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NO. 74763-1

**COURT OF APPEALS, DIVISION I
OF THE STATE OF WASHINGTON**

In re the Guardianship of
MARILYN ALBERTSON

STATE OF WASHINGTON, DEPARTMENT OF SOCIAL AND
HEALTH SERVICES,

Petitioner,

v.

CHARGE d'AFFAIRES, Guardian of the Estate, and KIRSTEN
MURRAY, Guardian of the Person,

Respondents.

PETITIONER'S OPENING BRIEF

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I. INTRODUCTION

The Superior Court erred when it approved guardian fees and costs that exceed the amount allowed by state law, impaired the State's ability to comply with Medicaid regulations, and jeopardized Washington's ability to seek federal Medicaid funding thereby increasing the expenditure of state taxpayer dollars.

Medicaid is a cooperative state and federal public assistance program that pays medical expenses, including the cost of skilled nursing care, for indigent individuals such as Marilyn Albertson. Under the Medicaid program, Washington receives federal matching funds to offset public state dollars paid on behalf of Medicaid recipients. To receive those federal matching funds, the State must comply with state and federal Medicaid rules and regulations. Medicaid is a payer of last resort, and will not reimburse the State for the costs of care to the extent an individual is able to pay those costs. Medicaid regulations therefore require that a person who receives Medicaid and resides in a skilled nursing facility, like Marilyn Albertson, contribute a portion of her income towards the cost of care.

A Guardian of the Person and a Guardian of the Estate have been appointed for Ms. Albertson. Washington law limits the compensation that a Superior Court may approve for guardians of Medicaid recipients. These

limits were imposed by the Legislature to comply with Medicaid requirements. The Superior Court entered an order that approved fees and costs for the Guardian of the Estate that exceeded the amounts allowed by Washington law. Further, the Superior Court ordered the payment of those fees and costs in a manner that impairs the State's ability to comply with state and federal Medicaid regulations. The Superior Court ordered that the Department of Social and Health Services (DSHS) ignore Ms. Albertson's income when it determines her eligibility for Medicaid, and prohibited DSHS from requiring that Ms. Albertson contribute towards the cost of her care. As a result, the Superior Court's order jeopardizes Washington's ability to obtain Medicaid funding from the federal government because the State is prohibited from complying with Medicaid regulations. The Superior Court's order should be reversed.

II. ASSIGNMENTS OF ERROR

1. The Superior Court erred when it approved guardian fees and costs for the Guardian of the Estate, including attorney fees and costs, in excess of the amounts allowed by RCW 11.92.180 and Chapter 388-79 WAC. Finding Nos. 1, 1.1 through 1.5, 2, and 2.1 through 2.2. CP 11-12.

2. The Superior Court erred when it found that the fees and costs requested by of the Guardian of the Estate for the period February 1, 2015, through April 30, 2015, were just and reasonable under WAC 388-

79-050(4)(c), because the evidence in the record does not support the findings. Finding Nos. 1 and 1.1 through 1.5. CP at 10-12.

3. The Superior Court erred when it found that the attorney's fees and costs incurred by the Guardian of the Estate for the period February 1 through April 30, 2015, were just and reasonable under WAC 388-79-050(4)(c), because the evidence in the record does not support the findings. Findings No. 2 and 2.1 through 2.2. CP at 12.

4. The Superior Court erred when it ordered that the Guardian of the Estate's unpaid fees and costs, including attorney's fees and costs, be paid from Marilyn Albertson's income before calculation of the amount of her contribution toward the costs of long-term care. CP at 14.

5. The Superior Court erred when it ordered that the Guardian of the Estate's unpaid fees and costs, including attorney's fees and costs, be paid from Marilyn Albertson's income at the rate of \$1,509.21 per month. CP at 14.

6. The Superior Court erred when it ordered that the income used to pay the Guardian of the Estate's fees and costs, including attorney's fees and costs, shall not be considered to be available to Ms. Albertson to pay the costs of institutional care. CP at 15.

7. The Superior Court erred when it ordered that the income used to pay the Guardian of the Estate's unpaid fees and costs, including

attorney fees and costs, shall not be considered by DSHS or any other entity or person to be Ms. Albertson's assets. CP at 15.

8. The Superior Court erred when it ordered that the monthly fee advances approved for the Guardian of the Estate and the Guardian of the Person were to be paid from Marilyn Albertson's income before calculation of the amount of her contribution toward the costs of long-term care. CP at 15.

9. The Superior Court erred when it ordered that the income used to pay the monthly fee advances to the Guardian of the Estate and the Guardian of the Person shall not be considered by the Department of Social and Health Services or any other entity or person to be Ms. Albertson's assets. CP at 15.

III. ISSUES PERTAINING TO ASSIGNMENTS OF ERROR

1. RCW 11.92.180 limits the guardian fees and administrative costs (including attorney's fees) that may be approved by the Superior Court to the amount allowed by DSHS rule when an incapacitated person resides in a long-term care facility, receives Medicaid to pay for the cost of long-term care, and is required to contribute a portion of her income towards the cost of that care. Did the Superior Court abuse its discretion when it approved guardian fees and costs, including attorney's fees and

costs, in excess of the amounts allowed by RCW 11.92.180 and Chapter 388-79 WAC? Assignments of Error Nos. 1 through 3.

2. Washington's Medicaid State Plan and state and federal Medicaid rules set forth standards for determining an individual's eligibility for Medicaid benefits. Did the Superior Court commit an error of law when it ordered DSHS to determine Medicaid benefits and to allow for payment of guardian fees and costs, including attorney's fees and costs, in a manner that conflicts with state and federal Medicaid rules? Assignments of Error Nos. 4 through 9.

3. Washington's Medicaid State Plan and applicable state rules set forth standards to determine how much a Medicaid recipient must contribute towards the cost of her long-term institutional care. Did the Superior Court commit an error of law when it ordered DSHS to allow for payment of guardian fees and costs, including attorney's fees and costs, in a manner that conflicts with federal and state Medicaid rules? Assignments of Error Nos. 4, 5, 6, and 8.

IV. STATEMENT OF THE CASE

Marilyn Albertson resides in a skilled nursing facility in Port Townsend, Washington. CP at 11 (Finding No. 1.1), 278. In December 2014, Charge d'Affaires Guardian Associates was appointed Guardian of the Person and the Estate of Ms. Albertson. CP at 313-315. Charge

d’Affaires is a certified professional guardianship agency. A professional guardian is a person or entity who is not a family member, who charges a fee for services, and who has been appointed the guardian of three or more incapacitated persons.¹ RCW 11.88.008. Professional guardians are certified and regulated by the Certified Professional Guardianship Board. GR 23.

As guardian, Charge d’Affaires is a fiduciary for Ms. Albertson and has a duty to act for her benefit and in her best interest. Certified Professional Guardianship Board (CPGB) Standard of Practice No. 400. It is responsible for protecting and preserving Ms. Albertson’s estate, and for providing for her care and maintenance. RCW 11.92.040(5), (7). It has a duty to provide informed consent for medical care, and to maintain her in the least restrictive setting that is appropriate for her care needs. RCW 11.92.043(4), (5). Charge d’Affaires must maintain meaningful contact with Ms. Albertson, and maintain regular communication with the persons who provide care and services to her. CPGB Standard of Practice No. 404. It must also provide timely and accurate reports to the superior court

¹ In 2010, the last year statistics were reported by the Certified Professional Guardianship Board, there were 242 certified professional guardians and 41 certified professional guardian agencies in Washington. 2010 Annual Report at 5. The report is at <http://www.courts.wa.gov/guardianportal/index.cfm?fa=guardianportal.board&content=annualreports>.

regarding its activities and Ms. Albertson's condition. CPBG Standard of Practice No. 401.

On February 1, 2015, Ms. Albertson began receiving Medicaid to help pay for the cost of her skilled nursing care. CP at 274. Under the Medicaid program, Washington is eligible for federal funding to defray the costs of providing medical services, including long-term nursing care, to the elderly and indigent. As a condition of receiving these funds, federal law requires that Washington adopt and follow a State Plan for administering Medicaid that is consistent with federal Medicaid regulations, and adopt rules implementing that plan. Federal regulations and Washington's plan require that Medicaid recipients living in skilled nursing facilities pay some of their income towards the costs of their care.

In addition, Washington's State Plan, state law, and state Medicaid regulations limit the compensation that may be paid to guardians of Medicaid clients. Pursuant to RCW 11.92.180, these fees and costs cannot exceed the amount allowed by DSHS rule, which is a maximum of \$175 per month. WAC 388-79-030(1). The usual and customary guardian services for which the \$175 monthly fee is *per se* adequate for a Medicaid client include, but are not limited to: acting as a representative payee; managing the client's financial affairs; preserving and/or disposing of property; making health care decisions; visiting and/or maintaining contact

with the client; accessing public assistance programs; communicating with service providers; and preparing any reports or accountings required by the court. WAC 388-79-050(4)(b)(ii). Administrative costs, including attorney's fees, cannot exceed \$600 in any three-year period. WAC 388-79-030(3).

Under DSHS's rule, the superior court has the discretion to approve a higher fee if it finds the guardian performed extraordinary services. The types of extraordinary services that may justify a fee in excess of \$175 include, but are not limited to: unusually complicated property transactions; substantial interactions with adult protective services or criminal justice agencies; extensive medical services setup needs and/or emergency hospitalizations; and litigation other than litigating an award of guardianship fees or costs. WAC 388-79-050(b)(iii). These are specific, time-limited types of services. *In re Guardianship of Lamb*, 173 Wn.2d 173, 188, 265 P.3d 876 (2011).

