The Honorable Thomas S. Zilly

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

M.R., et al., Plaintiffs, v. SUSAN DREYFUS, et al., Defendants.	NO. C10-2052-TSZ DEFENDANTS' MOTION FOR PARTIAL SUMMARY JUDGMENT ON DUE PROCESS CLAIMS NOTE ON MOTION CALENDAR: June 14, 2013

I. INTRODUCTION

Plaintiffs' first cause of action is a claim that Defendants violated the due process rights of Medicaid beneficiaries. First, Plaintiffs claim that they—along with each of the other 45,000 recipients of in-home personal care services in the State of Washington—had the right to individual, pre-deprivation administrative hearings to challenge a system-wide reduction in benefits in January 2011. The reduction at issue was a mass change that took effect automatically by operation of law. Neither the Constitution nor the Medicaid Act require a State to provide individual hearings prior to implementing a mass change to public benefits.

Second, Plaintiffs claim that they received inadequate notice of the reduction, either because the notice did not include information about certain administrative processes not directly related to the reduction at issue—namely exceptions to rule and significant change

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assessments—or because the notice failed to include information about alternative, out-of-home placements. The notice sent to Plaintiffs prior to the January 2011 reductions accurately described the reduction at issue. There is no legal basis for Plaintiffs' claim that additional details about Defendants' programs and policies should have been included. Moreover, through individual notices and the promulgation of public rules, Defendants have provided Plaintiffs with ample notice of the many Medicaid and non-Medicaid programs they may qualify for in addition to or instead of in-home personal care services. Plaintiffs' due process claims should be dismissed as a matter of law.

II. PROCEDURAL HISTORY

Facing severe budget shortfalls in late 2010, the state Department of Social and Health Services (DSHS) and its then-Secretary Susan Dreyfus announced reductions to the services that would be authorized through the Medicaid in-home personal care benefit. The reduction was to take effect on January 1, 2011. Plaintiffs filed suit on December 21, 2010, and moved for a temporary restraining order and preliminary injunction. Dkt. 11. This Court denied the motion for temporary restraining order and deferred the motion for preliminary injunction pending oral argument. Dkt. 73. Plaintiffs immediately appealed the denial of the restraining order to the Ninth Circuit, which issued an order staying the reductions until this Court could rule on the motion for preliminary injunction. Dkt. 86-1. Following further briefing and oral argument, this Court denied the motion for preliminary injunction. Dkt. 171. Among other things, the Court held that Plaintiffs were not likely to succeed on the merits of their due process claim. Dkt. 171, at 33 ("Plaintiffs are not entitled to notice or hearing rights for an across-the-board budget reduction").

Plaintiffs appealed the preliminary injunction denial to the Ninth Circuit. Their request for emergency stay was denied. Dkt. 186. In an Opinion issued on December 16, 2011, a divided Ninth Circuit panel reversed this Court's order, and the reduction was preliminarily enjoined as to the named Plaintiffs. Dkt. 216. Both parties subsequently petitioned the Ninth

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Circuit for a panel rehearing; Defendants also petitioned for rehearing en banc. All petitions were denied, though nine judges would have taken the case en banc and affirmed this Court's denial of preliminary injunction. Dkt. 234. The panel Opinion was slightly amended, and the mandate issued on June 18, 2012. Dkt. 235.

The panel Opinion addressed only one of Plaintiffs' claims, ruling that Plaintiffs have raised serious questions going to the merits of their claim that the reduction of in-home personal care services violates the Americans with Disabilities Act. While Plaintiffs' due process and Medicaid claims were briefed and argued at length, the Ninth Circuit did not reach those issues. Defendants' present motion addresses only the due process claim.[1]

III. FACTS

This case involves a challenge to a reduction in the amount of paid personal care services the Washington State Department of Social and Health Services (DSHS) authorizes for Medicaid-eligible individuals who live in their own homes.[2] Personal care services are an optional category of "medical assistance" that states may choose to provide under the federal Medicaid Act. 42 U.S.C. § 1396d(a)(24); 42 U.S.C. § 1396a(a)(10)(A). Personal care includes "a range of human assistance provided to persons with disabilities and chronic conditions of all ages which enables them to accomplish tasks that they would normally do for themselves if they did not have a disability." Centers for Medicare and Medicaid Services (CMS),

[1] Plaintiffs' Second Amended Complaint includes eight causes of action. For summary judgment purposes Defendants plan to address the claims in three sets. In this first motion for partial summary judgment, Defendants address the due process claim. Next, Defendants will address most of Plaintiffs' causes of action involving the federal Medicaid Act: the "reasonable standards," "comparability," "CMS approval," and "freedom to choose" claims. Finally, and depending in part on aggregate data about the putative class expected to be available by June 1, 2013, Defendants expect to file for summary judgment on the more fact-intensive Medicaid "sufficiency" claim, the Americans with Disabilities Act claim, and the Rehabilitation Act claim.

[2] For a more extensive discussion of the background of this case, see Defendant's Response to Plaintiffs' Motion for Preliminary Injunction, Dkt. 123, at 5-10 (discussing Washington's Medicaid program, the CARE assessment process, and the executive decision that initiated the state's action at issue) and Defendants' Response to Plaintiffs' Motion for Temporary Restraining Order, Dkt. 66, at 4-6 (discussing the function and content of Washington's Medicaid state plan).

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U.S. Dep't of Health & Human Servs., Pub. No. 45, *State Medicaid Manual,* § 4480.[3] Personal care tasks include both "activities of daily living" such as eating, bathing, dressing, and toileting; and "instrumental activities" such as food preparation, housekeeping, essential shopping, and telephone use. *Id.*; Wash. Admin. Code § 388-106-0010. In its State Plan negotiated with the federal Medicaid agency, DSHS has chosen to provide personal care services to qualifying Medicaid recipients. Dkt. 13-1, at 6.

