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THE HONORABLE THOMAS S. ZILLY

UNITED STATES DISTRICT COURT  
FOR THE WESTERN DISTRICT OF WASHINGTON  
AT SEATTLE

M.R. et al.,

Plaintiffs,

No. C10-2052Z

vs.

ORDER

SUSAN DREYFUS, et al.,

Defendants.

THIS MATTER comes before the Court on plaintiffs’ motion for a temporary restraining order and a preliminary injunction, docket no. 11. Having reviewed all papers filed in support of, and in opposition to, plaintiffs’ motion, and having considered the oral arguments of counsel, the Court entered a Minute Order, docket no. 73, denying the motion for a temporary restraining order and deferring the motion for a preliminary injunction. This Order explains the Court’s reasons for denying the requested temporary restraining order.

1 **Background**

2 Many of the issues now before the Court have been previously litigated. *See*  
3 *Freeman v. Wash. Dep't of Soc. & Health Servs.*, 2010 WL 3720285 (W.D. Wash.).  
4 In *Freeman*, the plaintiffs unsuccessfully challenged reductions made in 2009 to the  
5 number of base hours for in-home “personal care services” allotted to certain  
6 individuals in connection with the Medicaid program. In this action, plaintiffs seek to  
7 enjoin deeper cuts to these base hours, alleging that, if the planned reductions take  
8 effect on January 1, 2011, the level of available personal care services will fall below  
9 the minimum amount necessary for individuals to remain safely in their homes and, as  
10 a result, some plaintiffs will be (or already have been) forced to move to nursing  
11 facilities or other institutions. Plaintiffs assert that the intended decreases in base  
12 hours violate the Medicaid Act, the Americans with Disabilities Act, and the Due  
13 Process Clause of the Fourteenth Amendment to the United States Constitution. The  
14 Court concludes that plaintiffs have not made a sufficient showing of irreparable injury  
15 or likelihood of success on the merits to warrant the extraordinary remedy of a  
16 temporary restraining order.  
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20 Under the Medicaid Act, also known as Title XIX of the Social Security Act,  
21 42 U.S.C. §§ 1396a-1396w, the federal government provides monetary assistance to  
22 participating States, which then contribute the remaining resources necessary to  
23 furnish medical care and other services to qualified individuals. If a State elects to  
24 participate in Medicaid – which all fifty do – it must operate its program in conformity  
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1 with applicable federal laws. *Alexander v. Choate*, 469 U.S. 287, 289 n.1 (1985). The  
2 federal government administers Medicaid through the Centers for Medicare and  
3 Medicaid Services (“CMS”). 42 C.F.R. § 400.200. Washington’s Medicaid program  
4 is managed by the Department of Social and Health Services (“DSHS”).  
5  
6 RCW 74.04.050.

7 Under the Medicaid program, each participating State must submit, and have  
8 approved by CMS, a state plan for the provision of “medical assistance.” *See* 42  
9 C.F.R. § 430.10. Only some categories of “medical assistance,” such as inpatient and  
10 outpatient hospital care, are mandatory for participating States, while others, such as  
11 in-home “personal care services,” are optional. *See* 42 U.S.C. §§ 1396d(a) &  
12 1396a(a)(10)(A). Washington has elected to provide “personal care services,” which  
13 are defined by the Medicaid Act as services that are  
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16 furnished to an individual who is not an inpatient or resident of a  
17 hospital, nursing facility, intermediate care facility for the mentally  
18 retarded, or institution for mental disease that are (A) authorized for the  
19 individual by a physician or in accordance with a plan of treatment or  
20 (at the option of the State) otherwise authorized for the individual in  
21 accordance with a service plan approved by the State, (B) provided by an  
22 individual who is qualified to provide such services and who is not a  
23 member of the individual’s family, and (C) furnished in a home or other  
24 location.

25 42 U.S.C. § 1396d(a)(24). DSHS has further divided personal care services into two  
26 types of activities for which beneficiaries might require physical or verbal assistance,  
27 namely activities of daily living (“ADLs”) and instrumental activities of daily living  
28 (“IADLs”). WAC 388-106-0010. ADLs include basic personal tasks like bathing,

1 dressing, eating, and toilet use, while IADLs consist of functions performed around the  
2 home or community, for example, shopping, meal preparation, and housekeeping. *Id.*

3  
4 In administering Washington's long-term personal care services program,  
5 DSHS uses a system known as the Comprehensive Assessment and Reporting  
6 Evaluation ("CARE"). WAC 388-106-0065. CARE takes into account five criteria,  
7 namely (i) cognitive performance score; (ii) clinical complexity; (iii) mood/behavior  
8 and behavior point score; (iv) ADL score; and (v) exceptional care. WAC 388-106-  
9 0125. Based on the results of CARE, DSHS places the beneficiary into one of  
10 seventeen acuity classifications. *Id.* DSHS has assigned each acuity classification a  
11 specific number of base hours of personal care services. *Id.* Beneficiaries with the  
12 most severe functional disabilities are assigned to the category with the highest  
13 number of base hours.  
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16 In September 2010, Washington Governor Christine Gregoire issued Executive  
17 Order 10-04, which directed each State agency to reduce expenditures to compensate  
18 for a projected budget shortfall in the 2011 fiscal period. Exs. 2-3 to Brenneke Decl.  
19 (docket no. 12). In response to the Governor's Executive Order, DSHS announced  
20 plans to reduce in-home personal care service base hours by an average of ten  
21 percent,<sup>1</sup> effective January 1, 2011. *Id.* at Ex. 4. DSHS sent written notifications to all  
22 beneficiaries of these services on December 6, 2010. *Id.* at Ex. 1 at 2-3. This  
23 litigation ensued shortly thereafter. Among the plaintiffs in this case are disabled and  
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25 <sup>1</sup> This figure reflects the difference in the average numbers of base hours across all acuity categories  
26 for 2010 (161.2 hours) and 2011 (144.4 hours). When the decrease for each acuity group is separately  
considered, the range of values is between 6.3% (Group E Medium) and 18.8% (Group B Low).

