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COURT OF APPEALS  
DIVISION II  
OF THE STATE OF WASHINGTON

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DEPARTMENT OF SOCIAL AND HEALTH SERVICES  
Appellant,

v

VENNETTA GASPER AND TOMMYE MYERS  
Respondents.

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BRIEF OF RESPONDENTS

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## I. INTRODUCTION

The Department of Social & Health Services has appealed a decision recognizing the rights of two elderly disabled women to choose their caregivers under Department in-home care programs. Vennetta Gasper receives personal care services through the MPC (Medicaid Personal Care) Program; Tommye Myers receives personal care services through the COPEs (Community Options Program Entry System) Program.

Last year, despite no improvement in the condition of either woman, the Department reduced the paid personal care for each by more than 30 hours per month. The reductions were based on a new rule imposing a mandatory, automatic and inflexible reduction in personal care hours for recipients who chose caregivers who reside with them.<sup>1</sup> The rule is commonly referred to as “the shared living rule,” but that label invites a misimpression. The rule is not applied generally to recipients who share living situations with others; it is only applied in the not-uncommon

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<sup>1</sup> This rule, along with a majority of rules governing the CARE assessment system are codified at WAC 388-72A at all times relevant to this appeal and through the date this brief was submitted. However, effective June 17, 2005, the rules will be recodified at WAC 388-106. WSR 05-11-082.

instances when a recipient chooses to receive personal care services from a provider with whom the recipient lives.<sup>2</sup>

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

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

The Department seeks to justify the shared living rule on the theory that it is intended to prevent payment for personal care services that

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<sup>2</sup> The Department’s brief at page 2 contains the following assertion: “The majority of participants select providers with whom they have no other relationship and who come into the participants’ residences to provide services.” The assertion is made without any citation and is irrelevant. There is no dispute that many recipients choose live-in providers, related or unrelated.

primarily benefit the caregiver or the caregiver's household unit.<sup>3</sup> The effect of the shared living rule, however, is to deny payment for personal care services for such needs as meal preparation, housekeeping, or shopping when a caregiver prepares a meal or does housekeeping that benefits only the recipient and does not benefit the caregiver.

Respondents are not asking the Department to pay for services that benefit anyone other than them. They agree that a caregiver should not be paid for work that benefits the caregiver. The records in each of their cases establish that the personal care services the respondents need far exceed the housekeeping, meal preparation and shopping their caregivers would otherwise perform.

The shared living rule violates federal and state laws guaranteeing recipients the free choice of care provider. The rule also violates federal comparability requirements established to ensure that all Medicaid recipients receive services that are comparable in amount, duration and scope. The Department pays for certain personal care services for recipients with outside caregivers, while denying payment for the same services to recipients who live with their caregivers. This automatic,

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<sup>3</sup> In the remainder of this brief, references to benefit to the caregiver also include benefit to the caregiver's household unit as a whole. Additionally, the words "caregiver" and "provider" are used interchangeably.

inflexible, across-the-board denial of paid services to one class of recipients disregards need and violates comparability.

## **II. STATEMENT OF THE CASE**

### **A. The Department's statement of the case.**

Respondents agree with much of the Department's Statement of the Case as presented in Appellant's Brief, sections A – through B3 (pp. 5 – 10). However, the assessment process has nothing to do with the present appeal.

### **B. The CARE assessment process.**

#### **1. Information gathering.**

Information gathering is one function of the assessment process. WAC 388-72A-0020 *et seq.* But, much of the information gathered about client need has no impact on the number of hours awarded.<sup>4</sup> Gasper AR 50

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<sup>4</sup> For example, a case manager gathers information as to a recipient's preference of room temperature. Myers AR 71, Gasper AR 56. Obviously, this has no bearing on the hours awarded.

at ¶ 11, Myers AR 64 at ¶ 10.<sup>5</sup> The shared living rule is a perfect illustration. A case manager may assess a recipient as needing total help with meal preparation, and note in the assessment that the recipient's meals must be prepared entirely separately from the caregiver's due to special dietary needs. The case manager may not award personal care hours in recognition of these needs because the computerized assessment program marks those needs as "fully met." WAC 388-72A-0095(1)(c).

## **2. Calculation, classification and adjustment.**

The Department spends some time discussing the assessment system and describing how the system groups recipients based on several factors. Appellant's Brief, pp. 6-10. This discussion is irrelevant to the validity of the shared living rule. Ms. Myers and Ms. Gasper are not challenging the base hours awarded in their cases; they are only challenging the shared living reduction imposed by the shared living rule.

The methodology of obtaining the base hours is irrelevant to this appeal. It does not matter what information about the recipient's need for

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<sup>5</sup> Respondents adopt the appellant's citation conventions as discussed in Appellant's Brief at footnotes 14 and 18.

assistance with meal preparation, housekeeping or shopping is gathered (or not gathered) in the assessment process because the shared living rule results in a 15% cut of personal care hours for recipients who live with their caregivers. Appellant's Brief, pp. 10, 12. The reduction is the same – 15% - irrespective of cognitive needs, clinical complexity, moods and behaviors, or any other issue the Department otherwise assesses in order to award personal services hours. *Id.*

### **3. The shared living rule.**

The shared living rule is based on an assumption that taxpayer money should not be paid to live-in caregivers for tasks that benefit the caregiver. Appellant's Brief, pp. 10-11. However, the impact of the rule, at least in some cases, goes beyond this stated purpose. Gasper AR at 50, Myers AR at 64. If the recipient's need for assistance with meal preparation, housekeeping or shopping exceeds what the live-in caregiver can accomplish while doing his or her own shopping, meal preparation and housekeeping, the caregiver should be paid for work that benefits only the recipient.

When live-in caregivers do perform some or all of the "Incidental Activities of Daily Living"<sup>6</sup> for a recipient at the same time as the caregiver accomplishes these tasks for himself, denying payment would not violate the choice-of-provider requirement. But this is not what happens in the situations of Ms. Gasper and Ms. Myers. Gasper AR 46 - 50, Myers AR 57 - 64. Their need for help with IADLs far exceeds the work the caregivers would otherwise do. *Id.*

The unrebutted testimony by sworn Declarations demonstrates this. *Id.* Ms. Gasper is incontinent, so her bedding and clothing must be laundered separately from the caregiver's. Gasper AR 48 (Laundry is treated by the Department as part of housekeeping. WAC 388-72A-0035(2)(b)). Her caregiver spends 30 extra hours per month on the 1 to 2 loads of laundry per day she must do for Ms. Gasper alone – that work involves stripping and remaking Ms. Gasper's bed, treating Ms. Gasper's soiled bedding or clothing, and putting away clean laundry. *Id.* Ms. Myers requires a special renal and diabetic diet. Myers AR 55. She eats different kinds of foods at different times than her caregiver, requiring an extra 45 hours per month of her caregiver's time. *Id.* Overall, these caregivers spend

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<sup>6</sup> "Incidental Activities of Daily Living" or "IADLs" are those services impacted by the shared living rule – shopping, housekeeping, meal preparation and wood supply (for recipients like Ms. Gasper for whom wood is the primary source of heat).

an additional 150 hours per month (for Ms. Gasper) and 164 hours (for Ms. Myers) providing shopping, housekeeping and meal preparation services over and above what they do already for themselves or their households. Gasper AR 49, Myers AR 56. The Department will not allow these tasks to go undone. The Department requires the caregivers to meet all identified needs, including these IADL needs; it just will not pay them for the time it takes to do the work. Gasper AR 68 – 71, Myers AR 80 – 82 and WAC 388-72A-0095(1) (c).

