IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
AT HUNTINGTON

BENJAMIN H., et al.,

Plaintiffs,

v.

CIVIL ACTION NO. 3:99-0338

JOAN OHL, Secretary of the Department of Health and Human Resources,

Defendant.

POST TRIAL MEMORANDUM

This case concerns whether the Defendant's payments to providers ensure that poor, disabled individuals in West Virginia have adequate access to health care services that are critical to meeting their needs – specifically residential habilitation and respite care services through the Medicaid home and community based MR/DD waiver program. The Medicaid Act requires the Defendant to assure that payments to providers are consistent with efficiency, economy, quality of care, and access. 42 U.S.C. § 1396a(a)(30)(A). The undisputed evidence in the record shows that the Defendant's rates do not meet to these mandates. Beneficiaries receive services from inadequately trained workers, there is little continuity of care among workers, and there are long gaps in obtaining any services at all. Rather then set rates so as to ensure quality of care and access, the Defendant's ground rule for rate setting was stated time and again at trial – "you can't spend any more money." For these reasons, the Defendant's actions are arbitrary and capricious and contrary to law.

I. ISSUE PRESENTED

WHETHER THE DEFENDANT'S PAYMENTS FOR ONE-ON-ONE RESIDENTIAL HABILITATION, RESPITE I, AND RESPITE II HOME AND COMMUNITY BASED MR/DD WAIVER SERVICES ARE CONSISTENT WITH 42 U.S.C. § 1396a(a)(30)(A), WHICH REQUIRES THESE PAYMENTS TO BE CONSISTENT WITH EFFICIENCY, ECONOMY, QUALITY OF CARE AND SUFFICIENT TO ENSURE ADEQUATE ACCESS.

82

A trial was held on March 7th, and additional evidence was taken by agreement on March 14th. On March 27th, the record was supplemented by the Defendant's submission of an additional exhibit to which the plaintiffs do not object. The record on this issue is now closed. As requested by the Court, section III of this memorandum discusses the applicable federal law, and section IV applies the law to the evidentiary record.

II. THE NATURE OF THE SERVICES AT ISSUE

A. Residential habilitation services

One-on-one residential habilitation services provide individuals with mental retardation or developmental disability with "assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting." WVDHHR MR/DD Waiver Renewal Application at 20;[1] *see also* Arnold Tr. at 43:lines 4-8 (residential habilitation workers "come into the individual's home and help them improve or maintain their residential living skills and assist them with making progress toward specific residential living goals"); Ziglear Tr. at 59:lines13-60 (residential habilitation teaches social and other skills to allow the individual to participate more fully in their community – to go to the bank, the drugstore, the library, or a clothing store). The need for one-on-one residential habilitation services is determined not by the beneficiaries' desires or the behavioral health center's billing program but rather by the beneficiaries' individualized treatment plan, which is developed by an inter-disciplinary team. Mullins Tr. at 141:lines 2-13; Ren. App. at 6.

One-on-one residential habilitation workers need to be qualified and well-trained. Susan Given, the mother of 22-year-old Zachary, who is autistic and profoundly mentally retarded, explained that

[1] Hereafter "Ren. App."; submitted to the Court by the Defendant on February 25, 2000.

workers need to be "qualified, well-trained individuals ... if, in fact, you want to habilitate these individuals and not just baby-sit." Tr.T. at 81:17-22. Margaret McGarrity spoke of the qualifications needed to work with her 14-year-old son, John Joseph, who is autistic and has Tourette's and Down Syndrome. Residential habilitation workers need to "be able to deal with communicating, knowing how to deal with his behaviors, to not set him up to fail but to set him up to succeed." Tr.T. at 104:23-24.

B. Respite care services

Respite care services are "provided to individuals unable to care for themselves; furnished on a short term basis because of the absence or need for relief of those persons normally providing the care." Ren. App. at 18. There are two types of respite care services at issue, Respite Care Level I and Respite Care Level II. According to Steve Mullins, Bureau of Medical Services, Respite I, also called "community respite," is reimbursed when a beneficiary's family finds a respite care worker and identifies that person to a behavioral health agency, which then acts as a billing agent. Tr.T. at 143:15-23. Respite II is known as "agency respite" because the respite care worker is on the payroll of the behavioral health center as an employee. Tr.T. at 143:24-144:2. The need for respite care is determined not by the recipient's desires or the behavioral health center's billing program but rather by the beneficiaries' individualized treatment plan ("ITP"), which is developed by an inter-disciplinary team ("IDT"). Tr.T. at 141:12-13; Ren. App. at 6.

Respite care workers are caring for children and adults who have complex medical needs and often challenging behaviors and, thus, must be qualified and well-trained. As noted by Joan Arnold, Director of The Arc of Wood County in Parkersburg:

> [W]ith respite, parents are looking for someone to come in and provide quality care for their child and meet their child's needs during the time the parent isn't there and also give their child a quality experience. They're definitely looking for something more than the 14-year-old who has just finished the Girl Scout baby-sitting badge.... These are kids that have seizures, and the respite worker needs to be able to handle the seizures. They need to be able to change adult diapers. They need to be able to communicate with the person, position

> the person properly. And, you know, it's not somebody that comes in like the college student who's going to sit there doing homework.