When the guardian of a Medicaid client residing in a skilled nursing facility requests fees and costs, and when those fees and costs exceed the maximum allowed by WAC 388-79-030, the guardian must give DSHS ten days notice before filing its request with the superior court. WAC 388-79-050(4)(a). *See also* RCW 11.92.180 (citing to RCW 11.92.150). If DSHS agrees that higher fees should be allowed on an

exceptional basis, it may allow them. *Id.* If it does not agree the higher fees are warranted, it may file an objection with the superior court. If the superior court determines that the facts and the law warrant fees and costs in excess of the amount allowed by WAC 388-79-030 and approves them, DSHS will adjust the Medicaid client's contribution towards the cost of long-term care to allow for payment of the amount approved by the court. WAC 388-79-050(4)(c). Contribution towards costs of care cannot be reduced to pay for fees incurred before a client becomes eligible for Medicaid. WAC 388-79-050(5).

Six months after being appointed, the Guardian for Ms. Albertson petitioned the superior court for approval of fees and costs for the period February 1 through April 30, 2015, and to appoint a successor Guardian of the Person. CP at 277-305. A successor guardian of the person was requested because Ms. Albertson's care facility is located in Port Townsend, some distance from the Guardian. CP at 278.

The Guardian requested \$3,906.27 in fees and costs, of which \$2,610.99 were incurred after Ms. Albertson became eligible for Medicaid. CP at 279. This is an average fee of \$870 per month from February through April 2015, well in excess of the \$175 allowed by DSHS's rule. The petition did not identify any extraordinary services that were performed after Ms. Albertson became eligible for Medicaid. *See* CP

at 278-80, 301-05. The Guardian requested attorney's fees and costs of \$3,480 for the same period, well in excess of the \$600 maximum allowed by DSHS rule. CP at 280, 306-10. The petition did not identify any extraordinary legal services provided for the benefit of Ms. Albertson. CP at 280.

The Guardian asked the court to approve a monthly advance of \$250 for the Guardian of the Person and \$175 for the Guardian of the Estate. CP at 282. It asked the court to order DSHS to allow for payment of any unpaid fees at the rate of \$900 per month; this was in addition to the combined monthly advance of \$425. CP at 281. The Guardian asked the court to order DSHS to allow payment of fees before it calculated Ms. Albertson's contribution toward the cost of long-term care. CP at 283-84.

DSHS objected to the Guardian's fee request. CP at 264-76. It argued that the requested fees exceeded the amounts allowed under WAC 388-79-030, and that the Guardian failed to show it had performed extraordinary services to justify extraordinary fees. CP at 268-69. It also argued that the court should allow DSHS to determine the amount of any reduction in the contribution towards costs of care so that it could do so in compliance with Medicaid rules. CP at 269-70, 273. Medicaid rules cap that reduction at the Medically Needy Income Level (MNIL) of \$733 per month. CP at 275-76. If the court approved the Guardian's request and

DSHS could not comply with that cap, it would lose federal Medicaid reimbursement for Ms. Albertson's cost of care.

On June 19, 2015, a Superior Court Commissioner approved the appointment of a successor Guardian of the Person. CP at 258-63. The Commissioner reserved ruling on the request for fees pending further hearing. CP at 263. Ultimately, the Commissioner approved the requested fees and costs. CP at 242-245.

The Commissioner ordered that Ms. Albertson's participation toward her cost of care be reduced by \$1,150 per month, \$250 as a fee advance for the Guardian of the Person and \$900 towards unpaid fees; the Guardian of the Estate was not allowed a fee advance. *Id.* at 244. The order directed that the income used to pay the fees and costs "shall not be considered by the Department of Social and Health Services or any other entity or person to be Ms. Albertson's assets." *Id.* In effect, DSHS was prohibited from considering this income when determining Ms. Albertson's Medicaid eligibility and benefits. The Commissioner also ordered that the fees be paid from income before DSHS calculated Ms. Albertson's contribution towards the cost of long-term care. *Id.* These provisions required the State to violate its Medicaid State Plan, and federal and state Medicaid regulations.

DSHS filed a motion for revision of the Commissioner's order. 79-82, 83-153. The Honorable George Bowden gave his oral decision denying the motion on October 16, 2015. CP at 61-62. The court approved the fees requested by the Guardian. CP at 61. The court reserved ruling on whether to order payment of fees at a rate in excess of the MNIL cap imposed by Medicaid rules. *Id.* It directed the Guardian's attorney to draft specific findings as to the services provided by the Guardian and its attorney. *Id.* It also asked for additional information on the length of time it would take to pay the approved guardian fees and attorney's fees if the MNIL of \$733 were applied to cap the rate at which fees could be paid. CP at 61-62.

In response to the court's request, the Guardian of the Estate filed a declaration requesting an additional \$3,772.12 in fees that accrued in January 2015, and May 1 through October 31, 2015. CP at 46. These months are outside the time period covered by the initial accounting. The Guardian also requested an additional \$11,887.60 in attorney fees. CP at 24-44, 47-48. The bulk of the attorney fees were incurred litigating the Guardian's initial fee request. CP at 25-26, 47. The Guardian also asked the Court to order that all of Ms. Albertson's monthly income be diverted to pay approved fees and costs. CP at 26-27, 48. DSHS filed its objection,

arguing that the Guardian's proposed payment rate impaired DSHS's ability to comply with Medicaid rules and regulations. CP at 17-23.

On January 27, 2016, the court entered an order denying the motion for revision. CP at 10-16. The court reserved the issue of approval of fees and costs that accrued outside the period covered by the accounting. CP at 11-14. The court approved a monthly advance of \$175 for each Guardian. CP at 15. It ordered that unpaid guardian and attorney fees be paid at the rate of \$1,509.21 per month. CP at 14. The court also ordered that that fees be paid before the calculation of Ms. Albertson's costs of care, and that the income used to pay fees shall not be considered by DSHS to be part of Ms. Albertson's assets. CP at 14-15. DSHS filed for discretionary review of the superior court's order.

V. STANDARD OF REVIEW

The superior court erroneously interpreted RCW 11.92.180 and Chapter 388-79 WAC, the DSHS rule implementing the statute. Questions of statutory interpretation present questions of law that are reviewed *de novo*. *Lamb*, 173 Wn.2d at 184; *Bostain v. Food Exp., Inc.*, 159 Wn.2d 700, 708, 153 P.3d 846 (2007); *Cockle v. Dep't of Labor & Indus.*, 142 Wn.2d 801, 807, 16 P.3d 583 (2001). Interpretation of agency regulations are also questions of law that are reviewed *de novo*. *Cobra*

Roofing Serv., Inc. v. Dep't of Labor & Indus., 122 Wn. App. 402, 409, 97 P.3d 17 (2004).

A superior court's award of guardian fees and costs and the award of attorney's fees to a guardian are reviewed for an abuse of discretion. *Lamb*, 173 Wn.2d at 184. The superior court abuses its discretion if its decision is manifestly unreasonable or based on untenable grounds. *In re Estate of Black*, 153 Wn.2d 152, 173, 102 P.3d 796 (2004). If the superior court's ruling is based on an erroneous view of the law or involves the application of an incorrect legal analysis, it necessarily abuses its discretion. *Dix v. ICT Group, Inc.*, 160 Wn.2d 826, 833, 161 P.3d 1016 (2007). An abuse of discretion also occurs when the superior court's ruling relies on unsupported facts. *Gildon v. Simon Prop. Grp., Inc.*, 158 Wn.2d 483, 494, 145 P.3d 1196 (2006).

VI. ARGUMENT

The superior court failed to correctly interpret and apply the governing law when it approved fees and costs for the Guardian of the Estate. The court approved fees and costs in excess of the amounts allowed by law, yet failed to include necessary findings regarding the appropriateness of the fees that were approved. Further, the superior court's order directs DSHS to determine and calculate Medicaid eligibility for Ms. Albertson in a manner that violates state and federal Medicaid

laws. It also directs how DSHS is to exercise the authority solely delegated to it by the Legislature. The Superior Court's order should be reversed.

A. Overview of Medicaid in Washington for Persons Residing in Skilled Nursing Facilities

Generally, individuals are responsible for the cost of their medical care, including the cost of skilled nursing care. However, Congress makes federal funds available to states for long-term care services for indigent citizens through the Medicaid program. 42 U.S.C. § 1396; *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 502, 110 S. Ct. 2510, 110 L. Ed. 2d 455 (1990). "The cornerstone of Medicaid is financial contribution by both the Federal Government and the participating State." *Harris v. McRae*, 448 U.S. 297, 308, 100 S. Ct. 2671, 65 L. Ed. 2d 784 (1980). States pay the costs of caring for residents of long-term care institutions using state funds that are then reimbursed in part by the federal government.² "Participation [in the Medicaid program] by the State of Washington is voluntary. However, once the State makes the decision to participate in the program, it must comply with the federal Medicaid laws and regulations." *Multicare*

² The level of federal reimbursement is based on the federal medical assistance percentages (FMAP), which are calculated annually for each state, using a formula based on the state's average per capita income. 42 U.S.C. § 1396d(b); 42 C.F.R. § 433.10. Washington's FMAP for Fiscal Year 2015 was 50.00%. 79 Fed. Reg. 71,428 (December 2, 2014).

Medical Center v. State of Wash., 768 F. Supp. 1349, 1357 (W.D. Wash. 1991). *See also Lamb*, 173 Wn.2d at 186; RCW 74.09.500.

In order to receive federal funds, the states must maintain “state plans for medical assistance” that conform to requirements designed in part to safeguard federal funds and ensure that care meets federal standards. 42 U.S.C. § 1396-1; 1396a(a). *See also Multicare*, 768 F. Supp. at 1356-57 (discussing the State Plan process).³ A state's Medicaid plan must include “reasonable standards . . . for determining eligibility for and the extent of medical assistance under the plan.” 42 U.S.C. § 1396(a)(17). Medicaid laws require that persons similarly situated be treated equally. 42 U.S.C. § 1396a(10)(B)(i); 42 C.F.R. § 40.240(b). If the state fails to comply with federal Medicaid regulations and its State Plan, it can lose access to federal Medicaid funds. 42 U.S.C. § 1396c. As a result, state taxpayer dollars must be used to replace the lost federal funding.