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

The Draft Study asserts that the percentage of time devoted by outside caregivers to household tasks ranged from a low of 26% to a high of 46%. SHS-0003. The range for caregivers who resided in the same household as their clients was more narrow: 33% to 42%. SHS-0003. These figures include not only IADL services, but also “conferring with a client’s family, talking with other [sic] about the client’s needs, and

reassuring or redirecting a client related to a specific behavior.” SHS-0002, last paragraph. The study does not report the actual number of hours it takes a caregiver to perform IADLs each month. The study does not provide data to distinguish clients who are clinically complex from clients who are not. There is no indication about whether the client is the only one who benefits from the work that was classified as “Household or Coordination” or “Household Without.” SHS-0001 through -0003.

Although the study did not examine how much time a caregiver must spend on IADL services that benefit only the client, there is an assertion below the data table as follows:

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

SHS-0003.

The Department does not explain, in the study or elsewhere, how it arrived at the 15% figure. It does not relate to individual or even generalized facts about time savings realized by recipients with live-in providers.

Some version of a shared living rule has existed for the MPC program for many years. Appellant’s Brief, p. 11. (No such rule was applied to COPES recipients before 2004.) Case managers exercised

discretion in applying the former shared living rule for MPC recipients. This is apparent from Ms. Gasper's previous assessments. Gasper AR 79-94. Those assessments indicate she lived with her caregiver, but there is no discussion of the former shared living rule. Her 2003 assessment reflects base hours of 87. Gasper AR 84. The case manager then added 97 hours for "unscheduled task" and "cognitive support" needs. *Id.* In other words, the final award of hours reflected Ms. Gasper's personal care needs *despite* the version of the shared living rule then in effect for MPC.

Neither caregiver in these cases can continue providing care at the significantly reduced rate. Gasper AR 47, 50, Myers AR 64. The Department suggests in briefing that this may not be the case. *See, e.g.,* Appellant's Brief, p. 21. The Department offers no support for this speculation, and it directly contradicts the unrebutted record. Ms. Gasper lives in her caregiver's home. Gasper AR 46. Ms. Gasper has no family relationship with the caregiver. If the caregiver must find work outside the home, she will terminate the caregiver contract, and Ms. Gasper will have to move out. Gasper AR 47, 50. Ms. Myers' caregiver will seek work outside the home, forcing Ms. Myers to find an outside caregiver to come in. Myers AR 64. There will be no shared living reduction imposed on Ms. Myers if she hires an outside caregiver. WAC 388-72A-0087, WAC 388-72A-0092 and WAC 388-72A-0095.

**4. The Department's examples do not illuminate the issues in this case.**

While the Department's assessment instrument and the hypothetical examples of its application raise a number of problem issues unrelated to the shared living reduction, this is not the place to address them.

**C. The respondents were properly assessed.**

Ms. Gasper and Ms. Myers agree that their assessments contained accurate information about their needs and diagnoses, and that the shared living reduction applied to each of them was consistent with the (challenged) shared living rule.

**D. Procedural history.**

Ms. Gasper and Ms. Myers agree with the Department's description of the procedural history of the case with the following exceptions.

The evidence before the trial court consisted of the administrative record developed during the administrative hearings *and* the rule-making files. The Department is mistaken in its characterization of what the

caregivers said in their Declarations. (“Both caregivers indicated that they *might not* be willing to continue as caregivers ....” Appellant’s Brief, p. 18, emphasis added). Both caregivers indicated, unequivocally, in their Declarations that they *would not* be able to continue as caregivers.<sup>7</sup> Gasper AR 47, 50, Myers AR 64.

### III. SUMMARY OF ARGUMENT

The shared living rule violates federal Medicaid and state law statutory provisions guaranteeing recipients the right to free choice of provider and federal Medicaid provisions guaranteeing comparability of amount, duration and scope of services among recipients. 42 C.F.R. §431.51 (free choice of provider), 42 U.S.C. §1396a(a)(10)(B) and 42 C.F.R. §440.240(b)(1) (comparability).

As the trial court properly concluded, the shared living rule violates the respondents’ right to receive services from the qualified provider of their choice. Appellant’s Brief, Appendix A-4 at ¶ 3.1. (There is no dispute in these cases about the qualification of either provider.) The

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<sup>7</sup> The Department also claims in this section of its brief that there was no evidence Ms. Gasper and Ms. Myers “... had experienced difficulty in obtaining qualified caregivers who would be willing to provide the reduced level of hours of service.” *Id.* This question is not before the court in this case and was not raised by the Department at the administrative hearings.

Department has assessed Ms. Gasper and Ms. Myers as needing a number of hours of paid care. Gasper AR 44, 74, Myers AR 58, 87. Because each exercised her right to choose a provider who lives with her, her hours were reduced by 15% without regard to her individual needs. *Id.* In other words, Ms Gasper and Ms. Myers can only get the last 15% of the hours of paid care if they choose a provider other than the qualified providers they prefer. If they remained in the same situation with an outside provider, each would get the additional 15%. It is not the living situation, but rather the choice of provider that triggers application of the shared living reduction. The providers in this case are ready and willing to provide the additional 15% of paid care hours, but the Department seeks to avoid paying for them. Gasper AR 47, 50, Myers AR 61, 64. Its argument that the provider could still provide the last 30+ hours (or 15%) of personal care services for free misconceives the issue in this case: this case is about an individual's right to choice of provider for Medicaid (i.e., paid) services.

In response to the trial court's finding that the shared living rule violates comparability requirements, the Department asserts that these requirements are waived for COPES recipients (such as Ms. Myers) and that, in any case, the shared living rule does not violate comparability

requirements. Appellant's Brief, pp. 39 – 43. But the COPES Waiver Agreement does not contemplate a decrease of services to waiver recipients; it permits the opposite by allowing the State to provide *additional* services to waiver recipients without having to provide comparable services to non-waiver clients. See Appendix 1-2, ¶10.

Waiving comparability to increase available services furthers the state and federal interest in providing care at home, rather than in a nursing home, by paying for services that enable an individual to remain at home. WAC 388-72A-0055(4), Appendix 1-1 at 2. For example, the Department may use COPES funds to pay for a wheelchair ramp at a recipient's home. Appendix 1-12 at h. The COPES program *expands* upon the services that are available under the Medicaid State Plan.

The shared living rule violates comparability requirements because a covered benefit -- personal care services for assistance with IADLs -- is provided to one class of recipients (those who choose outside caregivers) while the same benefit is denied to another (those with live-in caregivers). The Department's argument turns the purpose and intent of the COPES Waiver on its head. There is no rational basis to distinguish between an MPC, State Plan recipient of personal care hours (for whom the Department concedes comparability requirements must be followed) and a recipient of personal care hours under the COPES program.

