the state. These agencies shall submit area plans, as required by the department. They shall also submit, in the manner prescribed by the department, such other program or fiscal data as may be required.

(4) The department shall develop an annual state plan pursuant to the Older Americans Act of 1965, as now or hereafter amended. This plan shall include, but not be limited to:

- (a) Area agencies' programs and services approved by the department;
- (b) Other programs and services authorized by the department; and
- (c) Coordination of all programs and services.

(5) The department shall establish rules and regulations for the determination of low income eligible persons. Such determination shall be related to need based on the initial resources and subsequent income of the person entering into a program or service. This determination shall not prevent the eligible person from utilizing a program or service provided by the department or area agency. However, if the determination is that such eligible person is nonlow income, the provision of RCW 74.38.050 shall be applied as of the date of such determination.

[1975-'76 2nd ex.s. c 131 § 3.]

**RCW 74.39.001
Finding.**

The legislature finds that:

Washington's chronically functionally disabled population is growing at a rapid pace. This growth, along with economic and social changes and the coming age wave, presents opportunities for the development of long-term care community services networks and enhanced volunteer participation in those networks, and creates a need for different approaches to currently fragmented long-term care programs. The legislature further recognizes that persons with functional disabilities should receive long-term care services that encourage individual dignity, autonomy, and development of their fullest human potential.

[1989 c 427 § 1.]

RCW 74.39.005

Purpose.

The purpose of this chapter is to:

- (1) Establish a balanced range of health, social, and supportive services that deliver long-term care services to chronically, functionally disabled persons of all ages;
- (2) Ensure that functional ability shall be the determining factor in defining long-term care service needs and that these needs will be determined by a uniform system for comprehensively assessing functional disability;
- (3) Ensure that services are provided in the most independent living situation consistent with individual needs;
- (4) Ensure that long-term care service options shall be developed and made available that enable functionally disabled persons to continue to live in their homes or other community residential facilities while in the care of their families or other volunteer support persons;
- (5) Ensure that long-term care services are coordinated in a way that minimizes administrative cost, eliminates unnecessarily complex organization, minimizes program and service duplication, and maximizes the use of financial resources in directly meeting the needs of persons with functional limitations;
- (6) Develop a systematic plan for the coordination, planning, budgeting, and administration of long-term care services now fragmented between the division of developmental disabilities, division of mental health, aging and adult services administration, division of children and family services, division of vocational rehabilitation, office on AIDS, division of health, and bureau of alcohol and substance abuse;
- (7) Encourage the development of a statewide long-term care case management system that effectively coordinates the plan of care and services provided to eligible clients;
- (8) Ensure that individuals and organizations affected by or interested in long-term care programs have an opportunity to participate in identification of needs and priorities, policy development, planning, and development, implementation, and monitoring of state supported long-term care programs;
- (9) Support educational institutions in Washington state to assist in the procurement of federal support for expanded research and training in long-term care; and
- (10) Facilitate the development of a coordinated system of long-term care education that is clearly articulated between all levels of higher education and reflective of both in-home care needs and institutional care needs of functionally disabled persons.

[1995 1st sp.s. c 18 § 10; 1989 c 427 § 2.]

Notes:

Conflict with federal requirements -- Severability -- Effective date -- 1995 1st sp.s. c 18: See notes following RCW 74.39A.030.

RCW 74.39.041**Community residential options — Nursing facility eligible clients.**

(1) To the extent of available funds and subject to any conditions placed on appropriations for this purpose, the department may provide one or more home and community-based waiver programs in accordance with section 1915(c) of the federal social security act for Washington residents who have a gross income in excess of three hundred percent of the federal supplemental security income benefit level. The waiver services provided in accordance with this section may differ from, and shall operate with a separate limit or limits on total enrollment than, those provided for persons who are categorically needy as defined in Title XIX of the federal social security act. The department shall adopt rules to establish eligibility criteria, applicable income standards, and the specific waiver services to be provided. Total annual enrollment levels and the services to be provided shall be as specified in the waiver agreement or agreements with the federal government, subject to any conditions on appropriations for this purpose.

