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SC Court of Appeals

IN THE STATE OF SOUTH CAROLINA

In The Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT
Carolyn C. Matthews, Administrative Law Judge

Case 10-ALJ-08-0774-AP

Richard Stogsdill ..... Appellant,

v

South Carolina Department of Health and Human Services ..... Respondent.

RECORD ON APPEAL

Volume I

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RICHARD STOGSDILL V. SCDHHS

DOCKET NO.

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NOTICE OF APPEAL

THE STATE OF SOUTH CAROLINA

IN THE COURT OF APPEALS

APPEAL FROM THE SOUTH CAROLINA ADMINISTRATIVE LAW COURT

Honorable Carolyn C. Matthews

Docket No.: 10-CLJ-08-0774-AP

Richard Stogsdill,
Appellant,

v.

South Carolina Department of Health and Human Services,
Respondent.

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NOTICE OF APPEAL

Richard Stogsdill appeals the order of Honorable Carolyn C. Matthews dated and filed in Richland County, South Carolina, on March 13, 2013, which was received by Appellant on March 14, 2013.

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April 9, 2013

THE STATE OF SOUTH CAROLINA

IN THE COURT OF APPEALS

APPEAL FROM THE SOUTH CAROLINA ADMINISTRATIVE LAW COURT

Honorable Carolyn C. Matthews

Docket No.: 10-CLJ-08-0774-AP

Richard Stogsdill,
Appellant,

v.

South Carolina Department of Health and Human Services,
Respondent.

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APR 09 2013
SC Court of Appeals

CERTIFICATE OF SERVICE

I hereby certify that I am serving by hand delivery on this date the Notice of Appeal to the offices listed below:

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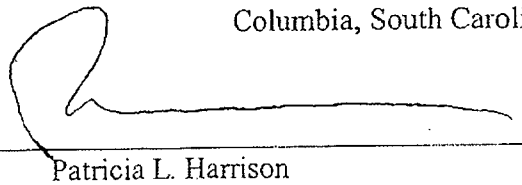

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ORDERS

RECEIVED MAR 14 2013

FILED

MAR 13 2013

SC ADMIN. LAW COURT

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

Richard Stogsdill,

Appellant,

vs.

South Carolina Department of Health and Human Services,

Respondent.

Docket No.: 10-ALJ-08-0774-AP

The Honorable Carolyn C. Matthews
March 13, 2013

Appearances: Patricia L. Harrison, Esquire, for Appellant
Richard G. Hepfer, Esquire, for Respondent

STATEMENT OF THE CASE

This matter is before me pursuant to the appeal of Richard Stogsdill (Appellant) from the final decision of Respondent, South Carolina Department of Health and Human Services (DHHS). Respondent determined that Appellant failed to state that DHHS by its agent, Department of Disabilities and Special Needs (DDSN), committed an error in fact or law in reducing Appellant's services. Appellant timely appealed that decision to the Administrative Law Court (ALC or Court). The ALC has jurisdiction to hear this matter pursuant to S.C. Code Ann. § 1-23-600 (Supp. 2012).

STANDARD OF REVIEW

This case is before the Court as an appeal from a Final Order of DHHS pursuant to S.C. Code Ann. § 1-23-600(D) of the Administrative Procedures Act (APA). An Administrative Law Judge reviews the case in an appellate capacity under the APA. In South Carolina, the provisions of the APA, specifically, Section 1-23-380(A)(6), govern the circumstances in which an appellate body may reverse or modify an agency decision. That section states:

> The Court may reverse or modify the decision if substantial rights of the appellant have been prejudiced because the administrative findings, inferences, conclusions or decisions are:
>
> (a) in violation of constitutional or statutory provisions;

(b) in excess of the statutory authority of the agency;
(c) made upon unlawful procedure;
(d) affected by other error of law;
(e) clearly erroneous in view of the reliable, probative and substantial evidence on the whole record; or
(f) arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

S.C. Code Ann. § 1-23-380(A)(6) (2009).

A decision is supported by "substantial evidence" when the record as a whole allows reasonable minds to reach the same conclusion reached by the agency. Bilton v. Best Western Royal Motor Lodge, 282 S.C. 634, 321 S.E.2d 63 (Ct. App. 1984). The well-settled case law in this state has also interpreted the rule to mean that a decision will not be set aside simply because reasonable minds may differ on the judgment. Lark v. Bi-Lo, 276 S.C. 130, 276 S.E.2d 304 (1981). The fact that the record, when considered as a whole, presents the possibility of drawing two inconsistent conclusions from the evidence does not prevent the agency's finding from being supported by substantial evidence. Waters v. South Carolina Land Resources Conservation Comm'n, 321 S.C. 219, 467 S.E.2d 913 (1996) and Grant v. South Carolina Coastal Council, 319 S.C. 348, 461 S.E.2d 388 (1995), both citing Palmetto Alliance, Inc. v. South Carolina Public Service Comm'n, 282 S.C. 430, 319 S.E.2d 695 (1984). See also, Miller v. State Roofing Co., 312 S.C. 452, 441 S.E.2d 323 (1994) and Bilton, 282 S.C. 634, 321 S.E.2d 63 (Ct. App. 1984).

In applying the substantial evidence rule, the factual findings of the administrative agency are presumed to be correct. Rodney v. Michelin Tire Co., 320 S.C. 515, 466 S.E.2d 357 (1996), citing Kearse v. State Health and Human Services Finance Comm'n, 318 S.C. 198, 456 S.E.2d 892 (1995). Furthermore, the reviewing court is prohibited from substituting its judgment for that of the agency as to the weight of the evidence on questions of fact. Grant v. South Carolina Coastal Council, 319 S.C. 348, 461 S.E.2d 388 (1995), citing Gibson v. Florence Country Club, 282 S.C. 384, 318 S.E.2d 365 (1984). Finally, the party challenging an agency action has the burden of proving convincingly that the agency's decision is unsupported by substantial evidence. Waters v. South Carolina Land Resources Conservation Comm'n, 321 S.C. 219, 467 S.E.2d 913 (1996), citing Hamm v. AT&T, 302 S.C. 210, 394 S.E.2d 842 (1994).

Of course, the ALC may always reverse or remand a decision, which is affected by an error of law. Gilliam v. Woodside Mills, et al., 312 S.C 523, 435 S.E.2d 872 (Ct. App. 1993).

However, in reviewing the errors of law asserted by the Appellant, the ALC does need to give deference to the Department's interpretation of its own rules and the relevant federal rules and manual provisions applied. Hampton Nursing Center v. State Health and Human Services Finance Commission, 303 S.C. 143, 399S.E. 2d 434 (Ct. App. 1990) and Ruocco v. S.C. Board of Registration for Professional Engineers and Land Surveyors, 314 S.C. 111, 441 S.E. 829 (Ct. App. 1994).

FACTS/BACKGROUND

Appellant in this matter is a Medicaid-eligible individual, who has been receiving services under the South Carolina Mental Retardation/Related Disabilities (MR/RD) Waiver. Under this Waiver, beneficiaries can be provided a mix of services through the Department of Disabilities and Special Needs (DDSN). Waivers are mechanisms within the Medicaid Program under which, by having certain generic requirements of the Medicaid program "waived," States are able to provide services to individuals in ways not allowed under the regular Medicaid Program. On January 1, 2010, the five-year renewal of the MR/RD Waiver, as approved by the Centers for Medicare and Medicaid Services (CMS), went into effect. The renewed Waiver included a cap or limit on some services and excluded others.

DDSN is responsible for the day-to-day operation of the Waiver. DHHS is the agency that administers the South Carolina Medicaid Program and is responsible for the overall administration of the Waiver. This appeal is directly from the DHHS Decision sustaining the action of DDSN reducing services to Appellant. The reduction was the result of the limitations set forth in the renewed Waiver.

Prior to the Waiver changes, Appellant was receiving a combined 69 hours of Personal Care Aide and Companion Care services per week and about 36 hours of Respite Care per week. Personal Care Aide II (PCAII) services consist of hands-on personal care that a person needs to accomplish their activities of daily living such as bathing, toileting, dressing and eating. Adult Companion Services are similar to PCAII services but include an aspect of community integration. Respite Care can be a range of services, including personal care but is designed to provide services when the normal caregiver is absent or needs relief.

The Waiver capped any combination of PCAII and Adult Companion services at 28 hours per week. The normal cap for Respite Services under the new Waiver is 68 hours per month (or almost 16 hours per week), but exceptions can be granted for up to 240 hours per

month (or about 56 hours per week). Under the new limits, Appellant's services were reduced to 28 hours of PCAII-type services (including Adult Companion services) per week and 68 monthly hours of Respite Care. After the initial cuts, Appellant's Service Coordinator applied for an increase in Respite Care, and Appellant was granted a total of 172 hours of Respite Care per month (or about 40 hours per week).

In accordance with the new Waiver, Appellant's Occupational and Speech Therapies were discontinued. After Reconsideration was denied, Appellant appealed the reductions and the elimination of services to the DHHS Appeals Division. In the Decision of the Department's Hearing Officer, the actions of Respondent were sustained. Appellant subsequently appealed this decision to the Administrative Law Court.

STATEMENT OF ISSUES ON APPEAL

1. Does the substantial evidence in the Record on Appeal support Respondent South Carolina Department of Health and Human Services' decision that changes in the waiver service were lawfully made?
2. Does the agency appeals process have defects that deprive Appellant of due process?
3. Does the substantial evidence in the Record on Appeal support Respondent South Carolina Department of Health and Human Services' decision that the previous Administrative Decision relating to Appellant was carried out insofar as the changes were permitted in the waiver?
4. Does the substantial evidence in the Record on Appeal support Respondent South Carolina Department of Health and Human Services' decision that the integration mandate of the Olmstead case was not violated?

DISCUSSION

1. Changes in Waiver

Section 1915(c) of the Social Security Act [42 USC §1396n(c)] permits states to waive the requirement that persons with mental retardation or a related disability live in an institution in order to receive certain Medicaid services. "[The program] allow[s] states to experiment with methods of care, or to provide care on a targeted basis, without adhering to the strict mandates of the Medicaid system." See Bryson v. Shumway, 308 F. 3d 79 (1st Cir. 2002), cited in Doe v. Kidd, 501 F.3d 348 (4th Cir. 2007). Under S.C. Code Ann. §44-6-5 et seq. DHHS is the single state agency designated to administer the South Carolina's Medicaid Program. §1902(a)(5) [42

USC §396a(a)(5)] and 42 CFR §431.10.