## IV. ARGUMENT

The shared living rule is invalid because it exceeds the Department's statutory authority. *Campbell v. DSHS*, 150 Wn.2d 881, 892; 83 P.3d 999 (2004) (“...an agency rule will be declared invalid if it exceeds the statutory authority of the agency.”) An agency's rule that conflicts with a statute is beyond that agency's authority and requires invalidation. *Edelman v. State ex. rel. Public Disclosure Com'n*, 116 Wn.App. 876, 886, 68 P.3d 296 (2003), *aff'd Edelman v. State ex rel. Public Disclosure Com'n*, 152 Wn.2d 584, 99 P.3d 386 (2004).

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

**1. Federal Medicaid law guarantees free provider choice.**

Section §431.51(a)(1) of Title 42 C.F.R. provides:

Section 1902(a)(23) of the [Social Security] Act provides that recipients may obtain services from any qualified Medicaid provider that undertakes to provide the services to them.

The federal Medicaid statutes are found in the Social Security Act.

The Social Security Act is a remedial statute and should be liberally

construed to carry out its beneficent purposes. *Haberman v. Finch*, 418 F.2d 664, 667 (2<sup>nd</sup> Cir. 1969) (liberal construction) and *Brown and Bartlett v. United States*, 330 F.2d 692, 696, (6<sup>th</sup> Cir. 1964) (beneficent purposes).

Ms. Myers receives services under the COPES program, a Medicaid program operated under an agreement (called “a waiver”) between the State and the Federal Government. 42 U.S.C. §1396n. The COPES Waiver Agreement<sup>8</sup> reiterates the right to free choice of provider:

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

Appendix 1-13, ¶D (Emphasis added.). The MPC program (also a Medicaid program) must comply with the State Plan.<sup>9</sup> The State Plan states:

The Medicaid agency assures that an individual eligible under the plan may obtain Medicaid services from any . . . person . . . that is qualified to perform the services.

State Plan, Appendix 2-1 at (a).

The shared living rule denies Ms. Myers and Ms. Gasper the choice guaranteed by the Social Security Act, the Code of Federal

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<sup>8</sup> Relevant portions of the COPES Waiver Agreement are attached to this brief as Appendix 1.

<sup>9</sup> Relevant portions of the Medicaid State Plan are attached to this brief as Appendix 2.

Regulations, the COPES Waiver Agreement and the Medicaid State Plan. It bars them from receiving the IADL services to which they are entitled from the qualified providers of their choice.

**2. The caregivers here are qualified, willing providers.**

The Department cites authority for the proposition that recipients cannot choose to receive care from an unqualified provider. Appellant's Brief, pp. 32 – 33.<sup>10</sup> That proposition is not in dispute. All parties agree, however, that Ms. Green and Mr. Myers are appropriate, qualified providers. Gasper AR 43, Myers AR 50. The Department does not contend these providers are “unqualified.” The Department implies instead that they are “unwilling” to provide covered services. Appellant's Brief, pp. 32 – 35.

The record in this case establishes that the caregivers are qualified and willing to provide the services the respondents were assessed as needing without the 15% shared living reduction. Gasper AR 47, 50, Myers AR 61, 64. The Department's response is that if the providers are unwilling to provide the last 15% of the hours without compensation, then

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<sup>10</sup> For example, the citations in the first paragraph of Appellant's Brief at page 33 including *O'Bannon* and *Kelly Kare*.

they are not willing to be providers. Appellant's Brief, p. 35. But the issue here involves the freedom of choice of a provider for Medicaid (i.e., paid) services. What if the Department proposed to reduce the hours by 99% or 100% instead of 15%? It could make the same argument that free choice of provider is not implicated because the client can still choose the same provider if the provider is willing to work for 1% of the prior rate, or for free. That argument would fail for the same reason it should fail here: what is at issue is freedom to choose a provider of paid care.

The Department reduced respondents' hours of paid care based solely on their choice of providers. Gasper AR 44 at ¶ 9, Myers AR 50 at ¶ 9. The shared living rule requires an automatic and inflexible reduction whenever a recipient lives with his or her provider; there is no examination of need. WAC 388-72A-0095(1)(c). The notices the Department sent to the respondents regarding their benefit reduction specify the reason for the reduction of their personal care services as follows: "The department will not pay for shopping, housework, laundry, meal preparation or wood supply when you and your individual provider, agency worker or personal aide live in the same household." Gasper AR 78, Myers AR 91. Absent the rule, each would receive 190 hours per month of care. Myers AR 5 (Final Administrative Order Finding of Fact 10), Gasper AR 5 (Final Administrative Order Finding of Fact 11).

The shared living rule mandates a finding that IADL needs are “fully met” on an informal (unpaid) basis, even if those needs are not met. WAC 388-72A-0095(1)(c). In the shared living situation, the provider must decide whether he or she will provide some amount of personal care services for free if the recipient’s care needs with meal preparation, housekeeping, shopping, or wood supply exceed what the provider would ordinarily do for themselves or their family. Both Ms. Myers and Ms. Gasper have individualized service plans as required by the Department’s regulations, and their caregivers must agree to provide the services set out in the service plan.<sup>11</sup> WAC 388-71-0515. The service plans written by the Department for Ms. Gasper and Ms. Myers require their caregivers to perform work set out in the plan; it just will not pay them for doing it.

The Department cites *Antrican v. Buell*, 158 F. Supp. 2d 663 (E.D.N.C. 2001), in which the court considered a claim that the rates paid

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<sup>11</sup> For example, although Ms. Gasper’s need for total assistance with shopping is marked as “fully met” by operation of the shared living rule, Ms. Green is expected as the paid provider to “Take client to store, Do all shopping for client, Carry heavy packages for client, Put items away, Pick up medication. Client is taken along on shopping trips as she is unable to be left at home. She is unable to participate in the task of shopping as much as a child would be.” Gasper AR 70. Similarly, although Ms. Myers’ need for total assistance with meal preparation is marked as “fully met” by operation of the shared living rule, Mr. Myers is expected to “Make food accessible to client, Prepare breakfast, Prepare dinner, Prepare lunch, Ask for client’s choices, Prepare renal diet. Client is not able to do any meal prep. She is too weak, unsteady, and unable to stand that long . . . After dialysis at 2:30 AM client is hungry. Client adheres to a Renial [sic] diet.” Myers AR 81.

for dental care were so low that few dentists were willing to participate. *Buell* held that comparability was not necessarily violated if dental reimbursement rates were low; but the *Buell* court did not consider a requirement that dentists perform certain services for free if they agreed to provide other services paid for at the Medicaid rate. More significantly for purposes of this case, the reimbursement in *Buell* applied to all participating dentists; here the challenged rule applies only to recipients who live in the same home as the provider.

### **3. The shared living rule is based on provider choice.**

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

Consider the hypothetical recipient who lives with one daughter while another daughter lives next door. The mother receives the full scope

of covered services she needs, including hours for IADLs, if her caregiver is the daughter next door. But if she chooses the daughter she lives with as caregiver, a shared living reduction will be applied. In both cases, she is sharing a home with the same daughter. The situations are distinguished not by her living circumstances, but by her choice of provider.