In Washington, Medicaid is administered by the Washington Health Care Authority (HCA) and DSHS. RCW 74.04.050(3), RCW 74.09.530. On July 1, 2011, HCA became the single state agency authorized to administer Washington’s Medicaid program. RCW 74.09.530(1)(a). But under statute and agreement between the agencies, DSHS continues to handle aspects of the Medicaid system. *See* RCW 74.04.050(3). State

³ Washington’s state plan is on-line at <http://www.hca.wa.gov/about-hca/apple-health-medicaid/medicaid-title-xix-state-plan>.

compliance with Medicaid rules is monitored by the U.S. Department of Health and Human Services (DHHS) and the Centers for Medicare and Medicaid Services (CMS).

For persons residing in skilled nursing facilities like Ms. Albertson, Medicaid benefits are determined in a two-step process. The first step requires a determination of whether the Medicaid applicant is eligible to receive Medicaid benefits. Eligibility is dependent in part upon an individual's available income and resources. 42 U.S.C. § 1396a(a)(10)(A)(i)(IV). All of an applicant's income and resources must be considered. 42 C.F.R. § 725(e); WAC 182-512-0200 to WAC 182-512-0880. A Medicaid applicant's "income" is anything a person receives in cash or in-kind that can be used to meet his/her needs for food or shelter. WAC 182-512-0600(1).

If an applicant is Medicaid eligible, then the state Medicaid agency must determine how much of the Medicaid recipient's total income must be paid towards the cost of institutional care, and how much of the remaining difference will be paid by Medicaid. 42 C.F.R. § 435.725. Federal regulations require that a state reduce its payment to a facility for services provided to an individual by the amount of that individual's total income, minus any applicable deductions. 42 C.F.R. § 435.725. Any reduction in the patient's contribution must be made up by Medicaid funds

so long as the reduction is due to a Medicaid eligible expense. *Lamb*, 173 Wn.2d at 187. If the reduction is not eligible for Medicaid reimbursement, state taxpayer dollars must be used.

A Medicaid client contributes her income, minus these deductions, to the Medicaid institution to help defray the cost of long-term care. *Id.* Federal regulations refer to this patient contribution as “post-eligibility treatment of income” or “application of patient income to the cost of care.” *See e.g.* 42 C.F.R. § 435.725. In Washington, it is commonly referred to as “participation.” WAC 182-513-1100 (copy attached as Appendix A).⁴ Of relevance to this case, the requirement of participation prohibits state agencies from paying any amounts that are the responsibility of the client. The federal regulations “are consistent with the statutory plan that Medicaid funds not be paid to reimburse those costs that patients with resources of their own can afford.” *Florence Nightingale Nursing Home v. Perales*, 782 F.2d 26, 29 (2d Cir.1986).

Washington has adopted regulations implementing the participation requirement for clients in skilled nursing facilities like Ms. Albertson. WAC 182-513-1380 (copy attached as Appendix B). The types and amounts of deductions allowed to be taken from a Medicaid client’s

⁴ Many of the state Medicaid rules and regulations have recently been revised and are not yet codified through the Coder Reviser. Appendices A and B are copies of the rules currently in effect and published in the Washington State Register. For the entire text of the current rules, see Wash. St. Reg. 16-14-012 (filed June 23, 2016).

participation are set by federal regulation and are clarified in Washington's Medicaid State Plan. All of a Medicaid client's income is contributed toward the cost of care unless it is instead diverted to one of the allowable deductions. 42 C.F.R. § 435.725. States are required to deduct, in order: a personal needs allowance; spousal maintenance; family maintenance; necessary medical expenses not covered by Medicaid; and state supplemental security income (SSI) payments received by a person who is admitted to a medical facility for 90 days or less. 42 C.F.R. § 435.725(c).

Guardianship-related expenses are not named in the federal regulations as a required or optional deduction from participation. *See* 42 C.F.R. § 435.725(c); *Lamb*, 173 Wn.2d at 187. In its current Medicaid State Plan, Washington received federal approval to deduct guardian fees, plus administrative costs including the guardian's attorney's fees, from participation as part of the personal needs allowance. *Lamb*, 173 Wn.2d at 187; CP at 211. However, the deduction for a guardian's fees and costs is limited in two ways.

First, the State Plan limits fees to \$175 per month except in extraordinary circumstances, and limits administrative costs (including the guardian's attorney's fees) to \$600 per three-year period. CP at 211, 275-76. These limitations are reflected in DSHS's rule, and are discussed more

fully below in Section IV(B)(2). *See* WAC 388-79-030. Second, the total personal needs allowance deductions from the individual's income, including guardian fees and costs, cannot exceed the one-person Medically Needy Income Level (MNIL) cap. State Plan, Suppl. 14 to Attach. 2.6-A, at 3; WAC 182-513-1380(4); CP at 211, 275-76. The current MNIL for a single individual is \$733 per month. CP at 276.⁵

These limitations on guardian fees and costs are also integrated into the process the State uses to determine a client's participation in the cost of long-term care. The State uses WAC 182-513-1380 to determine participation. Under that rule, the State excludes or sets aside income to allow for payment of the following expenses in hierarchical order: (a) a monthly personal needs allowance of \$57.28;⁶ (b) mandatory federal, state and local income taxes; (c) certain wages; and (d) guardianship fees and administrative costs, including attorney fees, as allowed by Chapter 388-79 WAC. WAC 182-513-1380(4); CP at 276. Participation is the income

⁵ The MNIL cap changes on January 1 of each year when the Social Security Administration issues its annual cost-of-living adjustments. The current standards are at: <http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources>.

⁶ WAC 182-513-1380 uses the term "personal needs allowance" to refer only to the portion of the personal needs allowance paid directly to the individual client as a discretionary spending allowance. The Medicaid regulations and the State Plan characterize as the personal needs allowance the sum of all four deductions allowed under WAC 182-513-1380(4), including the discretionary spending allowance. 42 C.F.R. § 435.725(c).

that remains after the post-eligibility process in WAC 182-513-1380.
WAC 182-513-1100.

For every dollar a client's participation is reduced, a dollar must be spent from state and federal Medicaid funds to cover the client's medical and personal care costs. Because client participation in the cost of care is mandatory, the failure of a state agency to properly calculate participation, and to reduce Medicaid expenditures accordingly, is a violation of Medicaid regulations. 42 C.F.R. § 435.725 (state agency must reduce Medicaid payments to reflect participation).

Deductions from participation beyond the MNIL cap are not eligible Medicaid expenditures under Washington's State Plan, and are not eligible for federal matching funds. Increasing Medicaid payments to cover guardianship fees and costs beyond the MNIL cap constitutes misuse of Medicaid funds and jeopardizes state Medicaid funding. The DSHS rule limiting guardian fees requires that any award of guardian fees "ensure that federal Medicaid funding is not jeopardized by noncompliance with federal regulations limiting deductions from the client's participation amount." WAC 388-79-050(4)(b)(i).

Guardian fees thus cannot be awarded from a client's participation if to do so would violate Medicaid regulations involving the MNIL cap on the personal needs allowance deductions. When the superior court orders

that guardian fees be taken from a client's income in the form of reduced participation above the MNIL cap, the State is unable to comply with Medicaid regulations and is unable to seek federal Medicaid reimbursement. As a result, no Medicaid funds are available to pay the costs of skilled nursing care, and state taxpayer dollars must be used in their place resulting in increased costs to the State. This is one of the quandaries the superior court order at issue here presents.

B. The Superior Court Committed Error of Law and Abused Its Discretion When It Approved Guardian Fees and Costs in Excess of the Amounts Allowed Under Washington Law

The Legislature has limited the compensation that may be awarded to the guardian of an incapacitated person who resides in a skilled nursing facility, receives Medicaid to pay for the costs of skilled nursing care, and is required to contribute a portion of her income to offset that cost. The Legislature further directed DSHS to adopt rules that implement that legislative directive. Here, the superior court ignored the limitation on compensation imposed by the Legislature. In doing so, it rendered DSHS's rule implementing the Legislature's directive meaningless. The superior court's order approving fees and costs should be reversed.

1. Washington law limits the compensation that may be awarded to guardians of Medicaid recipients who reside in long-term care facilities

Generally, guardians are permitted reasonable compensation for their services, but they cannot be compensated at state or county expense. RCW 11.92.180. However, different rules apply when the incapacitated person receives Medicaid and is required to contribute towards the cost of her skilled nursing care. In these cases, the Legislature explicitly limited the guardian fees and costs a superior court may approve. In 1994, the Legislature amended RCW 11.92.180 to require that:

Where the incapacitated person is a department of social and health services client residing in a nursing facility or in a residential or home setting and is required by the department of social and health services to contribute a portion of their income towards the cost of residential or supportive services then the department shall be entitled to notice of proceedings as described in RCW 11.92.150. The amount of guardianship fees and additional compensation for administrative costs shall not exceed the amount allowed by the department of social and health services by rule.

Laws of 1994, ch. 68 § 1 (emphasis added); *see also* RCW 11.92.180.

Prior to the 1994 amendment, if an incapacitated person received Medicaid, the superior court was only required to find that a guardian's fees were just and reasonable. This was the same standard the court applied in non-Medicaid cases. However, the Legislature's 1994 amendment made it clear that, while a guardian was still allowed

compensation, additional limitations now applied to a guardian's request for fees and costs when the incapacitated person received Medicaid and resided in a long-term care facility.

At the same time it amended RCW 11.92.180, the Legislature adopted RCW 43.20B.460, which states:

The department of social and health services shall establish by rule the maximum amount of guardianship fees and additional compensation for administrative costs that may be allowed by the court as compensation for a guardian or limited guardian of an incapacitated person who is a department of social and health services client residing in a nursing facility or in a residential or home setting and is required by the department of social and health services to contribute a portion of their income towards the cost of residential or supportive services.

Laws of 1994, ch. 68 § 2 (emphasis added); *see also* RCW 43.20B.460.