Under state law, DSHS is required to "assess the level of functional disability of persons eligible for personal care services" and provide services "to the extent funding is available according to the assessed level of functional disability." Wash. Rev. Code § 74.09.520(3). To implement that requirement, DSHS developed a uniform system for assessing a person's level of functional disability, known as the Comprehensive Assessment Reporting Evaluation (CARE). Wash. Admin. Code § 388-106-0065. CARE was adopted in 2003. Wash. St. Reg. 03-05-097 (Feb. 19, 2003).

The CARE assessment is an interview conducted in the recipient's home. CARE uses the answers given by the recipient or other respondents to measure the recipient's ability to self-perform each activity of daily living and each instrumental activity. Wash. Admin. Code § 388-106-0075. CARE also measures the recipient's cognitive performance, clinical complexity, and mood and behaviors. Wash. Admin. Code § 388-106-0085. Based on those results, CARE assigns each recipient to one of 17 classification groups with other individuals with similar levels of disability. Each classification group is assigned a number of "base

[3] According to its Foreword, the *State Medicaid Manual* "is an official medium by which [CMS] issues mandatory, advisory, and optional Medicaid policies and procedures to the Medicaid State agencies." It is published online at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html as publication number 45. "Courts have accorded CMS' interpretations of the Medicaid Act, such as that found in the *State Medicaid Manual,* 'respectful consideration' based on the agency's expertise, the statute's complexity and technical nature, and the broad authority delegated to the Secretary of Health and Human Services under the [Medicaid] Act." *Katie A., ex. rel. Ludin v. Los Angeles County*, 481 F.3d 1150, 1155 n.11 (9th Cir. 2007) (citations omitted).

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hours" of personal care per person. Wash. Admin. Code §§ 388-106-0080, -0125. Prior to the reduction at issue, base hours for adults ranged from 27 to 420 hours per month. Wash. St. Reg. 10-14-055 (June 30, 2010).[4]

To determine an individual recipient's service authorization, CARE multiplies base hours by a percentage representing the amount of time that unpaid "informal supports" such as family or friends are available to assist the recipient. Wash. Admin. Code § 388-106-0130. Extra "add-on" hours will be awarded in certain circumstances, such as if laundry equipment is off-site or if the recipient's home is heated only by firewood. Wash. Admin. Code § 388-106-0130(3), *as amended*, Wash. St. Reg. 13-06-006 (recodifying from subsection (4)). Like the initial assignment to a classification group, the post-classification adjustments are based on information collected in the CARE assessment.[5]

Due to a severe budget crisis in 2010, Governor Christine Gregoire ordered an across-the-board 6.287% reduction in spending for all state agencies. Dkt. 12-7, at 2-6; *see* Wash. Rev. Code § 43.88.110(7) (requiring the governor to make "across-the-board reductions in allotments" if a cash deficit is projected during a biennial fiscal period). DSHS determined that Medicaid personal care services was one of the programs that could undergo modest reductions without creating significant hardships for recipients. *E.g.*, Dkt. 124, at 2-3. State law specifically contemplated the possibility of funding changes to the personal care program, requiring DSHS to make any reductions "in a manner that assures that priority for maintaining services is given to persons with the greatest need as determined by" the CARE assessment. Wash. Rev. Code § 74.09.520(3).

[4] The base hours implemented in 2005 were adjusted in 2007 by adding additional classification groups and increasing base hours for some groups. Wash. St. Reg. 07-18-057 (Aug. 31, 2007). Prior to the reductions in January 2011, base hours were reduced in July 2009, Wash. St. Reg. 09-14-046 (June 24, 2009); and increased in July 2010. Wash. St. Reg. 10-14-055 (June 30, 2010).

[5] For participants in the New Freedom waiver program, personal care services are authorized in the form of dollars per month rather than hours per month. An individual's budget is based on the hours determined under the CARE formula multiplied by the rate paid to personal care providers. Wash. Admin. Code § 388-106-1445.

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DSHS made an emergency amendment to the regulation assigning base hours to each CARE classification group. Wash. St. Reg. 11-02-041 (Dec. 30, 2010).[6] The amendment, effective January 1, 2011, reduced base hours by an average of ten percent, with smaller percentage reductions for the groups representing the highest levels of functional disability. DSHS implemented the reductions based on the same classification group and post-classification adjustments determined by each recipient's most recent finalized CARE assessment, but re-calculating authorized hours using the new base hours. 5th McNeill Decl. ¶ 9; Cool Decl. ¶ 5.

Prior to the reduction, DSHS sent written notice to all personal care recipients and their paid care providers explaining how the reduction would affect them individually. Dkt. 12-2, 12-3, 12-4, 12-5. Each letter explained the reason for the reduction and the specific change for each recipient. *Id.* The letters to recipients noted that there was no administrative appeal right to contest the program-wide change, and that the recipient's case manager could be contacted if the recipient had questions or concerns. Dkt. 12-2, 12-5. However, DSHS regulations state that a recipient's current assessment will be modified or a reassessment conducted where a recipient's situation changes significantly between annual assessments. Wash. Admin. Code §§ 388-106-0050(1) (reassessment where there are significant changes to a person's ability to care for himself or herself), -0050(2) (modified assessment where, *inter alia*, there are changes in the level of informal support available to the recipient).

IV. ARGUMENT

Plaintiffs allege that the January 2011 reductions violated their right to due process guaranteed by 42 U.S.C. § 1983 and the Fourteenth Amendment, and by the Medicaid Act. They specifically allege that DSHS's notice to recipients regarding the reductions was untimely, inaccurate and misleading; that DSHS failed to transition recipients to adequate

[6] The reduction was ratified by the legislature prior to the new base hours taking effect. Dkt. 47-4, ¶ 5; *see* 2010-11 Wash. Sess. Laws page nos. 21-35 (2d Spec. Sess., ch. 1 §§ 203-205) (amendments to state operating budget effective Dec. 11, 2010).