**4. The shared living rule overshoots its alleged purpose of avoiding payment for services that benefit caregivers.**

The Department defends the shared living rule on the ground that living with a caregiver necessarily results in the caregiver's ability to perform a large part of the IADLs a recipient needs along with the caregiver's own without expending additional time. Appellant's Brief, pp. 10 – 12.<sup>12</sup> This assumption is not always true. In particular, it is not true for Ms. Gasper and Ms. Myers. Gasper AR 50, Myers AR 64. This case is not about normal cleaning of common areas and family shopping, or about throwing an extra handful of noodles in the pot. The records in both of these cases demonstrate IADL needs far exceeding what the caregivers

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<sup>12</sup> In its Concise Explanatory Statement (CES) prepared following adoption of the shared living rule, the Department claimed the shared living rule was necessary to "comply with a federal requirement that the in-home paid caregiver living with the recipient will not be paid for activities that related to his/her room and board." SHS-0367-0368. The shared living rule goes well beyond this federal mandate not to pay for services that benefit only the caregiver. The shared living rule prevents payment for meal preparation, housekeeping, shopping, or wood supply that benefits *only the recipients*.

perform for their own households. Myers AR 60-82, Gasper AR 46-50, 52-70. How does it benefit Ms. Green's household to do 8 extra loads of laundry each week exclusively for Ms. Gasper, or to search and clean her drawers daily looking for hidden food? Gasper AR 48-49. How does it benefit Mr. Myers to scrutinize labels at the grocery store to ensure they do not contain any of several ingredients Ms. Myers cannot eat, or to get up in the middle of the night to make his mother a snack after dialysis? Myers AR 61-63.

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

The Department argues that respondents' "clinically complex medical conditions automatically qualify them for additional assistance with special care needs, including laundry and meal preparation activities." Appellant's Brief, p. 44. This assertion is unsupported by the record. There is nothing in the Department's rules that indicates that

hours are awarded to recipients, including those who are classified as clinically complex, in order to address any particular personal care need, including IADLs. A clinically complex recipient who needs no help at all with IADLs receives the *same number of hours* as a clinically complex recipient who in all other respects is identical to the first, but needs total assistance with IADLs. WAC 388-72A-0087.<sup>13</sup> The examples appended to Appellant's Brief are not helpful since every example indicates that all "shared living" IADL needs are "met" or "not applicable." Appellant's Brief, Appendix A-7 through A-10.

**5. The shared living reduction results in loss of provider choice.**

The record establishes that application of the shared living rule in the cases here would result in the respondents losing their providers of choice even for the reduced hours awarded. Ms. Green will have to ask Ms. Gasper to leave because she cannot provide for free a significant portion of services for which she was formerly paid. Gasper AR at 47 & 50. Ms. Myers will also lose her provider of choice because he will have

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<sup>13</sup>The base rate for the clinically complex groups, such as Group C, is based on the existence of at least one clinically complex medical condition + an "ADL score" which does not consider whether the recipient does or does not need IADL assistance.

to seek work outside the home to ensure that his family has adequate income. Myers AR at 64. Ironically, if Ms. Myers hires an outside provider, that person will be paid for shopping, meal preparation and housekeeping.

**6. State law guarantees free provider choice.**

Under RCW 74.39A.270(4), and consistent with the federal law requirements discussed above, home care clients (including COPES and MPC clients) are guaranteed “the right to select . . . any individual provider providing services to them.”<sup>14</sup> Until it adopted the shared living rule, the Department’s rules were generally consistent with this strong mandate. Other Department rules provide that the recipient has “primary

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<sup>14</sup> This provision codifies Initiative 775, Section 6(4). RCW 74.39A.270(4) is not ambiguous. If a statute’s meaning is plain, courts give effect to the plain meaning. *Campbell v. Department of Social and Health Services*, 150 Wn.2d 881, 894, 83 P.3d 999 (2004). If the statutory language is ambiguous, the statute’s legislative history, including legislative bill reports, may be reviewed to help determine a statute’s intent. *Greenen v. Washington State Bd. of Accountancy*, 110 P.3d 224, 227 (2005). Even if the statute was ambiguous, the Department’s explanation of the purpose of the statute, along with its claim that an interest group was being assuaged by the inclusion of the protective language in RCW 74.39A.270(4), does not approach what is considered by the courts to be legislative history. See *Louisiana-Pacific Corp. v. ASARCO Inc.*, 131 Wn.2d 587, 599, 934 P.2d 685 (1997). (Statement made by unidentified House Staff Counsel at committee hearing does not measure up to any reasonable definition of legislative history for the purpose of determining legislative intent.)

responsibility for locating, screening, hiring, supervising, and terminating an individual provider,”<sup>15</sup> and that the recipient’s choice of provider can only be overridden on the basis of a “reasonable, good faith belief that the person will be unable to appropriately meet the client’s needs.”<sup>16</sup>

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

The shared living rule cannot be reconciled with “the right to select” one’s caregiver. In effect, the Department has amended the statutory guarantee by establishing an irrebuttable presumption that *all* recipients in shared living situations have *all* of their IADL needs met *all* the time simply because they reside with a paid caregiver.<sup>17</sup>

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<sup>15</sup> WAC 388-71-0505(1).

<sup>16</sup> WAC 388-71-0546.

<sup>17</sup> Permanent irrebuttable presumptions are disfavored under the due process clause. *Cleveland Board of Education v. LaFleur*, 414 U.S. 632, 646, 94 S.Ct. 791, 39 L.Ed.2d

**B. The shared living rule is invalid because it violates federal Medicaid law guaranteeing that services are comparable in amount, duration and scope for all recipients.**

**1. Comparability requirements apply to Medicaid Personal Care Services.**

Medicaid Personal Care, or “MPC,” is a Medicaid “State Plan” program authorized under 42 U.S.C. §1396d(a)(24) and RCW 74.09.520(2). State plans for medical assistance are governed by 42 U.S.C §1396a. Under that statute, a State plan for medical assistance must provide that the medical assistance made available to any categorically needy individual shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual. 42 U.S.C §1396a (a)(10)(B). This requirement is echoed in 42 C.F.R §440.240(b):

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52 (1974). A rule was found to violate due process in *LaFleur* when it amounted to a conclusive presumption that every pregnant teacher who has reached a certain date of pregnancy was physically incapable of performing her job, even when medical evidence may be wholly to the contrary. As with retaining employment, the interest in retaining the caregiver of one’s choice is a significant protected interest. Imposition of the shared living rule will mean that Ms. Gasper and Ms. Myers will lose their caregiver of choice. This goes against the federal and state legislative intent that Medicaid recipients have the freedom to choose a qualified provider.

The Supreme Court in *Vlandis v. Kline* held that an irrebuttable presumption violated due process when it was not necessarily or universally true in fact, and where the State had reasonable alternative means of making the crucial determination. 412 U.S. 441, 452, 93 S.Ct. 2230, 37 L.Ed.2d. 63 (1973). Although it may require a slightly more complex process, a state’s interest in administrative ease alone cannot save a rule from invalidity under the due process clause. *Id.* at 451.