Respondent has the statutory authority to enter into a Waiver agreement with the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers the Program. The major changes include the new limits on Personal Care Aide Services (PCA), Adult Companion Services (ACS), and Respite Care. Speech Language pathology, Occupational and Physical Therapy are among the services eliminated. The elimination of "daily" respite is a reimbursement change, which does not eliminate the service. Therefore, the Departments have properly exercised their authority to amend the Waiver, and CMS, the responsible federal agency has approved the change.

A general notice was sent out to all DDSN clients notifying them of the pending changes and encouraged those affected to work with DDSN Service Coordinators (case managers) to mediate the impact of the new service limits. Service coordinators were trained in the changes. Notices were sent to all beneficiaries who were directly impacted. Service Coordinators contacted the effected clients in order to help rearrange services to get needed coverage within the new Waiver limits.

The general requirements of the services are set forth in 42 CFR §440.230 Sufficiency of amount, duration, and scope, and read as follows:

> (a) The [State Medicaid] plan must specify the amount, duration, and scope of each service that it provides for--
> (1) The categorically needy; and
> (2) Each covered group of medically needy.
> (b) Each service must be *sufficient in amount, duration, and scope* to reasonably achieve its purpose.
> (c) The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under Sec. Sec. 440.210 and 440.220 to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition.
> (d) The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures. (Emphasis added)

However, §440.230(b) means adequacy of the service as a whole. Therefore, the Hearing Officer could have made a finding that the services to this specific Appellant were insufficient, but would not be able, under §440.230(b) to generalize to the adequacy of the services provided within the Waiver program.

Services have been provided with reasonable promptness, even assuming that the provision of services is included in the reasonable promptness provisions. Sec. 1902(a)(8) [42 USC §1396a(a)(8)] provides as follows:

> A State plan for medical assistance must—
>
> (8) provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals;

In his Decision, the Hearing Officer specifically found that the services were provided with reasonable promptness. There seems to be a split among the federal circuits with respect to the meaning of the "reasonable promptness" provision, and this and other legal issues were preserved in the Decision for future review. Some courts have held that the reasonable promptness provision only means prompt payment for services received and, by implication, not assuring that the services themselves are rendered. See, Equal Access for El Paso, Inc. v. Hawkins, 562 F.3d 724 (5th Cir.2009); Brown v. Tenn. Dep't of Finance & Admin., 561 F.3d 542, 544-45 (6th Cir.2009); Doe v. Kidd, 501 F.3d 348, 355-56 (4th Cir.2007) and Bruggeman v. Blagojevich, 324 F. 3d 906 (7th Cir. 2003). A few circuits and district courts have gone in the other direction and have treated the Medicaid Act as requiring a state to provide certain actual medical services. Bryson v. Shumway, 308 F.3d 79, 81, 88-89 (1st Cir.2002); Doe v. Chiles, 136 F.3d 709, (11th Cir.1998); Boulet v. Cellucci, 107 F.Supp.2d 61 (D.Mass.2000).

The controversy stems from the definition of "medical assistance" in 42 USC §1396d(a), which now reads as follows:

> (a) The term "medical assistance" means payment of part or all of the cost of the following care and services **or the care and services themselves, or both.**

Before the Hearing Officer's Decision in this matter, the underlined and bolded part was added by the Patient Protection and Affordable Care Act (ACA, Pub.L 111-145) effective March 23, 2010. Although the legislative history does indicate that this amendment was intended to correct any misunderstandings of the meaning of the term, it is still for courts to determine the retroactive effect, if any, of the amendment. In any case, any misunderstandings are not relevant here because the Hearing Officer had substantial evidence to find that services themselves had been provided with reasonable promptness. It is the amount of the services that is at issue here.

The Program Coordinator from the District Office received an application from the Service Coordinator to increase the Respite Care to make up for the reduction in PCAII Services. The application was from the Service Coordinator, Ms. Yankowitz. The Service Coordinator had recommended 228 hours of respite services per month. This took into consideration the attending physician's orders, as was required in the previous Administrative Decision. The Service Coordinator's request was within the limits created by the new Waiver. Therefore, I find that the substantial evidence in the Record on Appeal supports the finding that the changes in the waiver were lawfully made.

2. Due Process

Appellant asserts that DDSN's initial notice to Appellant about the reduction in services was defective and in violation of due process because it did not comply with the following regulation:

> §431.210 Content of notice.
>
> A notice required under Sec. 431.206 (c)(2), (c)(3), or (c)(4) of this subpart must contain--
> (a) A statement of what action the State, skilled nursing facility, or nursing facility intends to take;
> (b) The reasons for the intended action;
> (c) The specific regulations that support, or the change in Federal or State law that requires, the action;
> (d) An explanation of--
> (1) The individual's right to request an evidentiary hearing if one is available, or a State agency hearing; or
> (2) In cases of an action based on a change in law, the circumstances under which a hearing will be granted; and
> (e) An explanation of the circumstances under which Medicaid is continued if a hearing is requested.

Specifically, Appellant complains that the notice does not adequately describe the action taken by the agency.

The "regulations that support... the action" are set forth in the general description of the home and community based waivers in 42 CFR §440.180 of the Medicaid Regulations which reads in pertinent part:

> 440.180 Home or community-based services.

(a) Description and requirements for services. ``Home or community-based services'' means services, not otherwise furnished under the State's Medicaid plan, that are furnished under a waiver granted under the provisions of part 441, subpart G of this chapter.

(1) These services may consist of any or all of the services listed in paragraph (b) of this section, as those services are defined by the agency and approved by CMS.

Appellant alleges that his parents were warned that they would be responsible for the cost of services provided during the pendency of the appeal. This is set forth in 42 CFR §435.602(a) which is included in Part 435, Eligibility, of 42 CFR, Subpart G entitled General Financial Requirements and Options:

Sec. 435.602 Financial responsibility of relatives and other individuals.

(a) Basic requirements. Subject to the provisions of paragraphs (b) and (c) of this section, in determining financial responsibility of relatives and other persons for individuals under Medicaid, the agency must apply the following requirements and methodologies:

(1) Except for a spouse of an individual or a parent for a child who is under age 21 or blind or disabled, the agency must not consider income and resources of any relative as available to an individual.

(2) In relation to individuals under age 21 (as described in section 1905(a)(i) of the Act), the financial responsibility requirements and methodologies that apply include considering the income and resources of parents or spouses whose income and resources would be considered if the individual under age 21 were dependent under the State's approved AFDC plan, whether or not they are actually contributed, except as specified under paragraphs (c) and (d) of this section. These requirements and methodologies must be applied in accordance with the provisions of the
State's approved AFDC plan.

(3) When a couple ceases to live together, the agency must count only the income of the individual spouse in determining his or her eligibility, beginning the first month following the month the couple ceases to live together.

(4) In the case of eligible institutionalized spouses who are aged, blind, and disabled and who have shared the same room in a title XIX Medicaid institution, the agency has the option of considering these couples as eligible couples for purposes of counting income and resources or as eligible individuals, whichever is more advantageous to the couple.

This addresses the calculation of Medicaid eligibility. The Medicaid Fair Hearing regulations allow the agency to recoup the cost of services maintained during the pendency of an appeal:

Sec. 431.230 Maintaining services.

(a) If the agency mails the 10-day or 5-day notice as required under Sec. 431.211 or Sec. 431.214 of this subpart, and the recipient requests a hearing before the date of action, the agency may not terminate or reduce services until a decision is rendered after the hearing unless--

(1) It is determined at the hearing that the sole issue is one of Federal or State law or policy; and

(2) The agency promptly informs the recipient in writing that services are to be terminated or reduced pending the hearing decision.

(b) If the agency's action is sustained by the hearing decision, the agency may institute recovery procedures against the applicant or recipient to recoup the cost of any services furnished the recipient, to the extent they were furnished solely by reason of this section.

Appellant alleges that ex parte communication took place in violation of SC Code Ann. § 1-23-360 which provides:

SECTION 1-23-360. Communication by members or employees of agency assigned to decide contested case.

Unless required for the disposition of ex parte matters authorized by law, members or employees of an agency assigned to render a decision or to make findings of fact and conclusions of law in a contested case shall not communicate, directly or indirectly, in connection with any issue of fact, with any person or party, nor, in connection with any issue of law, with any party or his representative, except upon notice and opportunity for all parties to participate. An agency member:

(1) May communicate with other members of the agency; and

(2) May have the aid and advice of one or more personal assistants.

Any person who violates the provisions of this section shall be deemed guilty of a misdemeanor and upon conviction shall be fined not more than two hundred fifty dollars or imprisoned for not more than six months.

Ex parte communication was not done by the Hearing Officer, however, there was preliminary communication which took place between DDSN and the Director of the Appeals Division. This communication has not been shown as prejudicial. The person identified by Appellant as having violated this provision was, at the time, the Director of the Division of Appeals and Hearings. He was not the person assigned to make the findings of fact and conclusions of law in this case. Even if he had been the person, it goes against reason that the adjudicator cannot find out what the posture of the case is before issuing a Notice of the Hearing. For the foregoing reasons, I find that adequate due process was afforded to Appellant.

3. Previous Administrative Decision

Respondent asserts that the Decision in the 2009 case of [Appellant] v. SCDHHS, 09-

MISC-017 was a final Order, which the Hearing Officer expected to be carried out. Respondent did not object to the incorporation of the previous case, and the record reflects that the Hearing Officer in this case reviewed it. However, the Hearing Officer declined to apply it dispositively to the Appellant's need for care at this time. Respondent asserts that the previous case ended with the Remand and the Hearing Officer did not retain jurisdiction of the case for further review. The Court agrees.

During the time the previous Order was being implemented, the new Waiver required all services to be reevaluated, taking into consideration the new limits. The evidence substantiates the Hearing Officer's decision to examine the reduction in services to Appellant brought on by the new wavier limits. Moreover, it appears that upon remand to the DDSN, Appellant's case was reevaluated and reauthorized by the new Service Coordinator, taking into account the orders of the Appellant's attending physician. The substantial evidence reflects that the previous administrative decision was carried out while conforming with the changes in the Waiver.

4. The Olmstead Mandate

Olmstead v. L.C. ex rel Zimrig, 527 U.S. 581 (1999) sets forth the requirements for the administering of waiver services. Neither Olmstead nor the DDSN's enabling statutes requires the Department to maintain service at the pre-2010 level. The new waiver went into effect on January 1, 2010. At that time, Appellant was receiving a combined 69 hours of Personal Care Aide and Companion Care services per week and about 36 hours of Respite Care per week. .