Tr.T. at 43:10-23.

III. THE LEGAL STANDARD

Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.*, sets forth the provisions governing Medicaid. Medicaid is a joint federal and state program to provide medical care for needy individuals. Costs of the program are shared by the federal and state governments, with the federal government contributing a greater portion of the necessary funds. States are not required to participate in Medicaid. However, once a state elects to participate, it must do so in accordance with the mandatory requirements of the federal Medicaid statute and regulations. *Benjamin H. v. Ohl*, No. 3:99-0338 , slip op. at 2 (S.D.W.Va. July 15, 1999); *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 500 (1990).

West Virginia has elected to participate in Medicaid and accepts federal funds. Under federal Medicaid law, services are to be rendered by qualified providers to Medicaid-eligible persons. The state then makes payments directly to the providers. Except for nominal copayments, the provider cannot bill the recipient for the services; rather, Medicaid payment must be accepted as payment in full. 42 C.F.R. § 447.15.

In addition, the "Medicaid statutes impose a duty on state programs to adequately reimburse their Medicaid providers." *Ohio Hosp. Ass'n v. Ohio Dep't of Human Serv.*, 62 Ohio St. 3d 97, 100-01, 579 N.E.2d 695, 698 (1991). Specifically, the state must comply with 42 U.S.C. § 1396a(a)(30)(A), which requires the state to:

> provide methods and procedures relating to utilization of, and the payment for, care and services available under the plan ... to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

42 U.S.C. § 1396a(a)(30)(A). *See also* 42 C.F.R. § 447.204. "The purpose of this subsection is to

ensure adequate access and quality of care in the context of noninstitutional Medicaid providers." *Arkansas Medical Society v. Reynolds*, 6 F.3d 519, 530 (8th Cir. 1993). *See also, e.g., DeGregorio v. O'Bannon*, 500 F. Supp. 541, 549-50 (E.D. Pa. 1980) (law requires states to design reimbursement formula to engage sufficient providers "to make the state's Medicaid program meaningful in all respects"). *See generally Pressley Ridge Schools, Inc. v. Stottlemyer*, 947 F. Supp. 929, 932 (S.D.W.Va. 1996) (finding West Virginia's Medicaid agency violated section 1396a(a)(30)(A) when it implemented retroactive payment provisions against plaintiff, a nonprofit behavioral health care provider which relied "almost exclusively upon Medicaid funding in providing services to emotionally and behaviorally disturbed children").

Section 1396a(a)(30)(A) has been a part of the Medicaid Act since 1968. *See* 42 U.S.C. § 1396a, historical and statutory notes. It was last amended in 1989, to require that payments be "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." Omnibus Budget Reconciliation Act of 1989, Pub. L. No.101-239, § 6402(a). Previously, this "access" requirement had been implemented only through a regulation, 42 C.F.R. § 447.204. In legislative history, Congress explained that it was enacting the statutory provision because states were improperly limiting provider fees as "one method of controlling program costs." Report of the House Budget Committee on H.R. 3299 (Sept. 20, 1989) *reprinted in Medicare & Medicaid Guide (CCH)*, Extra Edition No. 596 (Oct. 5, 1990) at 390. Medicaid eligibility would be meaningless if providers are not willing to treat Medicaid recipients, and "without adequate payment levels, it is simply unrealistic to expect physicians to participate in the program...." *Id.*

Nothing in the statute sets a minimum rate of reimbursement that states must provide. However, every court that has reviewed the provision has held that it does require states to take the necessary steps

to ensure that rates are consistent with the four factors set forth in the statute -- efficiency, economy, quality of care, and access. Courts have developed differing standards for reviewing states' actions against the statutory factors: a process-oriented standard and a result-oriented standard.

The Eighth and Ninth Circuit Courts of Appeal and the Ohio Supreme Court apply a process-oriented standard to meeting the statutory demands. Specifically, the state Medicaid agency must undertake a process of investigation or study to justify its rates and, thus, ensure future results. In *Arkansas Medical Soc'y v. Reynolds*, 819 F. Supp. 816 (E.D. Ark. 1993), *aff'd*, 6 F.3d 519 (8th Cir.), the court examined Medicaid rates for home health benefits, personal care services, and other outpatient services, and required the state to employ objective study when setting these rates.

> [T]he state must consider, on the basis of some reasonably principled analysis, the substantive requirements of 42 U.S.C. § 1396a(a)(30)(A) in setting its payment rates. The state's payment rates are not proper if the methods and procedures it utilizes in formulating its rates, rather than being bona fide and objective, are merely an exercise to make the best case to support the state's rates, and the state considers only factors favorable to its position while failing to consider the relevant factors.

See Arkansas Medical Society, 6 F.3d 519, 530 (8th Cir. 1993) (affirming the district court, holding that the agency "must offer evidence to show that the relevant factors have been considered"). The Ninth Circuit further concluded that a state "cannot know if it is setting rates that are consistent with efficiency, economy, quality of care and access without considering the costs of providing such services." *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491, 1496 (9th Cir. 1997), *cert. denied*, 522 U.S. 1044 (1998). Thus, the Medicaid agency was required to "rely on responsible cost studies, its own or others', that provide reliable data as a basis for its rate setting." *Id. See also Ohio Hosp. Ass'n v. Ohio Dep't of Human Serv.*, 62 Ohio St. 3d 97, 102, 579 N.E.2d 695, 698-99 (Ohio S.Ct. 1991) (invalidating outpatient hospital rate regulation as "adopted solely for budgetary reasons without due consideration of its effect on the quality of care").