(2) If a nursing facility resident becomes eligible for home and community-based waiver service alternatives to nursing facility care, but chooses to continue to reside in a nursing facility, the department must allow that choice. However, if the resident is a medicaid recipient, the resident must require a nursing facility level of care.

(3) If a recipient of home and community-based waiver services may continue to receive home and community-based waiver services, despite an otherwise disqualifying level of income, but chooses to seek admission to a nursing facility, the department must allow that choice. However, if the resident is a medicaid recipient, the resident must require a nursing facility level of care.

(4) The department will fully disclose to all individuals eligible for waiver services under this section the services available in different long-term care settings.

[2001 c 269 § 2.]

**RCW 74.39A.005
Findings.**

The legislature finds that the aging of the population and advanced medical technology have resulted in a growing number of persons who require assistance. The primary resource for long-term care continues to be family and friends. However, these traditional caregivers are increasingly employed outside the home. There is a growing demand for improvement and expansion of home and community-based long-term care services to support and complement the services provided by these informal caregivers.

The legislature further finds that the public interest would best be 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.

The legislature finds that as other long-term care options become more available, the relative need for nursing home beds is likely to decline. The legislature recognizes, however, that nursing home care will continue to be a critical part of the state's long-term care options, and that such services should promote individual dignity, autonomy, and a homelike environment.

The legislature finds that many recipients of in-home services are vulnerable and their health and well-being are dependent on their caregivers. The quality, skills, and knowledge of their caregivers are often the key to good care. The legislature finds that the need for well-trained caregivers is growing as the state's population ages and clients' needs increase. The legislature intends that current training standards be enhanced.

[2000 c 121 § 9; 1993 c 508 § 1.]

RCW 74.39A.007

Purpose and intent.

It is the legislature's intent that:

- (1) Long-term care services administered by the department of social and health services include a balanced array of health, social, and supportive services that promote individual choice, dignity, and the highest practicable level of independence;
- (2) Home and community-based services be developed, expanded, or maintained in order to meet the needs of consumers and to maximize effective use of limited resources;
- (3) Long-term care services be responsive and appropriate to individual need and also cost-effective for the state;
- (4) Nursing home care is provided in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident and timely discharge to a less restrictive care setting when appropriate; and
- (5) State health planning for nursing home bed supply take into account increased availability of other home and community-based service options.

[1993 c 508 § 2.]

RCW 74.39A.009 Definitions.

Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

- (1) "Adult family home" means a home licensed under chapter 70.128 RCW.
- (2) "Adult residential care" means services provided by a boarding home that is licensed under chapter 18.20 RCW and that has a contract with the department under RCW 74.39A.020 to provide personal care services.
- (3) "Assisted living services" means services provided by a boarding home that has a contract with the department under RCW 74.39A.010 to provide personal care services, intermittent nursing services, and medication administration services, and the resident is housed in a private apartment-like unit.
- (4) "Boarding home" means a facility licensed under chapter 18.20 RCW.
- (5) "Cost-effective care" means care provided in a setting of an individual's choice that is necessary to promote the most appropriate level of physical, mental, and psychosocial well-being consistent with client choice, in an environment that is appropriate to the care and safety needs of the individual, and such care cannot be provided at a lower cost in any other setting. But this in no way precludes an individual from choosing a different residential setting to achieve his or her desired quality of life.
- (6) "Department" means the department of social and health services.
- (7) "Enhanced adult residential care" means services provided by a boarding home that is licensed under chapter 18.20 RCW and that has a contract with the department under RCW 74.39A.010 to provide personal care services, intermittent nursing services, and medication administration services.
- (8) "Functionally disabled person" is synonymous with chronic functionally disabled and means a person who because of a recognized chronic physical or mental condition or disease, including chemical dependency, is impaired to the extent of being dependent upon others for direct care, support, supervision, or monitoring to perform activities of daily living. "Activities of daily living", in this context, means self-care abilities related to personal care such as bathing, eating, using the toilet, dressing, and transfer. Instrumental activities of daily living may also be used to assess a person's functional abilities as they are related to the mental capacity to perform activities in the home and the community such as cooking, shopping, house cleaning, doing laundry, working, and managing personal finances.
- (9) "Home and community services" means adult family homes, in-home services, and other services administered or provided by contract by the department directly or through contract with area agencies on aging or similar services provided by facilities and agencies licensed by the department.
- (10) "Long-term care" is synonymous with chronic care and means care and supports delivered indefinitely, intermittently, or over a sustained time to persons of any age disabled by chronic mental or physical illness, disease, chemical dependency, or a medical condition that is permanent, not reversible or curable, or is long-lasting and severely limits their mental or physical capacity for self-care. The use of this definition is not intended to expand the scope of services, care, or assistance by any individuals, groups, residential care settings, or professions unless otherwise expressed by law.
- (11) "Nursing home" means a facility licensed under chapter 18.51 RCW.
- (12) "Secretary" means the secretary of social and health services.
- (13) "Tribally licensed boarding home" means a boarding home licensed by a federally recognized Indian tribe which home provides services similar to boarding homes licensed under chapter 18.20 RCW.