1 elderly individuals who are currently receiving, or within the recent past received, in-  
2 home personal care services through Washington’s Medicaid program. Also named as  
3 plaintiffs in this action are two nonprofit associations and a union that represents  
4 personal care service providers.<sup>2</sup>

5  
6 **Discussion**

7 **A. Standard for a Temporary Restraining Order**

8 Preliminary injunctive relief requires a party to demonstrate (1) a likelihood of  
9 success on the merits; (2) a likelihood of irreparable harm in the absence of  
10 preliminary relief; (3) a balance of equities tipping in favor of relief; and (4) a  
11 weighing of public interest that supports an injunction. *Stormans, Inc. v. Selecky*, 586  
12 F.3d 1109, 1127 (9th Cir. 2009). Courts employ a substantially identical analysis  
13 when addressing a motion for a temporary restraining order. *Stuhlberg Int’l Sales Co.*  
14 *v. John D. Brush & Co.*, 240 F.3d 832, 839 n.7 (9th Cir. 2001). A temporary  
15 restraining order, as with any preliminary injunctive relief, is “an extraordinary  
16 remedy never awarded as of right.” *See Winter v. Natural Res. Def. Council, Inc.*,  
17 129 S. Ct. 365, 376 (2008).

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20 **B. Irreparable Injury**

21 In predicting that the anticipated reductions in base hours of personal care  
22 services will cause a deterioration in health and institutionalization of beneficiaries,  
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25 <sup>2</sup> The parties have not briefed whether and to what extent these organizations have standing, and the  
26 Court declines to address these issues sua sponte. Even assuming these entities have standing and can demonstrate some injury independent of the alleged harm to the individual plaintiffs, they still would not be entitled to injunctive relief at this stage of the proceedings because they have not demonstrated a likelihood of success on the merits of the various claims in this case.

1 plaintiffs have taken the position that DSHS has never awarded more than the  
2 minimum time necessary for recipients to safely remain in their homes and that the  
3 scheduled cuts in base hours will result in individuals having less assistance than they  
4 absolutely require. Plaintiffs, however, have failed to establish a correlation between  
5 the base hours at issue and the amount of services needed to avoid injury or  
6 institutionalization.  
7

8         The current method for calculating the number of personal care service hours a  
9 beneficiary will receive was implemented in 2004. At that time, in response to a  
10 legislative directive and based on studies conducted during preceding years, *see* Moss  
11 Decl. at ¶¶ 3 & 5 (docket no. 68), DSHS promulgated regulations outlining the five  
12 criteria of CARE, pursuant to which an adult needing personal care services is  
13 assigned to a particular category that is associated with a specific number of base  
14 hours. For example, in 2004, an individual assessed as falling within “Group E High”  
15 would have had 420 base hours. WAC 388-72A-0087 (2004). An individual’s base  
16 hours are then adjusted, either up or down, in accordance with several factors,  
17 including informal supports, multiple clients in the same household, and the  
18 characteristics of the living environment, for example, offsite laundry facilities or  
19 wood used as a sole source of heat. WAC 388-106-0130(2)-(4) (2010). The result of  
20 this computation is “the maximum number of hours that can be used to develop [a]  
21 plan of care.” Emergency Rule 388-106-0130(6), Wash. St. Reg. 10-22-066 (Oct. 29,  
22 2010).  
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1           Although the CARE classification process, whereby a beneficiary is placed into  
2 one of the seventeen categories enumerated in WAC 388-106-0125, involves an  
3 individualized assessment, the number of base hours allotted to each of the seventeen  
4 categories is not linked with individual need. Rather, the categories reflect the relative  
5 acuity of individuals, with beneficiaries in classifications that receive more base hours  
6 having more need for personal care services than those in categories associated with  
7 lower numbers of base hours. Moss Decl. at ¶¶ 3 & 4 (docket no. 68). When CARE  
8 was implemented in 2004, the base hours were allocated among the fourteen original  
9 acuity levels in a “budget-neutral” manner, dividing the then-available resources  
10 between the various categories of recipients. *See* Leitch Decl. at ¶ 7 (docket no. 67);  
11 *see also* Moss Decl. at ¶ 4 (“CARE does not measure how many hours a person  
12 ‘needs,’ but instead determines what a person’s share of available resources should be  
13 based upon the individual’s level of acuity compared to other recipients”); *compare*  
14 WAC 388-72A-0087 (2004) (recodified in 2005 as WAC 388-106-0125). The base  
15 hours remained constant from 2004 until 2008, when three additional classifications  
16 were created. *See* WAC 388-106-0125 (2008).

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20           In 2009, the base hours for each category were reduced, with the largest  
21 percentage decreases applied to the classifications associated with the least acuity.  
22 *See* Emergency Rule 388-106-0125, Wash. St. Reg. 09-14-046 (July 1, 2009). For  
23 example, the change for “Group E High” was under one percent, while “Group A  
24 Low” experienced a downward adjustment of roughly ten percent. In 2010, some of  
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1 these base hours were restored, using the same principle in reverse, *i.e.*, the categories  
2 with the greatest acuity were placed as closely as possible to pre-existing levels, while  
3 other classifications did not regain as much ground. This methodology is consistent  
4 with explicit legislative instructions:  
5

6       The personal care services benefit shall be provided to the extent funding  
7 is available according to the assessed level of functional disability. Any  
8 reductions in services made necessary for funding reasons should be  
9 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.