By contrast, the Courts of Appeal for the Third and Seventh Circuits use a result-oriented

approach when applying the statute. These Circuits hold that section 1396a(a)(30)(A) requires "each state to provide a *result*, not to employ any particular methodology for getting there." *Methodist Hosp. v. Sullivan*, 91 F.3d 1026, 1030 (7th Cir. 1996) (emphasis in original). *See also Rite Aid of Pennsylvania v. Houstoun*, 171 F.3d 842, 851 (3d Cir. 1999) ("we conclude that section 30(A) mandates only substantive compliance with its specified factors of efficiency, economy, quality of care, and access").[2]

The result-oriented standard is not without benchmarks, however. First, the state must "assure" that the four statutory outcomes will occur. The Third Circuit defines "assure" to mean "'to make certain and put beyond doubt ... to ... ensure positively.'" *Rite Aid*, 171 F.3d at 851 (quoting Black's Law Dictionary 123 (6th ed. 1990)). Second, the process used by the state must be "reasonable and sound." *Id.* at 853. It must "protect the public from possible ill effects of an agency testing out new formulae or prices at random, then correcting the results once a violation has occurred." *Id.* at 852. Finally, a state cannot act arbitrarily or capriciously. *Id.* For example, a state cannot simply "act like any other buyer of health care by offering a certain price, and seeing what response or result that price brings forth." *Id.* at 851-52. *Cf. Methodist Hosp.*, 91 F.3d at 1029 *with Rite Aid*, 851 n. 9. The Department may also act arbitrarily or capriciously if it relies on factors other than those intended by Congress. *Id.* at 853.

Notably, for purposes of this case, the split among the circuits is not important. As shown below, measured against either of these standards, the Defendant's residential habilitation and respite rates fail to meet the statutorily mandated outcomes of quality of care and access.

IV. ARGUMENT

The evidence in this case overwhelmingly establishes that payments are not consistent with the

---

[2] Significantly, unlike the plaintiffs here, the pharmacies in *Rite Aid* did not challenge the substantive impact of the rate setting as failing to comply with section 1396a(a)(30)(A), but rather challenged the way in which the Department set and promulgated the rates. *Rite Aid of Pennsylvania*, 171 F.3d at 850.

quality of care and access requirements of the Medicaid Act. A number of quality of care problems were identified at trial, and these problems were repeatedly tied to the low levels of reimbursement. In addition, residential habilitation and respite rates paid by other payers and for other payment programs far exceed the rates paid by the Defendant for the waiver MR/DD program. As a result, these services are not available to class members to the extent that they are available to others.

A. Undisputed evidence establishes that problems with quality of care are pervasive, and they exist because of the Defendant's inadequate payment rates.

1. Workers are inadequately trained.

The Defendant admits that direct care workers need training in the type of care they are giving and, usually, training about the individual they are caring for. Mullins Tr. at 131:14-21. However, undisputed testimony shows that residential habilitation and respite care services are being provided to class members by untrained, or inadequately trained, workers. Linda Williams testified that her son, Chad, needs residential habilitation services from care-givers who understand his disability and provide "a lot of consistency and a lot of focus on social behavior." Tr.T. at 26:16-23. Unfortunately, the individuals who are being sent to her home are "unable to exhibit socially appropriate behavior; so therefore, he doesn't learn. He doesn't have good role models." *Id.* at 26:24-27:4. On one occasion, Ms. Williams was summoned anxiously by Chad to his apartment, only to find the nineteen-year-old worker passed out on the sofa, with beer cans "all over the place, stark naked from the waist down." *Id.* at 27:22-28:3. Ms. Williams also testified that in a recent treatment plan meeting the residential habilitation workers

> were being disruptive, intrusive interrupting professional discussions that were going on. At one point one of them said, Excuse me while I have my ass chewed out.... [M]y son has a lot of frontal lobe damage, and these are things that we're trying to teach him is how to be socially appropriate in given situations. And to do that he has to be able to observe that.

Id. at 30:3-15. Similarly, Karen Boles testified that the individuals who are providing respite services to

her son for $5 an hour usually have no background with his disabilities; some have no training at all. Tr.T. at 10:25, 11:25. This inexperience has affected services to the extent that Ms. Boles calls it "no service." *Id.* at 11:4-9. *See also* Given Tr. at 78:20-25-79:1-6 ("[v]ery often," workers "don't realize the importance of coming on time, doing what they're supposed to do when they're there, understanding the relationship between the programs that are written and the way they need to be carried out and ultimately the training benefit that Zach is to get from that").