[2004 c 142 § 14; 1997 c 392 § 103.]

Notes:

Effective dates -- 2004 c 142: See note following RCW 18.20.020.

Short title -- 1997 c 392: "This act shall be known and may be cited as the Clara act." [1997 c 392 § 101.]

Findings -- 1997 c 392: "The legislature finds and declares that the state's current fragmented categorical system for administering services to persons with disabilities and the elderly is not client and family-centered and has created significant organizational barriers to providing high quality, safe, and effective care and support. The present fragmented system results in

A-43

RCW 74.39A.030**Expansion of home and community services — Payment rates.**

(1) To the extent of available funding, the department shall expand cost-effective options for home and community services for consumers for whom the state participates in the cost of their care.

(2) In expanding home and community services, the department shall: (a) Take full advantage of federal funding available under Title XVIII and Title XIX of the federal social security act, including home health, adult day care, waiver options, and state plan services; and (b) be authorized to use funds available under its community options program entry system waiver granted under section 1915(c) of the federal social security act to expand the availability of in-home, adult residential care, adult family homes, enhanced adult residential care, and assisted living services. By June 30, 1997, the department shall undertake to reduce the nursing home medicaid census by at least one thousand six hundred by assisting individuals who would otherwise require nursing facility services to obtain services of their choice, including assisted living services, enhanced adult residential care, and other home and community services. If a resident, or his or her legal representative, objects to a discharge decision initiated by the department, the resident shall not be discharged if the resident has been assessed and determined to require nursing facility services. In contracting with nursing homes and boarding homes for enhanced adult residential care placements, the department shall not require, by contract or through other means, structural modifications to existing building construction.

(3)(a) The department shall by rule establish payment rates for home and community services that support the provision of cost-effective care. In the event of any conflict between any such rule and a collective bargaining agreement entered into under RCW 74.39A.270 and 74.39A.300, the collective bargaining agreement prevails.

(b) The department may authorize an enhanced adult residential care rate for nursing homes that temporarily or permanently convert their bed use for the purpose of providing enhanced adult residential care under chapter 70.38 RCW, when the department determines that payment of an enhanced rate is cost-effective and necessary to foster expansion of contracted enhanced adult residential care services. As an incentive for nursing homes to permanently convert a portion of its nursing home bed capacity for the purpose of providing enhanced adult residential care, the department may authorize a supplemental add-on to the enhanced adult residential care rate.

(c) The department may authorize a supplemental assisted living services rate for up to four years for facilities that convert from nursing home use and do not retain rights to the converted nursing home beds under chapter 70.38 RCW, if the department determines that payment of a supplemental rate is cost-effective and necessary to foster expansion of contracted assisted living services.

[2002 c 3 § 10 (Initiative Measure No. 775, approved November 6, 2001); 1995 1st sp.s. c 18 § 2.]

Notes:

Findings -- Captions not law -- Severability -- 2002 c 3 (Initiative Measure No. 775): See RCW 74.39A.220 and notes following.

Conflict with federal requirements -- 1995 1st sp.s. c 18: "If any part of this act is found to be in conflict with federal requirements that are a prescribed condition to the allocation of federal funds to the state, the conflicting part of this act is inoperative solely to the extent of the conflict and with respect to the agencies directly affected, and this finding does not affect the operation of the remainder of this act in its application to the agencies concerned. The rules under this act shall meet federal requirements that are a necessary condition to the receipt of federal funds by the state." [1995 1st sp.s. c 18 § 74.]

