

FILED  
COURT OF APPEALS  
DIVISION II  
NO. 33088-1-II

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

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VENETTA GASPER and TOMMYE MYERS,

Respondents,

v.

DEPARTMENT OF SOCIAL AND HEALTH SERVICES,

Appellant.

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**CORRECTED BRIEF OF APPELLANT**

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## I. INTRODUCTION

This case concerns the administration by the Department of Social and Health Services (the “Department” or “DSHS”) of programs authorized under federal and state law to provide services to needy disabled individuals in their homes or in community settings rather than in institutions. Ultimately at issue is the Department’s ability to administer these programs in an equitable and cost-effective manner.

The Department operates four programs, three of which are Medicaid funded, that offer home and community-based assistance to individuals who meet eligibility requirements. By paying for recipients to have assistance in activities such as bathing, dressing, eating, and toilet use, these programs give eligible individuals the chance to avoid having to receive care in institutional settings, such as nursing homes or, in some cases, hospitals.<sup>1</sup>

The Department assesses the functional capacity of participants to determine the number of monthly paid service hours for which they are eligible. Participants then select one or more providers for the services

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<sup>1</sup> A complete list of services that may be provided at public expense can be found in WAC 388-72A-0041, although the package of services paid for any individual client depends on the needs of the individual as assessed by the Department and such other factors as the availability of informal supports through friends or family members.

covered by the program. DSHS contracts with the providers in return for direct payment to them by DSHS.<sup>2</sup>

The majority of participants select providers with whom they have no other relationship and who come into the participants' residences to provide services. However, a significant number choose someone already residing in their household—a family member or close friend—as their service provider.

As allowed by federal and state law, and as a means to allocate scarce public funds for such programs on an equitable basis, the Department developed an assessment tool that incorporates what is called the “shared living rule.” Under this rule, the Department makes a modest reduction in the level of assistance offered to individuals who choose to live with their paid caregivers, recognizing that there are tasks—such as housekeeping, shopping for food, and preparing meals—that the caregivers would be performing for the residential unit anyway, even if they were not paid to provide services to the recipient(s) with whom they reside.

The respondents contend that the shared living rule violates federal and state law by (1) restricting recipients' freedom to choose any provider they want and (2) not providing “comparable” services to recipients who

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<sup>2</sup> This arrangement is described, albeit in a different context, in *Bennerstrom v. Dept. of Labor & Industries, et al.*, 120 Wn. App. 823, 828, 86 P.3d 826 (2004).

decide to live with their paid providers as compared to services provided to individuals who do not live with their providers. The trial court agreed, and issued a declaratory judgment invalidating the rule.

Because of the erroneous legal conditions and the significant fiscal consequences of the trial court's order—and the likely resulting reduction of services available to participants in this and/or other programs that will be necessary for the Department to address those consequences within its legislative appropriation—DSHS respectfully asks this Court to reverse the trial court and reject the challenge to the shared living rule.

## **II. ASSIGNMENTS OF ERROR**

1. The trial court erred by entering its Order Granting Motion To Strike (CP 213-14), striking the Declaration of Penny Black attached to the Department's Response To Petitions For Review. (CP 213-14.)
2. The trial court erred by entering Finding of Fact 2.3.<sup>3</sup>
3. The trial court erred by entering Finding of Fact 2.4.
4. The trial court erred by entering Finding of Fact 2.5.
5. The trial court erred by entering Finding of Fact 2.8.
6. The trial court erred by entering Conclusion of Law 3.1.
7. The trial court erred by entering Conclusion of Law 3.2.

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<sup>3</sup> The trial court's Findings of Fact, Conclusions of Law, Declaratory Judgment and Order Granting Relief from Administrative Orders can be found at CP 256-261. Pursuant to RAP 10.4(c), a copy is attached in the Appendix, at pp. A 1-6.

8. The trial court erred by entering Conclusion of Law 3.4.
9. The trial court erred by entering Conclusion of Law 3.5.
10. The trial court erred by entering Conclusion of Law 3.6.
11. The trial court erred by entering Conclusion of Law 3.7.
12. The trial court erred by entering Conclusion of Law 3.8.
13. The trial court erred by entering its Order.

### **III. ISSUES**

1. Did the trial court, in deciding the validity of an agency rule, abuse its discretion by rejecting the proffered testimony of the agency official responsible for developing and administering the rule? This issue pertains to Assignment of Error 1.

2. Did the trial court err as a matter of law by declaring that WAC 388-72A-095(1)(c) (the shared living rule) violates 42 C.F.R. § 431.51(a)(1)? This issue pertains to Assignments of Error 2, 3, 4, 5, 6, 8, 9, 10, 11, 12, and 13.

3. Did the trial court err as a matter of law by declaring that WAC 388-72A-095(1)(c) violates RCW 74.39A.270(4)? This issue pertains to Assignments of Error 2, 3, 4, 5, 6, 8, 9, 10, 11, 12, and 13.

4. Did the trial court err as a matter of law by declaring that WAC 388-72A-095(1)(c) violates 42 U.S.C. § 1396a(a)(10)(B)(i)? This issue pertains to Assignments of Error 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, and 13.

5. Did the trial court err as a matter of law by declaring that WAC 388-72A-095(1)(c) violates 42 C.F.R. § 440.240(b)? This issue pertains to Assignments of Error 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, and 13.

6. Did the trial court err as a matter of law by declaring WAC 388-72A-095(1)(c) invalid as applied in connection with a state-funded program that is not subject to the restrictions of the Medicaid Act?

#### **IV. STATEMENT OF THE CASE**

##### **A. The Benefit Programs At Issue**

DSHS administers four publicly funded long-term care programs generically referred to as “home and community programs.” WAC 388-71-0405. These programs provide a range of personal and home-care assistance designed to allow low-income disabled individuals to reside in their own homes instead of nursing homes or other facilities.

Three of the four programs are funded in part by the federal government under Title XIX of the Social Security Act, commonly known as the Medicaid Act. “The Medicaid program is a cooperative federal-state program whereby the federal government provides financial assistance to the states so they may furnish medical care to needy individuals.” *Independent Acceptance Co. v. State of California*, 204 F.3d 1247, 1249 (9th Cir. 2000); *see generally* 42 U.S.C. §§ 1396-1396v. Participation in the Medicaid program is voluntary, but states that choose

to participate must comply with the Act's requirements and with regulations promulgated by the federal Department of Health and Human Services ("DHHS"). *Id.*

The four programs affected by the trial court decision are Medicaid Personal Care,<sup>4</sup> the COPEs waiver program,<sup>5</sup> the Medically Needy In-Home Waiver program,<sup>6</sup> and the Chore program.<sup>7</sup> 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 388-71-0425(1).

#### **B. The CARE Assessment Process**

Eligibility for home and community services under one of these programs is determined by an individualized assessment of the recipient's need for services.<sup>8</sup> Pursuant to legislative direction to assure that long-term care needs "will be determined by a uniform system for comprehensively assessing functional disabilities" (RCW 74.39.005), the

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<sup>4</sup> Medicaid Personal Care is a Medicaid program authorized under 42 U.S.C. § 1396d(a)(24) and RCW 74.09.520(2).

<sup>5</sup> COPEs ("Community Options Program Entry System") is a Medicaid home and community-based waiver program authorized under 42 U.S.C. § 1396n(c) and RCW 74.39A.030(2). Waiver programs are exempt from certain Medicaid Act requirements, as discussed below.

<sup>6</sup> Medically Needy In-Home is a Medicaid home and community-based waiver program authorized under 42 U.S.C. § 1396n(c), RCW 74.09.700(2)(a)(i), and RCW 74.39.041(1). This program and COPEs serve different income eligibility groups, but are otherwise similar.