2. Class members suffer from inconsistent and sporadic care

The undisputed testimony in the record also shows that class members' residential habilitation and respite care services are inconsistent and sporadic, with beneficiaries often experiencing long and debilitating gaps in receiving any services at all. Otto Boles, called "Champ" by his family, is a 37-year-old man who has cerebral palsy. Boles Tr. at 7:2-4. Champ needs residential habilitation services. *Id.* at 8:3-7. During the three and a half years he has been on the waiver, approximately 37 workers have provided these services to him. *Id.* Ms. Boles' described how this turn over negatively affects the quality of care that her son receives:

> [H]e operates well in a real scheduled, structured environment, and we think this is a lot of the problem with his behavior outbursts, is that he doesn't know who's coming; when they come, he doesn't know how long they're going to stay. And he gets attached to people, and they leave and he thinks he's done something wrong.

Tr.T. at 12:9-17. Champ's treatment plan also calls for trained respite workers. *Id.* at 12:16-25. However, respite services have always been "very sporadic." *Id.* at 8:1-5. Champ has had six respite workers. *Id.* at 6:21-23. The last time he received these services was on September 25, 1999. *Id.* at 8:1-5.

Linda Williams testified similarly regarding the quality of care provided to her son, Chad. Deposition (Dep.) of Linda Williams. Due to a traumatic brain injury, Chad needs "a lot of structure, a lot of consistency" with residential habilitation services, including assistance with controlling his

aggressive behavior and with bathroom and toileting. *Id.* at 26:7-23. However, since he began receiving waiver services in 1995, Chad has been served by "between 25 and 30, probably more" providers. *Id.* at 25:13-17.

Susan Given described the waiver care provided to her son Zachary, who is autistic, profoundly mentally retarded and non verbal with challenging behaviors. Tr.T. at 74:21-25. He does not tolerate change well. *Id.* at 75:2-4. Zachary has been on the waiver program for about six years. *Id.* at 75:5-9. Over that time, there have been approximately 60 residential habilitation workers in the Given's home. *Id.* at 75:13-15. When staff leaves, there are gaps before another worker comes to the home. The gap varies from weeks, to months, to days, and the family has gone six months without staff. *Id.* at 75:19-24. Residential habilitation staff do not consistently show up for work. *Id.* at 76:3-7. During the summer of 1999, care was particularly inconsistent, with "someone new every day coming." *Id.* at 77:18-22. This staff turnover causes Zachary's care to suffer:

> Zach, because of his disability, because of the autism, very often he has a lot of self-stimulating behaviors and he's like living in his own little world, and so he lacks motivation. So periods of inactivity only — he feeds — you know, he feeds on that. So it's hard to get him started after a period of inactivity and not doing anything. Then whenever you want him to do something, you have a lot of behaviors, not wanting do ... what's required and that sort of thing.... It's hard to get him back on the program.

Tr.T. 76:11-23. *See also* Nichols Tr. at 17:2-16, 18:14-19 (describing inability of agencies to attract workers for her son, Daniel, and a five year gap without respite services); McGarrity Tr. at 106:10-20 (describing waiver recipient who has had 11 different workers within 12 months); Arnold Tr. at 44:9-15 ("I ask them [the families] how things are going and if they've got workers, if they have staff, and invariably they don't have staff there.... And when I ask them what happened, they've gone to some job that pays better"); *see id.* at 46:19-47:3 (discussing situation of Arc worker whose 18-year-old son has seizures and cancer but has not received residential habilitation waiver services since August of 1998);

see id. at 47:18-49:21 (discussing situation of Arc worker who cannot locate residential habilitation services that her 10-year-old daughter needs so that she will not "get back to being just a floppy rag doll").

3. Class members pay out-of-pocket for qualified care.

The undisputed evidence shows that the Defendant's payment levels are also having a direct, negative financial effect on waiver families. A number of families are supplementing the Medicaid rate out of their own pockets. Margaret McGarrity testified that if she had to rely totally on the waiver payment to have direct care staff for her 14-year-old son, John Joseph, she "wouldn't have anybody." Tr.T. at 105:1-4. As a result, over the last four years,

> in order to get someone to work with my son that is, number one, qualified and, number two, trained and, number three, used to working with him, and in addition to that, to keep the continuity of how they work with him, I pay in addition – they get paid exactly what they get paid at the county [school system] level, and that's $10 an hour. They are not paid that through the waiver. They're paid $6 minus the 8 percent that goes to the centers and then, of course, when they report their taxes. So basically they would clear, if we just counted the waiver, about $4.40. So I augment that with my funds to make them receive $10 an hour.

Tr.T. at 103:6-16. *See also* Given Tr. at 78:14-17 (family supplements waiver rate by $3 per hour, but not everyone can afford to do this); Nichols Tr. at 19:19-20:10 (families are forced to supplement the waiver rates).