10 RCW 74.09.520(4). Based on this statutory language and the regulations involved, the  
11 Court concludes that CARE assesses only relative need for personal care services, not  
12 absolute or minimum requirements, and that the base hours assigned to each category  
13 enumerated in WAC 388-106-0125 correlate with legislative appropriations, as  
14 opposed to individual need.  
15

16       In arguing to the contrary, plaintiffs rely heavily on the declaration of Charles  
17 Reed,<sup>3</sup> who describes “the CARE tool” as “generat[ing] an automated base number of  
18 in-home personal care hours that a consumer is entitled to receive to meet their unmet  
19 needs for care. This number represents the minimum number of personal care hours  
20 that are necessary in order to meet the individually-assessed needs of the client and to  
21 permit the client to remain safely at home.” Reed Decl. at ¶ 30 (docket no. 18).  
22

23 Plaintiffs also rely on the declaration of Penny Black, who states that “[t]he CARE  
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25 <sup>3</sup> In his declaration, Mr. Reed has indicated that, after serving as both an Assistant Secretary and  
26 Deputy Secretary of DSHS, he retired from DSHS in July 2000. Reed Decl. at ¶¶ 3 & 6 (docket  
no. 18). Thus, Mr. Reed’s tenure with DSHS expired before CARE was implemented in 2004.



1 assessment tool produces an accurate measure of essential need. . . . [It] is designed  
2 to, has proven effective to, and is used by [DSHS] to measure the unmet needs that  
3 must minimally be met in order to support a client in his or her home without  
4 compromising health or safety.” Black Decl. at ¶ 28 (docket no. 19).<sup>4</sup> Mr. Reed’s and  
5 Ms. Black’s explanations do not appear to be aimed at CARE itself, but rather at a  
6 computerized or otherwise automated system or “tool” that incorporates all of the steps  
7 outlined in Washington’s long-term care services regulations.  
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10 The “CARE tool” about which Mr. Reed and Ms. Black have testified by  
11 declaration does not appear to be equivalent to the Comprehensive Assessment  
12 Reporting Evaluation or CARE referenced in WAC 388-106-0125. CARE does not  
13 itself generate either a minimum or a maximum number of hours; it merely classifies  
14 an individual into one of seventeen groups, as a result of which base hours are  
15 identified. The base hours are then, outside of CARE, adjusted either up or down  
16 depending on factors external to the individual. To conclude that CARE sets a  
17 minimum (or maximum) number of hours would ignore the additional computations  
18 required by WAC 388-106-0130. Moreover, to treat the figure calculated pursuant to  
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21 <sup>4</sup> According to her declaration, from 2000 until 2005, Ms. Black held the position of Director of the  
22 Home and Community Services Administration within the Aging and Disability Services  
23 Administration of DSHS. Black Decl. at ¶ 4 (docket no. 19). While still employed by DSHS in that  
24 capacity, Ms. Black provided a declaration to the Washington State Court of Appeals in connection  
25 with DSHS’s motion for an emergency stay in an unrelated case. *See* Black Decl. (Apr. 11, 2005),  
26 attached to Work Decl. (docket no. 71). In this earlier declaration, Ms. Black averred that,  
“[f]ollowing the assessment, eligible individuals are classified into fourteen groups that reflect the  
intensity of care that is needed. This classification results in a baseline determination of the number of  
hours of in-home care [DSHS] *may be able to fund.*” *Id.* at ¶ 10 (emphasis added). Ms. Black’s  
previous explanation, which linked the numbers of base hours to available resources and not to  
individual needs, appears to contradict her current position.

1 WAC 388-106-0125 and WAC 388-106-0130 as a minimum, rather than a maximum,  
2 disregards the express wording of the latter regulation.

3  
4 The various declarations of personal care services beneficiaries that plaintiffs  
5 have submitted in connection with their motion do not convince the Court otherwise.  
6 When asked during oral argument which declarations most strongly support plaintiffs’  
7 contention that the proposed reductions will result in irreparable injury, plaintiffs’  
8 counsel referred the Court to the declarations of Donna Hayes, Jeanine Starr, James  
9 Braddock, S.J., and Sean Walsh.<sup>5</sup> A review of these declarations indicates that  
10 plaintiffs’ predictions are based largely on speculation.  
11

12 For example, Ms. Starr is a service provider for plaintiff J.B. Starr Decl. at ¶ 2  
13 (docket no. 34). Ms. Starr predicts that as a result of the budget reductions, which will  
14 reduce J.B.’s monthly personal care service hours from 82 to 68, J.B. “will *likely* be  
15 admitted to a nursing home.” *Id.* at ¶¶ 16, 26 (emphasis added). Similarly, Sean  
16 Walsh is the clinical operations and long term care manager at Elderhealth NW, a  
17 provider of personal care services. Walsh Decl. at ¶ 2 (docket no. 25). Mr. Walsh  
18 testifies that several of Elderhealth’s clients face the prospect of “several months of  
19 slow decline rather than requiring *immediate* hospitalization or institutionalization” as  
20 a result of the proposed budget cuts. *Id.* at ¶¶ 14-17 (emphasis added). Neither  
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25 <sup>5</sup> Plaintiffs’ counsel also mentioned individuals with the initials J.H. and J.B. After reviewing the  
26 docket, the Court has been unable to locate any specific declarations from these plaintiffs. The Court  
presumes that counsel was referring to the declarations filed by Donna Hayes in support of J.H.  
(docket no. 47) and Jeanine Starr in support of J.B. (docket no. 34).

1 Ms. Starr's nor Mr. Walsh's declarations quantify the level of personal care services  
2 needed to avoid such grim prospects and they offer no concrete sense of immediacy.