<sup>7</sup> The Chore program is a wholly state-funded program authorized under RCW 74.39A.110. It is not a Medicaid program.

<sup>8</sup> The client must also meet certain income and resource limitations. These vary somewhat from program to program, and are not at issue in this litigation.

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

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 designee<sup>10</sup> 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,

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<sup>9</sup> 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.

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

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).<sup>11</sup>

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.”)<sup>12</sup> The rule has been part of the Medicaid Personal Care program—and thus has been part of the state’s Medicaid Plan—since at least 1993.<sup>13</sup>

Part of the development of the CARE assessment tool included a time study of caregivers in a variety of settings. SHS-0001-4<sup>14</sup>. The study

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

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

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

<sup>14</sup> 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.<sup>15</sup>

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

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<sup>15</sup> 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.<sup>16</sup> 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.<sup>17</sup> 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.<sup>18</sup> 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

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<sup>16</sup> 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.

<sup>17</sup> 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>.

<sup>18</sup> 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.<sup>19</sup> 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.<sup>20</sup>

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.<sup>21</sup> 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

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<sup>19</sup> This reduction has not been challenged by respondents.

<sup>20</sup> 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).

<sup>21</sup> 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 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 6-22 (Gaspers petition) and 280-301 (Myers petition). The two cases were consolidated pursuant to a stipulation and order entered on August 20, 2004. CP 23-25.

The Department filed a joint response to both petitions on January 3, 2005. CP 97-121. Appended to the response was a declaration of Penny Black, the Director of the Home and Community Services Division of the DSHS Aging and Disability Services Administration, giving background information about the history and design of the CARE assessment tool and in particular the shared living rule. CP 122-139.

On February 25, 2005, the trial court, over the Department's objection, granted a motion to strike Ms. Black's declaration. CP 213. However, the trial court did allow the Department to supplement the record with the rule-making file relating to the adoption of the regulations implementing the CARE assessment tool. CP 214.

The only evidence before the trial court was that contained in the records of the two administrative proceedings, both of which were certified to the trial court by the Department. Both records contained statements from the respondents' caregivers, in which they indicated why

they thought additional hours were justified by the circumstances of their clients. Both caregivers also indicated that they might not be willing to continue as caregiver if their hours of paid compensation, as determined by the CARE assessment, were reduced from the level previously authorized using the prior assessment process. There was no evidence that the clients had not received appropriate care or that they had experienced difficulty in obtaining qualified caregivers who would be willing to provide the reduced level of hours of service.

On April 1, 2005, the trial court entered its Findings of Fact, Conclusions of Law[,] Declaratory Judgment and Order Granting Relief from Administrative Orders. CP 256-61. In addition to reversing the two administrative decisions, the trial court invalidated the shared living rule on the basis that “it exceeds the statutory authority of the agency by violating choice of provider protections under 42 C.F.R. § 431.51(a)(1) and RCW 74.39A.270(4) and comparability requirements under and 42 C.F.R. § 440.240(b).” CP 260, ¶ 4.1. The court made no findings that either client had in fact been unable to secure a qualified caregiver who was willing to provide the number of hours authorized, nor that either client had experienced or was at risk of experiencing a loss of appropriate care.

Appellants filed a timely appeal on April 6, 2005. CP 262-73. The Department agreed to restore the respondents' service hours without application of the shared living rule pending appeal, and by order of April 14, 2005, this Court granted Appellants' Motion to stay the effectiveness of the trial court's order invalidating the rule with respect to all other clients.

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

The Administrative Procedure Act (APA) governs the Court's review of (1) the trial court's refusal to admit the Black declaration into evidence, (2) the trial court's declaratory judgment invalidating the shared living rule, and (3) the administration decisions of the Board of Appeals. *See generally* RCW 34.05.570; *Burnham v. Dep't of Social & Health Servs.*, 115 Wn. App. 435, 438, 63 P.3d 816, *review denied*, 150 Wn.2d 1013 (2003).

The Court employs the "abuse of discretion" standard in reviewing the trial court's refusal to consider the evidence offered by the Department to explain the history and background of the shared living rule. *Okamoto v. Employment Security Dep't*, 107 Wn. App. 490, 494-95, 27 P.3d 1203 (2001), *review denied*, 145 Wn.2d 1022 (2002).

The validity of the rule is a question of law that the Court of Appeals reviews de novo. *Littleton v. Whatcom County*, 121 Wn. App.

108, 117, 86 P.3d 1253 (2004). The Court assumes the rule is valid. *Assn. of Washington Business v. Dep't of Revenue*, 121 Wn. App. 766, 770, 90 P.3d 1128 (2004). The respondents have the burden of proving the rule is invalid. RCW 34.05.570(1)(a); *Washington Independent Telephone Assn. v. Utilities and Transportation Commission*, 148 Wn.2d 887, 903, 64 P.3d 606 (2003).

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

Finally, the respondents must prove that the decisions of the Board of Appeals are invalid. RCW 34.05.570(1)(a); RCW 34.05.570(3). The Court of Appeals applies the APA standards directly to the agency record, sitting in the same position as the trial court. *Burnham*, 115 Wn. App. at 438. The respondents must show they have been “substantially prejudiced” by the rule and by the decisions. RCW 34.05.570(1)(d); *Assn. of Washington Business*, 121 Wn. App. at 770.

## VI. SUMMARY OF ARGUMENT

The trial court, by striking the declaration of the state official responsible for developing and implementing the CARE assessment, effectively limited the Department's defense of the shared living rule to the rule-making file, contrary to RCW 34.05.370(4). In addition, the trial court's ruling invalidating the shared living rule was based on a flawed understanding of the rule and its application to the situations of the two respondents.

The Medicaid Act requires that recipients be able to choose among qualified and willing providers. There was no evidence that the shared living rule has interfered with the ability of either respondent, or any other recipient, to exercise that choice. The only evidence in the record is that the respondents' current providers may no longer be willing to provide the service at the lower number of hours being offered—in other words, that they may no longer be willing providers. Further, the provision of Initiative 775, now codified as RCW 74.39A.270(4), stating that recipients “retain” the right to select their providers, does not create a choice of provider requirement that is different from Medicaid law. The shared living rule does not violate the choice of provider requirement of either federal or state law, and the trial court's holding to the contrary was incorrect.

The Medicaid Act “comparability” provision requires that services to various categories of recipients be comparable. The requirement does not apply to the home and community based waiver programs at issue

here, because waiver of that requirement is inherent in the waiver application and approval process. In any event, the shared living rule does not violate the comparability requirement, because all similarly situated recipients are treated alike.

Both federal and state law grant considerable discretion to the Department to structure its programs of assistance for in-home care for disabled persons. The Department is the state agency responsible for administering the Medicaid program consistent with state law, and its promulgation of the shared living rule reflects its determination that the rule complies with both state and federal law. Moreover, by approving Washington's state Medicaid plan, which includes Medicaid Personal Care, and the two waiver programs (COPES and the Medically Needy In-Home Waiver), the federal agency responsible for administering the Medicaid Act has indicated that the programs comply with federal Medicaid law. This Court should give substantial deference to the determinations of both agencies and reverse the trial court's ruling invalidating the shared living rule.

## VII. ARGUMENT

### A. **The Trial Court Erred In Refusing To Consider Evidence From The State Official Responsible For Developing And Implementing The Shared Living Rule**

The APA contemplates three circumstances in which the actions of an administrative agency may be subjected to judicial scrutiny. One is the traditional method of petitioning for review of individual administrative

decisions. RCW 34.05.570(3). A second is through a petition for declaratory judgment with respect to the validity of an agency rule. RCW 34.05.570(2). Finally, there is a catch-all provision for “other agency action.” RCW 34.05.570(4).