When interpreting a statute, this Court looks at the overarching objective of the statute. *Cockle*, 142 Wn.2d at 822. The Court's fundamental objective is to ascertain and carry out the intent of the Legislature. *Campbell & Gwinn*, 146 Wn.2d 1, 9, 43 P.3d 4 (2002); *State v. J.M.*, 144 Wn.2d 472, 480, 28 P.3d 720 (2001). A change in legislative intent is presumed when a material change is made in a statute. *Darkenwald v. State Emp't Sec. Dep't*, 183 Wn.2d 237, 252, 350 P.3d 647 (2015). With the amendment of RCW 11.92.180 and the adoption of RCW 43.20B.460, the Legislature expressed a clear intent to change how compensation was to be awarded to guardians of Medicaid clients, and to limit that compensation.

The final bill report summarizing the 1994 statutory changes gave two independent rationales for the Legislature's amendment to RCW 11.92.180 and adoption of RCW 43.20B.460. First, the Legislature found that the guardian fees charged to Medicaid clients had increased significantly, resulting in increased costs to the state. Final B. Rep. on S.B. 6604, 53rd Leg., Reg. Sess. (Wash. 1994); CP at 217. These fees increased from \$125,000 in 1989 to \$1.6 million in 1993. *Id.* Second, Washington was informed by the federal government that it was out of compliance with federal Medicaid rules "because [Washington] does not have specific standards defining which guardianship charges will be recognized as reasonable and which will not." *Id.* See also *Lamb*, 173 Wn.2d at 187 n. 12.

RCW 11.92.180 and RCW 43.20B.460 are two related statutes that must be interpreted in relation to each other. *ITT Rayonier, Inc. v. Dalman*, 122 Wn.2d 801, 807, 863 P.2d 64 (1993). They express a clear legislative intent that guardian fees and costs in Medicaid cases be limited. They also express a clear intent that DSHS adopt rules to implement that limitation, and that the superior courts abide by those rules when approving fees in Medicaid cases. Statutes are mandatory, and the superior court in this case did not follow the law. The order approving fees should be reversed.

2. DSHS's rule implements the Legislature's intent that guardian fees charged in Medicaid cases be limited to maintain compliance with Medicaid regulations

Rules of statutory construction apply to administrative rules and regulations, particularly when they are adopted pursuant to express statutory authority. *Dep't of Licensing v. Cannon*, 147 Wn.2d 41, 56, 50 P.3d 627 (2002) (quoting *City of Kent v. Beigh*, 145 Wn.2d 33, 45, 32 P.3d 258 (2001)). Administrative rules are interpreted to ascertain and give effect to their underlying policy and intent. *Id.* Rules and regulations are to be given a rational, sensible interpretation. *Cannon*, 147 Wn.2d at 57. They should be interpreted so that no portion of a rule superfluous, void, or insignificant. *Hayes v. Yount*, 87 Wn.2d 280, 290, 552 P.2d 1038 (1976). The interpretation adopted should always be the one that best advances the legislative purpose. *Rozner v. City of Bellevue*, 116 Wn.2d 342, 347, 804 P.2d 24 (1991).

Further, the goal in interpreting a statute or administrative rule is to achieve a harmonious statutory scheme, and to avoid conflicts between different provisions of that scheme. *Dep't of Labor & Indus. v. Tyson Foods, Inc.*, 143 Wn. App. 576, 582, 178 P.3d 1070 (2008). To reach this goal, courts give deference to the interpretation of the administrative agency in charge of the statute's or rule's enforcement. *White v. State*, 49 Wn.2d 716, 725, 306 P.2d 230, 235 (1957). The United States Supreme

Court further stated that “[W]hen the construction of an administrative regulation rather than a statute is in issue, deference [to the administrative agency] is even more clearly in order.” *Udall v. Tallman*, 380 U.S. 1, 16, 85 S.Ct. 792, 801, 13 L. Ed. 2d 616 (1965). This is particularly true when the regulation is adopted pursuant to express legislative authority, as is the case here. *Hayes*, 87 Wn.2d at 291.

If the rule is clear on its face, its meaning is derived from the plain meaning of the language of the rule. *Cannon*, 147 Wn.2d at 56. An administrative rule is unclear if it can be reasonably interpreted in more than one way, although it is not ambiguous simply because different interpretations are conceivable. *Id.* The spirit or purpose of a rule should prevail over express but inept wording. *State v. Burke*, 92 Wn.2d 474, 478, 598 P.2d 395 (1979). Where the scope of a regulation is unclear, the agency’s interpretation of its own rule is entitled to deference. *Green v. Dep’t of Soc. & Health Servs.*, 163 Wn. App. 494, 508, 260 P.3d 254 (2011).

As directed by the Legislature, DSHS adopted a rule that sets forth the maximum fees and costs that may be awarded to the guardian of a Medicaid client. Chapter 388-79 WAC. The Guardian of the Estate argued to the superior court that the rule actually imposes no limits on the fees the superior court may approve so long as it finds that the fees are just and

reasonable. CP at 65-66. In doing so, it argued that the superior court should look to only one subsection of DSHS's rule, and ignore the other substantive sections. CP at 67.

Without citation to authority, the Guardian argued its interpretation was consistent with the rule-making history of Chapter 388-79 WAC. CP at 66-68. By adopting the Guardian's interpretation of the rule, the superior court ignored the mandate of RCW 11.92.180 to limit fees in Medicaid cases and the very purpose behind the rule. To fully understand Chapter 388-79 WAC, this Court should account for and interpret the rule within the context of the statutory scheme within which it was adopted.

Here, the Legislature acted to limit guardian fees in Medicaid cases due to concerns about escalating costs and non-compliance with federal Medicaid standards; the legislative intent is clear. Final B. Rep. on S.B. 6604, 53rd Leg., Reg. Sess. (Wash. 1994); *Lamb*, 173 Wn.2d at 188 n. 12. Chapter 388-79 WAC was adopted pursuant to express statutory authority in RCW 11.92.180 and RCW 43.20B.460 that compensation of guardians be limited in Medicaid cases. DSHS's interpretation aligns with the stated goal of RCW 11.92.180 and does not conflict with any statutory mandate.

The rule-making history of Chapter 388-79 WAC tracks the change in the statutory scheme, and reflects a significant shift towards express limitations on guardian fees to maintain compliance with federal

Medicaid requirements. The initial Notice of Proposed Rule in 1998 stated that the purpose for the new Chapter 388-79 WAC was to “set amounts that the court can order for guardianship fees for clients of the department. These rules will also satisfy the Health Care Financing Authority (HCFA) [now the Centers for Medicare and Medicaid Services (CMS)] and remove the state from the compliance list.” Wash. St. Reg. 98-03-085 (filed January 21, 1998). The notice makes it clear that the rules are proposed to comply with the federal Medicaid program requirements. *Id.*

As initially written, the rule was consistent with the pre-1994 version of RCW 11.92.180. The 1998 rule simply required that the superior court determine whether the fees requested by the guardian were “just and reasonable.” Wash. St. Reg. 98-10-055 (filed April 30, 1998). The initial rule provided no guidance as to when fees in excess of the maximum set by the rules would be just and reasonable. Similarly, RCW 11.92.180 and the case law interpreting it, provided no guidance as to how to consider fee requests in cases where the incapacitated person was a recipient of Medicaid.

Shortly after Chapter 388-79 WAC was implemented in 1998, it was apparent that the new rule did not address federal concerns that there were no guidelines in Washington for evaluating guardian fees in Medicaid cases. Since initial adoption of the rule, DSHS received

additional notices from the federal government regarding Washington's noncompliance with federal Medicaid regulation. Wash. St. Reg. 02-01-043 (filed December 11, 2001). For example, a letter from the federal Centers for Medicare and Medicaid Services dated February 22, 1995, warned that federal regulators do not automatically consider court-approved fees to be reasonable, and that DSHS is required to make an independent determination of a "reasonable" fee for a guardian and be able to explain how the amount was determined. Wash. St. Reg. 03-06-094 (filed March 4, 2003).

In 2003, DSHS proposed amending the rule to add language to establish a way to measure if requested fees are reasonable. *Id.* This was necessary based on the need to comply with federal Medicaid requirements and to cap escalating expenditures. *Id.* The notice of proposed rule-making noted:

The major weakness of the current WAC chapter is that the usual and customary services provided by a guardian, (that is, that package of services provided in exchange for a "reasonable" fee set forth in a federally mandated rule), is not defined. Neither the courts, certified guardians or ADSA [Aging and Disability Services Administration, now the Aging and Long-Term Support Administration (AL TSA)] staff have a way to measure what constitutes a usual and customary set of services. Nor can they determine with any consistency what would constitute "extraordinary" services that deserve a higher rate of compensation. As previously stated, the department is required by federal statute to establish a maximum fee amount. A pattern of DSHS

allowing more than the maximum amount, especially when the client does not need extraordinary services, would result in a loss of federal funding.

Id.

The 2003 proposed rule amendments would add language needed to establish a mechanism for determining whether the fees being awarded were reasonable in order to comply with federal mandates and to “cap escalating expenditures.” *Id.* The amendments would also “establish reasonable and maximum rates for guardian fees and costs associated with guardianships.” *Id.*

The amendments were adopted in July 2003. Wash. St. Reg. 03-16-022 (filed July 28, 2003). The most significant change was the addition of WAC 388-79-050. That section, in relevant part, provides:

- (4) Should fees and costs in excess of the amounts allowed by WAC 388-79-030 be requested:
 - (a) at least ten days before filing the request with the court, the guardian must present the request in writing to the appropriate regional administrator to allow the department an opportunity to consider whether the request should be granted on an exceptional basis.
 - (b) In considering a request for extraordinary fees or costs, the department must consider the following factors:
 - (i) The department's obligation under federal and state law to ensure that federal medicaid funding is not jeopardized by noncompliance with federal regulations limiting deductions from the client's participation amount;
 - (ii) The usual and customary guardianship services for which the maximum fees and costs under WAC 388-79-030 must be deemed adequate for a medicaid client, including but not limited to:
 - (A) Acting as a representative payee;

- (B) Managing the client's financial affairs;
 - (C) Preserving and/or disposing of property;
 - (D) Making health care decisions
 - (E) Visiting and/or maintaining contact with the client;
 - (F) Accessing public assistance programs on behalf of the client;
 - (G) Communicating with the client's service providers; and
 - (H) Preparing any reports or accountings required by the court.
- (iii) Extraordinary services provided by the guardian, such as:
- (A) Unusually complicated property transactions;
 - (B) Substantial interactions with adult protective services or criminal justice agencies;
 - (C) Extensive medical services setup needs and/or emergency hospitalizations; and
 - (D) Litigation other than litigating an award of guardianship fees or costs.
- (c) Should the court determine after consideration of the facts and law that fees and costs in excess of the amounts allowed in WAC 388-79-030 are just and reasonable and should be allowed, then the department will adjust the client's current participation to reflect the amounts allowed upon receipt by the department of the court order setting the monthly amounts.