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replacement services; that DSHS reduced personal care services without conducting reassessments; and that DSHS failed to provide pre-reduction administrative hearings to each recipient. Second Amended Complaint at ¶ 5.1.4 (Dkt. 188-1, at 51). Because the DSHS notices were constitutionally adequate and met the relevant Medicaid requirements, Plaintiffs' due process claim should be dismissed as a matter of law.

A. Summary Judgment Standard

The purpose of summary judgment is to avoid unnecessary trials when there is no dispute as to the material facts before the court. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 251 (1986). Judgment in favor of the moving party is appropriate when, viewing the evidence and inferences arising from there in the light most favorable to the nonmoving party, there are no genuine issues of material fact in dispute and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c); *Semegen v. Weidner*, 780 F.2d 727 (9th Cir. 1985); *Burlington N. R.R. Co. v. Time Oil Co.*, 738 F. Supp. 1339 (W.D. Wash. 1990). The party seeking summary judgment bears the initial burden of demonstrating the absence of a genuine issue of material fact. *Celotex Corp. v. Catrett*, 477 U.S. 317 (1986). The moving party need not negate elements of the opposing party's case. *Lujan v. Nat'l Wildlife Fed'n*, 497 U.S. 871 (1990). Once the moving party has met its burden, the non-moving party must then produce concrete evidence, without merely relying on allegations in the pleadings, that there remain genuine factual issues. *Anderson*, 477 U.S. at 248.

B. Medicaid Recipients Have No Right To Administrative Hearings To Challenge Legal Amendments That Result In A Mass Change To Benefits

1. Constitutional due process does not require individual hearings when a change to the law results in a mass change to benefits.

The U.S. Constitution provides that no State shall "deprive any person of . . . property, without due process of law[.]" U.S. Const. amend. XIV, § 1. Because the receipt of public benefits such as Medicaid services constitutes a property interest, a recipient must generally have "timely and adequate notice detailing the reasons for a proposed termination" or

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reduction of services, and a chance to challenge the termination or reduction. *Goldberg v. Kelly*, 397 U.S. 254, 267-68 (1970). The Constitution requires individual hearings to contest government action where "[a] relatively small number of persons . . . [are] exceptionally affected, in each case upon individual grounds[.]" *Bi-Metallic Inv. Co. v. State Bd. of Equalization*, 239 U.S. 441, 446 (1915).

In contrast, no individual hearing is required where government action affects a large class of persons based on generally applicable grounds, even where the practical effect on the individual is the same. *Id.* at 445. Where the beneficiary's service levels are adjusted by legislative action rather than on an individual basis, "a welfare recipient is not deprived of due process" because "the legislative determination provides all the process that is due." *Logan v. Zimmerman Brush Co.*, 455 U.S. 422, 432 (1982). Similarly, where the legislature delegates power to an agency to promulgate law through quasi-legislative rulemaking, "due process ordinarily does not demand procedures more rigorous than those provided" in the statutes governing administrative procedure. *Ass'n of Nat'l Advertisers, Inc. v. FTC*, 627 F.2d 1151, 1165-66 (D.C. Cir. 1979), *cert. denied*, 447 U.S. 921 (1980). A hearing is therefore unnecessary when the reason for reduction to a service is a "mass change" to the laws governing the government program, as opposed to an "individual adverse action." *Atkins v. Parker*, 472 U.S. 115, 129-31 (1985).

The seminal "mass change" case, *Bi-Metallic*, is analogous. In that case, property taxes in Denver were increased by way of an order from the State Board of Equalization "increasing the valuation of all taxable property [by] 40 per cent." *Bi-Metallic*, 239 U.S. at 443. The plaintiff real estate owner brought suit on the grounds that due process required an individual right to be heard. *Id.* at 444. In rejecting that argument, the Supreme Court noted that all of the property in the county had already been assessed, and that any landowner whose "property has been valued at a rate different from that generally prevailing in the county . . . had his opportunity to protest and appeal" that previous property assessment. *Id. at 444*; *see*

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Londoner v. Denver, 210 U.S. 373, 385-86 (1908) (individual hearing right to contest initial property tax assessments). Because the percentage change was taken from facts already established individually and with a right to appeal, "it must be assumed that the property owners in the county all stand alike." *Bi-Metallic,* 239 U.S. at 444-45. The state Board's order thus could take effect automatically without individual hearings. *Id.* at 445. As the Court noted, "[t]here must be a limit to individual argument in such matters if government is to go on." *Id.*

Here, DSHS changed the base hours of personal care for all recipients. That change in the law reflected a legitimate exercise of legislative power by the Washington legislature. *See* 2010-11 Wash. Sess. Laws page nos. 21-35 (2d Spec. Sess., ch. 1, §§ 203-205) (ratifying DSHS's proposed reductions to the personal care budget). The reductions affected all recipients on the same generally-applicable grounds, namely by changing the base hours for each of the 17 classification groups. Like the property tax adjustment in *Bi-Metallic*, the base hour adjustment could be made automatically based on an assessment to which recipients had already been given a separate hearing right.

DSHS conducts individualized assessments annually for every recipient. Wash. Admin. Code § 388-106-0050(1). A recipient who was, for instance, found to need only limited assistance with eating could challenge that determination in a fair hearing. Wash. Admin. Code § 388-106-1305. If the recipient's eating needs significantly change between annual assessments, the recipient is entitled to a new in-person assessment, also subject to hearing rights. Wash. Admin. Code §§ 388-106-0050(1), -0140(1). An assessment can also be modified for a number of reasons—including to note changes to the recipient's informal supports—without requiring a full new assessment. Wash. Admin. Code § 388-106-0050(2).