Under Olmstead, States are required to provide community-based treatment for persons with mental disabilities when the State's treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the state and the needs of other with mental disabilities. Id. at 587.

Appellant argues that the Supreme Court in Olmstead said that if the person wants to live in the community and the State's treating professionals think he can and the State can reasonably accommodate such a placement, then the person should be supported in the community. The proposed cuts in services to Appellant, could lead to his having to be institutionalized, and, therefore, the cuts should be prohibited.

Appellant is living in the community, and it is speculative as to whether the reduction in services will cause him to be institutionalized. If it is assumed to be true that he would be

institutionalized, the State's responsibility under Olmstead (to support a person in the community) is not boundless. Olmstead, at 603. If the accommodation would fundamentally alter the State's program, the State does not have to make the accommodation.

ORDER

THEREFORE, IT IS HEREBY ORDERED that the decision of the South Carolina Department of Health and Human Services is **AFFIRMED.**

Carolyn C. Matthews

CAROLYN C. MATTHEWS
Administrative Law Judge

March 13, 2013
Columbia, South Carolina

CERTIFICATE OF SERVICE
This is to certify that the undersigned has this date served this order in the above entitled action upon all parties to this cause by depositing a copy hereof, in the United States mail, postage paid, or in the Interagency Mail Service addressed to the party(ies) or their attorney(s).

This 13 day of March 2013

By: Paige P. Snyder
Judicial Law Clerk

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FINAL ADMINISTRATIVE ORDER IN THE APPEAL MATTER OF R.S. (PETITIONER) v. SCDHHS (RESPONDENT)

Appeals Case #10-MISC-042 (MR/RD)
MID# 7715326001
Hearing Date: May 11, 2010

JURISDICTION

Procedure in this case is governed under the authority granted by the South Carolina General Assembly to the South Carolina Department of Health and Human Services (SCDHHS) to administer various programs and grants (See e.g., S.C. Code Ann §44-6-5, et seq.). This appeal has been conducted pursuant to the provisions of the Appeals and Hearings regulations of the SCDHHS (S.C. Code Ann. R. 126-150 et seq.) and the South Carolina Administrative Procedures Act (S.C. Code Ann. §1-23-310 et seq.)

STATEMENT OF THE CASE

The Petitioner is a Medicaid-eligible individual, who has been receiving services under the South Carolina Mental Retardation/Related Disabilities (MR/RD) Waiver. Under this Waiver, beneficiaries can be provided a mix of services through Department of Disabilities and Special Needs (SCDDSN). Waivers are mechanisms within the Medicaid Program under which by "waiving" certain generic requirements of the Medicaid Program the federal government permits States to provide services to individuals in ways not allowed under the regular Medicaid Program. On January 1, 2010, the five-year renewal of the MR/RD Waiver, as approved by the Centers for Medicare and Medicaid Services (CMS), went into effect. The renewed Waiver included a cap or limit on some services and excluded others.

The SCDDSN is responsible for the day-to-day operation of this Waiver. The Department of Health and Human Services (Department, DHHS, Respondent) is the agency that administers the South Carolina Medicaid Program, and so, is also responsible for the overall administration of the Waiver. This appeal is directly from a DDSN Reconsideration of a reduction in services to the Petitioner. The reduction was the result of the limitations set forth in the renewed Waiver. The Reconsideration upheld the original reduction, thus, this appeal is before the Appeals Division of the DHHS. In this case, the hearing was held on Tuesday, May 11, 2010, at which time I asked for Briefs on the many legal issues raised in the appeal and as further put forth at the hearing.

It appears that as the time for the January 1, 2010, limitations in the Waiver services was getting close, the DDSN Service Coordinators (the workers who coordinate the participants' care) began to talk with participants about the cuts and what adjustments could be made so that there would, insofar as possible, be no gaps in services. However, because the Petitioner did believe that there would be gaps in his service, he asked, in accordance with the proper procedure, that the Director of DDSN reconsider the DDSN's actions and maintain his services to pre-January levels. The Director of DDSN denied that request (See the Reconsideration Decision) and, therefore, appeal was made to the DHHS Division of Appeals and Hearings, as is also proper.

ISSUES

Thus, the issue before me in this case is whether the SCDDSN acted correctly in reducing the Petitioner's services. Both sides in this matter have filed briefs on this and many other issues weighing on the matter. The original appeal, dated February 11, 2010, raised a number of issues, summarized below:

1. The reduction and termination of certain Waiver services without proper Notice;
2. The failure to apply reasonable medical standards in determining service needs;
3. Violation of the notice requirements of due process and the promptness requirements established by the Centers of Medicare and Medicaid Services (CMS);
4. Violation of Olmstead v. L.C., 527 U.S. 581 (1999) and related CMS directives;
5. Failure to use the federal stimulus funds to maintain the Petitioner's services.

The Respondent's Prehearing Brief, with attachments, dated May 6, 2010, attempted to explain how:

1. The Respondent and it's agent the SCDDSN had the authority to amend the Waiver so as to reduce the services, and properly did so;
2. That the Departments had applied reasonable standards of medical necessity in serving the Petitioner;
3. That the proper due process and standards of promptness were followed;
4. That, in reducing services, the Departments did not violate Olmstead v. L.C., 527 U.S. 581 (1999) and other related federal laws; and
5. That the federal stimulus funds did not impact the case at all.

The Petitioner's Post-hearing Brief, in addition to further arguing the issues set forth above by example and caselaw, expanded upon the following issues, which I believe were raised at the hearing:

1. That the Waiver Amendment was not a change in law;
2. That in a previous appeal, the Hearing Officer had found that the Petitioner needed certain services and thus the capped services did not meet his needs; and
3. That, the budget explanation for the reduction is a pretext since the reductions will actually result in the same payments to DDSN.

The Respondent's Post-hearing Brief was dated June 14, 2010 and dealt with the due process and the Olmstead issues mostly by attempting to distinguish the caselaw presented by the Petitioner.

I was expecting additional information, but I believe that I did not clearly communicate that during the hearing and since it appears that I have sufficient information to decide the matter, I will now do so. After June 14, 2010, no further information was submitted. I apologize for the delay in rendering the Decision. Our normal cases involve one or two factual issues and normally one legal issue at most. There were a number of legal arguments raised in this case, which had to be studied. During that process, I took comfort in knowing that the Petitioner's services were maintained at the pre-2010 level during the pendency of the appeal.

INFORMATION BEFORE THE HEARING OFFICER

1. I am generally familiar with the operations of the Departments' and with the Waiver at issue here;
2. I have the legal Briefs mentioned above;
3. I have the DDSN Director's Reconsideration determination and a clarification that was requested from DDSN about the effects of the reduction on the Petitioner's services (Respondent's Exhibit #1);
4. I have the testimony of the following individuals:
    a. Ms. Dawn Shealy, from the county Department of Special Needs (DSN) Board was familiar with the services the Petitioner was receiving and signed the decision granting the Petitioner additional Respite Services.
    b. Mr. Jacob Chorey, of the central DDSN office, is the current Waiver Coordinator who is responsible for the overall operation of the Waiver.
    c. Ms. N. S. is the Petitioner's mother and is one of his caregivers.
5. I have the following documents.

    a. Petitioner's Exhibits:

Exhibit 1. SC Supreme Court Petition in the case of Karen W. v. DHHS et al., a December 23, 2009, Complaint in the Original Jurisdiction of the Supreme Court (of South Carolina) seeking a mandamus for the provision of federal funds to maintain SCDDSN services. ;

Exhibit 2. A "Review Of The MR/RD Waiver As Operated By The Department Of Disabilities And Special Needs," performed by the SCDHHS Division of Audits, dated February 28, 2006;

Exhibit 3. A seventy-five page document by Protection and Advocacy for People with Disabilities, Inc., entitled "Unequal Justice For South Carolinians with Disabilities: Abuse and Neglect Investigations;"

Exhibit 4. A seventy-five page document by Protection and Advocacy for People with Disabilities, Inc., entitled "No Place to Call Home: How South Carolina Has Failed Residents of Community Residential Care Facilities;"

Exhibit 5. An eighty-page, December 2008 Review of the Department of Disabilities and Special Needs by the Legislative Audit Council;

Exhibit 6. A Detailed Claims Report, showing Medicaid payments made on behalf of the Petitioner from August 2001 to December 2008;

Exhibit 7. The Minutes of the August 20, 2009 meeting of the SCDDSN Commission;

Exhibit 8. The Minutes of the May 21, 2009 meeting of the SCDDSN Commission;

Exhibit 9. The Minutes of the May 19, 2009 meeting of the SCDHHS Medical Care Advisory Committee;

Exhibit 10. An AARP Public Policy Institute paper on State Long Term Care Reform with an October 15, 2009; letter from David Goodell, Associate State Director, Operations of SCDDSN attached;

Exhibit 11. A Direct Care Alliance, Inc. Policy Brief No. 13 on "The Best and Worst State Practices in Medicaid Long Term Care;"

Exhibit 12. The Minutes of the State Budget and Control Board Meeting of September 3, 2009;

Exhibit 13. A White House Press Release, dated June 22, 2009, about President Obama's commemoration of the anniversary of the Olmstead decision;

Exhibit 14. The Cost Factor Estimates (5 year) of Appendix G-2 of the previous Waiver;

Exhibit 15. Part of Appendix J: Cost Neutrality Demonstration of the January 1, 2010 Waiver document;

Exhibit 16. A page, dated December 2nd 2009, entitled "Briefs Filed in Three States to Enforce Supreme Court's Olmstead Decision;"

Exhibit 17. A copy of S.C. Code Ann. §44-26-140;

Exhibit 18. A June 11, 2009, letter from Emma Forkner, the Director of SCDHHS to Suzanne Bostic, Director of the Center for Medicaid and State Operations at the US Department of Health and Human Services;

Exhibit 19. A Detailed Claims Report, showing Medicaid payments made on behalf of the Petitioner from March 2007 to December 2008;

Exhibit 20. A June 9, 2009, memo from Eugene A. Laurent, Ph.D., the State Director of DDSN to the Executive Directors and DDSN Boards, Subject: Apology;

Exhibit 21. A 2/26/2010 letter from the DDSN Commission to State Representative Daniel T "Dan" Cooper;

Exhibit 22. The United States' *Amicus Curiae* Memo in the Marlo v. Cansler case;