4. Providers admit quality of care problems in their workforce.

Waiver program providers admit the problems with quality. Lin Preston is employed by Open Doors, a small behavioral health center which exists to serve individuals with developmental disabilities mainly through the waiver program. Tr.T. at 24:15-25:2. Ms. Preston testified that maintaining a qualified work force and avoiding staff shortages is a "never ending battle." Tr.T. at 40:24. The turnover in workers in significant, a "whopping 56% from November 1998 through October 1999." Tr.T. at 29:16-20; Plaintiffs' Trial Exhibit (Pl. Trial Exh.) 1. *See also* Ziglear Tr. at 56:6-7, 64:24-65:10

(35% turnover rate results in long gaps in having a worker available to go to a home and affects the client in terms of having to adjust to somebody new coming into the home); DeWalt Dep. at 34:4-5, 36:21-23 (60% annual turnover rate in direct care staff). Ms. Preston summarized the effects of inadequate payments on the efficiency and quality of care, as follows:

> [A]s an employer I hate to see consumers have – [to] get a staff person trained and in two months, six months down the road that person is gone. We're coming back in, training somebody else new. They have to get used to that new staff. We see behaviors. We see all kinds of things. I really want to see learning. I want to see people growing and doing things. And I think the only way we can do this to have consistent staff that are there and that want to be there. Tr. T. at 10:1–19.

> "[T]he people we serve are our number one priority. To ensure that they receive the best possible services to gain new skills and have meaningful productive lives, my agency must be able to also support the economic needs of our direct care staff. Our consumers need the consistency of a stable work force in order to meet their goals in a timely manner. With the current reimbursement rates..., I do not think that my agency has the necessary tools to continue to do this effectively [sic]." Pl. Trial Exh. 1.

5. The poor quality of care is attributable to the problems with rates.

The Defendant pays MR/DD waiver providers $9 per hour for one-on-one residential habilitation, $8 per hour for Respite II (agency respite), and $6 per hour for Respite I (community respite). Amended Trial Order, Stip. ¶ 11. Witness after witness directly linked these low payment rates to the problems with quality. The Defendant offered no credible evidence to rebut this testimony.

a. The low rates do not cover providers' cost of providing the services.

"Since the payments themselves must also be consistent with quality of care, the Department must consider the costs of providing quality care." *Orthopaedic Hosp.*, 103 F.3d at 1497. Providers repeatedly testified that the Department's reimbursement rates do not cover their costs of providing one-on-one residential habilitation and respite services. According to Open Doors provider Lin Preston, "The current reimbursement rate of $9.00 ($8.55/ after the 5% state provider tax) for Residential Habilitation 1:1 code, WO234, and the $8.00/hour (really $7.60 after provider tax) for agency Respite

code, WO107, are insufficient." Pl. Trial Exh. 1.[3] These rates do not cover the program's costs, which total about $9.98 per hour. Tr.T. at 2619-27:16. The program is losing money.[4] It costs Valley Healthcare $8.65 per hour just to employ residential habilitation services, as follows: Workers are paid $6.25 per hour. Taxes and fees on worker salaries come to 13 percent, or about $7.11 per hour. DeWalt Dep. at 32:9-34:12. The remaining $1.54 per hour is the amount spent on non-reimbursed services, training, and orientation. *Id.* at 33:20-34:2. Over and above the $8.65 it costs to employ the workers, Valley Healthcare has administrative costs just under $3 per hour. Totaled up, it costs Valley Healthcare $11.65 per hour to provide the residential habilitation service. *See also* Ziglear Tr. at 54:24-55:2 (her cost in providing residential habilitation services is $10.40 per hour).

Notably, the Defendant admits that centers which have a higher proportion of clients who require one-on-one staffing are faring poorly financially in comparison to those who provide services to people in higher staff-to-client ratios.[5] Mullins Tr. at 133:5-8; 138:24-139:7.

The obvious connection between low rates and poor quality of care and required state Medicaid agencies to take steps to bring the program within the statutory factors set forth in section 1396a(a)(30)(A) has not gone unnoticed. In *Orthopaedic Hospital*, 103 F.3d at 1496, the Court found Medicaid payments for outpatient services to be inadequate specifically because the Department had not considered the cost incurred in providing the services: "It stands to reason that the *payments* for hospital

---

[3] While state law does not dictate which monies the provider tax must be paid from, it must be paid, Preston Tr. at 35:20-26:4, and the only evidence in the record is that providers pay the tax on every rate. Preston Tr. at 36:1-4.

[4] For 1999, the program lost $6,000 on an accrual basis and on the cash basis, the company earned $10,000. Tr.T. at 41:13-20. In fact, Defendant's own exhibit, Standardized Financial Statements, the income statement for the 2nd quarter of 2000, shows that half of the 14 contracting facilities reported net income loss and two of the remaining facilities reported income less than $31,000. Exhibit 6.

[5] The individual's program plan determines the level of staffing. Mullins Tr. at 141:4-13.

outpatient services must bear a reasonable relationship to the costs of providing quality care incurred by efficiently and economically operated hospitals." *Id.* (emphasis in original). The Medicaid agency was ordered to set "reimbursement rates that bear a reasonable relationship to efficient and economical hospitals' costs of providing quality services, unless the Department shows some justification for rates that substantially deviate from such costs." *Id.*

b. The low rates mean poor conditions for direct care givers.

In addition to discussing the costs of providing the services, plaintiffs presented overwhelming testimony that the low payments mean poor conditions for direct care workers. The low rates mean low wages to direct care workers. At Open Doors, for example, these workers start out at $5.70 per hour; the average wage is $6.49 per hour. Preston Tr. at 26:17-19; 25:23-26:4; Pl. Trial Exh. 1. *See also* Ziglear Tr. at 55:21-56:2 (average pay to workers is about $7 or $8 dollars per hour); Boles Tr. at 10:16-20; Tr.T. at 15:8-13 (monthly billing showed residential habilitation and respite workers were paid "right at $5 an hour").