3  
4 The various declarations also reflect the fact that the decision to move into a  
5 nursing home is complicated by a host of external factors, and is not simply a function  
6 of the number of personal care service hours made available under Washington's  
7 Medicaid program. For example, Donna Hayes was a service provider for plaintiff  
8 J.H. *See* Hayes Decl. at ¶¶ 4, 7-8 (docket no. 47). In December, J.H. was forced to  
9 move to a nursing home when Ms. Hayes decided that they could no longer make their  
10 living arrangements work financially on J.H.'s reduced Medicaid hours. *Id.* at ¶ 8.  
11 The decision to move J.H. to a nursing home was ultimately complicated by his living  
12 situation and his joint financial situation with Ms. Hayes.

14 Similarly, S.J. testifies that she will be forced to move to a nursing home in  
15 January 2011 because her service provider, James Braddock, will need to pursue other  
16 means of earning income if S.J.'s hours are reduced. S.J. Decl. at ¶ 25 (docket no. 27).  
17 Although Mr. Braddock opines that the number of personal care service hours in S.J.'s  
18 reduced schedule will be insufficient to meet her minimum needs, his decision to  
19 resign as her care provider appears to have ultimately been the result of his own  
20 financial considerations, not S.J.'s needs. Braddock Decl. at ¶¶ 9, 27 (docket no. 28).  
21 S.J. believes that she will likely end up in a nursing home if she is unable to locate a  
22 new service provider on short notice. S.J. Decl. at ¶¶ 27, 33 (docket no. 27).  
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1           The Court has carefully reviewed all of the declarations submitted by plaintiffs,  
2 with special attention paid to those cited by counsel during oral argument, and the  
3 Court is not persuaded that any of the declarations support a conclusion that the  
4 number of personal care service hours provided by DSHS constitute the minimum  
5 level necessary to permit beneficiaries to remain safely in their homes.  
6

7           Plaintiffs also argue that DSHS has admitted that the planned reductions will  
8 result in otherwise unnecessary institutionalization as the level of personal care  
9 services drop below the minimum required to preserve the health and safety of  
10 beneficiaries. In support of this contention, plaintiffs cite to what appears to be an  
11 internal DSHS document concerning proposals for implementation of the Governor's  
12 budget cuts. Ex. 6 to Brenneke Decl. (docket no. 12-8). Plaintiffs quote the following  
13 language: "In some cases, a safe in-home plan of care will not be possible and clients  
14 may need to go to community residential or nursing facility settings." *Id.* at 6. DSHS  
15 responds that this statement is not an admission, but rather is internal dialogue that is  
16 typical of any large-scale decision-making process. *See* Moss Decl. at ¶ 8 (docket  
17 no. 68) ("This statement was made by a mid-level DSHS manager and was intended to  
18 portray a worst case scenario regarding potential impact on the 45,000 population of  
19 recipients."). The Court declines to construe the document submitted by plaintiffs,  
20 which has no identified author, and which does not reference any factual support for  
21 its predictions, as a judicial admission by DSHS that implementation of the 2011  
22 reductions will increase the rate of institutionalization.  
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1 Finally, even if the decreases in base hours might leave some plaintiffs without  
2 sufficient personal care services to safely remain in their homes, plaintiffs have not  
3 shown that they lack an adequate administrative remedy. DSHS staff are authorized  
4 by regulation to request an exception to a rule (“ETR”) for individual cases satisfying  
5 certain criteria. WAC 388-440-0001. In the notice sent to beneficiaries in December  
6 2010, DSHS indicated that the reductions scheduled to take effect on January 1, 2011,  
7 affected only “CARE generated hours,” and would not decrease any additional hours  
8 previously authorized via an ETR. *See* Ex. 10 to Response (docket no. 66-2 at 9). The  
9 notice also advised beneficiaries that requests for ETRs would be reviewed “using the  
10 established ETR request procedure.” *Id.* Plaintiffs complain that the ETR process is  
11 insufficient because it must be initiated by DSHS staff. During oral argument,  
12 however, counsel for DSHS explained that a beneficiary may simply ask a case  
13 manager for an ETR, and that ETR requests, which are processed by a central  
14 committee convening twice a week, experience both a quick turnaround and a high  
15 rate of approval. Moreover, any out-of-home placement automatically requires the  
16 case manager to evaluate whether an ETR is appropriate. The Court is persuaded that  
17 plaintiffs’ discounting of the ETR procedure, and its ability to avoid the disastrous  
18 consequences that plaintiffs predict, is not supported by the current record.  
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23 In sum, plaintiffs have not shown that the base hours identified in WAC 388-  
24 106-0125 are in any way coextensive or correlated with minimum values. Indeed,  
25 plaintiffs have not identified, and counsel conceded at oral argument that she is not  
26

1 aware of, any individual who, as a result of the 2009 reductions in base hours, was  
2 institutionalized or otherwise injured. Compare Moss Decl. at ¶ 8 (docket no. 68)  
3 (“When personal care hours were reduced for all recipients effective July 1, 2009, the  
4 negative consequences predicted by plaintiffs did not occur. Health and safety were  
5 not compromised, and people were not forced into nursing homes due to lack of  
6 personal care services.”). This dearth of evidence is inconsistent with plaintiffs’  
7 contention that the base hours reflect quantities absolutely necessary for individuals to  
8 continue to stay in their homes. The subsequent increases in base hours that took  
9 effect in 2010 also contradict plaintiffs’ position. Plaintiffs point to no assessment of  
10 individual needs that triggered the rise in base hours. Instead, the record suggests that  
11 the 2010 increases resulted merely from a budget surplus, negating any link between  
12 the numbers of base hours and what is “necessary in order to meet the individually-  
13 assessed needs of the client and to permit the client to remain safely at home.” Reed  
14 Decl. at ¶ 30 (docket no. 18). Because plaintiffs have not sufficiently established that  
15 base hours bear a direct relationship to the minimum amount of personal care services  
16 required for individuals to remain safely in their homes, plaintiffs have failed to show  
17 the irreparable injury necessary to justify the extraordinary remedy of a temporary  
18 restraining order.  
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1 **C. Likelihood of Success on the Merits**