Exhibit 23. The United States. Memo in Support of Motion for Summary Judgment in Marlo v. Cansler, CA No: 5:09-CV-00535-BO (W.D. NC, 12/23/2009);

Exhibit 24. A National Health Law Program discussion of Crabtree v. Goetz M.D. Tenn.);

Exhibit 25. Knowles v. Horn, CA No: 3:08-CV-1492-K (N.D. Tx., 2/10/2010);

Exhibit 26. Moore v. Medows, CA No: 1:07-CV-631-TWT (N.D. Ga., 12/9/2009);

Exhibit 27. The Affidavit of the Petitioner's behavioral support and counseling provider;

Exhibit 28. The Affidavit of the Petitioner's attending physician;

Exhibit 29. The Affidavit of the Petitioner;

Exhibit 30. A Notice of Termination of Service, dated 1/11/10, signed by Ms. Kimberly Bennett and directed to Hawthorne Medical Equipment;

Exhibit 31. A Notice of Termination of Service dated 1/11/10, signed by Ms. Kimberly Bennett and directed to Home Remedies;

Exhibit 32. A June 2009 e-mail exchange between Ms. S., the Petitioner's mother and a member of the DDSN's Commission;

Exhibit 33. Page 47 of the DDSN 2008-09 Accountability Report containing a graph of the cost of institutional versus community services;

b. Respondent's Exhibits:

Exhibit 1. 18 February 2010 Memo from Jacob Chorey to Vastine Crouch about the new Waiver effects upon the Petitioner;

Exhibit 2. The Respondent's Pre-hearing Brief;
Exhibit 3. March 1, 2010 Memo from Dawn Shealy to Service Coordinator, Suzanne Yankowitz granting an exception to the Waiver limit of Respite Services (to 172 total hours per month).
Exhibit 4. November 6, 2009 Memo on Waiver and Day Services Information Sessions.

FINDINGS OF FACT

I listened carefully to the testimony of the witnesses, observing their demeanor, and reviewed the multitude of documents submitted. In addition, as mentioned, I am somewhat familiar with the Departments' operations and the Waiver at issue here. Based upon that information, I make the following findings of fact:

1. I take official notice that on January 1, 2010, the Respondent's new MR/RD Waiver went into effect;
2. Based upon the testimony of Mr. Chorey and upon the documents submitted, I find that no later than the Summer of 2009, the Departments began the process of submitting a renewed Mental Retardation/Related Disabilities (MR/RD) Waiver to CMS;
3. Based upon the Testimony of Ms. Shealy, Mr. Chorey and the Notices submitted in the Respondent's Exhibit #4, and Petitioner's Exhibits ##30 & 31, I find that the new Waiver was discussed publically and staff from the local DSN Board discussed the new limitations of the Waiver and the potential effects on him with the Petitioner, in December of 2009, but that proper written notice to the Petitioner was not provided;
4. However, based upon the Reconsideration Decision of Dr. Buscemi (Hearing Officer's file), I find that the Petitioner was aware of the potential reduction in services affecting him and the reasons for the proposed reductions, when he appealed to the DHHS' Division of Appeals and Hearings;
5. Based upon the Memo of Mr. Chorey, Respondent's Exhibit #1, and on the Detailed Claims Reports submitted by the Petitioner (Exhibits ##6 & 19), I find that at the time of the proposed reductions the Petitioner was receiving the following services:
    a. 15 hours per week of Adult Companion Services;
    b. 54 hours per week of Personal Care II Services;
    c. 36 hours per week of Respite Care;
    d. Other Waiver and Medicaid Services, including supplies, medications, and, and some Therapies according to his Detailed Claims Reports (Exhibits ##6 & 19),

6. Based upon Mr. Chorey's Memo and the testimony of Ms. Shealy, I find that the Petitioner's services were to be reduced to the following levels;
    a. Adult Companion Services and Personal Care Services would be reduced to a combined total of 28 hours per week, the limit imposed by the new Waiver;
    b. Respite Care Services would be increased to a total of 172 hours per month or approximately 40 hours per week (172 hours/4.3 average number of weeks per month), an authorized exception to the normal limits;
    c. The Petitioner would continue to receive supplies and medications under the Waiver, but his Therapies, at least under the Waiver, would be terminated, since the new Waiver Services do not include PT, OT, and Speech Therapy (See, Petitioner's Exhibits ##14 &15).
7. Thus, I find that if the proposed reductions were to go into effect, the Petitioner would receive from the Waiver, a total of about 44 hours of "personal care type" services per week -- that is hands-on help with bathing, dressing, toileting, supervision, and so forth;
8. Based upon Respondent's Exhibit #3, I find that the 172 hours per month of Respite Services are an exception to the normal limits of 68 hours per month;
9. Based upon the testimony of Ms. Shealy, the Affidavit of the attending physician, and the testimony of the Petitioner's mother, Ms. N.S., I find that the Petitioner has a diagnosis of cerebral palsy and a history of seizures, although his seizures are currently controlled, and he is in need of some care or at least monitoring for 24 hours per day;
10. Based on the testimony of Ms. N.S., I find that the Petitioner's parents live on the same property, in close proximity to the Petitioner, and provide some of his care;
11. Based upon the Affidavits and testimony, I find that the Petitioner also has additional resources, such as a motorized wheelchair and other supplies and equipment to assist him in his daily routine.
12. Based upon his Affidavit, I find the Petitioner believes he needs his current level of services to remain in his current living arrangement and is uninterested in trying additional services that might be performed in a congregate setting.

CONCLUSIONS OF LAW

I reviewed the Briefs and presentations of the Parties and read the caselaw submitted. Based upon that information, I make the following Conclusions:

1. I conclude that in accordance §1915(c) of the Social Security Act [42 USC §1396n(c)] States may be permitted to waive certain generic requirements of the Medicaid Program and provide services in certain ways to allow persons with mental retardation or a related disability who would normally have to live in an institution to

live in the community. The Petitioner submitted extensive documentation to illustrate the dialogue that took place within the State leading up to the submission and approval of the Waiver renewal (Petitioner's Exhibits ##7-9, 12, 18, 20, 21 & 32), but does not say what rules were violated in the process of renewing the Waiver. I therefore further conclude that this State has properly entered into a new Waiver commencing on January 1, 2010, which reduced some services and eliminated others.

2. I have read the Petitioner's attending physician's Affidavit and believe that it should be given great weight in planning for the Petitioner's care. I further believe that the physician's orders were given great weight during the deliberations on the Petitioner's request for an exception to the Respite limits. The Petitioner, due to his excessive need for hands-on care as set forth in this Request (Respondent's Exhibit #3), was granted an exemption from the normal limit of 68 Respite hours per month, to 172 hours per month. Furthermore, as I understand the caselaw and other information submitted by the Parties, the Petitioner, as an adult, is not entitled to have the Waiver provide all medically necessary services, only those within the limits of the Waiver. I, therefore, conclude that, if the Waiver itself is lawful, that the proper considerations were taken in authorizing services to the Petitioner, and with reasonable promptness.
3. The Petitioner is a long time Waiver participant, who has been receiving services for some years. I believe that the Petitioner is arguing that he should have been given advanced notice of the exact reduction in services and a description of the hearing rights that apply. He is right. Full and descriptive notice of the agency action to be taken and the appeal rights attached should go to the participant in advance of the action to be taken. The notice should go to the participant, not just his service providers. Fortunately, the Reconsideration process in this case gave the DDSN another chance to fully describe the actions to be taken. It appears that at the time of the appeal to the DHHS, the Petitioner was aware of the agency action contemplated. I conclude that although faulty in many respects, which should be corrected, the Petitioner had adequate notice of the proposed agency actions and the reasons therefore to effectively prosecute his case.
4. As I understand the Petitioner's next legal argument, it is that Olmstead mandated that the State provide care to disabled individuals in the most integrated setting possible and that by reducing the Petitioner's "personal care-type" services and eliminating other services, the State is putting the Petitioner in jeopardy of less integration into the community and possibly even institutionalization. I cannot agree with that analysis. To me it seems as though the Petitioner is relatively assured of continuing in a non-institutional setting. Now, his parents are in close proximity. He has a lot of assistive equipment and services. Finally, there are many other services

offered by the Waiver that the Petitioner could avail himself of in order to avoid institutionalization and become even more fully integrated into the community. I believe that the predictions of some of the Petitioner's health care professionals (Petitioner's Exhibits ##27 & 28) must be speculative. I therefore conclude that, with respect to the Petitioner, the actions of the Respondents are not violative of Omstead and the Americans with Disabilities Act.

5. Petitioner's Exhibits ##2-4 and 10, 11, & 33 are general reviews and commentaries on the state of DDSN and other services to the disabled in South Carolina and do not seem directly relevant to the issue of whether the reductions in services were appropriate in this case. The thrust of those submissions seems to be that because the services rendered by DDSN and monitored by other South Carolina agencies has, in the past and recently, been the subject of criticism that the limitations set forth in the 2010 Waiver should not be allowed to be effectuated in this and in other cases. Again, I cannot agree with this proposition. It seems to me that the new Waiver should be given a chance to work. I therefore conclude that past problems with the Departments' and State's other programs do not make this Waiver illegal or improper.
6. As I understand the Petitioner's next legal argument, it is that the Federal Stimulus Funds, authorized under the American Recovery and Reinvestment Act (ARRA, Pub. L. No. 111-5), were diverted by the South Carolina Legislature, the Governor, and the Departments into a "rainy day" fund and should be released back to the programs for which they were intended. First of all, the Respondent, in its Prehearing Brief, has convincingly shown that the ARRA reduction restrictions deal with eligibility, not with services. Secondly, the Petitioner's Exhibit #1 shows me that this issue is or was before a much higher review panel than this one, and as a matter of comity, I will defer to that body or some higher authority. I cannot conclude that the Waiver reductions violated ARRA or that the Stimulus Funds were improperly used.
7. I have reviewed the record and the Decision in the previous case, [Petitioner] v. SCDHHS, 09-MISC-017. The Petitioner would have the Hearing Officer's findings as to the amount of services appropriate in the earlier case be dispositive as to the services now appropriate. Because of the intervening factor of the new Waiver with new limits, I cannot agree to that, and so conclude that the appropriate level of services in this case must be determined separately for this case, at this time.
8. The Petitioner points out that the renewal of the Waiver was not a change in law, and I believe that the Petitioner is correct in asserting that. However, I cannot find anywhere in the information submitted or in the Medicaid rules generally that there has to be a change in law in order to effectuate a renewal of this, or any, Waiver.