Severability -- 1995 1st sp.s. c 18: "If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected." [1995 1st sp.s. c 18 § 119.]

Effective date -- 1995 1st sp.s. c 18: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and shall take effect July 1, 1995." [1995 1st sp.s. c 18 § 120.]

RCW 74.39A.050**Quality improvement principles.**

The department's system of quality improvement for long-term care services shall use the following principles, consistent with applicable federal laws and regulations:

(1) The system shall be client-centered and promote privacy, independence, dignity, choice, and a home or home-like environment for consumers consistent with chapter 392, Laws of 1997.

(2) The goal of the system is continuous quality improvement with the focus on consumer satisfaction and outcomes for consumers. This includes that when conducting licensing or contract inspections, the department shall interview an appropriate percentage of residents, family members, resident case managers, and advocates in addition to interviewing providers and staff.

(3) Providers should be supported in their efforts to improve quality and address identified problems initially through training, consultation, technical assistance, and case management.

(4) The emphasis should be on problem prevention both in monitoring and in screening potential providers of service.

(5) Monitoring should be outcome based and responsive to consumer complaints and based on a clear set of health, quality of care, and safety standards that are easily understandable and have been made available to providers, residents, and other interested parties.

(6) Prompt and specific enforcement remedies shall also be implemented without delay, pursuant to RCW 74.39A.080, RCW 70.128.160, chapter 18.51 RCW, or chapter 74.42 RCW, for providers found to have delivered care or failed to deliver care resulting in problems that are serious, recurring, or uncorrected, or that create a hazard that is causing or likely to cause death or serious harm to one or more residents. These enforcement remedies may also include, when appropriate, reasonable conditions on a contract or license. In the selection of remedies, the safety, health, and well-being of residents shall be of paramount importance.

(7) To the extent funding is available, all long-term care staff directly responsible for the care, supervision, or treatment of vulnerable persons should be screened through background checks in a uniform and timely manner to ensure that they do not have a criminal history that would disqualify them from working with vulnerable persons. Whenever a state conviction record check is required by state law, persons may be employed or engaged as volunteers or independent contractors on a conditional basis according to law and rules adopted by the department.

(8) No provider or staff, or prospective provider or staff, with a stipulated finding of fact, conclusion of law, an agreed order, or finding of fact, conclusion of law, or final order issued by a disciplining authority, a court of law, or entered into a state registry finding him or her guilty of abuse, neglect, exploitation, or abandonment of a minor or a vulnerable adult as defined in chapter 74.34 RCW shall be employed in the care of and have unsupervised access to vulnerable adults.

(9) The department shall establish, by rule, a state registry which contains identifying information about personal care aides identified under this chapter who have substantiated findings of abuse, neglect, financial exploitation, or abandonment of a vulnerable adult as defined in RCW 74.34.020. The rule must include disclosure, disposition of findings, notification, findings of fact, appeal rights, and fair hearing requirements. The department shall disclose, upon request, substantiated findings of abuse, neglect, financial exploitation, or abandonment to any person so requesting this information.

(10) The department shall by rule develop training requirements for individual providers and home care agency providers. Effective March 1, 2002, individual providers and home care agency providers must satisfactorily complete department-approved orientation, basic training, and continuing education within the time period specified by the department in rule. The department shall adopt rules by March 1, 2002, for the implementation of this section based on the recommendations of the community long-term care training and education steering committee established in RCW 74.39A.190. The department shall deny payment to an individual provider or a home care provider who does not complete the training requirements within the time limit specified by the department by rule.

(11) In an effort to improve access to training and education and reduce costs, especially for rural communities, the coordinated system of long-term care training and education must include the use of innovative types of learning strategies such as internet resources, videotapes, and distance learning using satellite technology coordinated through community colleges or other entities, as defined by the department.

(12) The department shall create an approval system by March 1, 2002, for those seeking to conduct department-approved training. In the rule-making process, the department shall adopt rules based on the recommendations of the community long-term care training and education steering committee established in RCW 74.39A.190.