The low rates also mean that direct care workers do not receive any significant benefits through their work, which is typically a 40-hour week. Preston Tr. at 37:16-23; Pl. Trial Exh.1; Ziglear Tr. at 55:21-56:2 (workers do not get sick pay, discretionary leave, or a retirement plan).

To make matters worse, direct care workers are saddled with incidental costs that are not borne by their employers. Transportation to and from the residence of the Medicaid recipient is not reimbursable. Preston Tr. at 31:20-25. This factor is all the more important given the rural nature of West Virginia. Many people live in isolated areas and considerable time must be spent just traveling to the job. When combined with a low hourly wage, staff retention is the issue. *Id.*; Arnold Tr. at 48:24-29:4.

Low rates also mean that care givers receive inadequate training. State law requires direct staff

to have a certain level of minimal training, including CPR-First Aid and crisis prevention intervention. Tr.T. at 28:1-10; Pl. Trial Exh. 1. Client specific training is also needed before someone can work with an individual. Tr.T. at 28:19-22.; Pl. Trial Exh. 1. Lin Preston testified that the reimbursement rate is too low to allow for proper training. Tr.T. at 27:22-29:14; Pl. Trial Exh. 1. The only training that can be billed is the client specific training, and then only if the consumer has not used all of the units that are allocated for this service code each month. Pl. Trial Exh. 1. "This means that agencies have a minimum of approximately 32 hours of up front training costs that cannot be recouped." *Id.*

c. The low rates mean quality of care problems for waiver families.

As discussed above, the result of inadequate payments is high rates of worker turn over and unqualified workers. All of the family members who testified concluded that doors were being slammed in their faces because of the low rates. Ms. Boles testified that the individuals who quit providing services to Champ did so because of inadequate payment. Tr.T. at 9:8-22. The residential habilitation workers who quit providing services to Chad told Ms. Williams they were leaving because they "don't get paid enough to do this job." Dep. at 25:23-24-26:1-4. *See also* Nichols Tr. at 18:20-19:1, 19:8-12 (describing her desperate search for workers but because "the pay is $5.52, you know, they have not been able to get me anyone").

Given the Defendant's low payment rates, it is not surprising that the class members are experiencing problems with quality of their care. The Defendant says that "you pay people what it takes to hire them and keep them." Mullins Tr. at 137:17-24. However, it has not backed up these words with levels of payment that will allow provider agencies to hire and maintain trained and qualified staff.

B The Defendant's payments for the waiver services are not sufficient to ensure access.

The Defendant's rates are not consistent with the access requirement, which says that payments must be "sufficient to enlist enough providers so that care and services are available under the plan at

least to the extent that such care and services are available to the general population in the geographic area." 42 U.S.C. § 1396a(a)(30)(A).

Courts have held that reimbursement rates do not ensure sufficient access if they are "far below any reasonable estimate of what it actually costs providers to render the services." *E.g. Clark v. Kizer*, 758 F. Supp. 572, 577 (E.D. Cal. 1990), *aff'd in part and vacated in part on other grounds sub nom.*, *Clark v. Coye*, 967 F.2d 585 (9th Cir. 1992). The *Clark* court, which looked at access to dental care, was also persuaded by the fact that "the present rates are not even adequate to meet overhead, let alone allowing for some marginal profit." *Id.* at 577. As shown above, unrebutted testimony establishes that the present rates do not even meet providers' cost of providing the services.

The access factor also compares "access of beneficiaries to the access of other individuals in the same geographic area with private or public coverage...." H.R. Rep. No. 1010-247, 101st Cong., 1st Sess 390 (1989), *reprinted in* 1989 USCCAN 2060, 2116. Evidence adduced at trial establishes that the rates at issue are far below those received by providers from other payers. Open Doors has a contract with Greenbrier County Schools to provide similar services. Preston Dep. at 5:5-9. The services are reimbursed at $21 an hour. *Id.* Similarly, the workers at one center, who also work in the Monongolia County Schools, receive a starting school wage of $8.23 per hour and make $10.71 per hour after three years. Dep. at 34:13-36:7. These school workers are offered comprehensive benefits. *Id.* In Cabel County Schools, the daily rate of a substitute special education aide is $75, or $10.50 per hour. Given Tr. at 95: 16-25. Once an aide become a full-time employee, the wages go up and benefits are offered. *Id.*

In addition, unrebutted evidence establishes that the residential habilitation and respite payments for waiver recipients are much below the rates that the Defendant itself pays for similar or identical services provided to beneficiaries through other Medicaid programs. Ziglear Tr. at 57:6-62:2; Pl. Trial

Exh. 3. For example, Basic Living Skills services available to non-waiver Medicaid recipients under the rehabilitation option of the State Plan include services such as one-on-one training in the activities of daily living by a person with a GED or high school diploma. These services and the level of qualification required by staff performing them are analogous to the one-on-one residential habilitation services within the waiver program. *Id.* However, the reimbursement rate for the State Plan service, which waiver recipients cannot access, is $20 per hour, Pl. Trial Exh. 3, while the reimbursement rate under the waiver program is only $9 per hour. *Id.* Other one-on-one services covered under the State Plan for Medicaid recipients who are not on the waiver range from $12 per hour up to $20 per hour. *Id.*