WAC 388-79-050(4).

This new section provided the missing definitions required for the guardians, the courts, and DSHS to determine whether a guardian provided services that warranted fees and costs in excess of the maximum amount allowed by DSHS rule. The new section still allowed for the superior court to determine, after consideration of the facts and law, that fees in excess of the amounts allowed in WAC 388-79-030 were “just and reasonable.” However, now the “law” that the courts were to consider

(along with the facts) included the codified definitions in WAC 388-79-050(4) of “usual and customary” versus “extraordinary” that would be used to assess whether the requested fees were “just and reasonable.”

When the superior court is asked to approve fees and costs in a Medicaid case, it must apply WAC 388-79-050(4)(b)(ii) to assess whether services performed by the guardian are the usual and customary services performed by a guardian for a Medicaid client. If so, the \$175 maximum fee under WAC 388-79-030 is *per se* adequate and reasonable. If fees and costs above this maximum are requested, the court must apply the guidelines in WAC 388-79-050(4)(b)(iii) to assess whether an extraordinary fee is warranted. This is the only interpretation of the rule that advances the legislative policy and intent.

In contrast, the Guardian’s interpretation of DSHS’s rule places no limits on the fees a superior court may approve in Medicaid cases. CP at 64-68, 71. Under its interpretation, the superior court engages in the same analysis in both Medicaid and non-Medicaid cases when determining whether requested fees are just and reasonable. The Guardian argued below that WAC 388-79-040(4)(c) gives the superior court authority to approve any fees and costs that exceed the maximum allowed by WAC 388-79-030 so long as the court makes a finding that such fees are “just and reasonable,” regardless of the services provided. CP at 66, 67. Under

the Guardian's interpretation of the rule, the definitions of "usual and customary" and "extraordinary" guardian services in WAC 388-79-050(4)(b) apply only to DSHS so that it may "make its own determination of whether the request [for extraordinary fees] should be granted." CP at 66. Once DSHS makes that assessment, according to the Guardian, DSHS's role in the process is complete. In other words, under the Guardian's interpretation of the rule, DSHS engages in an analysis that serves no purpose and that achieves no result.

The Guardian's interpretation of the rule renders WAC 388-79-050(4)(a) and (b) and WAC 388-79-030 meaningless and superfluous, a result to be avoided. *Hayes*, 87 Wn.2d at 291. The Guardian's piecemeal approach also subverts the Legislature's clear intent to limit the guardian fees the superior court may award in Medicaid cases. Chapter 388-79 WAC should be read and interpreted within the context of the legislative scheme it was intended to implement. The superior court erred when it failed to do so, and its order approving fees should be reversed.

3. The superior court abused its discretion when it approved the fees and costs requested by the Guardian of the Estate

The superior court approved fees in excess of the amount allowed by RCW 11.92.180 and, in doing so, abused its discretion. The superior court approved guardian fees of \$2,610.99 for a three-month period of

time; this is an average fee of \$870 per month, nearly five times the maximum fee of \$175 allowed by WAC 388-79-030(1). CP at 10-11. As the basis for its order, the superior court found that the fees were reasonable pursuant to WAC 388-79-050(4)(c). *Id.* That rule provides that, if the superior court finds that fees and costs in excess of \$175 should be allowed, DSHS will adjust the Medicaid client's participation to reflect the amount allowed by the court. Absent a finding that the guardian performed extraordinary services beyond the usual and customary services, WAC 388-79-050(4)(c) does not authorize the superior court to give blanket approval of all of the fees and costs requested by the guardian, which is exactly what occurred here.

Further, the findings of the superior court do not identify extraordinary services to justify the excess fees the court approved. First, the court made numerous findings regarding the guardian's activities. CP at 10-13 (Finding Nos. 2, 3, 4). However, most of the activities listed in those findings occurred before Ms. Albertson began receiving Medicaid benefits in February 2015, and before the time period for which the Superior Court awarded the excess fees. CP at 304-05. These pre-Medicaid activities are detailed in the Guardian's declaration filed in response to the State's initial objection to the requested fees. CP at 233-41. A Medicaid client's participation towards the cost of care cannot be

reduced to pay for services performed before she becomes eligible for Medicaid. WAC 388-79-050(5). Further, the Guardian's activities prior to February 2015, are not relevant to whether the fees requested for February through April 2015, are reasonable under WAC 388-79-050.

Second, review of the Guardian's fee statements for the period February through April 2015, shows that the services performed by the guardian were the usual and customary services for which the \$175 per month maximum fee is deemed adequate. WAC 388-79-040(4)(b)(ii). *See* CP at 301-05. Usual and customary services include: acting as representative payee; managing the person's financial affairs; preserving and/or disposing of property; making health care decisions; visiting and/or maintaining contact with the client; accessing public assistance programs; communicating with service providers; and, preparing any required reports or accountings. WAC 388-79-050(4)(b)(ii).

The Guardian's billing invoices beginning February 2015, show these are the very activities for which the Guardian sought approval of excess fees and costs. CP at 301-03. These include: contact with the care facility; visits with Ms. Albertson; banking; participation in care conferences; communication with DSHS and the Social Security Administration; signing documents for the skilled nursing facility; signing Medicaid-related documents; preparation of a care plan and

inventory; researching potential successor guardians; and, preparing and filing documents with the court. *Id.* These are not extraordinary activities.

The only out-of-the-ordinary expenditure on the invoices involves the time spent visiting Ms. Albertson in person. The invoices show that the Guardian spent five or more hours each month visiting Ms. Albertson's care facility in Port Townsend, Washington. CP at 301-03. Presumably the time billed includes travel time, although that is not clear from the invoices. Arguably, given the distance, the travel time may support an additional fee. However, charging a Medicaid recipient \$90 an hour for travel time as the Guardian did in this case is not reasonable, and is not allowed by DSHS rule.

The Guardian's activities in this case are not the extraordinary services that justify an exceptional fee award averaging over \$870 per month. DSHS's rule is clear that a service cannot be both "usual and customary" and "extraordinary." If a service falls within the definition of "usual and customary," then that service may not be used to justify fees exceeding \$175 per month. To read the rule otherwise would yield an absurd or strained result, which the court must avoid. *Kilian v. Atkinson*, 147 Wn.2d 16, 21, 50 P.3d 638 (2002).

Third, the Superior Court further erred by granting the Guardian's request for \$3,480 in administrative costs for attorney's fees and costs. Pursuant to WAC 388-79-030(3), the amount of administrative costs, including attorney's fees and costs, shall not exceed \$600 during any three-year period.

Here, the Court simply approved the attorney's fees as requested based on the hours worked multiplied by the \$300 per hour rate that was billed. CP at 12, 24-27. The approved fees are nearly six times the amount allowed by statute and rule. The invoices submitted by the Guardian's attorney show fairly routine activities including communicating with the Guardian via e-mail and telephone, and rafting pleadings. CP at 306-12. These are not complicated or unusual tasks that warrant an extraordinary fee.

The superior court made no findings as to the appropriateness of the attorney's fees, the rate charged, or whether the attorney's services benefited the estate; the court appears to have reached the conclusion that the fees were just and reasonable with no analysis. CP at 12 (Finding No. 2). Instead, the court simply found that it was necessary to confirm the Guardian's appointment after Ms. Albertson became eligible for Medicaid. *Id.* (Finding No. 2.1). It also found that the Guardian sought appointment of a successor Guardian of the Person due to the location of

Ms. Albertson's care facility. *Id.* (Finding No. 2.2). These are not legal services that justify such an extraordinary fee.

The superior court abused its discretion when it approved the fees and costs requested by the Guardian of the Estate. The court did not follow the clear mandate of RCW 11.92.180 that fees and costs in Medicaid cases be limited to the maximum set by DSHS rule. The superior court's findings do not reflect the types of specific, time-limited activities that may support a fee award in excess of the \$175 per month maximum allowed by DSHS rule. To the extent the Guardian may have performed extraordinary services, the record shows those services were performed before Ms. Albertson became eligible for Medicaid. The superior court's order should be reversed.

C. The Superior Court Erred When It Ordered Payment of the Guardian's Fees and Costs in a Manner That Impairs the State's Ability to Comply with Medicaid Rules and Regulations

Marilyn Albertson receives public funds in the form of Medicaid to pay for the cost of her long-term care. The State determines her eligibility and benefits pursuant to Medicaid rules that are consistent with the federally approved Medicaid State Plan and federal Medicaid rules and regulations. The State is required to comply with these rules and regulations in order to receive federal reimbursement for its Medicaid

expenditures. Here, the superior court ordered the State to disregard those rules. The superior court did not have the authority to do so, and the order should be reversed.

1. The Legislature delegated the authority to administer the Medicaid program to the Health Care Authority and DSHS

In order to receive federal Medicaid funds, the states must maintain “state plans for medical assistance” that conform to requirements designed in part to safeguard federal funds and ensure that care meets federal standards. 42 U.S.C. § 1396a(a). The State must comply with Medicaid laws and regulations. *Lamb*, 173 Wn.2d at 186; *Samantha A. v. Dep’t of Soc. and Health Serv.*, 171 Wn.2d 623, 630, 256 P.3d 118 (2011); *S.A.H. Dep’t of Soc. and Health Serv.*, 136 Wn. App. 342, 348, 149 P.3d 410 (2006). *See also* RCW 74.09.500. If the State fails to comply with its federally approved State Plan, it can lose access to federal Medicaid funds. 42 U.S.C. § 1396c. State law also requires that the Medicaid program be administered to comply with federal Medicaid requirements and to maximize the receipt of federal funds. RCW 74.04.050(4), (5); RCW 74.09.510; RCW 74.09.530.