(13) The department 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.

(14) Under existing funds the department shall establish internally a quality improvement standards committee to monitor the development of standards and to suggest modifications.

(15) Within existing funds, the department shall design, develop, and implement a long-term care training program that is flexible, relevant, and qualifies towards the requirements for a nursing assistant certificate as established under chapter 18.88A RCW. This subsection does not require completion of the nursing assistant certificate training program by providers or their staff. The long-term care teaching curriculum must consist of a fundamental module, or modules, and a range of other available relevant training modules that provide the caregiver with appropriate options that assist in meeting the resident's care needs. Some of the training modules may include, but are not limited to, specific training on the special care needs of persons with developmental disabilities, dementia, mental illness, and the care needs of the elderly. No less than one training module must be dedicated to workplace violence prevention. The nursing care quality assurance commission shall work together with the department to develop the curriculum modules. The nursing care quality assurance commission shall direct the nursing assistant training programs to accept some or all of the skills and competencies from the curriculum modules towards meeting the requirements for a nursing assistant certificate as defined in chapter 18.88A RCW. A process may be developed to test persons completing modules from a caregiver's class to verify that they have the transferable skills and competencies for entry into a nursing assistant training program. The department may review whether facilities can develop their own related long-term care training programs. The department may develop a review process for determining what previous experience and training may be used to waive some or all of the mandatory training. The department of social and health services and the nursing care quality assurance commission shall work together to develop an implementation plan by December 12, 1998.

[2004 c 140 § 6; 2000 c 121 § 10; 1999 c 336 § 5; 1998 c 85 § 1; 1997 c 392 § 209; 1995 1st sp.s. c 18 § 12.]

Notes:

Finding -- Intent -- 1999 c 336: See note following RCW 74.39.007.

Short title -- Findings -- Construction -- Conflict with federal requirements -- Part headings and captions not law -- 1997 c 392: See notes following RCW 74.39A.009.

Conflict with federal requirements -- Severability -- Effective date -- 1995 1st sp.s. c 18: See notes following RCW 74.39A.030.

RCW 74.39A.095

Case management services — Agency on aging oversight — Plan of care — Termination of contract — Rejection of individual provider.

(1) In carrying out case management responsibilities established under RCW 74.39A.090 for consumers who are receiving services under the medicaid personal care, community options programs entry system or chore services program through an individual provider, each area agency on aging shall provide oversight of the care being provided to consumers receiving services under this section to the extent of available funding. Case management responsibilities incorporate this oversight, and include, but are not limited to:

(a) Verification that any individual provider who has not been referred to a consumer by the authority established under chapter 3, Laws of 2002 has met any training requirements established by the department;

(b) Verification of a sample of worker time sheets;

(c) Monitoring the consumer's plan of care to verify that it adequately meets the needs of the consumer, through activities such as home visits, telephone contacts, and responses to information received by the area agency on aging indicating that a consumer may be experiencing problems relating to his or her home care;

(d) Reassessment and reauthorization of services;

(e) Monitoring of individual provider performance. If, in the course of its case management activities, the area agency on aging identifies concerns regarding the care being provided by an individual provider who was referred by the authority, the area agency on aging must notify the authority regarding its concerns; and

(f) Conducting criminal background checks or verifying that criminal background checks have been conducted for any individual provider who has not been referred to a consumer by the authority.

(2) The area agency on aging case manager shall work with each consumer to develop a plan of care under this section that identifies and ensures coordination of health and long-term care services that meet the consumer's needs. In developing the plan, they shall utilize, and modify as needed, any comprehensive community service plan developed by the department as provided in RCW 74.39A.040. The plan of care shall include, at a minimum:

(a) The name and telephone number of the consumer's area agency on aging case manager, and a statement as to how the case manager can be contacted about any concerns related to the consumer's well-being or the adequacy of care provided;

(b) The name and telephone numbers of the consumer's primary health care provider, and other health or long-term care providers with whom the consumer has frequent contacts;

(c) A clear description of the roles and responsibilities of the area agency on aging case manager and the consumer receiving services under this section;

(d) The duties and tasks to be performed by the area agency on aging case manager and the consumer receiving services under this section;

(e) The type of in-home services authorized, and the number of hours of services to be provided;

(f) The terms of compensation of the individual provider;

(g) A statement by the individual provider that he or she has the ability and willingness to carry out his or her responsibilities relative to the plan of care; and

(h)(i) Except as provided in (h)(ii) of this subsection, a clear statement indicating that a consumer receiving services under this section has the right to waive any of the case management services offered by the area agency on aging under this section, and a clear indication of whether the consumer has, in fact, waived any of these services.