Therefore, I cannot conclude that the Waiver is defective for not being reflective of a change in the law.

9. The Petitioner has submitted some information showing the cost for Waiver services and a comparison of South Carolina's expenditures for these services with other State's (Exhibits ## 14 & 15). He would like to submit additional information showing that the "budget reduction" explanation for the service limitations and terminations is a fabrication. I cannot see any purpose that would be served by allowing that additional information. It is common knowledge that most, if not all, State agencies have experienced recent budget reductions. It seems fairly obvious that reducing services would reduce costs in some way, and page 1 of the Waiver document submitted with the respondent's Pre-hearing Brief only says, "Due to the State of South Carolina's budget situation...." That is, on its face, a believable statement in these economic times, but as I understand the Medicaid relationship between the State and federal governments, the statement is not required to be proved or demonstrated in order for the State to secure CMS' approval for the reduction in its Waiver services. I therefore conclude that additional information on the budget impact is not necessary.

DECISION

It appears to me that the Departments had the authority to renew the MR/RD Waiver and limit or exclude services from the Waiver in the renewal. It appears that the Departments did so with some input from the community. The Departments did not properly notify the Petitioner of the specific reductions to be imposed upon him. Even if you consider that the Petitioner, in filing his appeal, did preempt the imposition of the reduction by a week or so, the notification should still have gone to him and his responsible party, not just his providers. Even though the Reconsideration process did, in a sense, "cure" the error, the Departments must ensure proper communication and notice to the Waiver participants.

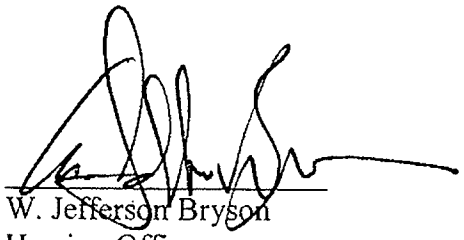
It further appears to me that the new Waiver is not violative of the Olmstead integration mandate or is adversely affected by other alleged defects in the Departments' programs, by alleged failure to comply with the ARRA, by the failure to promulgate the changes through the legislative process, or by possibly improperly justifying the changes as responses to budget reductions. Obviously, those legal arguments may be preserved for further review, if sought.

It also appears to me that the attending physician's orders were promptly considered in the request for an exception to the Respite Care limits and in the authorization of the exception to 172 hours of Respite Care per month. Neither the new Waiver nor the old Waiver guarantees that all medically necessary services will be provided to participants. The new Waiver imposes limits not present in the old Waiver, and therefore, the findings of the

Hearing Officer in the previous case are not binding on this case. I believe that the limitations were properly applied to this participant, and I urge the Petitioner to continue to work with his new Service Coordinator to explore other services, within the Waiver limits that engage him in activities outside the home and in the community.

Therefore, the Respondents' actions in this matter are sustained.

AND IT IS SO ORDERED.



W. Jefferson Bryson
Hearing Officer

DATED AT COLUMBIA
South Carolina

September 14, 2010

71. Filing Fee.

A. Cases for which Fee Required. Each request for a contested case hearing, notice of appeal, or request for injunctive relief before the Court must be accompanied by a filing fee in the amount set forth in Rule 71(C). A case will not be assigned to an administrative law judge and will not be processed until the filing fee has been paid or a waiver has been granted pursuant to Rule 71(B). This fee is not required for contested cases, appeals, or requests for injunctive relief brought by the State of South Carolina or its departments or agencies. For appeals brought pursuant to Al-Shabazz v. State, 338 S.C. 354, 527 S.E.2d 742 (2000), the fee will be assessed only for the seventh and subsequent appeals filed by an inmate during a given calendar year.

27

B. Request for Waiver. A party who is unable to pay the filing fee may request a waiver of the fee by filing a completed Request for Waiver form with the Clerk of the Court at the same time the request for a contested case, notice of appeal, or request for injunctive relief is filed with the Court. Request for Waiver forms shall be issued by the Clerk of the Court. If the filing fee is not waived, the party must pay the filing fee within ten days of the date of receipt of the order denying waiver of the filing fee. If the filing fee for a case is waived on behalf of a party, any motions filed by that party in that case are exempt from the motion fee as provided in Rule 71(D).

C. Schedule of Filing Fees. The filing fee will be assessed according to the following schedule:

Case Type
Fee

Dept. of Health and Human Services
$50

D. Motion Fees. A fee of $25 will be imposed for the following motions filed with the Court:

(1) Motion for Summary Judgment
(2) Motion to Intervene
(3) Motion to Dismiss
(4) Motion for Injunctive Relief (in a pending case).
(5) Motion to Compel

The fee must be submitted to the Clerk of the Court at the same time the motion is filed, unless a waiver of the filing fee in the case was previously granted to the party filing the motion. A motion will not be deemed filed until the fee is paid. The motion fee is not required for motions filed by the State of South Carolina or its departments or agencies.

2009 Revised Notes

Rule 71 provides for a schedule of filing fees as authorized by law. The filing fee varies according to the type and complexity of the case. The fee is required for all requests for a contested case hearing, notices of appeal, or requests for injunctive relief except for those brought by the State of South Carolina or its departments or agencies. For those appeals brought pursuant to Al-Shabazz v. State, 338 S.C. 354, 527 S.E.2d 742 (2000), the fee applies only to the third and subsequent filings by an inmate during a given calendar year. If a party is unable to pay the filing fee, he may request a waiver of the fee by filing the prescribed form with the Clerk of the Court. A case will not be assigned to an administrative law judge until the filing fee has been received or a waiver has been granted. Subsection (D) provides for a twenty-five dollar motion fee for certain motions filed with the Court. A motion will not be deemed filed with the Court until the fee has been paid. However, the motion fee is not required for motions filed by the State of South Carolina or its departments or agencies. In addition, if a party is granted a waiver of the filing fee, any fees for motions filed by that party are likewise waived.

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State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

November 16, 2009

CERTIFIED MAIL

Patricia L. Harrison, Esquire
611 Holly Street
Columbia, South Carolina 29205

RE: Administrative Decision in the Appeal Matter of Richard Stogsdill vs. SCDHHS
Appeals' Case #09-MISC-017
Medicaid ID#1285487101
Hearing Date: June 29, 2009

Dear Ms. Harrison:

The Administrative Decision in the referenced appeal matter is set forth in the enclosure.

Any party has the right to petition for further review of this Decision/Order, as provided in the Administrative Procedures Act [S.C. Code Ann. Section 1-23-310, et seq., (1976, as amended).] **To request an appeal, a Notice of Appeal must be filed with the Administrative Law Court, 1205 Pendleton Street, Brown Building - Suite 224, Columbia, S. C. 29201-3755 within thirty (30) days of receipt of this Decision/Order.** A **copy** of the Notice of Appeal should be provided to the S. C. Department of Health and Human Services' (SCDHHS) Office of General Counsel. The Notice of Appeal must be submitted in accordance with Rule 33 of the Rules of Procedure for the S.C. Administrative Law Court, which establishes specific requirements for the contents of a Notice of Appeal, as well as the requirement that a **copy** of the request for transcript accompany the Notice of Appeal. The **original** request for transcript should be directed to the SCDHHS' Division of Appeals at the address below. **In accordance with the ALC rules, the cost of producing the transcript will be the responsibility of the party requesting appellate review.** For a copy of the ALC rules, you may contact the Administrative Law Court at (803) 734-0550.

Also, please see the enclosed Rule 71 of the Rules of Procedure for the ALC, which sets forth the required filing fee for an appeal.

Division of Appeals and Hearings
Post Office Box 8206 • Columbia, South Carolina 29202-8206
(803) 898-2600 • Fax (803) 255-8206

Sincerely,

Vastine G. Crouch, Director
Division of Appeals and Hearings

vgc

Enclosures (2)

cc: Office of General Counsel, SCDHHS
Rick Hepfer, SCDHHS
Dr. Kathi Lacy, SCDDSN

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Case #09-MISC-017
Medicaid #1285487101

Hearing Date: June 29, 2009

JURISDICTION

This case is adjudicated under the authority granted by the South Carolina General Assembly to the South Carolina Department of Health and Human Services (DHHS / Respondent) to administer various programs and grants (See e.g., S.C. Code Ann. 44-6-10, et seq.). This appeal was conducted pursuant to the provisions of the Appeals and Hearings regulations of the South Carolina Department of Health and Human Services (Reg. 126-150, et seq.) and the South Carolina Administrative Procedures Act (S.C. Code Ann. 1-23-310, et seq.).

BACKGROUND

Petitioner is a Medicaid beneficiary who receives services through the South Carolina Mental Retardation/Related Disabilities Waiver (Waiver), a Home and Community Based Waiver within the Medicaid program. While the South Carolina Department of Health and Human Services (DHHS) is the state's single agency charged with operation of the state's Medicaid program, day-to-day administration of the Waiver is delegated to the South Carolina Department of Disabilities and Special Needs (DDSN). The program is referred to as a "waiver" because it allows certain federal Medicaid requirements to be "waived" so that certain services can be delivered in a non-institutional setting for those who qualify medically to be institutionalized.

On February 13, 2009, Petitioner notified DDSN that he was aggrieved by DDSN's alleged failure to provide certain MR/RD Waiver services. On March 3, 2009, DDSN informed Petitioner of its decision that Petitioner had not been denied medically necessary services or otherwise aggrieved. On April 1, 2009, Petitioner timely appealed the DDSN decision.

A hearing was scheduled for May 27, 2009. However, due to a lack of availability of Respondent's witnesses and Petitioner's counsel's request for a change of venue, the hearing was re-scheduled to occur on June 29, 2009.