State law provides that Washington accepts and assents to all provisions of federal law with respect to public assistance programs like Medicaid, and requires that such programs “shall be so administered as to conform to federal requirements with respect to eligibility for the

receipt of federal grants and funds.” RCW 74.04.050(4) (emphasis added). The statute goes on to require that “[t]he department and the [Health Care] authority shall make and enforce such rules and regulations as shall be necessary to insure compliance with the terms and conditions of such federal grants or funds.” RCW 74.04.050(5) (emphasis added). Rules promulgated pursuant to delegated authority, such as the rules at issue here, are presumed valid. *Campbell v. Dep’t of Soc. and Health Serv.*, 150 Wn.2d 881, 892, 83 P.3d 999 (2004).

With regard to the Medicaid program, the Legislature specifically required that the “standards for assistance and resource and income exemptions . . . shall be consistent with the provisions of the social security act and federal regulations for determining eligibility of individuals for medical assistance.” RCW 74.09.530 (emphasis added). *See also* RCW 74.09.510. These standards are set forth in DSHS’s and HCA’s Medicaid rules. The Legislature further directed that the “amount and nature of medical assistance and the determination of eligibility of recipients for medical assistance shall be the responsibility of the authority.” RCW 74.09.530(1)(b). *See also* RCW 74.09.510 (medical assistance may be provided in accordance with eligibility requirements established by the authority, as defined in the social security Title XIX state plan for mandatory categorically needy persons). DSHS and HCA are mandated by law to comply with Medicaid rules and regulations.

They are mandated to administer Medicaid in a manner that maximizes receipt of federal funds to offset scarce state funds.

The Legislature has delegated authority to determine eligibility criteria, assistance standards, and income exemptions for medical assistance, including Medicaid eligibility determinations, to DSHS and the Washington Health Care Authority (HCA). RCW 74.04.050(3), RCW 74.09.530. Thus, the administration of the Medicaid program is an executive, not a judicial function. RCW 74.09.500 and .510. Courts cannot substitute their own judgment for that of DSHS or HCA in areas where the agency has been charged by law with oversight and administration of a program. *In re Welfare of J.H.*, 75 Wn. App. 887, 894, 880 P.2d 1030 (1994); *Salary of Juvenile Director*, 87 Wn.2d 232, 245, 552 P.2d 163 (1976). Likewise, while the court in a guardianship matter, by statute, has authority to oversee the incapacitated person's estate, it must do so in a manner consistent with all applicable laws.

Further, the superior court should give deference to an administrative agency's interpretation and application of the regulations it administers. *Green*, 163 Wn. App. at 508. This is because "the agency has expertise and insight gained from administering the regulation that the reviewing court does not." *Id.* (quoting *Overlake Hosp. Assoc. v. Dep't of Health*, 170 Wn.2d 43, 56, 239 P.3d 1095 (2010)). This is especially true here, where the Medicaid regulatory scheme is complex

and highly technical and the need to comply with the federal regulatory scheme is necessary for continued federal funding.

In this case, the superior court usurped the Legislature's delegation of authority, and directed how Medicaid benefits were to be determined for Ms. Albertson. In doing so, it gave no deference to the State's interpretation of its Medicaid regulations and it ordered the State to disregard its Medicaid rules and regulations. The order should be reversed.

2. The superior court's order requires the State to violate Medicaid rules

The superior court's order prohibits the State from applying state and federal Medicaid rules when it determines Ms. Albertson's Medicaid benefits and participation. The order also does not allow the State to calculate participation in compliance with federal law. It does this by, first, requiring the State to ignore Ms. Albertson's resources and, second, requiring the State to make post-eligibility deductions from Ms. Albertson's income in excess of the MNIL cap in WAC 182-513-1380.

a. The superior court's order requires the State to ignore Ms. Albertson's income in violation of Medicaid rules

First, the superior court ordered the State to allow a monthly advance of \$175 for each Guardian (\$350 total), and to divert an

additional \$1,509.21 in monthly income to pay outstanding fees and attorney's fees. CP at 14-15. In other words, the court ordered that \$1,859.21 per month be used to pay for guardian fees and costs. The court specifically ordered that the funds used to pay the outstanding fees "shall not be considered by the Department of Social and Health Services or any other entity or person to be Ms. Albertson's assets." CP at 15.

Ms. Albertson has \$1,922 in monthly income. CP at 26. She retains \$57.28 per month as a personal needs allowance, leaving a balance of \$1,864.72. By ordering that fees be paid at the rate of \$1,859.21, and by excluding that income as an asset, the superior court ordered the State to ignore all but \$5.51 of Ms. Albertson's monthly income when determining her eligibility for Medicaid. Federal law requires that Medicaid eligibility be determined based on "total income received." 42 C.F.R. § 435.725(e). Similarly, Washington's Medicaid rule defines "income" as anything a person receives in cash or in-kind that can be used to meet his/her needs for food or shelter. WAC 182-512-0600(1). All of Ms. Albertson's income is available to her under both state and federal Medicaid rules. However, under this order those rules are rendered superfluous. There is no legal authority to order DSHS to ignore income when it determines Medicaid eligibility.

The superior court cited to RCW 11.92.035 and RCW 11.92.180 as authority for its order. CP at 15. However, neither statute authorizes the court to prohibit DSHS from considering all of a Medicaid recipient's income when calculating benefits. Also, neither statute authorizes the court to order the State to violate its own rules. RCW 11.92.035 addresses a guardian's obligation to pay claims against the estate, and RCW 11.92.180 requires the court to limit a guardian's fees and costs to the amount allowed by DSHS rule; as discussed fully above, the superior court's order ignores that mandate. The superior court also cited Chapter 388-79 WAC as authority for the order to disregard income when calculating Medicaid benefits. *Id.* The rule sets forth the maximum fees and costs that may be awarded to the guardian of a Medicaid client, and includes the guidelines to be applied when the court is asked to approve extraordinary compensation. The rule does not confer upon the court the authority to order DSHS to violate its own Medicaid rules or federal Medicaid standards and regulations.

- b. The superior court's order requires the State to deduct amounts in excess of the MNIL in violation of Medicaid rules.**

Second, the superior court's order requires the State to deduct from Ms. Albertson's participation an amount more than twice the MNIL

cap of \$733. Under Medicaid rules, deductions from participation are limited to the MNIL cap. The superior court's order is contrary to law.

Once DSHS determines what income is available to a Medicaid client, it calculates her participation towards the cost of skilled nursing care. Participation is calculated by reducing available income by the four exclusions set forth in WAC 182-513-1380(4), i.e. the monthly personal needs allowance, taxes, certain wages, and guardian fees. The combined total of these allocations cannot exceed the federally mandated one-person medically needy income level, or MNIL, which is currently set at \$733. WAC 182-513-1380(4); CP at 276. Applying this rule to Ms. Albertson, she has \$675.72 in available income to pay guardian fees and costs after deduction of the PNA of \$57.28.

Here, the superior court ordered that the \$1,509.21 monthly payment for accrued fees plus the \$350 advance for future fees be excluded from income by DSHS before calculation of Ms. Albertson's participation. CP at 15. The order presents two problems. First, under WAC 182-513-1380, fees are excluded from income as part of the process of calculating participation, not prior to that calculation. The superior court's order requires DSHS to reverse that process and to violate the rule.

Second, the resulting total of \$1,859.21 per month is two-and-a-half times the \$733 cap imposed by state and federal rules and regulations. As summarized below, the increase in expenditure of public funds under the Superior Court's order is striking.

	<u>By Rule</u>	<u>By Order</u>
Income:	\$1,922.00	\$1,922.00
PNA:	- 57.28	- 57.28
Guardian Fees:	<u>- 675.72</u>	<u>1,859.21</u>
Participation:	\$1,189.00	\$5.51

Under the superior court's order, \$1,183.49 in additional taxpayer dollars must be expended each month to pay for the costs of Ms. Albertson's care, dollars that would not be spent if the State were allowed to apply its Medicaid rules. Because this amount exceeds the MNIL cap set forth in the Medicaid State Plan and WAC 182-513-1380(4), the State cannot seek federal reimbursement for these funds. The result is an increased expenditure of state taxpayer dollars.

The Superior Court's order subverts the two policy rationales for the Legislature's 1994 amendment to RCW 11.92.180: the need to comply with federal Medicaid requirements, and the need to cap escalating guardian fees in Medicaid cases. *See* Final B. Rep. on S.B. 6604, 53rd Leg., Reg. Sess. (Wash. 1994). CP at 217. The Superior Court's order also subverts the separate mandate in RCW 11.92.180 that guardians cannot be compensated at state expense. Deductions from

participation beyond the MNIL are not allowable Medicaid expenditures and are not eligible for federal reimbursement. Under the superior court's order, DSHS must use state taxpayer dollars to offset the income diverted to pay fees. In essence, the State is subsidizing the Guardian's compensation.

Further, by specifically mandating how the State must calculate participation, the superior court essentially assumed the task of administering the Medicaid program for Ms. Albertson. In doing so, it directed the State to treat Ms. Albertson differently than other Medicaid recipients similarly situated. Medicaid laws require that similarly situated persons be treated equally, and that the assistance provided to any one individual not be less in amount, duration, or scope than the assistance provided to other individuals. 42 U.S.C. § 1396a(10)(B)(i); 42 C.F.R. § 40.240(b); *See also Samantha A.*, 171 Wn.2d at 630. By intruding upon the authority delegated to DSHS by the Legislature, and by limiting the State's ability to administer the Medicaid program for Ms. Albertson in compliance with federal and state requirements, the superior court impaired the State's ability to secure federal funding for Ms. Albertson.