2 **1. Medicaid Act Claims**

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4 The Court does not write on a clean slate. Cuts in Medicaid funding have been  
5 a frequent topic of litigation as States struggle to deal with these financially lean times.  
6 Here, plaintiff raises five claims under Medicaid, arguing that the State’s 2011  
7 reduction violates Medicaid’s (1) reasonable standards requirement; (2) sufficiency  
8 requirement; (3) comparability requirement; (4) free choice requirement; and  
9 (5) requirement that the State obtain federal approval for any modifications to its state  
10 plan.  
11

12 **a. Reasonable Standards Requirement**

13 The Medicaid Act requires state plans to have “reasonable standards . . . for  
14 determining . . . the extent of medical assistance under the plan which . . . are  
15 consistent with the objectives of [Medicaid].” 42 U.S.C. § 1396a(a)(17). Plaintiffs  
16 contend that DSHS’s reduction in personal care services is unreasonable because the  
17 different acuity classifications in CARE reflect the minimum hours necessary to  
18 permit beneficiaries to remain safely in their homes. Plaintiffs have not shown that  
19 CARE determines the actual minimum personal care service needs of individual  
20 beneficiaries, and they have not established that the State’s proposed downward  
21 adjustment will result in an unreasonable reduction below the absolute minimum level  
22 of care necessary to preserve each beneficiary’s health and safety.<sup>6</sup> Consequently,  
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26 <sup>6</sup> Plaintiffs argue that, even if the Court concludes that the base hours authorized by WAC 388-106-0125 do not represent the minimum number of hours needed to preserve an individual’s health and

1 plaintiffs have not shown a likelihood of success on the merits of their reasonable  
2 standards claim.<sup>7</sup>

3  
4 **b. Sufficiency Requirement**

5 Medicaid regulations also require that “[e]ach service must be sufficient in  
6 amount, duration, and scope to reasonably achieve its purpose.” 42 C.F.R.

7 § 440.230(b). The levels of services are sufficient if they meet the purposes of the  
8 specific program. *Curtis v. Taylor*, 625 F.2d 645, 651 (5th Cir. 1980). Plaintiffs

9 contend that the planned budget reduction violates Medicaid’s sufficiency requirement  
10 because DSHS will no longer provide enough personal care service hours for  
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13 safety in a non-institutional setting, at some point, a reduction in services must logically fall below a  
14 beneficiary’s level of need. Reply at 9 (docket no. 69). Plaintiffs further contend that *any* reduction in  
15 services based on an arbitrary, budget-driven figure is per se unreasonable, otherwise the State could  
16 reduce available funding for personal care services by seventy-five percent or more, thereby defeating  
17 the purpose of the program. *Id.* Although the Court acknowledges that a limit must exist, below  
18 which the State could not reasonably reduce funding for personal care services without running afoul  
19 of Medicaid’s reasonable standards requirement, the Court is not persuaded by the present record that  
20 the proposed 2011 reductions approach such lower threshold.

21  
22 <sup>7</sup> Plaintiffs cite several cases for the proposition that a reduction in Medicaid services without  
23 consideration of the needs of individual beneficiaries is unreasonable. *See Lankford v. Sherman*, 451  
24 F.3d 496 (8th Cir. 2006); *V.L. v. Wagner*, 669 F. Supp. 2d 1106 (N.D. Cal. 2009). But those cases  
25 involved the complete elimination of programs, or the wholesale elimination of categories of  
26 eligibility. For example, in *Lankford*, the State of Missouri passed a law that eliminated optional  
coverage for Medicaid recipients for durable medical equipment (“DME”). 451 F.3d at 501. The  
Missouri agency administering Medicaid then passed emergency regulations that reinstated the right of  
recipients to some, but not all, of the medically necessary DME devices. *Id.* The Eighth Circuit held  
that the reinstatement of eligibility as to only a portion of the DME devices was unreasonable because  
the regulation did not provide any mechanism for individuals to obtain non-covered DME devices. *Id.*  
at 513. Similarly, in *Wagner*, the State of California passed a law that eliminated some beneficiaries’  
eligibility for all covered services. 669 F. Supp. 2d at 1117. The law also eliminated categories of  
eligibility for other recipients. *Id.* Conversely, here, none of the beneficiaries are losing eligibility for  
in-home personal care services or categories of care. DSHS is merely exercising its broad discretion  
to modify the extent of medical assistance in light of scarce resources. *Beal v. Doe*, 432 U.S. 438, 444  
(1977). Moreover, unlike in *Lankford*, plaintiffs here have an available ETR process that provides a  
mechanism to address any gap in services that are necessary to maintain health or safety. *See* WAC  
388-440-0001.



1 beneficiaries to remain safely in their homes. As with the reasonable standards  
2 requirement, however, plaintiffs have not shown that CARE represents a minimum  
3 standard of care.  
4

5 Moreover, whether the available personal care service hours after the reduction  
6 are sufficient to meet the program’s purposes must be examined in the context of the  
7 substantial discretion States are afforded to choose the proper mix of amount, scope,  
8 and duration limitations on Medicaid coverage. *Alexander*, 469 U.S. at 303. As noted  
9 by the Supreme Court:  
10

11 [M]edicaid programs do not guarantee that each recipient will receive  
12 the level of health care precisely tailored to his or her particular needs.  
13 Instead, the benefit provided through Medicaid is a particular package of  
14 health care services . . . . That package of services has the general aim of  
15 assuring that individuals will receive necessary medical care, but the  
16 benefit provided remains the individual services offered – not “adequate  
17 health care.”