It is well settled that judicial review of an agency rule is not limited to the agency record created at the time the rule was adopted, although any supplemental evidence must be addressed to the decision at the time that it was made. *Aviation West Corp. v. Dept. of Labor & Industries*, 138 Wn.2d 413, 421, 980 P.2d 701 (1999), citing RCW 34.05.370(4).

The trial court’s ruling striking Ms. Black’s declaration contravened this principle. The effect of the ruling was that the validity of a complex and sophisticated agency rule designed to apportion limited public assistance resources among thousands of eligible clients was invalidated based on the bare administrative records involving just two of those clients. Had the trial court admitted Ms. Black’s declaration it would have had the following additional information about the shared living rule to consider in making its decision:

- An explanation of the scope and application of the CARE assessment. CP 124, ¶ 204.

- A more complete explanation of the time study conducted at the Department's instance, the results of which informed the development of the shared living rule. CP 125, ¶ 5.
- A detailed explanation of the actual effect of the rule as the CARE assessment in general (*Id.* ¶ 6) and as it was applied to the respondents. *Id.*, ¶ 7.
- The history of the development of the rule and its predecessors. CP 126-7, ¶¶ 8-10.
- An understanding of the fiscal impact to the Department (and thus to clients of other programs, funding for which would likely have to be reduced) if the shared living rule were to be held invalid. CP 127, ¶ 11.
- The additional costs and administrative burdens of implementing the changes to the rules that were being advocated by the respondents. CP 127-8, ¶¶ 12 and 13.
- The effect that implementation of the changes to the rule advocated by the respondents would have on other clients who reside with the caregivers. CP 128-9, ¶ 14.
- An explanation of why the shared living rule was different from a since-repealed rule that limited the number of hours per month for which any particular caregiver could be paid. *Id.*, ¶ 15.

The administrative hearings that were held in the two cases before the Court are typical of the thousands of such hearings that are held each year relating to DSHS-administered programs. The hearing focused strictly on whether the Department's rules were correctly applied, and, as with most hearings of this nature, the Department relied on non-lawyer staff to present the information in the clients' files explaining how the rules were applied.

As a result, the record does not contain the kind of explanatory information set forth in Ms. Black's declaration justifying or even explaining the regulations that were applied.

By striking Ms. Black's declaration, the trial court has effectively required that the Department be prepared to include in every record of every adjudicative proceeding sufficient justification of every rule that may be challenged on judicial review. That not only places an imposing burden on the Department, given the thousands of hearings that are conducted each year, it also burdens the administrative hearing process unnecessarily.

Where, as here, a petition for declaratory judgment invalidating an agency rule is coupled with judicial review of an adjudicative proceeding applying the rule, the court should not limit its consideration to the rule-making file or the administrative record. By doing so, the trial court abused its discretion, and the decision below should be set aside on that basis alone.

**B. The Trial Court Misunderstood The CARE Assessment**

Respondents do not appear to challenge the CARE assessment process itself; in fact, they stipulated at the administrative hearings that the assessment was properly administered to them. Gasper AR 44, ¶ 10; Myers AR 50, ¶ 10. Rather they argue—and the trial court appeared to

agree—that the CARE assessment did not adequately address the special needs that their situations present. This reflects a misunderstanding of how the CARE assessment operates, and how it was applied to the respondents.

In fact, the regulations spell out quite clearly that the CARE assessment generates an individual assessment of the need for assistance—as reflected in the assistance the client has actually used during the preceding seven days—and an allocation of paid hours according to an algorithm that is built into the process. The algorithm takes into account a number of factors, and the ultimate allocation is very much calibrated to the needs of the individual.

For example, respondents below pointed to the declarations of their caregivers about unusual levels of care required because of the circumstances of their clients. Yet, the examples in the appendix reflect that the CARE assessment addresses such circumstances. Thus, for example, Client 3, whose condition is clinically complex and who has significant cognitive impairment, is allocated 162 hours of paid care; Client 2, who is clinically complex but not cognitively impaired, is eligible for 119 hours, some 45 fewer hours; and Client 1, whose condition is not clinically complex and who has no cognitive impairment, receives

66 hours, 53 hours fewer than Client 2, and almost one hundred hours fewer than Client 3.

As these examples illustrate, the CARE assessment tool is a sophisticated method of analyzing the circumstances of individual clients and allocating the available public assistance fairly and efficiently across the entire spectrum of eligible clients. Respondents' arguments to the contrary are incorrect and should be disregarded.

### **C. The Shared Living Rule Complies With Federal Medicaid Law**

The trial court held that the Department exceeded its statutory authority by adopting a rule that conflicts with federal Medicaid law, and with a related state statute. CP 260, ¶ 4.1. More specifically, the court held that the rule conflicts with federal requirements for a "free choice of providers" and "comparability of services" and with RCW 74.39A.270(4). *Id.* These holdings were based on an incorrect analysis of applicable federal and state law, and should be reversed.

#### **1. The Medicaid Program In General**

Medicaid is a joint program of the federal and state governments for the benefit of low-income individuals. *See generally* 42 U.S.C. § 1396a-1396v. Under the Medicaid program, the federal government provides financial assistance to the states so that they can furnish medical care to needy individuals. 42 C.F.R. § 430.0; *Cordall v. State*, 96 Wn.

App. 415, 423, 980 P.2d 253 (1999), *rev. den'd.*, 139 Wn.2d 1017 (2000). The states administer the program under federal guidelines. *State of Louisiana v. Dep't of Health & Human Servs.*, 905 F.2d 877, 878 (5th Cir. 1990). States are not required to offer Medicaid programs, but if they do, they must comply with applicable federal laws. *State of California*, 204 F.3d at 1249.

The states—subject to the approval of the federal government—determine who is eligible for the program, the services that will be offered, the payment levels to service providers, and operating procedures. *Rite Aid of Pennsylvania, Inc. v. Houstoun*, 171 F.3d 842, 845 (3d Cir. 1999).<sup>22</sup>

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

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<sup>22</sup> Just as the scope of services includes both mandatory and optional services, federal law requires that certain individuals (“categorically needy”) be entitled to participate in Medicaid, while whether a participating state includes others (“medically needy”) is up to the state. These distinctions are not significant for the purposes of resolving the issue in this case.

plan is reviewed by the federal Centers for Medicare and Medicaid Services (“CMS”) for compliance with federal law. 42 C.F.R. §§ 430.14, 430.15; *State of Louisiana*, 905 F.2d at 878.<sup>23</sup> CMS must approve a plan before the state can receive federal funding. 42 C.F.R. § 430.30; *State of Louisiana*, 905 F.2d at 878.<sup>24</sup>

In addition to state plan services, Section 1915(c) of the Social Security Act authorizes CMS to exempt states from certain Medicaid requirements in certain circumstances. Services offered under waivers—by definition optional—are typically referred to as “waiver” services.<sup>25</sup>

The statute authorizing waivers provides in relevant part as follows:

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

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<sup>23</sup> CMS is the agency within DHHS that administers Medicaid at the federal level. *Walsh*, 538 U.S. at 650 n.3. Some of the cases cited in this brief refer to the agency by its former name, the Health Care Financing Administration (HCFA).

<sup>24</sup> Some state plan services are mandatory, while others are optional. *See* 42 U.S.C. § 1396a(a)(10) *M.A.C. v. Betit*, 284 F. Supp. 2d 1298, 1302, (D. Utah 2003) (“Each state participating in the Medicaid program must provide certain mandatory services. However, some Medicaid services are optional at the discretion of each state.”).

<sup>25</sup> As pertinent to this case, the Medicaid Personal Care program is an optional service under Washington’s Medicaid plan, and the COPES and Medically Needy In-Home programs are waiver services. The fourth program—Chore services—is funded entirely by the state and is therefore not subject to Medicaid law.