Unrebutted evidence in the record also establishes that the rates at issue here are below those paid by bordering states' Medicaid programs. West Virginia's residential habilitation rate, compared to other states, is "far lower ... not even lower, but dramatically lower." Ziglear Tr. at 53:18-23, 54:14-20. Indiana pays $33.68 per hour for res-hab services and $14.60 per hour for personal assistance, while Pennsylvania pays residential habilitation services at $16.00 to $19.03 per hour. Ohio -- which is less than two miles from this court house -- pays from $14.15 to $17.04 per hour for residential habilitation services. *Id.* at 54:9-20; Pl. Trial Exh. 3. Previous courts have found that rates paid by neighboring states for the same or similar services are relevant to determining whether a state meets the access requirement. *Rite Aid of Pennsylvania*, 171 F.3d at 848-49, 855 (citing with favor the Department's reliance on reimbursement rates in neighboring state); *Compare Arkansas Med. Society*, 6 F.3d at 530 (refusing to rely on Medicaid agency's contention that it considered rates paid in other states, in a case where the other states are unnamed).

To sum up, the Defendant's payments for one-on-one residential habilitation and respite services for class members are not consistent with quality of care and are not sufficient to ensure access to the population at least to the extent enjoyed by others in the service area. The plaintiffs have established

that the results required by 42 U.S.C. § 1396a(a)(30)(A) have not been accomplished.

C. The Defendant has failed to engage in the study and investigation needed to comply with section 1396a(a)(30)(A) of the Medicaid Act.

As discussed above, the Eighth and Ninth Circuit Courts of Appeal look at the process used by the Defendant to arrive at its rates. *Orthopaedic Hosp.*, 103 F.3d at 1491; *Arkansas Medical Society*, 6 F.3d at 519. The evidence before this Court shows that the Defendant has not taken any steps or followed any process to determine whether the residential habilitation and respite care rates are consistent with the requirements of section 1396a(a)(30)(A).

A waiver provider work group was organized to present evidence to the Defendant. However, the membership of this group was not broadly representative so as to allow the Defendant to have a full view of the landscape. The work group was organized by four behavioral health providers who were concerned that inadequate one-on-one residential habilitation and respite rates were causing them to be unable to recruit and retain staff. Mullins Tr. at 139:20-25-140:1-3; Ziglear Tr. at 53:8-13. Other affected persons, such as families of Medicaid recipients or direct care staff workers, were not involved in the work group and did not attend its meetings. Mullins Tr. at 131:1-6.[6] *Compare Orthopaedic Hosp,* 103 F.3d at 1500 (rates invalid because "nowhere does it appear that the Department inquired whether Medi-Cal beneficiaries had adequate access").

In addition to lacking in broad-based membership, it is clear that the process used by the group to discuss the rates was arbitrary and capricious. It was not based on the statutory factors of efficiency, economy, quality of care, and access. Rather, according to Departmental facilitator Steve Mullins, the work group, it was "operating under the [Department's] ground rule of you can't spend any more

[6] There is no evidence that the public hearings that occurred prior to the waiver renewal included consideration of the adequacy of payments, and the changes that were ultimately proposed in the *method* of respite care payment did not concern the *amount* of payments. Tr.T. at 146:1-14; 122:4-24.

money." Tr.T. at 140:12-14; 119:13-21; 135:15-24.[7] Thus, a payment rate could be increased only if another rate was decreased. *Id.*

Josephine Ziglear, from The Arc of Harrison County, sat on the work group, which met for about two and a half years. Tr.T. 69:7-14. She testified that the process came to a halt because of the Department's zero sum game. Tr.T. at 70:1-23; 73:22-74:2. *See also* Mullins Tr. at 119:1-11 (same). Thus, even though initial consensus was reached among the work group and the Department to increase residential habilitation rates to $12 per hour, Tr.T. at 118:1-17, the providers ultimately could not agree to this because the resulting rate reduction for some other services would be "financially devastating" to some providers. Defendant's Trial Exh. 1. While the State may have given "great weight" to what the providers said about rates, it did so within a rigid frame work of "you can't spend any more money." When providers were unable to reach a unified position as to which ear to cut off, the State informed them that consequently there would be no change in rates. Mullins Tr. at 119:5-11.

The work group and the Defendant did not develop any sort of specific findings about the effect of the reimbursement rates on the ability of the behavioral health centers to employ and retain workers in the three categories at issue. *Id.*, Tr.T. at 140:15-23. The Defendant also did not consider the impact of federally-mandated increases in minimum wages in setting or evaluating the efficacy of these rates. *Id.* at 144:5-10.

In this case, there is ample evidence that the reimbursement rates were based on budgetary concerns. "However, the state may not ignore the Medicaid Act's requirements in order to suit budgetary needs." *Arkansas Med. Society*, 6 F.3d at 531. "Abundant persuasive precedent supports the proposition that budgetary considerations cannot be the conclusive factor in decisions regarding

---

[7] This ground came from the Department itself, and according to the Defendant, should not be confused with budget neutrality under the federal Medicaid Act's waiver provisions. Tr.T. at 135:22-25-136:1-7.