Present at the hearing on Petitioner's behalf were Petitioner's guardian, Nancy Stogsdill; Petitioner's caregiver, David Todd; and Petitioner's counsel, Patricia L. Harrison. Documents presented on Petitioner's behalf and incorporated into the record include:

- *Petitioner's Exhibit 1*: Petitioner's Appeal by Petitioner's counsel dated April 1, 2009, and marked by Respondent as received on April 1, 2009 (faxed version);
- *Petitioner's Exhibit 2*: Petitioner's Appeal by Petitioner's counsel dated April 1, 2009, and marked by Respondent as received on April 3, 2009 (mailed version);
- *Petitioner's Exhibit 3*: Petitioner's Appeal by Petitioner's counsel dated April 1, 2009, containing the signature of Petitioner's guardian and marked by Respondent as received on April 8, 2009;
- *Petitioner's Exhibit 4*: Letter from Rena Taylor, PT, of West Wateree Medical Complex to Dr. Marquerite Carlton dated June 29, 2007;
- *Petitioner's Exhibit 5*: DDSN Authorization for Services dated January 13, 2009, to Home Remedies authorizing Petitioner to receive 3,458 units of Personal Care II services per week beginning August 27, 2008;
- *Petitioner's Exhibit 6*: DDSN Authorization for Services dated January 13, 2009, to Home Remedies authorizing Petitioner to receive 130 units of Personal Care II

services per week beginning August 27, 2008;

- *Petitioner's Exhibit 7*: The Kershaw Center Authorization to Release/Obtain Information signed January 27, 2009, by Petitioner's guardian and Petitioner;
- *Petitioner's Exhibit 8*: Four (4) separate MR/RD Waiver Personal Care (PC I and PC II) Needs Assessments dated June 2, 2009, and completed by Petitioner and Petitioner's guardian; dated June 3, 2009, and completed by Petitioner's 2nd shift PC aide; dated June 3, 2009, and completed by Petitioner's 1st shift aide; and dated June 8, 2009, and completed by an additional 1st shift aide;
- *Petitioner's Exhibit 9*: DDSN Service Coordination Annual Assessment for Petitioner completed on January 23, 2009;
- *Petitioner's Exhibit 10*: DDSN Service Coordination Annual Assessment for Petitioner completed on January 28, 2009;
- *Petitioner's Exhibit 11*: DDSN Affidavit of Thomas C. Joseph, M.D.;
- *Petitioner's Exhibit 12*: Confidential Assessment completed on June 3, 2009, by Psychological Consultant Lennie Schlager Mullis;
- *Petitioner's Exhibit 13*: Affidavit of Lennie S. Mullis;
- *Petitioner's Exhibit 14*: Detailed Claims Report of claims paid on behalf of Petitioner between August 24, 2001, and December 2008 with a cover letter from DHHS to Petitioner's guardian dated January 28, 2009;
- *Petitioner's Exhibit 15*: Transcript of Deposition of William Barfield dated June 16, 2009;
- *Petitioner's Exhibit 16*: Two-page letter from Bhavana Yajnik, M.D., dated August 30, 1988; Physical Therapy prescription from Thomas C. Joseph, M.D. dated April 29, 2005; Examination note from Lawrence B. Mauldin, M.D. dated January 19, 2004; "To Whom it May Concern" letter by an unknown author dated July 6, 2006; Examination note from Yasseen Kuzbary, M.D. dated April 3, 2008; and Progress Report from Camden Rehab dated December 27, 2008; and
- *Petitioner's Exhibit 17*: Analysis of unknown authorship of the annual cost of Medicaid-paid services for Petitioner purportedly based on the Detailed Claims Report marked as Petitioner's Exhibit 14.

At the hearing, Petitioner's counsel proffered a variety of documents related to a class-action lawsuit involving DDSN, South Carolina statutory provisions related DDSN, an October 2005 report on DDSN published by Protection and Advocacy for People with Disabilities, Inc., and a December 2008 South Carolina Legislative Audit Council Review of DDSN. These documents were received but not marked as exhibits. Petitioner's counsel, also, proffered media reports of the extra-marital activities of South Carolina Governor Mark Sanford, arguing their relevance to this case as examples of government waste of funds that could otherwise be used for programs such as the Waiver.

These documents were neither received nor marked as exhibits. None of these documents was entered into the record because, pursuant to Rule 401 of the South Carolina Rules of Evidence, they are utterly irrelevant to the matter at hand. Petitioner's counsel insisted, however, that this hearing Officer take judicial notice of the ongoing legal and ethical questions surrounding the Governor's travel and related state general fund expenditures. Notice was so taken although it holds no probative value in this proceeding.

After the hearing and within the timeframe prescribed at the hearing for such submissions, Petitioner's counsel presented her Brief of Appellant in Response to Questions Presented by Hearing Officer. Attached to the brief were Pages one (1) through eighteen (18) and Pages eighty-two (82) through ninety-one (91) of the South Carolina MR/RD Waiver for the period

October 1, 2004, through September 30, 2009, (Exhibit 1) and a February 4, 2009, letter from DDSN to Petitioner's Guardian. (Exhibit 2), along with additional copies of various documents introduced at the hearing and included in the list of Exhibits above.

Present at the hearing on Respondent's behalf were DHHS Deputy General Counsel Rick Hepfer and DDSN service coordinator Kimberly Bennett. Documents presented on Respondent's behalf and incorporated into the record include:

- *Respondent's Exhibit 1*: Notice of Hearing for hearing scheduled May 27, 2009, with postal service certified mail receipt card confirming receipt by Petitioner's counsel at her office on April 28, 2009;
- *Respondent's Exhibit 2*: Notice of Hearing for hearing scheduled June 29, 2009, with postal service certified mail receipt card confirming receipt by Petitioner's counsel at her office on June 1, 2009; and
- *Respondent's Exhibit 3*: Respondent's Prehearing Brief.

After the hearing and within the timeframe prescribed at the hearing for such submissions, a Post-Hearing Brief of Respondent was presented.

The official file also includes an e-mail exchange dated May 14, 2009, between the Office of the Hearing Officer, the Director of the DHHS Division of Appeals, General Counsel for DDSN, Deputy General Counsel for DHHS General Counsel and Petitioner's counsel regarding rescheduling the May hearing due the lack of availability of a DDSN witness and Petitioner's desire for a venue change to Kershaw county.

ISSUE

When viewed in the light most favorable to the Petitioner, the issues on appeal are multiple, intertwined and overlapping. This Hearing Officer found it very difficult to clearly identify Petitioner's specific grievances and arguments thereto. Petitioner's counsel consistently couched all issues raised in very broad terms, even when asked to submit a post-hearing brief clearly outlining the specific denial of Medicaid services of which Petitioner was complaining.

After wading through this mire, this Hearing Officer concludes that the determinative issue on appeal is whether the Respondent, by and through its agent DDSN, failed to provide Petitioner, with personal care, respite and adult companion services for the period covered by the January 2009 care plan.

In support of this position, Petitioner argued that any denial of services by DDSN was arbitrary and capricious because DDSN had failed to promulgate, pursuant to the South Carolina Administrative Procedures Act, regulations that were in compliance with the United States Supreme Court decision in *Olmstead* for establishing reasonable standards for determining medical necessity. Petitioner, also, argued that DDSN had violated the federal Medicaid Act and other federal law by providing greater funding to Medicaid beneficiaries living in institutions than to beneficiaries living in the community and, as such, has discriminated against those living in the community.

To remedy these failures, Petitioner requested Respondent to retrospectively identify those services ordered by Petitioner's physician that are eligible for Medicaid payment but were rendered to Petitioner and paid for by Petitioner's guardian out-of-pocket and to prospectively provide Medicaid payment for any and all services determined by Petitioner's treating physician to be medically necessary.

Any issues raised, or allegedly raised, in this protest not specifically addressed herein are expressly denied.

FINDINGS OF FACT

Having observed the witnesses and exhibits presented at the hearing and closely passed upon their credibility, and considering the burden of persuasion by the parties, I make the following Findings of Fact by a preponderance of the evidence:

1) Petitioner is a Medicaid beneficiary who receives Medicaid-sponsored services through the Waiver, and I so find;

2) Petitioner receives Personal Care services from two (2) different providers, Active Nursing and Home Remedies, and I so find;

3) Petitioner's DDSN file contains a service authorization dated January 13, 2009, for 3,458 units (or 864.5 hours) per week of Personal Care services from Home Remedies (*Petitioner's Exhibit 5*), and I so find;

4) The authorization for 864.5 hours of services was a mathematical error and the services authorized were never implemented by Home Remedies or delivered to Petitioner, and I so find;

5) Upon receipt of the authorization, Home Remedies immediately alerted DDSN to the error, and it was corrected by the production of another authorization for Home Remedies services covering the same time period and permitting the same number of hours (130 units per week or 32.5 hours) as Petitioner had been receiving from Home Remedies since August 27, 2008, and I so find;

6) The units of Personal Care services authorized for Petitioner through Active Nursing increased from 70 units (or 17.5 hours) on February 4, 2009, to 90 units (or 22.5 hours) on March 4, 2009, and I so find;

7) The Waiver explicitly allows services such as specialized medical equipment, therapy, audiology, dental, vision, psychological, and nursing which are skilled, medical services that usually are delivered by a licensed medical professional, such as a doctor, dentist, or therapist, and I so find;

8) Petitioner, Petitioner's guardian, the DDSN service coordinator and three (3) representatives from the personal care services agencies participated in a Service Coordination Annual Assessment in January of 2009 to determine the level of Waiver services Petitioner would be authorized to receive in the following year and, from this coordination, two Annual Assessment documents were produced, one dated January 23, 2009, and one dated January 28, 2009, and I so find;

9) During the Service Coordination Annual Assessment in January 2009, Petitioner and Petitioner's guardian both requested that additional Personal Care services be authorized for Petitioner, and I so find;

10) Both Annual Assessment documents affirmatively indicate that Petitioner has a primary care physician with whom he has regular visits, and I so find;

11) Petitioner's primary treating physician since he was a young child is Dr. Thomas C. Joseph, M.D., and I so find;

12) No one involved in the January 2009 care planning was or is a licensed medical or nursing care provider, and I so find;

13) No one involved in the January 2009 care planning was or is a licensed social worker, and I so find;

14) DDSN did not solicit input from Petitioner's treating physician during the January 2009 care planning process, and I so find;

15) As of June 29, 2009, Petitioner's primary care physician was of the professional opinion that Petitioner required a minimum of two (2) personal care aides for eight (8) hours per day each (sixteen (16) total hours), and I so find;

16) Petitioner's guardian requested respite services during the January 2009 care planning, and I so find;

17) Respite hours were authorized during the January 2009 care planning process, and I so find;

18) Petitioner's treating physician stated in his June 29, 2009, affidavit that the level of respite services included in the 2009 care plan was appropriate, and I so find;

19) During the January 2009 Service Coordination Annual Assessment, both Petitioner's guardian and Petitioner communicated socialization concerns to the Service Coordinator, and I so find;

20) The Service Coordinator noted in the assessment form that Petitioner's guardian sated that Petitioner "does not appear to be pleased being at home without social contact . . .," and I so find;