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

42 U.S.C. § 1396n(c)(1)<sup>26</sup>; *see also* 42 C.F.R. § 441.301; *Skandalis v. Rowe*, 14 F.3d 173, 174 (2<sup>nd</sup> Cir. 1994). The purpose of the waiver provision is to encourage states to experiment and innovate in serving the needs of their Medicaid clients. *ARC of Wash. State v. Braddock*, 403 F.3d 641, 644 (9<sup>th</sup> Cir. 2005) (rehearing and rehearing en banc pending) (“[T]he policy behind the Medicaid [waiver] provision is one of experimentation.”).

Without a waiver, states could not get federal funding for home and community services. *Rowe*, 14 F.3d at 714. CMS explains that waivers give states “the flexibility to develop and implement *creative alternatives* to placing Medicaid-eligible individuals in” institutions such as nursing facilities. *See* <http://www.cms.hhs.gov/medicaid/1915c/history.asp> (viewed May 4, 2005) (emphasis added); *see also* 42 C.F.R. § 430.25(a).

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

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<sup>26</sup> As if Medicaid laws were not complicated enough, the enumerated sections of the Social Security Act are codified with an entirely different numbering system in the U. S. Code. Thus, the statute cited here is in fact Section 1915(c) of the Social Security Act.

to encourage States to administer cost-effective programs that meet *specific local needs*.”

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

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

The waiver applications are quite detailed. *See* <http://www.cms.hhs.gov/medicaid/1915c/cwaiverapp.pdf> (standard 77-page application) (viewed May 9, 2005). CMS conducts an exhaustive review of all waiver applications. *See* <http://www.cms.hhs.gov/medicaid/1915c/proto1-2.pdf> (54-page guidance from CMS headquarters to regional offices) (viewed May 9, 2005). As the guidance shows, CMS approves waivers only after reviewing all aspects of the programs for compliance with federal law.

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

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

**2. The Shared Living Rule Complies With Federal Medicaid Law And State Law Choice Of Provider Provisions**

The trial court held that the shared living rule violates the “free choice of provider” provisions of federal Medicaid law. This conclusion was based on an incorrect understanding of the facts of this case and the application of the pertinent statutes and regulations to those facts. Accordingly, it should be set aside.

**a. The Shared Living Rule Is Consistent With Federal Choice Of Provider Requirements**

Medicaid law requires that no recipients should be denied a choice of willing and qualified providers. The basic rule is that the State Plan must provide that

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

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

There was no evidence in this case that either client was denied a choice of a willing and qualified provider. At most, the declarations of the two providers indicated a reluctance on their part to provide the care at the number of hours for which their clients were eligible. In other words, these two providers were indicating that if the hours were not increased, they would no longer be willing to provide care to their clients.

Medicaid recipients do not have the unbridled right to receive services from any person of their choosing, because the free-choice provisions are not absolute. *O'Bannon v. Town Court Nursing Center*, 447 U.S. 773, 785, 100 S. Ct. 2467, 65 L. Ed. 2d 506 (1980) (characterizing the Medicaid free-choice provisions as “the right to choose among a range of *qualified* providers, without government interference”) (emphasis in original). *See also, Kelly Kare, Ltd. v. O'Rourke*, 930 F.2d 170, 177 (2<sup>nd</sup> Cir. 1991) (rejecting a claim that decertification of the recipient’s preferred provider violated freedom of choice because “a Medicaid recipient’s freedom of choice rights are necessarily dependent on a provider’s ability to render services”).

Furthermore, the free-choice provisions allow the Department to (1) establish the fees it will pay providers and (2) set reasonable standards relating to provider qualifications. 42 C.F.R § 431.51(c). “Within specified limits, a recipient may seek to obtain services from any *qualified* provider, but *the provider* determines whether to furnish services to the particular recipient.” 56 Fed. Reg. 8832-01 (March 1, 1991) (emphasis added).

If a particular provider decides to no longer furnish services to a Medicaid recipient, then he or she no longer is “qualified” or “willing” to “undertake” those services. 42 U.S.C. § 1396a(a)(23)(A); 42 C.F.R § 431.51(b). A Medicaid recipient does not have the right to choose a provider who withdraws from the program or who, like the providers here,

are reluctant to limit the number of hours for which they are paid to those allowed by the Department.

The trial court's ruling would essentially turn the free-choice provision into a requirement for a certain level of Medicaid payment. But provider *selection* and provider *payment* are separate considerations under Medicaid law. A state's allegedly low level of payments does not amount to a violation of the free-choice law. *Antrican v. Buell*, 158 F. Supp. 2d 663, 671 (E.D.N.C. 2001), *partially aff'd on other grounds sub. nom. Antrican v. Odom*, 290 F.3d 178 (4<sup>th</sup> Cir. 2002), *cert. den.*, 537 U.S. 973 (2002). *Buell* involved a claim that the rates paid for dental care were so low that few dentists were willing to participate, and that recipients' freedom of choice were violated as a result. The court rejected this claim, noting that "[w]hether in the interest of higher profits or because rates are too low to remain solvent, health care providers may choose not to participate in a Medicaid program." *Buell*, 158 F. Supp. 2d at 671. The statute "does not encompass the right to free access to [providers] unwilling to service Medicaid patients." *Id.*<sup>27</sup>

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<sup>27</sup> The *Buell* court's conclusion relied in part on the following statement of Congressional intent: "[I]t is possible that some *providers of service may still not be willing* or considered qualified to provide the services in the State plan. This provision *does not obligate the State to pay the charges of the provider without reference to its schedule of charges or its standards of care.*" *Buell*, 158 F. Supp. 2d at 671 (quoting S. Rep. No. 744, 90<sup>th</sup> Cong., 1<sup>st</sup> Sess. (1967)) (emphasis added by court).

The same rationale applies here. The fact that the current live-in provider may not be willing to furnish and receive payment at the lesser numbers of hours authorized by the Department through its standard assessment does not rise to the level of a violation of the free-choice provisions.

**b. The Shared Living Rule Is Consistent With State Law**

In addition to holding that the shared living rule violates federal Medicaid law, the trial court found the rule to be in violation of RCW 74.39A.270(4). However, this statute does not create an independent choice of provider rule that is different from that provided by federal law. As explained above, the shared living rule is consistent with Medicaid statutes and regulations; thus, RCW 74.39A.270(4) is not implicated by the rule.

RCW 74.39A.270(4) was enacted as Section 6(4) of Initiative 775, approved by the voters in November, 2001. Ch. 3, Laws of 2002.<sup>28</sup> The initiative's primary purpose was to allow individual providers to organize and bargain their wages collectively with the state. Because collective bargaining is predicated upon the existence of an employer-employee relationship, the initiative provided that—contrary to the then-existing

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<sup>28</sup> The full text of the initiative can be found on the Secretary of State's homepage at: <http://www.secstate.wa.gov/elections/initiatives/text/i775.pdf>. (viewed May 13, 2005).

practice—providers would be considered employees, but “[s]olely for the purposes of collective bargaining.” *Id.*, § 6(1). To assuage concerns of advocacy groups that this pseudo-employment relationship would hamper the ability of an individual client to choose his or her provider, the drafters of the initiative included the following language:

Consumers and prospective consumers [of in-home health care services] *retain* the right to select, hire, supervise the work of, and terminate any individual provider providing services to them.

Initiative 775, § 6(4), codified as RCW 74.39A.270(4) (emphasis added).