18 *Id.* In this case, DSHS will continue to provide a substantial number of in-home  
19 personal care service hours following the proposed 2011 reductions. Indeed, the  
20 record reflects that Washington is a leading State in the number of personal care  
21 service hours provided to qualifying recipients, and plaintiff has not shown that the  
22 reductions will prevent the State from offering a package of services that has the  
23 general aim of providing necessary medical care.<sup>8</sup> Steve Eiken, et al., *Medicaid Long-*

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24 <sup>8</sup> Most States that provide optional personal care services under Medicaid have imposed limits on  
25 available services based on cost or hours. Allen J. LeBlanc, M. Christine Tonner, & Charlene  
26 Harrington, *State Medicaid Programs Offering Personal Care Services*, 22 Health Care Financing  
Rev. 1, 162 (Summer 2001). As all Medicaid plans are approved by CMS, the variation in federally  
approved State limitations on the availability of personal care services is indicative of the discretion  
afforded to the States in crafting personal care programs.

1 *Term Care Expenditures in FY 2009* (Thomson Reuters 2010) (Ex. 6 to Resp. (docket  
2 no. 66-1)); LeBlanc, et al., *supra* n.8 (Ex. 7 to Resp. (docket no. 66-1)).

3  
4 In light of the broad discretion granted to States to craft a manageable Medicaid  
5 plan, plaintiffs have not shown that the proposed 2011 reductions fail to satisfy the  
6 purpose of Washington’s program, namely providing disabled individuals with  
7 assistance with their ADLs and IADLs. WAC 388-106-0010. Consequently, on the  
8 record before the Court, plaintiffs have not shown a likelihood of success on the merits  
9 of their sufficiency claim.

10  
11 **c. Comparability Requirement**

12 Medicaid requires States to provide “comparable services when individuals  
13 have comparable needs.” 42 U.S.C. § 1396a(a)(10)(B). The comparability  
14 requirement is violated when beneficiaries with the same level of need are treated  
15 differently. *Jenkins v. Wash. Dep’t of Health & Human Servs.*, 160 Wn.2d 287, 157  
16 P.3d 388 (2007). In *Jenkins*, a number of Medicaid beneficiaries sought to enjoin  
17 DSHS from enforcing a regulation that reduced a beneficiary’s maximum authorized  
18 personal care service hours by fifteen percent if the beneficiary happened to live with  
19 his or her care provider. *Id.* at 290. Individuals who did not live with their care  
20 providers did not receive a reduction. *Id.* The fifteen percent reduction applied  
21 automatically, and did not require DSHS to evaluate a beneficiary’s individual  
22 circumstances. *Id.* at 292. The Washington Supreme Court concluded that the State  
23 had violated the comparability requirement because the rule treated beneficiaries in the  
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1 same classification differently. *Id.* at 300 (“[N]o reduction is justified unless an  
2 individual determination is made supporting that reclassification.” (emphasis added)).<sup>9</sup>  
3 Here, plaintiffs contend that DSHS’s proposed reduction would violate the  
4 comparability requirement because it does not take into consideration beneficiaries’  
5 individualized needs. Plaintiffs do not contend, however, that the planned reductions  
6 treat individuals with comparable needs differently. To the contrary, the proposed  
7 reductions treat all similarly-situated beneficiaries identically.<sup>10</sup> All individuals in the  
8 same classification face the same reduction. Plaintiffs have not shown likely success  
9 on the merits of their comparability claim under the Medicaid Act.  
10  
11

12 **d. Free Choice Requirement**

13 Medicaid also requires that beneficiaries be “informed of the feasible  
14 alternatives” to institutional care, and have individual choice. The Ninth Circuit has  
15 held that parties do not have free choice where the purported alternatives to  
16 institutional care are inadequate to meet their needs. *See Ball v. Rodgers*, 492 F.3d  
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18 <sup>9</sup> *Jenkins* cannot be read to require that DSHS treat individuals in different CARE classifications  
19 similarly because DSHS has already determined through CARE that the individuals in the different  
20 classifications are not comparable. Moreover, the Court notes that DSHS is required by statute to give  
21 priority in any funding reduction to individuals classified in the highest need category, so the  
legislature has already contemplated that individuals should be treated differently depending on the  
acuity of their medical condition. *See* RCW 74.09.520(4).

22 <sup>10</sup> To the extent that plaintiffs argue *Jenkins* requires an individual assessment of need following any  
23 reduction in services, plaintiffs appear to call into question the entire CARE system. As noted by the  
24 dissent in *Jenkins*, the number of base hours in WAC 388-106-0125 “is *not* a number of hours that an  
25 individual has been specifically assessed to require – the base number is a nonspecific, interim  
26 allocation associated with the classification group.” 160 Wn.2d at 314 (Fairhurst, J., dissenting)  
(emphasis in original). Consequently, an individualized assessment of need following a reduction in  
hours would be meaningless because the initial allocation of hours was not a function of need in the  
first instance. Plaintiffs do not, however, argue that the entire CARE system is inconsistent with  
Medicaid, and the Court declines to address the issue in the abstract.