21) The Service Coordinator checked "No" under the query in the assessment "Does this person seem satisfied with his/her current connection to the community?," and I so find;

22) The Service Coordinator included in her notes in the assessment that Petitioner "stated that he is not satisfied with his current connection to the community . . .," and I so find;

23) The Service Coordinator checked "No" under the query in the assessment "Does this person appear to be satisfied with the amount of contact with friends?," and I so find;

24) Adult Companion services are defined in the Waiver as "[n]on-medical care, supervision and socialization, provided to a functionally impaired adult," and I so find;

25) Petitioner's attorney executed this appeal on Petitioner's behalf on April 1, 2009, and I so find;

26) Petitioner did not submit his appeal *pro se* and then retain counsel, and I so find;

27) Petitioner's attorney is experienced in litigating Medicaid appeals and exhibits a broad knowledge of the applicable federal statutory and common law, and I so find;

28) This matter was originally scheduled to be heard on May 27, 2009, and Petitioner's attorney received notice of this date on April 28, 2009,and I so find;

29) On May 14, 2009, an e-mail communication between the parties and the DHHS hearings office concerned re-scheduling the hearing based on a lack of availability of a DDSN witness and Petitioner's attorney's request for a change in venue, and I so find;

30) The appeal hearing was then re-scheduled to occur on June 29, 2009, and Petitioner's Counsel was notified of this new date on June 1, 2009, and I so find;

31) Petitioner's counsel first contacted counsel for Respondent to review the file on June 24, 2009, and I so find;

32) At that time, Petitioner's attorney was informed that the file was not in the possession of Respondent's counsel but remained in the possession of the local DDSN board, and I so find;

33) Petitioner's counsel was afforded approximately one (1) hour, the maximum time available from the time she arrived at the DDSN office on June 26, 2009, prior to the Friday afternoon close of business at DDSN, to review the file, and I so find;

34) Petitioner's counsel was given unfettered access to Petitioner's full file at the hearing, and I so find;

35) Petitioner's counsel offered her post-hearing brief on July 7, 2009, more than three (3) months after the date of the appeal, and attaching documents that bore a facsimile transmission clearly indicating that Respondent had faxed at least those documents to Petitioner's counsel prior to the hearing, and I so find..

CONCLUSIONS OF LAW

Based upon the above Findings of Fact and the applicable law, I conclude the following in regard to the issues raised by Petitioner. Any other issues raised or allegedly raised during this appeal that are not specifically addressed herein are deemed denied.

As to Denial or Decrease of/Failure to Provide Personal Care Services

Petitioner presents two arguments in regard to personal care services. Petitioner argues that he suffered a reduction in personal care services provided through Home Remedies from an impossible level of 3,458 fifteen (15) minute units (or 864.5 hours) per week to 130 units (or 32.5 hours) per week. (See *Petitioner's Exhibits 5 & 6*) Petitioner also argues that he should have been authorized to receive more personal care services than those authorized in January of 2009.

Regarding Petitioner's argument about the reduction of Personal Care services, Petitioner does not have standing to pursue this argument because there was no injury in fact. Our state Supreme Court has held that, to pursue an action against an administrative agency, the individual pursuing the action must have suffered an injury in fact that is causally related to the agency conduct and for which the requested relief will likely redress the injury. Sea Pines Ass'n for the Protection of Wildlife, Inc. v. S.C. Dep't of Natural Res., 345 Sc 594, 550 S.E.2d 287 (2001).

Here, if any injury occurred in regard to the reduction of personal care services, it was merely on paper and not "in fact." The authorization for Home Remedies to provide 864.5 hours per week of personal care services was clearly a scrivener's error. There are only 168 hours in a week.

The impossibly high 864.5 hours of services was never implemented by the provider or delivered to Petitioner. Rather, upon receipt of the authorization, the provider immediately alerted DDSN to the error, and it was corrected.

Additionally, as is shown in Exhibit 7 of Petitioner's own Post-Hearing Brief, the authorized units of personal care services to be provided through Home Remedies has remained the same since August 27, 2008 (130 units per week or 32.5 hours). And, the units of personal care services authorized through Active Nursing has actually increased from 70 units (or 17.5 hours) on February 4, 2009, to 90 units (or 22.5 hours) on March 4, 2009.

Regarding Petitioner's argument that more personal care services hours should have been authorized in his January 2009 plan of care, the Waiver requires that "[a]n individual written plan of care will be developed by qualified individuals for each individual under this waiver." (*Petitioner's Post-hearing Brief, Exhibit 1, Page 3, Paragraph 13*)

"Qualified individuals" is not defined in the Waiver. Merriam-Webster's Dictionary defines "qualified" as "fitted (as by training or experience) for a given purpose."

The Waiver, further, requires that a formal system of quality control monitoring "will ensure that . . . plans of care are periodically reviewed to ensure that he services furnished are consistent with the identified needs of the individuals." (*Petitioner's Post-hearing Brief, Exhibit 1, Page 3, Paragraph 18*) "Identified needs" is not defined.

Here, "People Providing Input" during the January 2009 care planning process included Petitioner, Petitioner's guardian, personal care aides and a service coordinator from Home Remedies, and a personal care aide from Active Nursing. Absent from this group is any licensed medical or nursing care provider. (See *Petitioner's Exhibits 9 and 10*). DDSN did not solicit input from Petitioner's treating physician during the January 2009 care planning process.

The Waiver explicitly allows services such as specialized medical equipment, therapy, audiology, dental, vision, psychological, and nursing. (See *Petitioner's Post-hearing Brief, Exhibit 1, Pages 2 and 3*) These services are, clearly, skilled, medical services that usually are delivered by a licensed medical professional, such as a doctor, dentist, or therapist.

The "People Providing Input" during Petitioner's January 2009 care planning process did not rise to the professional level of "qualified individuals" needed to fully evaluate a care plan that could potentially include all the services allowed under the Waiver. The "People Providing Input" were not "fitted (as by training or experience)" for the care planning purpose. Therefore, the issue of Petitioner's personal care services for the remainder of the 2009 care plan is remanded to DDSN for additional care planning that takes Dr. Joseph's June 29, 2009, affidavit recommendations into account.

However, Petitioner is cautioned that Dr. Joseph's recommendations are subject to appropriate medical necessity and utilization control procedures and do not create a blank slate upon which services can be funded by the Medicaid program. The state agency administering a care plan under a Medicaid program "may place appropriate limits on a service based on such criteria as

medical necessity or on utilization control procedures" even if the program is a Waiver program. 42 C.F.R. 440.230.

As to Denial of/Failure to Provide Respite Services

Petitioner argues that his guardian "requested services which meet the definitions of . . . Respite services" when she spoke with the DDSN representative during care planning for Petitioner in January of 2009. (*Petitioner's Post-hearing Brief, Page 3*) Petitioner then asks this tribunal to order retrospective reimbursement of those similar services that Petitioner's guardian paid for out of her own pocket.

Petitioner's guardian did indeed request respite services, and this request was granted at a level Petitioner's treating physician found satisfactory. The undersigned fails to see Petitioner's grievance in this regard.

Under the query "Does the primary caregiver have the opportunity for rest/relief from care giving responsibilities?" the Service Coordinator checked "yes." She did check "No," under the following query, "If yes, does the amount of rest/relief appear to be enough?". (See *Petitioner's Exhibit 9, Page 28, g*). However, Petitioner's treating physician stated in his June 29, 2009, affidavit that the level of respite services included in the 2009 care plan was appropriate. (See *Petitioner's Exhibit 11, Paragraph 20*)

Furthermore, while extensive testimony was offered from Petitioner's guardian and supporting witness as to the level of Personal Care and Adult Companion services they felt were needed, nothing other than general statements about the need for Respite services was offered. Based on the lack of any other evidence in this regard coupled with the presence of the tacit approval of Petitioner's treating physician of the authorized level of services, I conclude that the level of Respite services authorized in the 2009 care plan was appropriate.

As to Denial of/Failure to Provide Adult Companion Services

Petitioner argues that his guardian "requested services which meet the definitions of . . . Adult Companion services" when she spoke with the DDSN representative during care planning for Petitioner in January of 2009. (*Petitioner's Post-hearing Brief, Page 3*) Petitioner then asks this tribunal to order retrospective reimbursement of those similar services Petitioner's guardian paid for out of her own pocket.

During the January 2009 Service Coordination Annual Assessment, both Petitioner's guardian and Petitioner communicated socialization concerns to the Service Coordinator.

Based on their discussions, the Service Coordinator noted in the assessment form that Petitioner's guardian sated that Petitioner "does not appear to be pleased being at home without social contact . . .." (See *Petitioner's Exhibit 9, Page 25, 4*) And, the Service Coordinator checked "No" under the query "Does this person seem satisfied with his/her current connection to the community?" and included in her notes that Petitioner "stated that he is not satisfied with his current connection to the community . . .." (See *Petitioner's Exhibit 9, Page 30, J4*) She also checked "No" under the query "Does this person appear to be satisfied with the amount of contact with friends?" (See *Petitioner's Exhibit 9, Page 31, K5*)

The Waiver defines Adult Companion services are defined in the waiver document as "[n]on-medical care, supervision and *socialization*, provided to a functionally impaired adult." (*emphasis added*) (See *Petitioner's Post-hearing Brief, Exhibit 1, Page 13*) As the most direct connection between available services and the person to whom they are to be made available, the

DDSN Service Coordinator should have recognized the need for Adult Companion services as articulated by Petitioner and Petitioner's guardian and included an appropriate level of such services in the January 2009 annual care plan for Petitioner.

Therefore, the issue of Petitioner's adult companion services for the remainder of the 2009 care plan is remanded to DDSN for additional care planning that takes Petitioner's and Petitioner's guardian's clear statements about socialization into account. However, this Hearing Officer is unable to grant the retrospective reimbursement relief Petitioner requests. There is no evidence in the record as to the Petitioner's guardian's actual out-of-pocket costs for the provision of Adult Companion Services. Testimony was offered at the hearing as to Petitioner's guardian's history of paying for services from a Licensed Practical Nurse for Petitioner, but no evidence was offered regarding individuals who may have provided Adult Companion services and how much they were compensated.

As to Denial of Procedural Due Process

Petitioner argues that he was denied procedural due process when his entire file was not available for her review on June 24, 2009, and June 26, 2009, merely three (3) business days prior to the hearing. In support of her argument, Petitioner cites 42 U.S.C 1396a(a)(3), 42 U.S.C. 1396a(a)(19), 42 C.F.R. 431.200 et. seq, and 397 U.S. 254 (1970) for their collective application regarding procedures and parameters for evidentiary hearings regarding a denial of Medicaid benefits.