Nothing in this language indicates an intent to expand the right of consumers of in-home care services. In fact, just the opposite is true: the use of the verb “retain” is strong evidence that the purpose was to maintain the status quo, and nothing more. Because no other state statute addressed the issue, the status quo was defined by choice of provider provisions of the Medicaid law. As explained previously, the shared living rule does not violate those provisions, and the trial court’s determination that there is a separate state right that the rule violates was incorrect.

In any event, the mere fact that the rule is applied to certain recipients does not mean that those recipients somehow lose their “right to select, hire, supervise the work of, and terminate their providers.” There is no evidence that any recipient has been denied any choices of willing

providers, and the trial court's holding that the rule violates RCW 74.39A.270(4) was error, and should be set aside.

**3. The Shared Living Rule Is Consistent With The “Comparability of Services” Requirement**

The trial court also held that the shared living rule violates the federal “comparability” requirement. This holding is incorrect for two reasons: (1) the requirement does not apply to the COPES and Medically Needy In-Home programs and (2) in any event, all Medicaid recipients in each of the three affected programs have the same amount, duration, and scope of services as similarly situated Medicaid recipients.

**a. In General, States Must Offer Comparable Services To Similarly Situated Medicaid Recipients, But The Requirement Can Be Waived**

The basic rule is that “states must provide comparable medical assistance to all Medicaid recipients within each classification, so long as the medically needy do not receive greater benefits than the categorically needy (although the reverse is permitted).” *Schott v. Olszewski*, 401 F.3d 682, 686 (6<sup>th</sup> Cir. 2005). Federal law does impose different requirements on states as they offer services to different categories of recipients—these categories are the “classification” referred to by the *Schott* court. Thus, medical assistance available to any categorically needy recipient “shall not be less in amount, duration, or scope than the medical assistance made

available to any other” categorically needy recipient. 42 U.S.C. § 1396a(a)(10)(B)(i); 42 C.F.R. § 440.240(b). Similarly, the medical assistance available to any medically needy recipient “shall not be less in amount, duration, or scope than the medical assistance made available to” any other medically needy recipient. 42 U.S.C. § 1396a(a)(10)(C)(i); 42 C.F.R. § 440.240(b). Finally, the medical assistance available to the categorically needy must be at least equal to the amount, duration, and scope of assistance available to the medically needy. 42 U.S.C. § 1396a(a)(10)(B)(ii); 42 C.F.R. § 440.240(a). This is the “comparability” rule applicable to Medicaid programs.

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

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

*Schweiker v. Hogan*, 457 U.S. 569, 573 n.6, 102 S. Ct. 2597, 73 L. Ed. 2d 227 (1982). The comparability provisions do not limit the broad

discretion that states otherwise have to structure their Medicaid programs, particularly waiver programs.

Congress allows states to seek waivers of the comparability requirement as a means of facilitating the offering of home-based and community-based services. Before 1981, Medicaid

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

[Legislation in 1981] added new section 1915(c) to the [Social Security] Act to encourage the provision of services to Medicaid recipients in noninstitutional settings. This section authorizes the Secretary to waive Medicaid statutory requirements to enable a State to cover a broad array of home and community-based services. These services must be furnished . . . only to persons who would otherwise require the level of care provided in [a facility such as a nursing home], the cost of which could be reimbursable under the State's plan.

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

**b. CMS Waived The Provision For The COPES And Medically Needy In-Home Programs**

The comparability provisions of federal Medicaid law do not apply to the COPES program or the Medically Needy In-Home program. CMS waived that provision as part of the Department's Section 1915(c) waiver

applications. Therefore, the trial court was incorrect in holding that the shared living rule violates the comparability provision.

As part of the standard application for a Section 1915(c) waiver, the Department requested and received CMS approval to waive the comparability requirement. See <http://www.cms.hhs.gov/medicaid/1915c/cwaiverapp.pdf> (Web site with CMS's standard application for a 1915(c) waiver) (visited May 9, 2005). CMS explains that the "waiver of [42 U.S.C. § 1396a(a)(10)(B)] is a *necessary component* of all waiver proposals." See State Medicaid Manual, § 4442.1, at <http://www.cms.hhs.gov/manuals/pub45pdf/sm4440.pdf> (visited May 9, 2005) (emphasis added).<sup>29</sup> Indeed, Item No. 10 of the waiver application is an assertion by the state to CMS as follows:

A *waiver* of the *amount, duration and scope* of services requirements contained in section 1902(a)(10)(B) of the Act [at 42 U.S.C. § 1396a(a)(10)(B)] *is requested*, in order that services not otherwise available under the approved Medicaid State plan may be provided to individuals served on the waiver.

See <http://www.cms.hhs.gov/medicaid/1915c/cwaiverapp.pdf> (emphasis added) (viewed May 9, 2005).

Accordingly, by approving the waiver requests for the COPES and Medically Needy In-Home programs, CMS relieved the Department from

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<sup>29</sup> The Manual is "a publication of [DHHS] that explains to the states how [the federal government] applies statutory and regulatory provisions in administering the Medicaid program[.]" *Skindzier v. Commissioner of Social Services*, 258 Conn. 642, 784 A.2d 323, 331-32 (Conn. 2001) (quotations and citations omitted).

any requirement that otherwise would have existed with respect to the comparability of services available under these programs. Therefore, the trial court was incorrect in holding that the shared living rule violates the comparability provision.

**c. The Trial Court Erred In Finding The Shared Living Rule Violated Comparability Requirements, Because The Department Does Offer Comparable Services To Similarly Situated Recipients Under All Three Programs**

Despite the general rule of comparability, and even in the absence of a Section 1915(c) waiver of that rule, states retain discretion to structure their Medicaid programs in different ways, depending on local circumstances.

We have made it clear that the Medicaid Act “gives the States *substantial discretion* to choose the proper mix of amount, scope and duration limitations on coverage, as long as care and services are provided in ‘the best interest of the recipients.’”

*Walsh*, 538 U.S. at 655 (quoting *Alexander v. Choate*, 469 U.S. 287, 303, 105 S. Ct. 712, 83 L. Ed. 2d 661 (1985)) (emphasis added).

The states have “broad discretion” and “considerable latitude” to define the Medicaid benefits it will finance. *Walsh*, 538 U.S. at 666. The “only proper application” of the comparability provision “is in situations where the same benefit is funded for some recipients but not others.” *Rodriguez v. City of New York*, 197 F.3d 611, 616 (2<sup>nd</sup> Cir. 1999), *cert.*

*den.*, 531 U.S. 864, 121 S. Ct. 156, 148 L. Ed. 2d 104 (2000). In this case, “the same benefit” -- home and community services -- “is funded for” all Medicaid recipients who are eligible for the three programs. *Rodriguez*, 197 F.3d at 616. This demonstrates that the services are offered on a comparable basis.

In *Rodriguez*, the Court rejected the argument that the state was required to provide “safety monitoring” services merely because it already covered other “personal care” services. *Rodriguez*, 197 F.3d at 615, 616. The fact that the two types of services were “comparable” did not mean that the state was obligated to expand the “optional” services it already covered. *Rodriguez*, 197 F.3d at 615.

In *Alexander*, the “amount, duration, and scope” issue pertained to restrictions on the number of inpatient hospital days for which the State of Tennessee would provide Medicaid coverage. The Court

rejected a challenge brought by a class of handicapped persons to a Tennessee cost-saving measure that reduced the number of annual days of inpatient hospital care for Medicaid patients from 20 to 14, emphasizing that the change did not deny beneficiaries “meaningful access” to medical services.

*Walsh*, 538 U.S. at 303 (citing *Alexander*, 469 U.S. at 302, 306).

The shared living rule complies with the comparability requirement. The Department exercised its “broad discretion” to

determine that Medicaid recipients who choose caregivers with whom they live should not be allocated as many hours of paid services as those recipients who do not live with their caregivers, based on the reasonable premise that certain services that benefit the entire living unit would be provided by others in the living unit.