The plan must provide that the services available to any individual in the [categorically needy] group . . . are equal in amount, duration, and scope for all recipients within the group.

Significantly, both the federal statute and regulations clearly compare services between “individuals” within the same group, contrary to the Department’s assertion that the requirement means comparing groups of recipients to other groups. Appellant’s Brief, p. 38.

**2. Comparability requirements apply to COPEs services.**

COPEs is a Medicaid home and community-based waiver program authorized under 42 U.S.C. §1396n(c), and RCW 74.39A.030(2). As the Department points out, the COPEs waiver application includes language about waiving comparability requirements. Appendix 1-2, ¶10. The Department fails to place that language in context, however. This is the paragraph the Department claims waives comparability:

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

Appendix 1-2, ¶10 (emphasis added). This language does not restrict waiver services; it expands them. The purpose of this provision is to permit the State to provide *additional* services under the Waiver that it cannot provide under the Medicaid State Plan.

Medicaid requirements apply to waiver programs unless they are specifically waived. *See, e.g., McMillan v. McCrimon*, 807 F.Supp. 475 (C.D. Ill. 1992) where the court held that although 42 U.S.C. §1396n(c)(3) allows the federal government to waive comparability, that statute does not allow a waiver of other Medicaid requirements set out in 42 U.S.C. §1396a(a)(8). *Id.* at 482. Furthermore, in order to obtain a specific waiver of a Medicaid requirement, the state’s request had to actually *mention* what it was the state desired to waive. *Id.* at 482. Here, the COPES Waiver specifically provides for broader services than are allowed under the Medicaid State Plan.

The COPES Waiver allows recipients to avoid nursing home placement. Appendix 1-1, ¶2a. It provides more services than Medicaid would otherwise provide in order to prevent nursing home placement. For example, the Department can pay for “environmental modifications” such as a wheelchair ramp at a recipient’s home under the COPES program, but not otherwise under Medicaid. Appendix 1-12 at h. The COPES Waiver allows the State to use federal Medicaid funding to pay for services to individuals that would not otherwise be paid for under Medicaid when:

there has been a determination that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility ...

42 U.S.C. §1396n(c)(1).

The COPES Waiver Agreement provision regarding comparability (quoted above) is explicitly limited; comparability is waived only to allow provision of services to waiver recipients not available under the State Plan. The Waiver provides COPES recipients with all the personal care services available under the State Plan and more.

Relationship to State Plan service:

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

Appendix 1-10, ¶4 .

Appendix G to the COPES Waiver assures that “clients who . . . receive services under the COPES waiver receive a full package of personal care services under the waiver . . .” Appendix 1-18. Refusing to cover needed personal care services for IADLs violates the State’s promise to provide at least the services available under the State plan, and to provide a “full package” of personal care services to COPES waiver recipients.

**3. Comparability requirements hinge on recipient need.**

Comparability requirements exist to ensure that eligible clients with comparable need for a service receive the service, regardless of the etiology of the need – a proposition with which the Department and the respondents agree. *See generally* Appellant’s Brief, pp. 43 – 44.

But the shared living rule has no mechanism to consider actual need. WAC 388-72A-0095(1)(c). It is applied automatically. The Department decreased Ms. Gasper’s and Ms. Myers’ 190 “base hours” by more than 30 per month without regard to their actual need for help with meal preparation, housekeeping or shopping.

The Department argues that the Pennsylvania policy struck down in *White v. Beal*, 555 F.2d 1146 (3<sup>rd</sup> Cir. 1977) is inapplicable to the shared living rule. In *White*, the court rejected Pennsylvania’s contention that the Social Security Act granted permission to “pay the expenses of some who would benefit (those requiring eyeglasses because of pathology) but paying nothing to others (those requiring them because of eye defects) who have the same need for the lenses.” *Id.* at 1150. The Department argues it should be permitted to do what the court rejected in *White*, i.e., pay for help for some recipients who need assistance with meal preparation, shopping, housekeeping or wood supply while not paying for

others who also need assistance. Neither the Social Security Act nor the COPES Waiver Agreement allow the State to pay for assistance with IADL tasks for some who would benefit from them (those with outside providers), while paying nothing for IADL tasks for others (those with live-in providers) *when both groups have the same needs*.

The Department asserts that “the [shared living] rule reflects a judgment that the *need* of a person who lives with a caregiver is different from that of a person who does not . . . .” Appellant’s Brief, p. 43. (Emphasis in original.) This judgment is incorrect, at least some of the time. A long term care recipient’s need for personal care services is not limited to “routine household maintenance tasks,” nor are his or her non-routine IADL needs always subsumed into the routine household tasks of a live-in caregiver. Given that the Medicaid in-home care population is by definition disabled, the likelihood that any one recipient may have IADL needs above and beyond what one would think of as routine household maintenance tasks is fairly good. This is all the more true for COPES recipients who are, by definition, eligible for nursing home placement. WAC 388-72A-0055(4).

**4. The shared living rule is not a reasonable utilization control.**

Where they don't conflict with specific requirements such as those relating to choice of provider or comparability, a state may impose reasonable utilization controls on Medicaid programs, but those limits must be appropriate and related to such criteria as medical necessity or utilization control procedures. 42 U.S.C. §1396a(a)(30)(A); 42 C.F.R. §440.230(d).<sup>18</sup> Denying needed services to Medicaid in-home care recipients is not a valid method of utilization control as it is inconsistent with the objectives of the Social Security Act and is not permitted under the plain language of the statute, which authorize states to implement cost-containment measures only for specific reasons. 42 U.S.C. §1396a(a)(30)(A).

Caps or limits on Medicaid services have been struck down in several cases. In *DeLuca v. Hammons*, 927 F.Supp. 132, 133 (S.D.N.Y. 1996), the court struck down a New York regulation that imposed a daily cap of four hours of in-home care personal services per day for new applicants who needed more than four hours of care per day but who did

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<sup>18</sup> Utilization controls are permitted under the statute only as necessary to safeguard against *unnecessary* utilization, to assure that payments for services are consistent with efficiency, economy and quality of care and to enlist sufficient providers. 42 U.S.C. §1396a(a)(30)(A).

not require total assistance. The court held the cap was an arbitrary and unreasonable means of utilization control. The cap, the court held, failed to take into account the amount of services that have been determined to be necessary for the recipient's health and safety. *DeLuca* at 136.<sup>19</sup> The shared living rule is not an appropriate or necessary safeguard against unnecessary utilization of services. There is no indication in the administrative records that Ms. Myers or Ms. Gasper utilized unnecessary personal care services. Like the cap struck down in *DeLuca*, the shared living rule fails to provide services that these women obviously need.