1 1094, 1107 (9th Cir. 2007). Plaintiffs argue that they lack free choice because the  
2 reduced hours of personal care service will necessarily be insufficient to provide a  
3 genuine alternative to institutional care. As with their other Medicaid claims, plaintiffs  
4 have failed to make an adequate showing that CARE reflects the minimum number of  
5 personal care service hours necessary to maintain adequate in-home care, and as such,  
6 they have not shown a likelihood of success on the merits of their free choice claim.  
7

8 **e. Federal Approval Requirement**

9 Plaintiffs' final contention under the Medicaid Act is that DSHS's proposed  
10 reductions in personal care service hours require federal approval by CMS. Federal  
11 approval is not required because Washington's Medicaid plan does not describe a  
12 minimum number of personal care service hours or, for that matter, a method of  
13 calculating personal care service hours. *See* Ex. 6 to Brenneke Decl. (docket no. 12).  
14 As such, the planned reductions do not amend the state plan or trigger the need for  
15 federal approval. *See Freeman*, 2010 WL 3720285 at \*9 ("Because [Washington's]  
16 state Medicaid plan does not indicate the number of hours or the methodology to be  
17 used in determining the number of hours to be provided to recipients, any modification  
18 to that methodology need not be reflected in an amendment to the state plan.").

19 Plaintiffs have failed to show a likelihood of success on the merits of this claim.<sup>11</sup>  
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24 <sup>11</sup> In *Freeman*, Judge Bryan noted that the State sought retroactive approval of the 2009 reductions  
25 from CMS after the plaintiffs filed suit in that case. 2010 WL 3720285 at \*10. Here, plaintiffs  
26 contend that the State's retroactive request for approval in *Freeman* constitutes an admission that any  
reduction in personal care services requires federal approval. Reply at 12 (docket no. 69). The Court  
is not persuaded by this argument. The State's decision to make a retroactive request for approval of  
the 2009 reductions can also be viewed as a reasonable response to the lawsuit filed by the plaintiffs in

1           **2.     Americans with Disabilities Act Claims**

2           The Americans with Disabilities Act (“ADA”) precludes public entities from  
3 administering programs in ways that have the effect of segregating disabled  
4 individuals from the general community. *Olmstead v. L.C. ex rel Zimring*, 527 U.S.  
5 581 (1999). The ADA’s “integration mandate” requires that persons with disabilities  
6 receive services in the most integrated setting appropriate to their needs. *Cota v.*  
7 *Maxwell-Jolly*, 688 F. Supp. 2d 980, 994 (N.D. Cal. 2010) (citing *Olmstead*, 527 U.S.  
8 at 597). To analyze whether a State’s actions violate the ADA’s integration mandate,  
9 the Court must apply the following three-prong test: (1) whether the State’s treatment  
10 professionals have determined that community placement is appropriate; (2) whether  
11 the affected persons do not oppose such treatment; and (3) whether the placement can  
12 be reasonably accommodated, “taking into account the resources available to the State  
13 and the needs of others with . . . disabilities.” *Olmstead*, 527 U.S. at 607 (emphasis  
14 added).  
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18           The Ninth Circuit clarified the scope of the ADA’s integration mandate in *Arc*  
19 *of Wash. State, Inc. v. Braddock*, 427 F.3d 615 (9th Cir. 2005). In that case, the  
20 plaintiffs alleged that the State of Washington’s cap on the number of individuals who  
21 could participate in its community care programs violated the ADA. *Id.* at 617. The  
22 Ninth Circuit rejected the plaintiffs’ contention, holding that so long as a State is  
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*Freeman*, who alleged that the State had failed to obtain required federal approval. Moreover, if the  
26 Court accepted plaintiffs’ argument, it would create a disincentive for the State to seek approval in the  
future out of fear that the request for approval would be deemed an admission that federal approval  
was necessary. *Cf.* Fed. R. Evid. 407.

1 genuinely and effectively in the process of deinstitutionalizing disabled persons with  
2 an even hand, the court would not interfere. *Id.* at 620. Based on the record in that  
3 case, the Ninth Circuit found that Washington had a genuine commitment to  
4 deinstitutionalization, and declined to find an ADA violation. *Id.* at 621.

6 In contrast, in a prior case, the Ninth Circuit concluded that a State violates the  
7 ADA's integration mandate when the State categorically refuses to provide a process  
8 for deinstitutionalization for an entire class of individuals. *Townsend v. Quasim*, 328  
9 F.3d 511 (9th Cir. 2003). In *Townsend*, the Ninth Circuit held that a State program  
10 that provided community-based care for persons falling below a certain income level  
11 but not for disabled individuals with higher incomes, violated the ADA's integration  
12 mandate by discriminating against a category of disabled persons. *Id.* at 514. Unlike  
13 in *Arc of Washington*, in *Townsend*, all Medicaid-eligible disabled persons did not  
14 have the opportunity to participate in the program once space became available. *Id.*

17 In the present case, plaintiffs contend that DSHS's proposed 2011 reductions  
18 will violate the ADA's integration mandate by forcing individuals to either forego  
19 needed care or move to a nursing home. The ADA, however, does not require the  
20 "immediate, state-wide deinstitutionalization of all eligible . . . disabled persons, nor  
21 that a State's plan be always and in all cases successful." *Sanchez v. Johnson*, 416  
22 F.3d 1051, 1067-68 (9th Cir. 2005). Plaintiffs have failed to present facts that support  
23 their contention that DSHS's proposed reductions pose a real and immediate threat of  
24 mass institutionalization. Moreover, this case does not involve the type of wholesale  
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1 denial of benefits to an entire class of disabled individuals that was at issue in  
2 Townsend. To the contrary, the evidence produced by DSHS demonstrates that  
3 Washington has a genuine and effective commitment to deinstitutionalization. See Arc  
4 of Washington, 427 F.3d at 621. Over the last decade, the number of institutionalized  
5 disabled individuals in Washington has steadily declined. Leitch Decl. at ¶ 2 (docket  
6 no. 67); Moss Decl. at ¶ 2 (docket no. 68). As in the Arc of Washington case, the  
7 Court sees no basis for intervening under these circumstances. Plaintiffs therefore  
8 have not shown a likelihood of success on the merits of their ADA claim.