But once the facts are determined through a CARE assessment—once DSHS has made factual findings regarding the recipient's cognitive performance, clinical complexity, mood and behaviors, self-performance of personal care tasks, and informal supports—the recipient's

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personal care hours flow as a matter of law. Changing the number of base hours associated with the classification groups does not require DSHS to make any new factual findings that would be subject to correction through a hearing process.

For instance, DSHS staff conducted an assessment for lead Plaintiff M.R. on June 14, 2010. Dkt. 26-1. Based on her functional disabilities DSHS found that she was properly classified in group D Medium-High, with no reduction for informal supports and no circumstances such as wood heating or off-site laundry that would result in add-on hours. *Id.* She did not appeal those findings. 5th McNeill Decl. ¶ 30. Under the 2010 base hours, M.R. thus qualified for 236 hours per month of personal care. *See* Wash. St. Reg. 10-14-055 (June 30, 2010) (increasing base hours effective July 1, 2010). Under the base hours effective January 2011, she had a right to 215 hours per month. *See* Wash. St. Reg. 11-02-041 (Dec. 30, 2010). Like most members of group D Medium-High, M.R.'s hours were thus reduced by 8.9%, rounded to the nearest hour.[7] Implementing that change did not require any additional fact-finding or discretion. It was a purely mechanical application of the new law to the established facts, implemented by reprogramming the CARE application. Cool Decl. ¶ 5. Like the percent change to property assessments in *Bi-Metallic*, applying the legal change to the established facts was a simple matter of multiplying the known number by a new percentage. Given that M.R. did not dispute her 2010 CARE assessment within the 90-day appeal deadline, when implementing the new base hours the state could validly rely on her classification group and other established details from that assessment.

On the other hand, Plaintiff S.J. *did* appeal her 2010 CARE assessment. McDonough Decl., Ex. A. After an evidentiary hearing and a second level of administrative review, the assessment was affirmed in a final order issued on December 3, 2010. *Id.* DSHS could validly rely on the facts established in that final order when it implemented the change to base hours

[7] The exception is those who receive add-on hours for circumstances such as off-site laundry or wood heating, or hours under an exception to rule. Unlike base hours, add-on hours and hours awarded as an exception to rule were not reduced by a percentage basis in January 2011.

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just weeks later.[8]

Put another way: in light of the mass change to personal care base hours, Plaintiffs have no continuing property interest in personal care services as calculated based on the pre-2011 base hours. Plaintiffs' right to receive personal care services is a creation of state law, and was explicitly subject to change based on funding levels. Wash. Rev. Code § 74.09.520(3) (noting that personal care services "shall be provided to the extent funding is available" and providing a method for implementing "reductions in services made necessary for funding reasons"). Plaintiffs have no "right to the maintenance of the same level of property entitlement" that they received prior to 2011 because the state retains the "power to substitute a different, less valuable entitlement at a later date." *Atkins*, 472 U.S. at 129 (so holding as to Congressional acts); *see also id.* at 147-48 (Brennan, J., dissenting) ("a welfare or utility service recipient whose entitlement *should* be reduced or terminated under relevant statutes can claim no valid interest in continuation"). DSHS's compliance with the legal procedures for agency rule-making provided Plaintiffs with all the process that was due.

2. The Medicaid hearing requirement does not apply when a State changes the regulations governing services for all recipients.

In order to qualify for federal Medicaid funding, a State must submit a plan that includes provisions "granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied[.]" 42 U.S.C. § 1396a(a)(3). Accordingly, federal regulations generally require a pre-deprivation hearing where a recipient "believes the agency has taken an action erroneously." 42 C.F.R. § 431.220(a)(2). However, no hearing is required "if the sole issue is a Federal or State law requiring an *automatic change* adversely affecting some or all recipients." 42 C.F.R. § 431.220(b) (emphasis added). Washington law similarly provides that individual recipients

[8] Those recipients whose most recent CARE assessments were not yet finalized due to a pending hearing as of January 2011 continued to receive benefits at the prior level until those claims were resolved. 5th McNeill Decl., Ex. D at 2.

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have no right to administrative hearings to challenge system-wide changes to public benefits programs. Wash. Rev. Code § 74.08.080(1)(b); Wash. Admin. Code § 388-418-0020(9).

Under the "automatic change" provision, a Medicaid hearing right attaches only to individual factual disputes. For instance, when Tennessee eliminated three of its seventeen Medicaid eligibility categories, the state was not required to provide hearings to all affected recipients. *Rosen v. Goetz*, 410 F.3d 919, 925-26 (6th Cir. 2005). The *Rosen* court rejected the idea that a state must provide *pro forma* hearings to those who disagreed with the change in policy, finding such "challenges to a State's legal or policy judgment" to be "impermissible" under 42 C.F.R. § 431.220(b). *Rosen*, 410 F.3d at 926; *see also Benton v. Rhodes*, 586 F.2d 1, 3 (6th Cir. 1978), *cert. denied sub. nom. Wisebaker v. Rhodes*, 440 U.S. 973 (1979) ("when a state decides to terminate optional [Medicaid] benefits on the basis of lack of appropriated funds . . . this is a matter of state law or policy" that is "not subject to any hearing requirements").

Rosen does differ from this case in a key respect: Tennessee could not implement its change automatically. While Tennessee's changes meant that many individuals would lose Medicaid coverage altogether, some individuals would still qualify under a different category with different eligibility criteria. As a result, the state asked affected recipients to complete a form and submit documents that might support continuing Medicaid eligibility under a different category. *Rosen,* 410 F.3d at 923. The new information and documents necessarily were considered on a case-by-case basis, with the potential for individual factual disputes that are properly the subject of individual administrative hearings. If a recipient was denied coverage under a different category of Medicaid coverage and raised a "valid factual dispute" about that coverage, the state would provide a hearing. *Id.* at 929; *see also Greene v. Babbitt*, 64 F.3d 1266, 1273 (9th Cir. 1995) (where Congress "narrowed eligibility" for a public benefits program by adding a new requirement, a hearing was required "to determine whether those previously eligible can meet the new and narrowed requirements").