The shared living rule does not create a situation where “the same benefit is funded for some recipients but not others.” *Rodriguez*, 197 F.3d at 616. Rather, the 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, because the former has at least one other person who resides in the home to take care of many routine household maintenance tasks. This does not result in a different *benefit* level to different categorical groups of recipients: all categorically needy recipients are treated the same; all medically needy recipients are treated the same; and the medically needy do not receive greater services than do the categorically needy.<sup>30</sup>

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<sup>30</sup> An example illustrates the point. Let us assume that Jane Doe and John Doe are both categorically needy Medicaid recipients. Jane makes the free choice that her provider will be someone with whom she lives. John makes the free choice that his provider will not be someone with whom he lives. The amount, duration, and scope of services available to Jane and John is the same. Jane’s choice does not mean that the services available to her are not comparable to the services available to John. It is Jane’s decision whether to choose someone with whom she lives as her provider. All Medicaid recipients in Jane’s situation will be treated the same. All recipients in John’s situation will be treated the same.

It would be absurd to say that every recipient should receive the same benefit regardless of need. Instead, where courts have found a comparability violation, states were providing different services to the same categories of recipients based on factors other than need. For example, one state offered eyeglasses only to recipients who needed them for “pathology” reasons but not for recipients who needed them “because of eye defects[.]” *White v. Beal*, 555 F.2d 1146, 1150 (2<sup>nd</sup> Cir. 1977). The court held that the comparability rule was violated because the distinction was based not on medical necessity but because of the cause of the necessity. No such distinction occurs with the shared living rule. All recipients have the choice of whether to select a provider who does or will live with them. All recipients who choose to live with a provider will receive a slightly reduced number of hours of coverage. The reason for the recipient’s decision is irrelevant.

Unlike the plaintiffs in *White*, the respondents are not denied comparable benefits based on their medical conditions. On the contrary, as discussed above, their clinically complex medical conditions automatically qualify them for additional assistance with special care needs, including laundry and meal preparation activities.

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

CMS, the federal agency charged with overseeing Medicaid, has approved each of the three Medicaid programs affected by the shared living rule--Medicaid Personal Care as part of the State Plan, and COPES and the Medically Needy In-Home program as part of Section 1915(c) waivers.

Approval of the programs by the federal agency that administers Medicaid is strong evidence that the rule complies with federal law. If CMS believed the rule or the programs violated federal law, it would so inform the state, and require a change or disapprove the state's plan or the waivers. It has done neither with respect to the shared living rule.<sup>31</sup> Because CMS's interpretations of Medicaid law are entitled to considerable deference, this Court should conclude that the rule does not violate the choice of provider or comparability requirements.

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

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<sup>31</sup> In fact, as noted above at p. 11, a version of the shared living rule has been part of Washington's Medicaid Personal Care program since at least 1993, and CMS has never questioned the propriety of the rule.

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

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

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

The same result should obtain here. CMS has approved the State Plan and the waivers, and has not objected to the shared living rule. CMS's actions are "reasonable when considered in terms of the Act's language and overall design, and in terms of the economic policy choices underlying the" affected programs." *Rowe*, 14 F.3d at 180-81. Further, CMS's conclusions are entitled to "considerable deference," especially given that the issues concern the interpretation of "a small corner of a labyrinthine statute." *Rowe*, 14 F.3d at 178.

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

If the statute is ambiguous, the Court determines whether the state agency's interpretation "is based on a permissible construction of the statute." *Id.* (quotations omitted). The agency's interpretation "is

generally entitled to deference, and to sustain it [the Court] need only find that the agency's interpretation was sufficiently rational to preclude [the Court] from substituting [its] judgment for that of the agency." *Id.* Courts give weight to the Department's interpretations of Medicaid law. *Burnham*, 115 Wn. App. at 438.

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

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

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

By issuing the shared living rule and applying it to the three Medicaid programs, the Department determined that the rule complied with federal Medicaid law. The free-choice and comparability provisions do not directly address the shared living rule, and so the Department's interpretation is entitled to deference. *Skamania County*, 144 Wn.2d at 43; *Burnham*, 115 Wn. App. at 438.

Furthermore, the Legislature delegated to the Department the authority to supply the details of the programs. *See, e.g.*, RCW 74.09.520(3) (Department "shall adopt" necessary rules for the Medicaid

Personal Care program); RCW 74.39.041(1) (Department “shall adopt rules to establish” details of the Medically Needy In-Home program). The Court should uphold the shared living rule, as part of these programs, because it is not “procedurally defective, arbitrary or capricious in substance, or manifestly contrary to the statute.” *Mead*, 533 U.S. at 227.<sup>32</sup>

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

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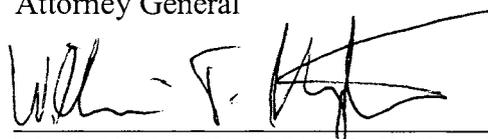
<sup>32</sup> The Legislature also indicated its intention that home and community-based services would “support and enhance”—but not supplant—informal supports naturally provided by caring friends and family. RCW 74.39A.005.

## VIII. CONCLUSION

For the reasons stated above, the decision of the trial court should be reversed, and the decision of the Department should be affirmed. In the alternative the case should be remanded for consideration of the declaration of Penny Black.

RESPECTFULLY SUBMITTED this 6th day of July, 2005.

ROB MCKENNA  
Attorney General

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

WILLIAM L. WILLIAMS, WSBA # 6474  
Sr. Assistant Attorney General  
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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, 2005, at Lacey, WA.

Sharon Paakkunen

BY \_\_\_\_\_  
STATE OF WASHINGTON  
JUL 11 2005  
COUNTY OF THURSTON

## Appendix

<u>Appendix #</u>	<u>DESCRIPTION</u>
A1-7	Findings of Fact, Conclusions of Law; Declaratory Judgment and Order Granting Relief From Administrative Orders
A8-10	Four Examples of Care Assessment



**FILED**  
APR - 1 2005  
SUPERIOR COURT  
BETTY J. GOULD  
THURSTON COUNTY CLERK

IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON  
IN AND FOR THE COUNTY OF THURSTON

VENNETTA GASPER and TOMMYE  
MYERS,

Petitioners,

vs.

DEPARTMENT OF SOCIAL AND  
HEALTH SERVICES,

Respondent.

No. 04-2-01400-7

FINDINGS OF FACT,  
CONCLUSIONS OF LAW;  
DECLARATORY JUDGMENT AND  
ORDER GRANTING RELIEF FROM  
ADMINISTRATIVE ORDERS

I. BASIS FOR FINDINGS

The findings are based on a trial held March 11, 2005 as well as the administrative and rulemaking records and briefing submitted prior to trial.

II. FINDINGS OF FACT

Upon the basis of the court record, the court FINDS:

2.1 Petitioners reside in Washington State and receive long term care services through Medicaid programs administered by Respondent. Ms. Gasper receives

FINDINGS OF FACT, CONCLUSIONS OF  
LAW AND ORDER - 1

Appendix A-1

NORTHWEST JUSTICE PROJECT  
711 Capitol Way S. #704  
Olympia WA 98501  
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1 services through the Medicaid Personal Care Program, and Ms. Myers through the  
2 COPES (Community Options Program Entry System) program.

3 2.2 On April 20, 2004, Respondent adopted by Emergency Rule changes to  
4 chapter 388-72A WAC. The rules in question went through further rulemaking until  
5 final rules were adopted by Rulemaking Order on September 20, 2004. Throughout  
6 the rule making process, these rules included the rule at issue in this case, known as  
7 "the shared living rule" at WAC 388-72A-0095(1)(c). The shared living rule states:

8 **WAC 388-72A-0095 What additional criteria are considered to  
9 determine the number of hours I will receive for in-home  
10 services?**

11 (1) In addition to criteria defined in WAC 388-72A-0081, 388-72A-  
12 0082, 388-72A-0083, 388-72A-0084, 388-72A-0087, or 388-71-0460,  
13 CARE will take into account:

14 (c) Your living arrangement.