(ii) The consumer's right to waive case management services does not include the right to waive reassessment or reauthorization of services, or verification that services are being provided in accordance with the plan of care.

(3) Each area agency on aging shall retain a record of each waiver of services included in a plan of care under this section.

(4) Each consumer has the right to direct and participate in the development of their plan of care to the maximum practicable extent of their abilities and desires, and to be provided with the time and support necessary to facilitate that participation.

(5) A copy of the plan of care must be distributed to the consumer's primary care provider, individual provider, and other relevant providers with whom the consumer has frequent contact, as authorized by the consumer.

(6) The consumer's plan of care shall be an attachment to the contract between the department, or their designee, and the individual provider.

(7) If the department or area agency on aging case manager finds that an individual provider's inadequate performance or inability to deliver quality care is jeopardizing the health, safety, or well-being of a consumer receiving service under this section, the department or the area agency on aging may take action to terminate the contract between the department and the individual provider. If the department or the area agency on aging has a reasonable, good faith belief that the health, safety, or well-being of a consumer is in imminent jeopardy, the department or area agency on aging may summarily suspend the contract pending a fair hearing. The consumer may request a fair hearing to contest the planned action of the case manager, as provided in chapter 34.05 RCW. When the department or area agency on aging terminates or summarily suspends a contract under this subsection, it must provide oral and written notice of the action taken to the authority. The department may by rule adopt guidelines for implementing this subsection.

(8) The department or area agency on aging may reject a request by a consumer receiving services under this section to have a family member or other person serve as his or her individual provider if the case manager has a reasonable, good faith belief that the family member or other person will be unable to appropriately meet the care needs of the consumer. The consumer may request a fair hearing to contest the decision of the case manager, as provided in chapter 34.05 RCW. The department may by rule adopt guidelines for implementing this subsection.

[2004 c 141 § 1; 2002 c 3 § 11 (Initiative Measure No. 775, approved November 6, 2001); 2000 c 87 § 5; 1999 c 175 § 3.]

Notes:

Findings--Captions not law--Severability -- 2002 c 3 (Initiative Measure No. 775): See RCW 74.39A.220 and notes following.

Findings -- 1999 c 175: See note following RCW 74.39A.090.

RCW 74.39A.100

Chore services — Legislative finding, intent.

The legislature finds that it is desirable to provide a coordinated and comprehensive program of in-home services for certain citizens in order that such persons may remain in their own homes, obtain employment if possible, and maintain a closer contact with the community. Such a program will seek to prevent mental and psychological deterioration which our citizens might otherwise experience. The legislature intends that the services will be provided in a fashion which promotes independent living.

[1980 c 137 § 1; 1973 1st ex.s. c 51 § 1. Formerly RCW 74.08.530.]

RCW 74.39A.110

**Chore services — Legislative policy and intent regarding available funds
— Levels of service.**

It is the intent of the legislature that chore services be provided to eligible persons within the limits of funds appropriated for that purpose. Therefore, the department shall provide services only to those persons identified as at risk of being placed in a long-term care facility in the absence of such services. The department shall not provide chore services to any individual who is eligible for, and whose needs can be met by another community service administered by the department. Chore services shall be provided to the extent necessary to maintain a safe and healthful living environment. It is the policy of the state to encourage the development of volunteer chore services in local communities as a means of meeting chore care service needs and directing financial resources. In determining eligibility for chore services, the department shall consider the following:

- (1) The kind of services needed;
- (2) The degree of service need, and the extent to which an individual is dependent upon such services to remain in his or her home or return to his or her home;
- (3) The availability of personal or community resources which may be utilized to meet the individual's need; and
- (4) Such other factors as the department considers necessary to insure service is provided only to those persons whose chore service needs cannot be met by relatives, friends, nonprofit organizations, other persons, or by other programs or resources.