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In contrast, DSHS required no new information to institute the reductions in this case. As illustrated above, implementing the new base hours rule involved simply inserting a new number into the existing equation, based on assessments to which recipients had a separate hearing right and which could be updated at any time to reflect significant changes. This case is therefore properly distinguished from those cases where a change in the law resulted in individual adverse actions based on *indeterminate* changes to individual benefits. Where a state issues Medicaid notices "not . . . to inform recipients of the reasons for their prior individualized coverage determinations, but only to inform those for whom such determinations have previously been made of changes to their programs," no individual hearing is required. *Wood v. Betlach*, __ F. Supp. 2d __, 2013 WL 474369, *16 (D. Ariz. 2013). The January 2011 amendment to base hours could be automatically implemented based on each recipient's previously-determined classification group, informal support multiplier, and add-on hours. DSHS was not required to offer pre-reduction individual hearings to all 45,000 recipients before implementing the automatic change.

3. Plaintiffs' proposed "cascading effects" exception to the mass change doctrine is unworkable and unsupported by law.

Plaintiffs have argued that a system-wide reduction to personal care services would create "cascading effects" of changes to the recipient's situation—thus requiring individual determination of these new, changed facts before the new law can take effect. Their proposed exception to the general mass change rule is unworkable, as well as inconsistent with case law.

Plaintiffs conflate changed circumstances with the types of factual disputes that give rise to a hearing right prior to implementation of a new law. Plaintiffs have failed to bring forward evidence that the 2011 reduction to personal care services triggered changes to the health, care needs, or informal supports of recipients. Even assuming for the sake of argument that those allegations were true, such changes are not disputes about pre-reduction facts that would prevent an automatic implementation of the new base hours. If an individual's care

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needs change significantly between assessments, DSHS will conduct an interim in-person CARE assessment. Wash. Admin. Code § 388-106-0050(1). If the individual's informal supports change, DSHS will modify the previous assessment without the requirement for another in-person visit. Wash. Admin. Code § 388-106-0050(2)(c). When an assessment is modified or an interim assessment conducted, the recipient has the right to an individual hearing to dispute DSHS's factual determinations. Wash. Admin. Code §§ 388-106-0050(3), -1305. But in those cases, the facts in dispute are those related to the interim or modified assessment, not any legal change that the recipient may allege was a precipitating factor.

Again, *Bi-Metallic* is instructive. The Supreme Court held that the plaintiff landowner had no right to an individual hearing to contest the state's valuation of its property when made as an across-the-board percentage increase from the prior assessed value. 239 U.S. at 445-46. Like any other fact, property values are subject to change over time. One might also expect that the tax rate on a property could have downstream effects on the property's value. Yet the Court was satisfied that due process was served by the state's reliance on the most recent property assessment. Whether the property right involved is real property or government benefits, once the relevant facts have been determined through appropriate process there is no need to revisit those facts before implementing across-the-board changes to the law. *See* Wash. Rev. Code § 74.08.080(2)(a) (public assistance benefits decisions become final if not appealed within 90 days); *Kingery v. Dep't of Labor & Indus.*, 132 Wn.2d 162, 169, 937 P.2d 565 (1997) ("An unappealed [agency] order is res judicata").

Moreover, the rule Plaintiffs propose is nonsensical when applied to the CARE tool. When DSHS conducts an assessment, the availability of informal supports factors into the hours of personal care that will be authorized: determining the unpaid assistance available is a necessary step toward determining the paid hours. Wash. Admin. Code § 388-106-0130(2). Plaintiffs' argument that informal supports must be measured after the authorized hours are known would thus set up a logical paradox: DSHS could not determine the service hours

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without measuring informal supports, yet could not determine informal supports without knowing how many hours would be authorized. That chicken-and-egg quandary is entirely unnecessary given the availability of modified assessments to account for post-assessment changes to informal supports. Until such a modification is requested, DSHS may validly rely on facts established at the prior CARE assessment.

C. DSHS Provided Plaintiffs With Adequate Notice Of The System-Wide Service Reduction

In addition to their claim that they should have been provided individual hearings prior to the reduced base hours taking effect, Plaintiffs claim that the notice they received was insufficient. Specifically, Plaintiffs have argued they should have been notified of DSHS's exception-to-rule process, the availability of significant change reassessments, and the availability of other Medicaid services including out-of-home placement. Dkt. 95, at 25-29. For the most part, those claims are disconnected from their protected property interest in personal care services as defined under Washington law. To the extent that their claims are linked to their actual protected interests, the notice was more than adequate.

1. DSHS met all Medicaid notice requirements.

a. The notice DSHS sent to Plaintiffs met the requirements of the Medicaid notice regulation.

Medicaid regulations require a participating state to provide notice to a recipient of "any action affecting his or her claim." 42 C.F.R. § 431.206(c)(2). The term "action" includes "a reduction of . . . covered services." 42 C.F.R. § 431.201. The notice must be sent at least ten days prior to the proposed action, *id.* at § 431.211, and must contain:

> (a) A statement of what action the State . . . intends to take;
> (b) The reasons for the intended action;
> (c) The specific regulations that support, or the change in Federal or State law that requires, the action;
> (d) An explanation of—
> (1) The individual's right to request an evidentiary hearing if one is available, or a State agency hearing; or

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> (2) In cases of an action based on a change in law, the circumstances under which a hearing will be granted; and
>
> (e) An explanation of the circumstances under which Medicaid is continued if a hearing is requested.