**5. The shared living rule violates comparability.**

The Department argues that, even if comparability applies, the shared living rule does not violate comparability, citing *Rodriguez v. New York*, 197 F.3d 611 (1999). In *Rodriguez*, the plaintiffs wanted the State of New York to pay for a new in-home care service – safety monitoring. Safety monitoring was not then provided to anyone as part of the State's

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<sup>19</sup> See also *Weaver v. Reagen*, 886 F.2d 194 (8<sup>th</sup> Cir. 1989), holding that Missouri's refusal to fund AZT for AIDS patients who had demonstrated medical need for the drug was an unreasonable utilization control and was inconsistent with the objectives of the Medicaid Act. *Id.* at 199-200. A two-year period of abstinence from alcohol prior to a Medicaid-funded liver transplant was arbitrary and unreasonable and not a valid utilization control. *Allen v. Mansour*, 681 F.Supp. 1232 (E.D. Mich. 1986).

Medicaid in-home care program. The court held that it could not force the state to begin providing that service.

In this case, Washington provides personal care hours for IADL tasks to current MPC and COPES recipients who are assessed as needing assistance and have outside providers. Washington provided those services to recipients with live-in caregivers until promulgating the rule at issue. Ms. Gasper and Ms. Myers do not ask for new services, but only to retain services that are currently available to recipients who do not live with their paid caregivers.

At least one court has distinguished *Rodriguez* on this exact basis. *Martin v. Taft*, 222 F.Supp.2d 940 (S.D. Ohio 2002). In *Martin*, mentally retarded and developmentally delayed persons sought to decrease the waiting time they faced to access community based care. The State of Ohio already offered such care, but in such limited amounts that it was virtually unavailable to the plaintiffs. The court denied Ohio's claim that it did not have to expand services under *Rodriguez* by noting, "In the case at bar, plaintiffs do not seek new programs; rather they seek to participate in waiver programs that already exist. *Id.* at 974.

The Department's excerpt from *Pharmaceutical Research v. Walsh*, 538 U.S. 644, 123 S.Ct. 1855, 155 L.Ed.2d 889 (2003) at p. 41 of its brief includes the Supreme Court's admonition that while the Medicaid

Act vests substantial discretion in the states to design Medicaid programs, those programs must be structured to provide for the best interests of the recipients. *Id.* at 655. In the case before this court, covering IADL services for all in-home recipients who need them is not only in the recipients' best interests, it is necessary to comply with federal and state free choice of provider requirements and federal Medicaid comparability requirements.

The Department also relies on *Alexander v. Choate*, 469 U.S. 287, 105 S.Ct. 712, 83 L.Ed.2d 661 (1985). In *Alexander*, the court rejected a challenge to Tennessee's reduction of coverage for in-patient hospital days from 20 to 14 days per year. The District Court specifically found that the 14-day limitation would fully serve 95% of even handicapped individuals eligible for Tennessee Medicaid. *Id.* at 203. There is no evidence that any percentage of recipients upon whom the shared living reduction is imposed will have their IADL needs adequately met.

In *Alexander*, unlike the reduction in this case, the reduction to covered inpatient hospital care days was applied *across the board* to all Medicaid recipients. All recipients and all hospitals were subject to the same service restrictions. Here, the denial of needed IADL services carves out from the entire recipient group one set of recipients – those with live-in caregivers. This carve-out is carried out even when the shared living

recipient's needs are not met, as with Ms. Gasper and Ms. Myers, by virtue of the shared living arrangement.

**C. The Department and CMS are not entitled to deference.**

Although an agency's authority to implement State law and design a Medicaid program is broad, that authority is limited. Nothing in the record establishes that the Department has ever analyzed or addressed free choice of provider or comparability requirements outside the context of litigation. The issues here are issues of law, and the Department has no special expertise to add.

**1. The Department is not entitled to *Chevron* deference because the statutes at issue (free choice of provider and comparability) are not ambiguous.**

The Department's discussion of deference does not take into account the first prong that must be met in applying the standard of *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 104 S.Ct. 2778, 81 L.Ed.2d 694 (1984). The *Chevron* court noted, "When a court reviews an agency's construction of the statute which it administers, it is confronted with two questions. First, always, is the question whether Congress has directly spoken to the precise question

at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress.” *Id.* at 842 – 843. In this case, the Department claims that the shared living rule does not violate statutes regarding free choice of provider or comparability. But this interpretation gets no deference because the statutes guaranteeing free choice of provider and comparability of service are not ambiguous. The statutory language is clear: recipients have free choice of provider and recipients receive services comparable to other recipients. 42 U.S.C. §1396a(a)(23)(A) (free choice) and 42 U.S.C. §1396a(a)(10)(B) (comparability). Because there is no ambiguity, an analysis under *Chevron* yields a conclusion that the agency has no deference in this case. There is no gap for the agency to fill.<sup>20</sup>

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<sup>20</sup> The *Chevron* holding regarding ambiguity of a statute in relation to agency deference is echoed in Washington case law. “If a statute falls within the agency’s expertise and is ambiguous, we accord great weight to the agency’s interpretation. We accord no deference, however, to the agency’s interpretation if the statute is unambiguous. *Ted Rasmussen Farms, LLC v. Department of Ecology*, 110 P.3d 823 (2005) citing *Edelman v. ex. rel. Pub. Disclosure Comm’n.*, 152 Wn 2d 584, 590, 99 P.3d 386 (2004).

**2. Rules that exceed or violate statutory authority are invalid and are not accorded deference.**

The statutory provisions cited by the Department as the authority for the shared living rule are RCW 74.08.090, RCW 74.09.520, RCW 74.39A.090, and RCW 74.39A.095. SHS-0334. None of these statutes provides specific or implied authority for the adoption of a rule reducing benefits formerly provided to in-home care recipients who choose providers who live with them.

RCW 74.08.090 provides general authority to the Department to promulgate rules regarding public assistance programs. But, that authority has limits. *Fecht v. DSHS*, 86 Wn.2d 109, 542 P.2d 780 (1975).<sup>21</sup> *See also Rice v. DSHS*, 26 Wn.App. 32, 610 P.2d 970 (1980).<sup>22</sup> The general statement of rulemaking authority in RCW 74.08.090 includes a

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<sup>21</sup> In *Fecht*, the court struck down a rule that limited general assistance payments to those 50 years of age and older despite no such age restriction in the General Assistance statutes. The court held that RCW 74.08.090 makes it clear that any rules and regulations promulgated by the department must be within the "spirit and purpose" of Title 74. The obvious intent of the legislature is to provide assistance to those individuals who are in "need." *Fecht* at 110-111.

<sup>22</sup> In *Rice*, the Court of Appeals struck down a rule that required a person in need of medical assistance to notify the Department of that fact within seven days of the date medical care is begun in order to receive coverage from the onset of the care. The court held that while the Department may set standards to measure the eligibility of persons applying for public assistance, in so doing: "those standards are to be consistent with the provisions of the public assistance statutes and are to comply with their spirit and purpose." *Rice* at 35.

requirement that the rules be consistent with the “spirit and purpose” of public benefit programs. It does not authorize the Department to promulgate rules in violation of State or Federal law. Nor does RCW 74.39A.090 or RCW 74.39A.095 indicate a legislative intent to grant authority to the Department to promulgate the shared living rule.