15 (i) If there is more than one client living in the same household, the  
16 status cannot be unmet for the following IADLs:

- 17 (A) Meal preparation,
- 18 (B) Housekeeping,
- 19 (C) Shopping,
- 20 (D) Wood supply.

21 (ii) If you and your paid provider live in the same household, the  
22 status must be met for the following IADLs:

- 23 (A) Meal preparation,
- (B) Housekeeping,
- (C) Shopping,
- (D) Wood supply.

Appendix A-2

1  
2 (iii) When there is more than one client living in the same  
3 household and your paid provider lives in your household, the status  
4 must be met for the following IADLs:

- 5 (A) Meal preparation,  
6 (B) Housekeeping,  
7 (C) Shopping, and  
8 (D) Wood supply.

9 2.3 The Department automatically reduces by 15% the personal care hours of  
10 recipients who live with their paid care providers. An automatic reduction is also  
11 applied to recipients who live in the same household as another recipient.

12 2.4 This shared living reduction is applied regardless of whether a recipient's  
13 needs for assistance with meal preparation, housekeeping, shopping, and wood  
14 supply are actually met by the shared living situation.

15 2.5 The shared living reduction is not applied to recipients who live with  
16 someone other than the recipient's paid care provider or another recipient.

17 2.6 Recipients cannot challenge the shared living reduction in a hearing in  
18 order to demonstrate they have unmet needs with meal preparation, housekeeping,  
19 shopping, or wood supply.

20 2.7 Because Petitioners live with their caregivers, and Ms. Myers also lives  
21 with another Medicaid recipient of long term care services, Respondent assessed  
22 Petitioners' needs for assistance with housekeeping, shopping and meal preparation  
23 as "fully met".

24 2.8 Petitioners' needs for assistance with housekeeping, shopping and meal  
25 preparation are not fully met by their shared living situation.

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Appendix A-3

FINDINGS OF FACT, CONCLUSIONS OF  
LAW AND ORDER - 3

NORTHWEST JUSTICE PROJECT  
711 Capitol Way S. #704  
Olympia WA 98501  
360-753-3610, x. 222  
360-753-0174 Fax

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### III. CONCLUSIONS OF LAW

The court makes the following conclusions of law from the foregoing findings of fact:

3.1 The shared living rule violates Petitioners' right to free choice of provider protected under 42 C.F.R. §431.51(a)(1) and RCW 74.39A.270(4).

3.2 The shared living rule violates federal Medicaid laws requiring comparability of amount, duration and scope of services among all recipients. Comparability provisions are codified at 42 U.S.C. §1396a(a)(10)(B)(i); 42 C.F.R. §440.240(b).

3.3 A rule is invalid if it is in conflict with, or otherwise exceeds, statutory authority.

3.4 The shared living rule, WAC 388-72A-0095(1)(c), should be declared invalid because it exceeds the statutory authority of the agency by violating state and federal laws regarding freedom of choice of provider and comparability requirements.

3.5 Respondent should not automatically deem as met, in shared living situations, Medicaid recipients' need for assistance with housekeeping, shopping, meal preparation and wood supply, but should assess those needs in the same way and to the same extent and should provide services to meet those assessed needs in the same way and to the same extent as services are provided to meet the needs of other Medicaid recipients who do not live in a shared living situation.

3.6 The administrative orders applying the shared living rule to Petitioners' cases should be set aside because the rule is outside the statutory authority of the agency.

3.7 Petitioners should receive personal care hours consistent with their unmet need for assistance with housekeeping, shopping and meal preparation services.

Appendix A-4

FINDINGS OF FACT, CONCLUSIONS OF  
LAW AND ORDER - 4 .

NORTHWEST JUSTICE PROJECT  
711 Capitol Way S. #704  
Olympia WA 98501  
360-753-3610, x. 222  
360-753-0174 Fax

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1 3.8 Petitioners should be awarded reasonable attorneys' fees for services  
2 received from Columbia Legal Services.

3  
4 IV. ORDER

5 Based on the above Findings and Conclusions, the court enters the following  
6 DECLARATORY JUDGMENT AND ORDER as follows:

7 4.1 The shared living rule, WAC 388-72A-0095(1)(c), is declared invalid in  
8 that it exceeds the statutory authority of the agency by violating choice of provider  
9 protections under 42 C.F.R. §431.51(a)(1) and RCW 74.39A.270(4) and  
10 comparability requirements under 42 U.S.C. §1396a(a)(10)(B)(i) and 42 C.F.R.  
11 §440.240(b).

12 4.2 The administrative orders applying the shared living rule to Petitioners'  
13 cases are reversed.

14 4.3 Respondent shall award Petitioners personal care hours consistent with  
15 their unmet need for assistance with housekeeping, shopping and meal preparation  
16 services, retroactive to June 1, 2004, the date the shared living rule was applied to  
17 their cases.

18 4.4 No overpayment shall be assessed for services Petitioners received  
19 pending their administrative hearings.

20 4.5 Respondent shall not automatically deem as met, in shared living  
21 situations, Medicaid recipients' need for assistance with housekeeping, shopping,  
22 meal preparation and wood supply, but shall assess those needs in the same way  
23 and to the same extent and shall provide services to meet those assessed needs in  
the same way and to the same extent as services are provided to meet the needs of  
other Medicaid recipients who do not live in a shared living situation.

Appendix A-5

1 4.6 Petitioners are entitled to reasonable attorneys' fees under RCW  
2 74.08.080 for services received from Columbia Legal Services in an amount to be  
3 determined by subsequent order.  
4

5  
6  
7 Dated: April 1, 2005

  
8 JUDGE RICHARD D. HICKS

9 Presented by:  
10 Attorneys for Petitioners:

11  
12 Meagan J. MacKenzie  
13 NORTHWEST JUSTICE PROJECT  
14 Meagan J. MacKenzie, WSBA# 21876

Amy L. Crewdson  
COLUMBIA LEGAL SERVICES  
Amy L. Crewdson, WSBA #9468  
by Meagan J. MacKenzie

15 Approved for Entry by:  
16 Attorney for Respondent:

17 IN ~~OPEN~~ OPEN  
18 COURT - DECLINED  
19 TO SIGN.

20 ASSISTANT ATTORNEY GENERAL  
21 Jeffrey T. Killip, WSBA #32101  
22

23 Appendix A-6

FINDINGS OF FACT, CONCLUSIONS OF  
LAW AND ORDER - 6

NORTHWEST JUSTICE PROJECT  
711 Capitol Way S. #704  
Olympia WA 98501  
360-753-3610, x. 222  
360-753-0174 Fax



Client #1

ADL	Assistance Used In Previous 7 Days	Score
<b>Maintenance</b>		
Bathing		*
Bed Mobility	Limited	2
Dressing	Extensive	3
Eating	Limited	2
<b>Mobility Section</b>		
Locomotion in room	Supervision	
Locomotion outside of room	Limited	
Walk in room	Limited	
<i>(Only Highest Score Counted)</i>	<i>Highest Score</i>	2
Medication management		*
Toilet use	Extensive	3
Transfer	Limited	2
Personal hygiene	Extensive	3
<b>TOTAL ADL SCORE</b>		<b>17</b>

Not included in Calculation  
Per WAC 388-72A-084(1)

Use the Highest Score from this Group  
Per WAC 388-72A-084(1)