Id. at § 431.210. Notably, those regulations do not specifically require individualized reasons for the reduction. *See Rosen,* 410 F.3d at 931 (holding that Medicaid termination notices did not violate 42 C.F.R. § 431.210 or due process when they did not include "specific, individualized reasons supporting the agency's conclusions").

The notices sent by DSHS met or exceeded those required elements. They explained (a) the specific impact on each individual recipient, (b) the revenue shortfall prompting the reductions, (c) the Governor's order that supplied the legal basis for the mass change to the rules, (d) the fact that no individual evidentiary hearings were available to contest the change in law and thus (e) that no continuing benefits were available. *See* Dkt. 12-2 (notice to in-home personal care recipients including individual notice of new hours); Dkt. 12-4 (notice to New Freedom waiver recipients including individual notice of new personal care budget). The notices were mailed between December 7 and December 14, 2010, providing more than ten days' notice. 5th McNeill Decl. ¶ 13. The Medicaid notice requirement was fully met.

b. The Medicaid waiver "feasible alternatives" rule does not require a state to provide notice regarding the availability of institutional placement when implementing a mass change to personal care benefit levels.

Plaintiffs also argue that DSHS's notices were insufficient because they failed to inform Plaintiffs of their option to choose to receive services in other settings outside their homes. Defendants had already informed Plaintiffs of their service options when they chose to enroll in their in-home Medicaid programs.

42 U.S.C. § 1396n(c)(2) and 42 C.F.R. § 441.302 provide that a state must make various assurances that are satisfactory to the federal Centers for Medicare and Medicaid (CMS) in order to obtain a federal waiver allowing the state to offer Medicaid services outside

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of institutional settings. One of those assurances is that the state will inform recipients who qualify for an institutional level of care of the waiver's "feasible alternatives" to receiving services in a hospital, nursing home, or similar facility. 42 U.S.C. §§ 1396n(c)(2)(C), 1396n(d)(2)(C); 42 C.F.R. § 441.302(d)(1). CMS directs states to include that assurance in any waiver application, including a description of how the client's choice will be documented. CMS, Pub. No. 45, *State Medicaid Manual* § 4442.7.[9] Once a recipient has been given the choice between institutional or home- and community-based services, the state has met its obligation. *Bertrand ex rel. Bertrand v. Maram*, 495 F.3d 452, 459 (7th Cir. 2007) (dismissing 42 U.S.C. § 1396n(c)(2)(C) claim where the recipient was not "kept ignorant of options open to him"); *see also Doe v. Kidd*, 501 F.3d 348, 359 (4th Cir. 2007) (dismissing 42 C.F.R. § 441.302(d)(2) claim where the waiver recipient "has already been given" that choice).

The "feasible alternatives" statutes are intended to ensure that Medicaid recipients are aware of alternatives to institutional care. In this case, every affected recipient *is already receiving* non-institutional care. It is self-evident that Plaintiffs have been informed of the availability of home care that they have already chosen.

Moreover, DSHS has adopted procedures meeting the federal requirements to the satisfaction of CMS, which has approved DSHS's Medicaid waiver programs. For instance, the COPES waiver explains that DSHS uses its "Acknowledgement of Services" form (Form 14-225) to document the recipient's freedom to choose between institutional and home and community-based services. 5th McNeill Decl., Ex. B. Per that assurance to CMS, DSHS requires recipients to complete the acknowledgement form when electing to receive services under the COPES waiver, or when the recipient's living situation changes. 5th McNeill Decl. ¶ 5. There is no support for Plaintiffs' claim that such notice must be provided more often.

[9] Online at http://www.cms.gov>Regulations and Guidance>Manuals> Paper Based Manuals> Publication #45>Chapter 4 -- Services> "sm 04 4 4440 to 4444.doc"; at https://www.lexis.com>Legal> Secondary Legal>CCH>Health Law>CMS Program Manuals>CCH CMS Program Manuals P 4442.7; and at Westlaw.com under the CCH-CMSMAN database.

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The Plaintiffs who participate in a waiver program have each signed form 14-225 or a similar notice. 5th McNeill Decl. ¶ 7, Ex. C. Moreover, while 42 U.S.C. § 1396n(c)(2) applies only to waiver programs, even the Plaintiffs receiving personal care services under Washington's non-waiver state plan program have received notice of their institutional, community, and in-home care options. *E.g.*, 5th McNeill Decl. ¶ 3. Plaintiffs merely complain that they were not *reminded* of that information. Such reminders are not required by Medicaid law. The notices previously received by Plaintiffs are enough to defeat their notice claim to the extent it is predicated on the "feasible alternatives" requirement.

2. DSHS provided constitutionally adequate notice.

Determining the process due under the Constitution generally requires balancing three factors: the private interest affected; the risk of error and the value of additional safeguards; and the burdens of imposing additional procedural requirements. *Mathews v. Eldridge*, 424 U.S. 319, 334-35 (1976). Before depriving an individual of a protected property interest, the state must provide notice "reasonably calculated, under all the circumstances, to apprise interested parties of the pendency of the action and afford them an opportunity to present their objections." *Mullane v. Cent. Hanover Bank & Trust Co.*, 339 U.S. 306, 314 (1950); *see Dunsenbery v. United States*, 534 U.S. 161, 167–68 (2002) (*Mullane* rather than *Mathews* "supplies the appropriate analytical framework" to determine the adequacy of notice). However, where government benefits are adjusted by a change to the governing regulations, the regulatory determination must be considered as part of the process provided. *See Atkins*, 472 U.S. at 130. Where a mass change results in a reduction to individual benefits, the notice is adequate if "individual notices [are] sent to all affected recipients and . . . the notice informs recipients of the change." *Ireson v. Chater*, 899 F. Supp. 446, 450 (N.D. Cal. 1995) (citing *Atkins*, 472 U.S. at 126). The notice language requested by Plaintiffs goes well beyond the demands of due process.