Medicaid." *Id.* (citations omitted). *See also Benjamin H. v. Ohl*, No. 3:99-0338 , slip op. at 25-26 (S.D.W.Va. July 15, 1999); *Orthopaedic Hospital*, 103 F.3d at 1499, n. 3 ("It is not justifiable for the Department to reimburse providers substantially less than their costs for purely budgetary reasons.") (citations omitted); *Ohio Hosp. Ass'n v. Ohio Dep't of Human Serv.*, 62 Ohio St. 3d at 102, N.E.2d at 699 (Medicaid agency violated the statute by adopting rates due to its own budgetary constraints and by failing to consider the rate's effect on the quality of care provided by the Medicaid program); *Rite Aid of Pennsylvania*, 171 F.3d at 853 ("We may find that an action is arbitrary and capricious if the agency relied on factors other than those intended by Congress, did not consider 'an important aspect' of the issue confronting the agency, provided an explanation for its decision which 'runs counter to the evidence before the agency....'") (citation omitted); *Illinois Hosp. Ass'n v. Illinois Dep't of Public Aid*, 576 F. Supp. 360, 371 (N.D.Ill.1983) ("By tieing [sic] payment rates solely to budgetary need, [the Illinois Department of Public Aid] has totally ignored the federal mandate that rates must be adequate to assure Medicaid beneficiaries reasonable access to hospital services of adequate quality, Section 1396a(a)(30)"). *Cf., e.g., Temple University v. White*, 941 F.2d 201 (3rd Cir. 1991), *cert. denied*, 502 U.S. 1032 (1992) (invalidating a hospital rate reduction based on a "budget neutrality adjustment"); *AMISUB (PSL), Inc. v. Colorado Dep't of Social Serv.*, 879 F.2d 789, 800-01 (10th Cir. 1989), *cert. denied*, 496 U.S. 935 (1990) (invalidating rates where state conceded that they had no relevance to the costs of an efficient hospital but were based on a "budget adjustment factor").[8]

Conclusion and Requested Relief

This Court should find the Defendant in violation of 42 U.S.C. § 1396a(a)(30)(A) because its rates for one-on-one residential habilitation, Respite I, and Respite II services under the home and

[8] These later cases apply the now-repealed Boren Amendment, 42 U.S.C. § 1396a(a)(13), which is "very analogous" to § 1396a(a)(30)(A). *Arkansas Med. Society*, 6 F.3d at 525.

community based MR/DD waiver are not consistent with efficiency, economy, and quality of care and do not ensure sufficient access. The rates are neither procedurally adequate nor do they achieve the requisite results.

The Defendant should be ordered to develop a plan to comply with § 1396a(a)(30)(A) within 120 days. As part of the plan development, the Defendant should be ordered to undertake responsible analysis that will provide reliable information as to providers' costs in providing one-on-one residential habilitation, and Respite I and II services, to the end that it determine the cost to efficient providers economically providing quality care. The Defendant should be ordered to consider protections that will ensure that direct care workers receive a living wage. The Defendant should then set reasonable rates, the Defendant bearing the burden of justifying any rate that substantially deviates from such determined costs.

BENJAMIN H., et al.,
By Counsel.

Jane Perkins
National Health Law Program, Inc.
211 N. Columbia St./2nd Floor
Chapel Hill, NC 27514
(919) 968-6308

Daniel F. Hedges (WV Bar # 1660)
Mountain State Justice, Inc.
922 Quarrier St, Suite 525
Charleston, WV 25301
(304) 344-3144

Kent Bryson (WV Bar # 7274)
West Virginia Advocates
1207 Quarrier St., 4th Fl.
Charleston, WV 25301
(304) 346-0847

Regan Bailey (WV Bar # 7055)
1806 Tilton Drive
Silver Spring, MD 20902
(301) 592-8186

COUNSEL FOR PLAINTIFFS

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
AT HUNTINGTON

BENJAMIN H., et al.,

Plaintiffs,

v. **CIVIL ACTION NO. 3:99-0338**

JOAN OHL, Secretary of the Department of Health and Human Resources,

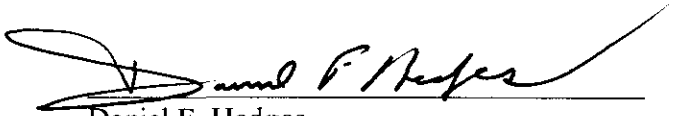
Defendant.

CERTIFICATE OF SERVICE

I, Daniel F. Hedges, counsel for the Plaintiffs in the above-styled matter, do hereby certify that I have served the foregoing **"POST TRIAL MEMORANDUM"** upon counsel for Defendant by sending a true and exact copy there by U.S. Mail, postage prepaid and properly addressed to their address of record as follows:

Kimberly L. Stitzinger
Assistant Attorney General
Bureau for Medical Services
7012 MacCorkle Avenue, S.E.
Charleston, WV 25304

Dated this 31st day of March, 2000.



Daniel F. Hedges