The superior court lacked authority to order the payment of guardian fees and costs in a manner that violates state and federal

Medicaid regulations. The order approving fees and costs should be reversed.

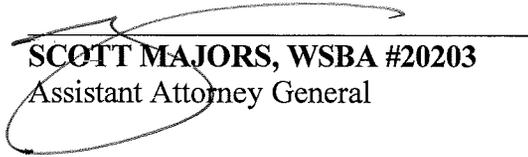
VII. CONCLUSION

The superior court abused its discretion when it approved Charge d’Affaires’ requested guardian and attorney’s fees. It did not follow the clear mandate of RCW 11.92.180 that fees and costs in Medicaid cases be limited to the maximum set by DSHS rule. It adopted an interpretation of Chapter 388-79 WAC advanced by the Guardian that rendered the substantive portions of the rule superfluous and meaningless. Further, the limited findings made by the superior court do not support the amount of fees and costs it approved.

The superior court further erred when it ordered the payment of fees and costs in a manner that impairs the State’s ability to comply with federal Medicaid regulations, Washington’s Medicaid State Plan, and Washington law. In doing so, the court impaired the State’s ability to secure federal Medicaid funds to pay for the cost of Ms. Albertson’s care. It also negated the Legislature’s delegation of authority to DSHS and HCA to not only administer Washington’s Medicaid program, but to do so in a manner that complies with federal regulations in order to maximize the receipt of federal funding. The superior court’s order approving guardian and attorney fees and costs should be reversed.

RESPECTFULLY SUBMITTED this 1st day of September,
2016.

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APPENDIX A

WAC 182-513-1100

NEW SECTION

WAC 182-513-1100 Definitions related to long-term services and supports (LTSS) .

This section defines the meaning of certain terms used in chapters 182-513, 182-514, and 182-515 WAC. Within these chapters, institutional, home and community based (HCB) waiver, program of all-inclusive care for the elderly (PACE), and hospice in a medical institution are referred to collectively as long-term care (LTC). Long-term services and supports (LTSS) is a broader definition which includes institutional, HCB waiver, and other services such as medicaid personal care (MPC), community first choice (CFC), PACE, and hospice in the community. Additional medical definitions can be found in chapter 182-500 WAC.

"Adequate consideration" means the reasonable value of the goods or services received in exchange for transferred property that approximates the reasonable value of the property transferred.

"Agency" means the Washington state health care authority and includes the agency's designee.

"Aging and long-term support administration (AL TSA)" means the administration by that name within the Washington state department of social and health services (DSHS).

"Alternate living facility (ALF)" is not an institution under WAC 182-500-0050; it is one of the following community residential facilities:

(a) An adult family home (AFH) licensed under chapter 70.128 RCW.

(b) An adult residential care facility (ARC) licensed under chapter 18.20 RCW.

(c) An adult residential rehabilitation center (ARRC) described in WAC 388-865-0235.

(d) An assisted living facility (AL) licensed under chapter 18.20 RCW.

(e) A developmental disabilities administration (DDA) group home (GH) licensed as an adult family home under chapter 70.128 RCW or an assisted living facility under chapter 18.20 RCW.

(f) An enhanced adult residential care facility (EARC) licensed as an assisted living facility under chapter 18.20 RCW.

(g) An enhanced service facility (ESF) licensed under chapter 70.97 RCW.

"Authorization date" means the date payment begins for long-term services and supports (LTSS) described in WAC 388-106-0045.

"Comprehensive assessment reporting evaluation (CARE) assessment" means the evaluation process defined in chapter 388-106 WAC used by a department designated social services worker or a case manager to determine a person's need for long-term services and supports (LTSS).

"Clothing and personal incidentals (CPI)" means the cash payment (described in WAC 388-478-0090, 388-478-0006, and 388-478-0033) issued by the department for clothing and personal items for people living in an ALF or medical institution.

"Community first choice (CFC)" means a medicaid state plan home and community based service developed under the authority of section 1915(k) of the Social Security Act and described in chapter 388-106 WAC.

"Community options program entry system (COPES)" means a medicaid HCB waiver program developed under the authority of section 1915(c) of the Social Security Act described in chapter 388-106 WAC.

"Community spouse (CS)" means the spouse of an institutionalized spouse.

"Community spouse resource allocation (CSRA)" means the resource amount that may be transferred without penalty from:

(a) The institutionalized spouse (IS) to the community spouse (CS); or

(b) The spousal impoverishment protection institutionalized (SIPI) spouse to the spousal impoverishment protection community (SIPC) spouse.

"Community spouse resource evaluation" means the calculation of the total value of the resources owned by a married couple on the first day of the first month of the institutionalized spouse's most recent institutionalization.

"Developmental disabilities administration (DDA) home and community based (HCB) waiver" means a medicaid HCB waiver program developed under the authority of section 1915(c) of the Social Security Act described in chapter 388-845 WAC authorized by DDA.

"Dependent" means an adult child, a parent, or a sibling meeting the definition of a tax dependent under WAC 182-500-0105; or a minor child.

"Developmental disabilities administration (DDA)" means an administration within the Washington state department of social and health services (DSHS).

"Equity" means the fair market value of real or personal property less any encumbrances (mortgages, liens, or judgments) on the property.

"Fair market value (FMV)" means the price an asset may reasonably be expected to sell for on the open market at the time of transfer or assignment.

"Home and community based services (HCBS)" means LTSS provided in the home or a residential setting to persons assessed by the department.

"Home and community based (HCB) waiver programs" means programs authorized under Section 1915(c) of the Social Security Act. The waiver authority enables states to waive federal medicaid requirements to provide LTSS to medicaid beneficiaries who would otherwise require the level of care provided in a hospital, nursing facility, or intermediate care facility for the intellectually disabled (ICF-ID).

"Institutionalized individual" means a person who has attained institutional status under WAC 182-513-1320.

"Institutional services" means services paid for by Washington apple health, and provided:

- (a) In a medical institution;
- (b) Through a home and community based (HCB) waiver;

or

(c) Through programs based on HCB waiver rules for post-eligibility treatment of income described in chapter 182-515 WAC.

"Institutionalized spouse" means a person who, regardless of legal or physical separation:

- (a) Has attained institutional status under WAC 182-513-1320; and
- (b) Is legally married to a person who is not in a medical institution.

"Likely to reside" means the agency reasonably expects a person will remain in a medical institution for thirty consecutive days. Once made, the determination stands, even if the person does not actually remain in the facility for that length of time.

"Long-term care services" see "Institutional services."

"Long-term services and supports" includes institutional and noninstitutional services authorized by AL TSA and DDA.

"Look-back period" means the number of months prior to the month of application that the agency will consider transfers of assets for programs subject to transfer of asset penalties.

"Medicaid personal care (MPC)" means a medicaid state plan program authorized under RCW 74.09.520.

"Most recent continuous period of institutionalization (MRCPI)" means the current period an institutionalized

spouse has maintained uninterrupted institutional status when the request for a community spouse resource evaluation is made. Institutional status is described in WAC 182-513-1320.

"Noninstitutional medical assistance" means any Washington apple health medical programs not based on HCB waiver rules in chapter 182-515 WAC, or rules based on residing in an institution thirty days or more.

"Nursing facility level of care (NFLOC)" is described in WAC 388-106-0355.

"Participation" means the amount a person must pay each month toward the cost of long-term care services they receive each month; it is the amount remaining after the post-eligibility process in WAC 182-513-1380, 182-515-1509, and 182-515-1514.

"Penalty period" means the period of time during which a person is not eligible to receive services subject to transfer of asset penalties.

"Personal needs allowance (PNA)" means an amount set aside from a person's income that is intended for clothing and other personal needs. The amount a person is allowed to keep as a PNA depends on whether the person lives in a medical institution, alternate living facility, or at home. Personal needs allowances are found at:
<http://hca.wa.gov/medicaid/eligibility/pages/standards.aspx>

"Residential support waiver (RSW)" means a 1915(c) medicaid waiver program authorized under RCW 74.39A.030. Persons eligible for this program may receive long-term care services in a licensed adult family home with a contract to provide specialized behavior services.

"Short stay" means residing in a medical institution for a period of twenty-nine days or less.

"Special income level (SIL)" means the monthly income standard for the categorically needy (CN) program that is three hundred percent of the SSI federal benefit rate (FBR).

"Spousal impoverishment" means financial provisions within Section 1924 of the Social Security Act that protect income and assets of the community spouse through income and resource allocation. The spousal allocation process is used to discourage the impoverishment of a spouse due to the need for LTSS by their spouse. This includes services provided in a medical institution, HCB waivers authorized under 1915(c) of the Social Security Act, and through December 31, 2018, services authorized under 1915 (i) and (k) of the Social Security Act.

"Spousal impoverishment protections institutionalized (SIPI) spouse" means a legally married person who only qualifies for the noninstitutional categorically needy (CN) Washington apple health SSI-related program because of the spousal impoverishment protections in WAC 182-513-1220.

"Spousal impoverishment protections community (SIPC) spouse" means the spouse of a SIPI spouse.

"State spousal resource standard" means minimum resource standard allowed for a community spouse.

"Third-party resource (TPR)" means funds paid to a person by a third party where the purpose of the funds is for payment of activities of daily living, medical services, or personal care. Third-party resources are described under WAC 182-501-0200.

"Transfer of a resource" or "transfer of an asset" means changing ownership or title of an asset such as income, real property, or personal property by one of the following:

(a) An intentional act that changes ownership or title; or

(b) A failure to act that results in a change of ownership or title.

"Transfer date for real property" or "transfer date of interest in real property" means:

(a) The date of transfer for real property is the day the deed is signed by the grantor if the deed is recorded; or

(b) The date of transfer for real property is the day the signed deed is delivered to the grantee.

"Transfer month" means the calendar month in which resources are legally transferred.