RCW 74.09.520(1) and (2) have no applicability to this case. Neither do subsections RCW 74.09.520(5), (6) and (7). RCW 74.09.520(4) provides no statutory authority for the rule. It directs the Department to implement a means to assess recipients’ need for personal care services, but it gives no license to award services inconsistent with that need, or to promulgate rules that violate freedom of choice or comparability guarantees. In fact, RCW 74.09.520(4) requires that “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.” Reducing services through the automatic services reductions of the shared living rule, which disregards need, exceeds and violates this authority.

In addition, RCW 74.09.520(3) requires the Department to ensure that its rules conform to federal rules regarding the provision of personal care services authorized under the Medicaid program. Ms. Gasper and Ms.

Myers contend the rule violates federal Medicaid rules regarding comparability and free choice of provider. Rules that exceed or violate statutory authority are invalid and are not accorded deference.

**3. Agency deference is limited.**

The court's determination of whether the shared living rule violates federal law is an issue of law and determined de novo. *Littleton v. Whatcom County*, 121 Wn.App. 108, 86 P.3d 1253 (2004). A state agency's interpretation of federal law requirements is not entitled to the same deference that would be accorded to a federal agency's interpretation. *DeLuca v. Hammons*, 927 F.Supp. 132, 133 (S.D.N.Y. 1996) citing *Turner v. Perales*, 869 F.2d 140, 141 (2d Cir. 1989). While a state has considerable authority to administer its Medicaid programs, that authority is limited. A state's plan for determining eligibility for medical assistance must be "reasonable" and "consistent with the objectives" of the Social Security Act. *Beal v. Doe*, 432 U.S. 438, 440, 53 L.Ed.2d 464, 97 S.Ct. 2366 (1977) quoting 42 U.S.C. §1396a(a)(17).

**4. CMS has not endorsed the shared living rule.**

The Department asserts that the federal government's approval of its Medicaid in-home care programs also means the federal government has approved the shared living rule. That approval, the argument goes, is then entitled to deference. There is no evidence in the record indicating that the United States Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) knows that the shared living rule exists.<sup>23</sup> An explanation about how the shared living rule operates is not found in the Medicaid State Plan, which covers the Medicaid Personal Care program or in the COPES Waiver Agreement between the Department and CMS. The rule-making file does not indicate that the proposed rule was distributed to CMS.

The Medicaid State Plan and the COPES Waiver Agreement with the federal government do not embrace the shared living rule. The COPES Waiver Agreement, for example, says that the state may pay for:

housekeeping chores such as bed making, laundry, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, *rather than the individual's family*.

Appendix 1-8, at d. (Emphasis added.)

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<sup>23</sup> CMS is the federal entity that approves Medicaid waivers and Medicaid State Plans.

The rule-making file also contains a CMS publication reiterating this policy. SHS-0005-0007. Ms. Gasper and Ms. Myers agree with the policy as set out in the Medicaid State Plan, COPES Waiver Agreement and the CMS publication. Caregivers should not be paid with taxpayer money to perform tasks that principally benefit the caregiver.

Even if CMS was aware of the shared living rule, that awareness has no relevance. CMS is not authorized to waive the federal Medicaid laws that guarantee Medicaid recipients' choice of provider and comparability of services.

**D. The trial court properly struck the Declaration of Penny Black.**

The Department attached a Declaration from Penny Black, Director of the Department's Home and Community Services, to its trial brief. CP 123-130. On Respondents' motion, the trial court struck the Declaration. CP 213-214. The trial court's decision to strike the Declaration may not be overturned absent abuse of discretion. *Washington Independent Tel. Ass'n v. Wash. Util. & Transp. Comm'n.*, 110 Wn. App. 498, 518, 41 P.3d 1212 (2002), *aff'd* 149 Wn.2d 498, 65 P.3d 319 (2003). The trial court abuses its discretion when its "decision rests on untenable grounds or untenable reasons." *Telford v. Thurston County Bd. of*

*Comm'rs.*, 95 Wn. App. 149, 166, 974 P.2d 886 (1999), *rev. den.*, 138 Wn.2d 1015, 989 P.2d 1143 (1999).

Under the APA, judicial review is limited to the agency record. *Motley-Motley, Inc. v. Pollution Control Hearings Board and Department of Ecology*, 110 P.3d 812, 819 (2005). Additional evidence may be admitted pursuant to RCW 34.05.562(1). If the taking of new evidence was not limited at the trial court level, the trial court would become the tribunal of original, rather than appellate jurisdiction, wasting the purpose behind the administrative hearing. *Id.* at 820. RCW 34.05.566(6) allows supplemental additions of any kind to the record *only* by court order.

Instead of attaching the Declaration to its brief, the Department should have moved the trial court for an order permitting it to supplement the record pursuant to RCW 34.05.562. Discovery of new evidence and/or presentation of new evidence to the trial court after the agency record has been finalized may be accomplished only by court order. *Washington Independent Tel. Ass'n, supra*, at 518.

The trial court's decision to strike the Ms. Black's Declaration was proper based not only on procedural grounds, but also because the Declaration did not satisfy any of the statutory bases that permit the taking of new evidence by the trial court. RCW 34.05.562. The Department's brief in this court indicates what information the trial court would have

had available if the Declaration had been admitted, but does not justify admission of that information on any basis recognized in RCW 34.05.562.

The Department contends that the trial court's decision to strike Ms. Black's Declaration deprived it of sufficient information to judge the validity of a "complex and sophisticated agency rule." The shared living rule is neither complex nor sophisticated. It rule imposes a "blanket reduction" in services, i.e., an automatic, inflexible reduction in services, based not on an individualized assessment of need, but on whether a recipient and a paid caregiver share an address.

Ms. Black's Declaration is a combined attempt to supplement the agency record and the agency rule-making file. Doing both may be allowed with permission from the court under RCW 34.05.562. But the trial court did not err in ruling that the evidence could not come in because of the procedural and evidentiary defects.

The Department's reliance on *Aviation West Corp. v. Dept. of Labor and Industries*, 138 Wn.2d 413, 417, 980 P.2d 701 (1999) is misplaced. In *Aviation West*, the trial court allowed Labor and Industries to testify at trial about its decision to adopt the rule regulating smoking in private work places, but confined that testimony to explaining why the agency decided to adopt the rule. *Id.* at 417. Most of Ms. Black's Declaration, on the other hand, did not explain the Department's decision

at the time the rule was adopted.

All of Ms. Black's Declaration regarding the CARE assessment, information about the Department's administration of its Medicaid programs, or how the Department would respond if Ms. Gasper's and Ms. Myers' caregivers could not care for them any more was not relevant because none of that has anything to do with the validity of the rule.<sup>24</sup> Further, Ms. Black's claims about the cost of sustaining the trial court's ruling are both without foundation and irrelevant; they should not be allowed to affect the outcome of this case.

This court does not need Ms. Black's Declaration to understand the shared living rule, which could not be more simple. The rule automatically reduces 15% of an in-home care recipient's personal care hours if the recipient lives with a paid caregiver.