Not included in Calculation  
Per WAC 388-72A-084(1)

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

**Classification: ADL Score of 17 and No Other Factor = Care Group A (High)**

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

**CALCULATING ADJUSTMENT**

<b>TOTAL POINTS</b>		<b>10</b>
<b>Qualifying ADL/IADLs</b>		<b>13</b>
<b>VALUE "A"</b>	Total Points divided by Qual ADL	<b>0.77</b>
<b>VALUE "B"</b>	One minus Value A	<b>0.23</b>
<b>VALUE "C"</b>	Value B divided by 1/3	<b>0.08</b>
<b>VALUE "D"</b>	Value A plus Value C	<b>0.85</b>
<b>Hours of Care Auth Per-Month</b>	Base Hrs times Value D	<b>66.30</b>

CLIENT #2

ADL	Assistance Used In Previous 7 Days	Score
<b>Maintenance</b>		
Bathing		*
Bed Mobility	Limited	2
Dressing	Extensive	3
Eating	Limited	2
<b>Mobility Section</b>		
Locomotion in room	Supervision	1
Locomotion outside of room	Limited	2
Walk in room	Limited	2
<i>(Only Highest Score Counted)</i>	<i>Highest Score</i>	2
Medication management		*
Toilet use	Extensive	3
Transfer	Limited	2
Personal hygiene	Extensive	3
<b>TOTAL ADL SCORE</b>		<b>17</b>

Not included in Calculation  
Per WAC 388-72A-084(1)

Use the Highest Score from this Group  
Per WAC 388-72A-084(1)

Not included in Calculation  
Per WAC 388-72A-084(1)

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

**Classification: ADL Score of 17 and Clinically Complex = Care Group C (Medium)**

<b>BASE HOURS</b>	<b>140</b>
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ADL group	Status (see above)	Score
Self administration of medication	Unmet	1
<b>Scheduled ADLs</b>		
Bed mobility	Unmet	1
Transfer	Unmet	1
Walking in room	Unmet	1
Eating	Unmet	1
Toilet use	Unmet	1
<b>Scheduled ADLs</b>		
Dressing	Unmet	1
Personal hygiene	Unmet	1
Bathing	Unmet	1
<b>IADLs</b>		
Meal preparation	Met	0
Ordinary housework	Met	0
Essential shopping	Met	0
Wood supply	N/A	
Travel to Medical	Unmet	1
<b>TOTAL</b>		<b>10</b>
<b>Number of Qualifying ADLs/IADLs</b>		<b>13</b>

**CALCULATING ADJUSTMENT**

<b>TOTAL POINTS</b>		<b>10</b>
<b>Qualifying ADL/IADLS</b>		<b>13</b>
<b>VALUE "A"</b>	Total Points divided by Qual ADL	<b>0.77</b>
<b>VALUE "B"</b>	One minus Value A	<b>0.23</b>
<b>VALUE "C"</b>	Value B divided by 1/3	<b>0.08</b>
<b>VALUE "D"</b>	Value A plus Value C	<b>0.85</b>
<b>Hours of Care Auth Per-Month</b>	Base Hrs times Value D	<b>119.00</b>

CLIENT #3

ADL	Assistance Used In Previous 7 Days	Score
<b>Maintenance</b>		
Bathing		*
Bed Mobility	Limited	2
Dressing	Extensive	3
Eating	Limited	2
<b>Mobility Section</b>		
Locomotion in room	Supervision	
Locomotion outside of room	Limited	
Walk in room	Limited	
<i>(Only Highest Score Counted)</i>	<b>Highest Score</b>	2
Medication management		*
Toilet use	Extensive	3
Transfer	Limited	2
Personal hygiene	Extensive	3
<b>TOTAL ADL SCORE</b>		<b>17</b>

Not included in Calculation  
Per WAC 388-72A-084(1)

Use the Highest Score from this Group  
Per WAC 388-72A-084(1)

Not included in Calculation  
Per WAC 388-72A-084(1)

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

**Classification: ADL Score of 17, Clinically Complex and Cognitive Impairment = Care Group D (Medium)**

<b>BASE HOURS</b>		<b>190</b>
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ADL group	Status (see above)	Score
Self administration of medication	Unmet	1
<b>Scheduled ADLs</b>		
Bed mobility	Unmet	1
Transfer	Unmet	1
Walking in room	Unmet	1
Eating	Unmet	1
Toilet use	Unmet	1
<b>Scheduled ADLs</b>		
Dressing	Unmet	1
Personal hygiene	Unmet	1
Bathing	Unmet	1
<b>IADLs</b>		
Meal preparation	Met	0
Ordinary housework	Met	0
Essential shopping	Met	0
Wood supply	N/A	
Travel to Medical	Unmet	1
<b>TOTAL</b>		<b>10</b>
<b>Number of Qualifying ADLs/IADLs</b>		<b>13</b>

**CALCULATING ADJUSTMENT**

<b>TOTAL POINTS</b>		<b>10</b>
<b>Qualifying ADL/IADLS</b>		<b>13</b>
<b>VALUE "A"</b>	Total Points divided by Qual ADL	<b>0.77</b>
<b>VALUE "B"</b>	One minus Value A	<b>0.23</b>
<b>VALUE "C"</b>	Value B divided by 1/3	<b>0.08</b>
<b>VALUE "D"</b>	Value A plus Value C	<b>0.85</b>
<b>Hours of Care Auth Per-Month</b>	Base Hrs times Value D	<b>161.50</b>

CLIENT #4

ADL	Assistance Used In Previous 7 Days	Score
<b>Maintenance</b>		
Bathing		*
Bed Mobility	Independent	0
Dressing	Extensive	3
Eating	Limited	2
<b>Mobility Section</b>		
Locomotion in room	Independent	*
Locomotion outside of room	Limited	2
Walk in room	Independent	*
(Only Highest Score Counted)	<b>Highest Score</b>	2
Medication management		*
Toilet use	Extensive	3
Transfer	Independent	0
Personal hygiene	Extensive	3
<b>TOTAL ADL SCORE</b>		<b>13</b>

Not included in Calculation  
Per WAC 388-72A-084(1)

Use the Highest Score from this Group  
Per WAC 388-72A-084(1)

Not included in Calculation  
Per WAC 388-72A-084(1)

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

**Classification: ADL Score of 13, Clinically Complex and Cognitive Impairment = Care Group D (Medium)**

<b>BASE HOURS</b>	<b>190</b>
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ADL group	Status (see above)	Score
Self administration of medication	Unmet	1
<b>Scheduled ADLs</b>		
Bed mobility	Independent	
Transfer	Independent	
Walking in room	Independent	
Eating	Unmet	1
Toilet use	Unmet	1
<b>Scheduled ADLs</b>		
Dressing	Unmet	1
Personal hygiene	Unmet	1
Bathing	Unmet	1
<b>IADLs</b>		
Meal preparation	Met	0
Ordinary housework	Met	0
Essential shopping	Met	0
Wood supply	N/A	
Travel to Medical	Unmet	1
<b>TOTAL</b>		<b>7</b>
<b>Number of Qualifying ADLs/IADLs</b>		<b>10</b>

**CALCULATING ADJUSTMENT**

<b>TOTAL POINTS</b>		<b>7</b>
<b>Qualifying ADL/IADLS</b>		<b>10</b>
<b>VALUE "A"</b>	Total Points divided by Qual ADL	<b>0.70</b>
<b>VALUE "B"</b>	One minus Value A	<b>0.30</b>
<b>VALUE "C"</b>	Value B divided by 1/3	<b>0.10</b>
<b>VALUE "D"</b>	Value A plus Value C	<b>0.80</b>
<b>Hours of Care Auth Per-Month</b>	Base Hrs times Value D	<b>152.00</b>