"Uncompensated value" means the fair market value (FMV) of an asset at the time of transfer minus the value of compensation the person receives in exchange for the asset.

"Undue hardship" means a person is not able to meet shelter, food, clothing, or health needs. A person may apply for an undue hardship waiver based on criteria described in WAC 182-513-1367.

"Value of compensation received" means the consideration the purchaser pays or agrees to pay. Compensation includes:

(a) All money, real or personal property, food, shelter, or services the person receives under a legally enforceable purchase agreement whereby the person transfers the asset; and

(b) The payment or assumption of a legal debt the seller owes in exchange for the asset.

"Veterans benefits" means different types of benefits paid by the federal department of veterans affairs (VA). Some may include additional allowances for:

(a) Aid and attendance for a person needing regular help from another person with the activities of daily living;

(b) A person who is housebound;

(c) Improved pension, the newest type of VA disability pension, available to veterans and their survivors whose income from other sources, including service connected disability, is below the improved pension amount;

(d) Unusual medical expenses (UME), determined by the VA based on the amount of unreimbursed medical expenses reported by the person who receives a needs-based benefit. The VA can use UME to reduce countable income to allow the person to receive a higher monthly VA payment, a one-time adjustment payment, or both;

(e) Dependent allowance veteran's payments made to, or on behalf of, spouses of veterans or children regardless of their ages or marital status. Any portion of a veteran's payment that is designated as the dependent's income is countable income to the dependent; or

(f) Special monthly compensation (SMC). Extra benefit paid to a veteran in addition to the regular disability compensation to a veteran who, as a result of military service, incurred the loss or loss of use of specific organs or extremities.

"Waiver programs/services" means programs for which the federal government authorizes exceptions to federal medicaid rules. In Washington state, home and community based (HCB) waiver programs are authorized by the developmental disabilities administration (DDA), or home and community services (HCS).

APPENDIX B

WAC 182-513-1380

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1380 Determining a ~~((client's))~~ person's financial participation in the cost of care for long-term care (LTC) services.

This rule describes how the ~~((department))~~ agency allocates income and excess resources when determining participation in the cost of care (the post-eligibility process). The ~~((department))~~ agency applies rules described in WAC ~~((388-513-1315))~~ 182-513-1315 to define which income and resources must be used in this process.

(1) For a ~~((client))~~ person receiving institutional or hospice services in a medical institution, the ~~((department))~~ agency applies all subsections of this rule.

(2) For a ~~((client))~~ person receiving waiver services at home or in an alternate living facility, the ~~((department))~~ agency applies only those subsections of this rule that are cited in the rules for those programs.

(3) For a ~~((client))~~ person receiving hospice services at home, or in an alternate living facility, the ~~((department))~~ agency applies rules used for the community options program entry system (COPES) for hospice applicants with gross income under the medicaid special income level (SIL) (three hundred percent of the federal benefit rate (FBR)), if the ~~((client))~~ person is not otherwise eligible for another noninstitutional categorically needy medicaid program. (Note: For hospice applicants with income over the medicaid SIL, medically needy medicaid rules apply.)

(4) The ~~((department))~~ agency allocates nonexcluded income in the following order and the combined total of ~~((4))~~ (a), (b), (c), and (d) of this subsection cannot exceed the effective one-person medically needy income level (MNIL):

(a) A personal needs allowance (PNA) of:

(i) Seventy dollars for the following ~~((clients))~~ people who live in a state veteran's home and receive a needs based veteran's pension in excess of ninety dollars:

(A) A veteran without a spouse or dependent child.

(B) A veteran's surviving spouse with no dependent children.

(ii) The difference between one hundred sixty dollars and the needs based veteran's pension amount for persons specified in ~~((subsection 4))~~ (a)(i) of this ~~((section))~~ subsection who receive a veteran's pension less than ninety dollars.

(iii) One hundred sixty dollars for a ~~((client))~~ person living in a state veterans' home who does not receive a needs based veteran's pension;

(iv) Forty-one dollars and sixty-two cents for all ~~((clients))~~ people in a medical institution receiving aged, blind, disabled, (ABD) or temporary assistance for needy families (TANF) cash assistance.

(v) For all other ~~((clients))~~ people in a medical institution the PNA is fifty-seven dollars and twenty-eight cents.

(vi) Current PNA and long-term care standards can be found at
(<http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml>)
<http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx>

(b) Mandatory federal, state, or local income taxes owed by the ~~((client))~~ person.

(c) Wages for a ~~((client))~~ person who:

(i) Is related to the supplemental security income (SSI) program as described in WAC 182-512-0050(1); and

(ii) Receives the wages as part of ~~((a department-approved))~~ an agency-approved training or rehabilitative program designed to prepare the ~~((client))~~ person for a less restrictive placement. When determining this deduction employment expenses are not deducted.

(d) Guardianship fees and administrative costs including any attorney fees paid by the guardian, after June 15, 1998, only as allowed by chapter 388-79 WAC.

(5) The ~~((department))~~ agency allocates nonexcluded income after deducting amounts described in subsection (4) of this section in the following order:

(a) Current or back child support garnished or withheld from income according to a child support order in the month of the garnishment if it is for the current month:

(i) For the time period covered by the PNA; and

(ii) Is not counted as the dependent member's income when determining the family allocation amount.

(b) A monthly maintenance needs allowance for the community spouse not to exceed, effective January 1, 2008, two thousand six hundred ten dollars, unless a greater amount is allocated as described in subsection (7) of this section. The community spouse maintenance allowance may change each January based on the consumer price index. Starting January 1, 2008, and each year thereafter the community spouse maintenance allocation can be found in the

long-term care standards chart at
(<http://www1.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml>)

<http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx>

. The monthly maintenance needs allowance:

(i) Consists of a combined total of both:

(A) One hundred fifty percent of the two-person federal poverty level. This standard may change annually on July 1st; and

(B) Excess shelter expenses as described under subsection (6) of this section.

(ii) Is reduced by the community spouse's gross countable income; and

(iii) Is allowed only to the extent the ~~((client's))~~ person's income is made available to the community spouse.

(c) A monthly maintenance needs amount for each minor or dependent child, dependent parent or dependent sibling of the community spouse or institutionalized person who:

(i) Resides with the community spouse: ~~((A))~~ For each child, one hundred and fifty percent of the two-person FPL minus that child's income and divided by three (child support received from a noncustodial parent is considered the child's income). This standard is called the community spouse (CS) and family maintenance standard and can be found at:

(<http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml>)

<http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx>

(ii) Does not reside with the community spouse or institutionalized person, in an amount equal to the effective one-person MNIL for the number of dependent family members in the home less the dependent family member's income.

(iii) Child support received from a noncustodial parent is the child's income.

(d) Medical expenses incurred by the ~~((institutional client))~~ institutionalized individual and not used to reduce excess resources. Allowable medical expenses and reducing excess resources are described in WAC ~~((388-513-1350))~~ 182-513-1350.

(e) Maintenance of the home of a single institutionalized ~~((client))~~ person or institutionalized couple:

(i) Up to one hundred percent of the one-person federal poverty level per month;

(ii) Limited to a six-month period;

(iii) When a physician has certified that the client is likely to return to the home within the six-month period; and

(iv) When social services staff documents the need for the income exemption.

~~(6) ((For the purposes of this section, "excess shelter expenses" means the actual expenses under subsection (6) (b) less the standard shelter allocation under subsection (6) (a). For the purposes of this rule:~~

~~(a) The standard shelter allocation is based on thirty percent of one hundred fifty percent of the two person federal poverty level. This standard may change annually on July 1st and is found at:~~

~~http://www.dshs.wa.gov/manuals/ez/sections/LongTermCare/LT_Cstandardspna.shtml; and~~

~~(b) Shelter expenses are the actual required maintenance expenses for the community spouse's principal residence for:~~

~~(i) Rent;~~

~~(ii) Mortgage;~~

~~(iii) Taxes and insurance;~~

~~(iv) Any maintenance care for a condominium or cooperative; and~~

~~(v) The food stamp standard utility allowance described in WAC 388-450-0195, provided the utilities are not included in the maintenance charges for a condominium or cooperative.~~

~~(7) The amount allocated to the community spouse may be greater than the amount in subsection (6) (b) only when:~~

~~(a) A court enters an order against the client for the support of the community spouse; or~~

~~(b) A hearings officer determines a greater amount is needed because of exceptional circumstances resulting in extreme financial duress.~~

~~(8)) A ((client)) person who is admitted to a medical facility for ninety days or less and continues to receive full SSI benefits is not required to use the SSI income in the cost of care for medical services. Income allocations are allowed as described in this section from non-SSI income.~~

(7) A person may have to pay third-party resources described in WAC 182-501-0200 in addition to the participation.

(8) A person is only responsible to participate up to the state rate for cost of care. If long-term care insurance pays a portion of the state rate cost of care, a

person only participates the difference up to the state rate cost of care.

(9) Standards described in this section for long-term care can be found at:

((~~<http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml>~~))

<http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx>

**COURT OF APPEALS, DIVISION I
OF THE STATE OF WASHINGTON**

In re the Guardianship of:
MARILYN ALBERTSON

STATE OF WASHINGTON,
DEPARTMENT OF SOCIAL AND
HEALTH SERVICES,

Petitioner,

v.
CHARGE d' AFFAIRES, Guardian of
the Estate, and KIRSTEN MURRY,
Guardian of the Person,

Respondents.

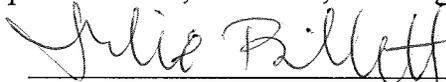
NO. 74763-1

DECLARATION OF
SERVICE

I, Julie Billett, declare that I electronically filed Petitioner's Opening Brief; and served Peter Andrus, Attorney for Charge D'Affaires, Guardian Assoc., Inc., Guardian of the Estate of Marilyn Albertson; and M. Geoffrey G. Jones, Attorney for Respondent Kirsten Murry, Guardian of the Person of Marilyn Albertson, by ABC Legal Messenger.

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

Dated this 15th day of September 2016, in Everett, Washington.


Julie Billett