**E. The court should award attorneys' fees to Columbia Legal Services pursuant to RCW 74.08.080 and RAP 18.1.**

If the respondents prevail before the Court of Appeals, they are entitled to an award of reasonable attorneys' fees and costs pursuant to

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<sup>24</sup> Ms. Black's assertion that the Department would help Ms. Gasper and Ms. Myers to find other caregivers or places to live if their current caregivers could no longer afford to provide care affirms the validity of one of the respondents' claims about the rule, i.e., that it violates their right to choose their caregiver.

RCW 74.08.080(3) and RAP 18.1. RCW 74.08.080(3) provides that a petitioner on judicial review from an order entered in a public assistance program may be awarded reasonable attorneys' fees and costs by the Superior Court, Court of Appeals, or Supreme Court if any of those courts renders a favorable decision. The Northwest Justice Project is precluded by a condition of its funding from seeking attorneys' fees, so no fees will be sought for work by its staff, but no such restrictions apply to Columbia Legal Services.

#### V. CONCLUSION

The judgment of the trial court should be affirmed.

RESPECTFULLY SUBMITTED this 17<sup>th</sup> day of June, 2005.

Attorneys for Gasper/Myers:

  
NORTHWEST JUSTICE PROJECT  
Meagan J. MacKenzie, WSBA 21876

  
COLUMBIA LEGAL SERVICES  
Amy L. Crewdson, WSBA 9468

## PROOF OF SERVICE

I certify that I hand-delivered a true and correct copy of the foregoing Respondents Brief to William L. Williams, William T. Stephens and Donna Turner Cobb, Assistant Attorneys General, at 670 Woodland Square Loop SE, Lacey WA 98503 on June 17, 2005.

I declare the foregoing to be true and correct under penalty of perjury under the laws of the State of Washington.

Signed at Olympia, Washington on June 17, 2005.

  
\_\_\_\_\_  
Amy L. Crewdson

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## Appendix

<b>Appendix #</b>	<b>Description</b>
1-1 thru 1-18	COPES Waiver Agreement Excerpts
2-1 thru 2-4	Medicaid State Plan Excerpts





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

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

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

t.  Other services (specify):

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

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

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

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

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

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

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

a.  Yes                      b.  No

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

a.  Yes                      b.  No

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

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

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

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

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b.      Homemaker:

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

     Other Service Definition (Specify):

c.   X   Home Health Aide services:

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

     Other Service Definition (Specify):

d.   X   Personal care services:

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

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

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

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

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

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

Justification attached. (Check one):

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

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

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

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

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

Case managers

Other (Specify):

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

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

As indicated in the plan of care

Other (Specify):

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

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

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

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

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

Other service definition (Specify):

e.  Respite care:

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

Other service definition (Specify):

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

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

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

1.  Yes

2.  No

Other service definition (Specify):

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

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h. X Environmental accessibility adaptations:

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

\_\_\_ Other service definition (Specify):

i. X Skilled nursing:

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

\_\_\_ Other service definition (Specify):

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B. ASSURANCE THAT REQUIREMENTS ARE MET

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

C. PROVIDER REQUIREMENTS APPLICABLE TO EACH SERVICE

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

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

D. FREEDOM OF CHOICE

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

**APPENDIX E - PLAN OF CARE**

APPENDIX E-1

a. PLAN OF CARE DEVELOPMENT

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

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

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

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

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

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

Every 3 months

Every 6 months

Every 12 months

Other (specify):

As indicated by a significant change in the client's condition or situation.

APPENDIX G-3

METHODS USED TO EXCLUDE PAYMENTS FOR ROOM AND BOARD

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

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

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

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

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

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

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

APPENDIX G-3 a

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

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

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

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

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

APPENDIX G-4

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

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

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

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New: HCFA-PM-99-3  
JUNE 1999

State: WASHINGTON

Citation

4.10 Free Choice of Providers

42 CFR 431.51  
AT 78-90  
46 FR 48524  
48 FR 23212  
1902(a)(23)  
P.L. 100-93  
(section 8(f))  
P.L. 100-203  
(Section 4113)

(a) Except as provided in paragraph (b), the Medicaid agency assures that an individual eligible under the plan may obtain Medicaid services from any institution, agency, pharmacy person, or organization that is qualified to perform the services, including of the Act an organization that provides these services or arranges for their availability on a prepayment basis.

(b) Paragraph (a) does not apply to services furnished to an individual –

(1) Under an exception allowed under 42 CFR 431.54, subject to the limitations in paragraph (c), or

(2) Under a waiver approved under 42 CFR 431.55, subject to the limitations in paragraph (c), or

(3) By an individual or entity excluded from participation in accordance with section 1902(p) of the Act,

Section 1902(a)(23)  
Of the Social  
Security Act  
P.L. 105-33

(4) By individuals or entities who have been convicted of a felony under Federal or State law and for which the State determines that the offense is inconsistent with the best interests of the individual eligible to obtain Medicaid services, or

Section 1932(a)(1)  
Section 1905(t)

(5) Under an exception allowed under 42 CFR 438.50 or 42 CFR 440.168, subject to the limitations in paragraph (c).

(c) Enrollment of an individual eligible for medical assistance in a primary care case management system described in section 1905(t), 1915(a), 1915(b)(1), or 1932(a); or managed care organization, prepaid inpatient health plan, a prepaid ambulatory health plan, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive emergency services or services under section 1905 (a)(4)(c).

TN # 03-015  
Supersedes  
TN # 99-10

Approval Date 10/17/03

Effective Date 8/11/03

Revision: HCFA-PM-94-5 (MB)

State/Territory: WASHINGTON

## SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation

42 CFR  
Part 440,  
Subpart B  
1902(a), 1902(e),  
1905(a), 1905(p),  
1915, 1920, and  
1925 of the Act.

1902(a)(10)(A) and  
1905(a) of the Act

3.1 Amount, Duration, and Scope of Services

- (a) Medicaid is provided in accordance with the requirements of 42 CFR Part 440, Subpart B and sections 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act.

(1) Categorically needy

Services for the categorically needy are described below and in ATTACHMENT 3.1-A. These services include:

- (i) Each item or service listed in section 1905(a)(1) through (5) and (21) of the Act, is provided as defined in 42 CFR Part 440, Subpart A, or, for EPSDT services, section 1905(r) and 42 CFR Part 441, Subpart B.
- (ii) Nurse-midwife services listed in section 1905(a)(17) of the Act, are provided to the extent that nurse-midwives are authorized to practice under State law or regulation and without regard to whether the services are furnished in the area of management of the care of mothers and babies throughout the maternity cycle. Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid agency without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider.
- // Not applicable. Nurse-midwives are not authorized to practice in this state.

TN No. 94.13  
Supersedes  
TN No. 91-22

Approval Date 7-29-94Effective Date 7-1-94



STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL  
CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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- 26. Personal care services
  - a. Eligibility for services.

Persons must living in their own home, Adult Family Home, family foster home, children's group care facility or licensed boarding home.
  - b. Persons must be determined to be categorically needy and have three ADL needs requiring minimal assistance or one ADL need requiring more than minimal assistance. ADL assistance is defined in WAC 388-71-0202 and WAC 388-72A-0035 and WAC 388-72A-0040.