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a. Plaintiffs' protected property interest in receiving personal care services is limited by state law to those hours generated through the CARE assessment.

Because Plaintiffs base their claims in part on benefits in which they have no protected property interest, we begin by identifying the relevant private interest in this case.

The Fifth and Fourteenth Amendments prohibit the government from depriving a person of property without due process of law. U.S. Const. amends. V, XIV. To establish that he or she has a protected property interest in a particular public assistance benefit, "a person clearly must have more than an abstract need or desire for it. . . . [or] a unilateral expectation of it. He [or she] must, instead, have a legitimate claim of entitlement to it." *Board of Regents of State Colleges v. Roth*, 408 U.S. 564, 577 (1972). A claim of entitlement to benefits must be "grounded in the statute defining eligibility for them." *Id.*; *see also Atkins*, 472 U.S. at 143 (Brennan, J., dissenting) ("Because [public assistance benefits] are a matter of statutory entitlement, recipients may claim a property interest only in the level of benefits to which they are entitled under the law, as calculated under whatever statutory formula is provided."). Thus, whether a particular public assistance benefit qualifies as a protected property interest depends on whether the statutes that create it, and the regulations that implement it, give rise to "a legitimate claim of entitlement to it." *Roth*, 408 U.S. at 577. In *Association of Orange County Deputy Sheriffs v. Gates*, 716 F.2d 733, 734 (1983), *cert. denied*, 466 U.S. 937 (1984), the Ninth Circuit elaborated on *Roth* by noting that "[a] reasonable expectation of entitlement is determined largely by the language of the statute and the extent to which the entitlement is couched in *mandatory* terms." (Emphasis added).

Federal law does not entitle Plaintiffs to personal care services. Those services are an optional category of medical assistance that Medicaid-participating states choose whether to provide. 42 U.S.C. §§ 1396d(a)(24) (defining personal care), (a)(10)(A) (listing mandatory categories of Medicaid assistance). The scope of any protected property interest in personal care services is thus defined purely as a matter of state law.

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In 1989 Washington's legislature added personal care services to the list of medical assistance provided to Medicaid recipients. 1989 Wash. Sess. Laws page nos. 2335-2336 (ch. 427, § 10). DSHS was ordered to adopt "such administrative rules as are necessary to ensure that [Medicaid] personal care services are provided to eligible persons in conformance with federal regulations" including financial and medical eligibility. Wash. Rev. Code § 74.09.520(3) (1989). The level of benefits is explicitly conditioned on the availability of funds:

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

Wash. Rev. Code § 74.09.520(4) (1989) (emphasis added). That statutory language remains unchanged to this day. Wash. Rev. Code § 74.09.520(3) (2013).

DSHS has exercised its statutory authority to set personal care benefits levels through the CARE formula described in its administrative rules. *E.g.* Wash. Admin. Code § 388-106-0135 (describing the "maximum hours that [a recipient] may receive"). The CARE formula is the only place in Washington law where an entitlement to personal care services "is couched in mandatory terms." For the purposes of a due process analysis, the service level described in the CARE rules is the relevant private interest. Plaintiffs can have no legitimate claim to benefits except as determined based on their "assessed level of functional disability"—that is, as determined by the CARE formula—and even then only "to the extent funding is available."

b. Plaintiffs were not entitled to notice of the Department's purely discretionary ability to authorize additional services beyond those to which Plaintiffs had a protected property interest.

Plaintiffs allege that Defendants' notices informing recipients of the personal care reductions violated due process by failing to inform recipients of DSHS's Exception To Rule

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(ETR) process, which can be used to provide an exception to the normal limits on services including Medicaid personal care. Simply put, the ETR process was not implicated in the mass change to base hours any more than it is implicated any time DSHS enforces a rule; DSHS is not required to notify recipients of the ETR process every time it enforces a rule to which exceptions are sometimes made. Moreover, DSHS's discretion to grant exceptions to its rules is explained in an agency rule promulgated as law. Even without individual notice, Plaintiffs may be presumed to have been aware of the ETR rule because "[a]ll citizens are presumptively charged with knowledge of the law." *Atkins*, 472 U.S. at 130.

Plaintiffs further argue that recipients have a due process right to contest any denial of exceptional hours. That claim also fails. As described above, Plaintiffs' interest in personal care services extends only to those described in the CARE rules, not to exceptional services that may be available through a suspension of those rules.

The ETR rule reads in its entirety:

> (1) The secretary of the department, or designee, authorizes department staff to request an exception to a rule in the Washington Administrative Code (WAC) for individual cases, except as noted in subsection (5) of this section, when:
> (a) The exception would not contradict a specific provision of federal law or state statute; and
> (b) The client's situation differs from the majority; and
> (c) It is in the interest of overall economy and the client's welfare; and
> (d) It increases opportunities for the client to function effectively; or
> (e) A client has an impairment or limitation that significantly interferes with the usual procedures required to determine eligibility and payment.
> (2) The secretary or the secretary's designee makes the final decision on all requests for exceptions to a rule.
> (3) Clients have no fair hearing rights as defined under chapter 388-02 WAC regarding exception to rule decisions by department staff.
> (4) Clients who do not agree with a decision on an exception to rule may file a complaint according to chapter 388-426 WAC.
> (5) This section does not apply to requests for noncovered medical or dental services or related equipment. See WAC 388-501-0160.

Wash. Admin. Code § 388-440-0001. DSHS provides written notice of decisions regarding

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exceptions to rule. Wash. Admin. Code § 388-440-0005. But by its terms, the ETR rule does not provide hearings to those who disagree with DSHS's decision not to grant an exception to a particular rule in an individual case. Wash. Admin. Code § 388-440-0001(3).