In determining the level of services to be provided under this chapter, the client shall be assessed using an instrument designed by the department to determine the level of functional disability, the need for service and the person's risk of long-term care facility placement.

[1995 1st sp.s. c 18 § 36; 1989 c 427 § 5; 1981 1st ex.s. c 6 § 16. Formerly RCW 74.08.545.]

Notes:

Conflict with federal requirements -- Severability -- Effective date -- 1995 1st sp.s. c 18: See notes following RCW 74.39A.030.

Severability -- 1989 c 427: See RCW 74.39.900.

Effective date -- Severability -- 1981 1st ex.s. c 6: See notes following RCW 74.04.005.

RCW 74.39A.270

Collective bargaining — Circumstances in which individual providers are considered public employees — Exceptions.

***** CHANGE IN 2006 *** (SEE 2475-S.SL) *****

(1) Solely for the purposes of collective bargaining and as expressly limited under subsections (2) and (3) of this section, the governor is the public employer, as defined in chapter 41.56 RCW, of individual providers, who, solely for the purposes of collective bargaining, are public employees as defined in chapter 41.56 RCW. To accommodate the role of the state as payor for the community-based services provided under this chapter and to ensure coordination with state employee collective bargaining under chapter 41.80 RCW and the coordination necessary to implement RCW 74.39A.300, the public employer shall be represented for bargaining purposes by the governor or the governor's designee appointed under chapter 41.80 RCW. The governor or governor's designee shall periodically consult with the authority during the collective bargaining process to allow the authority to communicate issues relating to the long-term in-home care services received by consumers.

(2) Chapter 41.56 RCW governs the collective bargaining relationship between the governor and individual providers, except as otherwise expressly provided in this chapter and except as follows:

(a) The only unit appropriate for the purpose of collective bargaining under RCW 41.56.060 is a statewide unit of all individual providers;

(b) The showing of interest required to request an election under RCW 41.56.060 is ten percent of the unit, and any intervener seeking to appear on the ballot must make the same showing of interest;

(c) The mediation and interest arbitration provisions of RCW 41.56.430 through 41.56.470 and 41.56.480 apply, except that:

(i) With respect to commencement of negotiations between the governor and the bargaining representative of individual providers, negotiations shall be commenced by May 1st of any year prior to the year in which an existing collective bargaining agreement expires;

(ii) With respect to factors to be taken into consideration by an interest arbitration panel, the panel shall consider the financial ability of the state to pay for the compensation and fringe benefit provisions of a collective bargaining agreement; and

(iii) The decision of the arbitration panel is not binding on the legislature and, if the legislature does not approve the request for funds necessary to implement the compensation and fringe benefit provisions of the arbitrated collective bargaining agreement, is not binding on the authority or the state;

(d) Individual providers do not have the right to strike; and

(e) Individual providers who are related to, or family members of, consumers or prospective consumers are not, for that reason, exempt from this chapter or chapter 41.56 RCW.

(3) Individual providers who are public employees solely for the purposes of collective bargaining under subsection (1) of this section are not, for that reason, employees of the state, its political subdivisions, or an area agency on aging for any purpose. Chapter 41.56 RCW applies only to the governance of the collective bargaining relationship between the employer and individual providers as provided in subsections (1) and (2) of this section.

(4) Consumers and prospective consumers retain the right to select, hire, supervise the work of, and terminate any individual provider providing services to them. Consumers may elect to receive long-term in-home care services from individual providers who are not referred to them by the authority.

(5) In implementing and administering this chapter, neither the authority nor any of its contractors may reduce or increase the hours of service for any consumer below or above the amount determined to be necessary under any assessment prepared by the department or an area agency on aging.

(6) Except as expressly limited in this section and RCW 74.39A.300, the wages, hours, and working conditions of individual providers are determined solely through collective bargaining as provided in this chapter. No agency or department of the state, other than the authority, may establish policies or rules governing the wages or hours of individual providers. However, this subsection does not modify:

(a) The department's authority to establish a plan of care for each consumer and to determine the hours of care that each consumer is eligible to receive;