### 11 **3. Due Process**

12 Plaintiffs' final argument is that DSHS's arbitrary, budget-driven service  
13 reductions violate the Due Process Clause of the Fourteenth Amendment to the United  
14 States Constitution. Plaintiffs contend that the Due Process Clause entitles them to  
15 notice and an opportunity for a hearing prior to the reduction of any benefits.

16 Plaintiffs have not, however, analyzed the issue under constitutional standards, but  
17 rather rely solely on regulatory notice requirements. Under Medicaid regulations,  
18 certain actions require notice and an opportunity to be heard, see, e.g., 42 C.F.R.  
19 § 431.200, but recipients are not entitled to a hearing if the sole issue is a state law  
20 requiring an automatic change affecting some or all recipients.<sup>12</sup> 42 C.F.R.

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23  
24 <sup>12</sup> Plaintiffs cite Ryan v. Dreyfus, 2009 WL 2914139 (W.D. Wash.) for the proposition that failure to  
25 provide notice and hearing rights upon termination of Medicaid benefits is a violation of the Due  
26 Process Clause. In Ryan, DSHS terminated a number of Medicaid beneficiaries' rights to receive  
skilled nursing services through the Adult Day Health ("ADH") program. Id. at \* 1. DSHS conceded  
that the plaintiffs were entitled to notice and hearing rights because it had already determined that the  
beneficiaries required ADH services as a medical necessity. Id. at \*2-3; see also 42 C.F.R.

1 § 431.220(b). The limitation on the hearing requirement arises out of the practical  
2 consideration that, absent some factual dispute about an individual’s right to benefits, a  
3 hearing would serve little, if any purpose. *See Rosen v. Goetz*, 410 F.3d 919, 926 (6th  
4 Cir. 2005); *Benton v. Rhodes*, 586 F.2d 1, 3 (6th Cir. 1978) (“[M]atters of law and  
5 policy are not subject to any hearing requirements under the applicable regulations,  
6 whether the hearing be pre- or post-termination.”).

8 Plaintiffs contend that 42 C.F.R. § 431.220(b) does not apply to eliminate their  
9 right to a hearing, relying heavily on *Claus v. Smith*, 519 F. Supp. 829 (N.D. Ind.  
10 1981), for the proposition that when an agency has discretion on how to implement a  
11 budget cut under Medicaid, the blanket elimination of hearing rights does not apply.  
12 In *Claus*, the court considered an Indiana statute that imposed a co-payment  
13 requirement on all Medicaid beneficiaries. 519 F. Supp. at 831. The statute also  
14 granted the Indiana Department of Public Welfare the sole discretion to exempt  
15 individuals from the co-payment requirement for hardship. *Id.* The court concluded  
16 that since the statute vested the State agency with the sole discretion to exempt  
17 individuals from compliance with the co-payment requirement, beneficiaries were  
18 entitled to notice and hearing rights. *Id.* at 833. In *Claus*, the right to an exemption for  
19 hardship necessarily raised a factual dispute that gave rise to a hearing requirement.

20 Conversely, in this case, DSHS has proposed an across-the-board reduction in personal  
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24 § 435.930(b) (requiring State agencies to continue to provide Medicaid services regularly to all  
25 eligible individuals until they are found to be ineligible). *Ryan* is inapposite because the present case  
26 does not involve a termination, without notice, of services for which plaintiffs were eligible. Instead,  
DSHS merely reduced the level of personal care services in an equivalent fashion as to similarly-  
situated beneficiaries.



1 care services – purely a question of policy that would not be proper for consideration  
2 in a hearing. Moreover, DSHS did not have discretion on how to impose the 2011  
3 reductions in personal care services; by statute, DSHS is obligated to give preference  
4 to beneficiaries with the greatest need when implementing budget reductions. See  
5 RCW 74.09.520(4). Accordingly, plaintiffs have not shown a likelihood of success on  
6 the merits of their due process claim.  
7

8 **D. Balance of Equities and Public Interest**

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10 Given, on the one hand, the speculative nature of the harm that plaintiffs allege  
11 will result in the absence of a temporary restraining order and, on the other hand, the  
12 fiscal consequences of an injunction to the State, the balance of equities weighs against  
13 granting the relief that plaintiffs seek. Because spending must be curbed before the  
14 end of the current fiscal year, any delay in implementing the reductions at issue will  
15 result in either greater decreases at a later time to reach the same financial goals or cuts  
16 to other programs. Moss Decl. at ¶ 10 (docket no. 68). DSHS has conducted a  
17 comprehensive review to determine how best to accomplish the fiscal goals, and it has  
18 applied its expertise in weighing the competing interests of the various clients it  
19 serves. The Court is in no position to substitute its judgment for that of DSHS  
20 concerning which programs will be least affected by budget curtailments. The Court,  
21 however, observes that the personal care services at issue do not encompass the types  
22 of skilled or clinical services generally associated with acute or critical medical  
23 attention and do not appear to warrant being treated as somehow sacred or untouchable  
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1 in connection with the difficult choices DSHS must make. The Court concludes that  
2 the public interest would not be served by forcing DSHS to target perhaps more  
3 vulnerable individuals or programs while the merits of plaintiffs' claims in this matter  
4 are resolved.  
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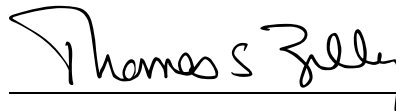
6 **Conclusion**

7 For the foregoing reasons, the Court has denied plaintiffs' motion for a  
8 temporary restraining order, docket no. 11.

9 IT IS SO ORDERED.

10 The Clerk is directed to send a copy of this Order to all counsel of record.

11 DATED this 5th day of January, 2011.  
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15 Thomas S. Zilly  
16 United States District Judge  
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