The rules governing personal care services specifically note that an ETR may be granted for "in-home personal care hours in excess of the amount determined to be available to you by the CARE tool." Wash. Admin. Code § 388-106-0140(2).[10] However, the ETR process is not specific to personal care services; it allows DSHS the flexibility to make an exception to nearly any program rule when warranted by compelling individual circumstances.

The ETR process thus allows DSHS to provide benefits *beyond those to which recipients have a legitimate entitlement*. Under the CARE tool and its associated regulations, Plaintiffs have already been authorized personal care services to the extent they are legally eligible. Wash. Admin. Code § 388-106-0135. The total services available were at all times subject to the availability of funding. Wash. Rev. Code § 74.09.520(3). Plaintiffs can have no legitimate claim to services that would require the suspension of the rules governing benefits levels. An individual who is not currently receiving personal care services through an ETR has no "legitimate claim of entitlement" and thus no property interest in those additional benefits.[11]

DSHS's discretionary ability to offer additional services in individual cases does not create any legally protected property interest implicating due process. DSHS was not required to notify Plaintiffs of the ETR process prior to implementing a mass change to base hours.

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[10] Prior to 2013, requests by recipients for additional hours were vetted by the recipient's case manager and the regional DSHS office before being forwarded for review by the ETR committee. Case managers requested ETRs for about four percent of all personal care recipients, and about eight-eight percent of requests were approved in whole or in part. Dkt. 170, ¶¶ 9, 14. The Department has since changed its procedure such that *any* recipient's request for additional hours will be reviewed by the ETR committee. DSHS Home and Community Services, Management Bulletin No. H13-001, "Exception to Rule Requests for In-home Personal Care Services" (Jan 9, 2013), available at https://fortress.wa.gov/dshs/adsaapps/Professional/MB/Default.aspx?year=2013.

[11] Conversely, Wash. Admin. Code § 388-106-1315(1) provides a hearing right for the termination or reduction of services authorized through an ETR to which a recipient may have a property interest by virtue of already receiving those services.

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c. Plaintiffs were not entitled to notice of the availability of a new CARE assessment when DSHS instituted the across-the-board service reduction.

CARE assessments are normally conducted annually, but will also be conducted where a person's ability to care for himself or herself changes significantly during the course of the year. Wash. Admin. Code § 388-106-0050(1). An assessment can also be modified without an in-person interview, for instance to account for "[c]hanges in the level of informal support available" to the recipient. Wash. Admin. Code § 388-106-0050(2). Plaintiffs claim that DSHS was required to notify them that they could request additional personal care hours if their circumstances changed as a result of the January 2011 base hour reductions. No such notice was required, especially given that Plaintiffs already had been given notice of their responsibility to bring significant changes to DSHS's attention.

All personal care recipients in Washington receive and sign a form summarizing their "rights and responsibilities" under DSHS programs. 5th McNeill Decl. ¶ 3, Ex. A. That form instructs recipients to "[t]ell your social service worker if there is a change in: Your medical condition; [or] The help you get from family or other agencies[.]" *Id.*, Ex. A. Even without such individual notice, Plaintiffs may be presumed to have known of the availability of new or modified CARE assessments. Recipients may always request a new assessment due to changed circumstances, regardless of what may have directly or indirectly precipitated the change. *See* Wash. Admin. Code § 388-106-0050(2)(c). Moreover, DSHS generally has no way of knowing if there is a change to a recipient's circumstances unless the recipient provides that information to DSHS staff. Recipients thus have the responsibility to notify a DSHS social worker of any changed circumstances, specifically including changes to the recipient's medical condition or unpaid assistance available. Wash. Admin. Code § 388-106-1303(6)(a), (6)(b). Again, Plaintiffs may be presumed to have been aware of those regulations because "[a]ll citizens are presumptively charged with knowledge of the law." *Atkins*, 472 U.S. at 130.

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Plaintiffs are correct that CARE modifications or reassessments would entail agency factual findings that recipients could challenge in administrative hearings. And Plaintiffs would of course have a right to appeal such individual assessments. Unlike the mass change to base hours at issue in this case, annual assessments and reassessments prompted by significant changes are individualized determinations. However, the fact that Plaintiffs would have a hearing right to challenge subsequent individual actions does not create a right to challenge the system-wide reductions at issue in this case. *See Jeneski v. Myers*, 163 Cal. App. 3d 18, 32, 209 Cal. Rptr. 178 (1984) (differentiating between the lack of appeal right to mass Medicaid reductions and the appeal right to subsequent agency decisions). "There must be a limit to individual argument in such matters if government is to go on." *Bi-Metallic*, 239 U.S. at 445.

V. CONCLUSION

Plaintiffs' due process claim is entirely a legal question properly determined under summary judgment. Because there is no merit to Plaintiffs' legal arguments for additional notice, their first cause of action should be dismissed.

RESPECTFULLY SUBMITTED this 23rd day of May 2013.

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CERTIFICATE OF SERVICE

I hereby certify that on May 23, 2013, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system, which will send notification of such filing to the following:

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The Honorable Thomas S. Zilly

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

M.R., et al.,

Plaintiffs,

v.

SUSAN DREYFUS, et al.,

Defendants.

NO. C10-2052-TSZ

[PROPOSED] ORDER GRANTING DEFENDANTS' MOTION FOR PARTIAL SUMMARY JUDGMENT ON DUE PROCESS CLAIMS

THIS MATTER came before the court on Defendants' Motion for Partial Summary Judgment on Due Process Claims and the accompanying declarations and exhibits in support of Defendants' Motion for Partial Summary Judgment. The Court having considered Defendants' motion, Plaintiffs' response, if any, and the records and files herein, and being fully advised, orders as follows:

IT IS HEREBY ORDERED

That Defendants' Motion for Partial Summary Judgment on Due Process Claims is granted.

DATED this _____ day of May 2013.

_____
UNITED STATES DISTRICT JUDGE

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