She further cites 374 S.C. 360 (2007) for it's pronouncement of the separate nature of the DDSN and local DDSN boards in arguing that the transfer of Petitioner's file from the local board to the state DDSN office was both a denial of due process and a violation of the records release limitation placed on Petitioner's file by his guardian.

Petitioner's counsel accurately cites 42 C.F.R. 431.242 as requiring that Petitioner be afforded an opportunity to examine, or have counsel examine, his file prior to and during the hearing.

> ***§ 431.242 Procedural rights of the applicant or recipient.***
>
> The applicant or recipient, or his representative, must be given an opportunity to (a) Examine at a reasonable time before the date of the hearing and during the hearing: (1) The content of the applicant's or recipient's case file; and (2) All documents and records to be used by the State or local agency or the skilled nursing facility or nursing facility at the hearing; (b) Bring witnesses; (c) Establish all pertinent facts and circumstances; (d) Present an argument without undue interference; and (e) Question or refute any testimony or evidence, including opportunity to confront and cross-examine adverse witnesses. (44 FR 17932, Mar. 29, 1979, as amended at 57 FR 56506, Nov. 30, 1992)

However, Petitioner's argument that he was denied such an opportunity is utterly without merit when viewed in light of Petitioner's attorney's independent responsibility in this regard.

Petitioner's attorney executed this appeal on his behalf on April 1, 2009, more than three (3) months prior to the hearing. Petitioner DID NOT submit his appeal *pro se* and then retain counsel.

Petitioner's attorney is experienced in litigating Medicaid appeals and exhibits a broad knowledge of the applicable federal statutory and common law. As of April 1, 2009, she had a responsibility to zealously advocate for Petitioner and such advocacy would include a review of the file "at a *reasonable* time" (emphasis added) prior to the hearing.

This matter was originally scheduled to be heard on May 27, 2009. Petitioner's attorney

received notice of this date on April 28, 2009. (See *Respondent's Exhibit 1*)

On May 14, 2009, an e-mail communication between the parties and the DHHS hearings office concerned re-scheduling the hearing based on a lack of availability of a DDSN witness and Petitioner's attorney's request for a change in venue. (See *Hearing Officer's file*) The hearing was then re-scheduled to occur on June 29, 2009, and Petitioner's Counsel was notified of this new date on June 1, 2009. (See *Respondent's Exhibit)*

In her brief, Petitioner's attorney asserts that she contacted counsel for Respondent on June 24, 2009, and asked to review the file. Petitioner's attorney does not indicate whether this was her first such request but, based on the lack of evidence to the contrary, the undersigned found that it was her first request.

At that time, Petitioner's attorney was informed that the file was not in the possession of Respondent's counsel but remained in the possession of the local DDSN board. **FN1** Petitioner's attorney was then afforded approximately one (1) hour, the maximum time available from the time she arrived at the DDSN office on June 26, 2009, prior to the Friday afternoon close of business at DDSN, to review the file. **FN2**

Petitioner's attorney argues, also, that she was not provided copies of the file. However, federal regulation does not require copies to be made for Petitioner, and there is no evidence that copies were requested by Petitioner's attorney. Further, Petitioner's own Post-hearing brief contains documents with a fax transmission stamp that indicates they were faxed from DDSN to Petitioner's counsel prior to the hearing.

Petitioner's attorney was then given unfettered access to Petitioner's full file at the hearing. And, to ensure adequate time to respond to any new information identified in the file at the hearing, Petitioner was afforded the opportunity to submit a post-hearing brief. Petitioner's attorney provided her brief on July 7, 2009, more than three (3) months after the date of the appeal.

A significant delay existed between the appeal (dated April 1, 2009) and Petitioner's attorney's request to review the file (June 24, 2009). Responsibility for this delay rests solely in the hands of Petitioner's attorney, and she did not offer any explanation which might reasonably justify the passage of almost three (3) months from the date of the appeal to the date of the request.

Her request then occurred on the eve of the day before the hearing. At that point, DDSN then took what action was possible in allowing the file to be reviewed. Clearly, an opportunity to review the file both prior to and during the hearing was present. Petitioner's attorney cannot rely on her delay to create the absence of an opportunity to review the file.

Furthermore, the time allowed to review the file was more than the "reasonable time" required. Petitioner's counsel's placed herself in the position of having minimal time to review the file when she failed to request to review it until Thursday, June 24, 2009, prior to the Monday, June

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1 As noted previously, Respondent is DHHS and Respondent's counsel is Deputy General Counsel with DHHS. However, the file was in the possession of the local DDSN board who is the DHHS' designee for day-to-day administration of the waiver services provided to Petitioner.

2 Petitioner's attorney argues that the transfer of the file from the local DDSN board to the state DDSN office was in violation of the limitation Petitioner's guardian placed on the HIPAA release she signed. This Hearing Officer is without jurisdiction to determine whether the transfer was such a violation.

29, 2009. Her failure to request the file prior to June 24 is especially troublesome because Petitioner's counsel was fully aware that a hearing was forthcoming when she herself requested the hearing on April 1, 2009, and, on June 1, 2009, received notice that it would occur on June 29, 2009.

Last, if Petitioner's counsel felt she was not prepared to prosecute her case, she should have requested a continuance. She did not do this. Instead, Petitioner's counsel attempts to rely on her own delay to create a Constitutional violation where there is, most clearly, none at all.

The undersigned notes with favor and appreciation the following sentence from Respondent's Post-Hearing brief:

> Apologies are certainly in order if the Respondent, its agents, or its attorney inconvenienced the Petitioner's attorney in her efforts to obtain documents. (See *Respondent's Post-hearing Brief, Page 6*)

However, the undersigned concludes, again, that full responsibility for any "inconvenience" in this regard belongs to Petitioner's counsel and her alone. This issue is denied.

As to Failure of DDSN to Promulgate Regulations or Establish Reasonable Standards

Petitioner also argues "that Respondent has erred by failing to establish reasonable standards to determine what services are needed for him to remain in the community . . .." (Petitioner's Post-hearing Brief, Page 2) The undersigned has already disposed of Petitioner's arguments in regard to specific services.

In regard to this general allegation as to the error or lack thereof of DDSN or DHHS to promulgate regulations surrounding client care planning, the undersigned concludes that subject matter jurisdiction is lacking. As previously stated, subject matter jurisdiction is conferred upon DHHS hearing officers pursuant to the Medicaid regulations and, by those regulations, is limited to terminations, suspensions, or reductions of Medicaid covered services. See 42 C.F.R. 431.200. This tribunal does not have subject matter jurisdiction to determine any issues other than those specifically associated with the actual provision of Medicaid services.

However, if this tribunal had subject matter jurisdiction over this issue, the undersigned would direct the attention of DDSN and DHHS to our Supreme Court's warning that agency policies attempting to establish a "binding norm" should be promulgated as regulations. Home Health Serv., Inc. v. S.C. Tax Comm'n, 312 S.C. 324, 440 S.E.2d 375 (1994).

DECISION

As to Denial or Decrease of/Failure to Provide Personal Care Services

Petitioner's personal care services for the remainder of the 2009 care plan is remanded to DDSN for additional care planning that takes Dr. Joseph's June 29, 2009, affidavit recommendations into account. Any further prayers for relief in this regard are denied.

As to Denial of/Failure to Provide Respite Services

This issue is denied.

As to Denial of/Failure to Provide Adult Companion Services

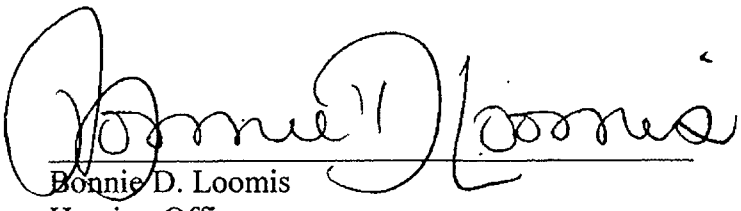
Petitioner's adult companion services for the remainder of the 2009 care plan is remanded to DDSN for additional care planning that takes Petitioner's and Petitioner's guardian's clear statements about socialization into account. Petitioner's request for retrospective reimbursement

is denied.

As to Denial of Procedural Due Process
This issue is denied.

As to Failure of DDSN to Promulgate Regulations or Establish Reasonable Standards
This issue is denied.

AND IT IS SO ORDERED.



Bonnie D. Loomis
Hearing Officer

11/16, 2009
Columbia, South Carolina.

BRIEFS

THE STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

APPEAL FROM THE SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

10-MISC-042

The Honorable W. Jefferson Bryson

Docket No.10-ALJ-08-0774-AP

Richard Stogsdill, Appellant,

v.

South Carolina Department of Health and Human Services, Respondent.

REPLY BRIEF OF APPELLANT

Patricia L. Harrison
611 Holly Street
Columbia, SC 29205
803/256-2017

ATTORNEY FOR APPELLANT

FILED
APR 14 2011
SC ADMIN. LAW COURT

Respondent argues that the reductions in MR/RD Medicaid waiver services are not subject to review by this Court because as the State Medicaid Agency DHHS has unfettered authority to administer all Medicaid waiver programs. Respondent asks this Court to violate Section 22 of Article 1 in the Bill of Rights of the South Carolina Constitution which states:

> No person shall be finally bound by a judicial or quasi-judicial decision of an administrative agency affecting private rights except on due notice and an opportunity to be heard ... nor shall he be deprived of liberty or property unless by a mode of procedure prescribed by the General Assembly, and he shall have in all such instances the right to judicial review.

Respondent cites *Bryson v. Shumway*, arguing that CMS allows states to "experiment...without adhering to the strict mandates of the Medicaid system." 308 F.3d 79 (1st. Cir. 2002). The Medicaid Act does allow states to "waive" just a handful of "strict mandates." But Congress does not allow states to ignore civil rights when the state administers its Medicaid programs. As the Fourth Circuit recently recognized in *Doe v. Kidd, II*, a case brought against officials of Respondent and DDSN: "Because South Carolina accepts Medicaid funding, these agencies are bound to comply with all related federal laws and regulations." Case No. 10-1191 (4th Cir. March 24, 2011), citing *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 502 (1990). Respondent can no more ignore the Americans with Disabilities Act (ADA) and the Supreme Court's holdings in *Olmstead*, than it can ignore the Civil Rights Act and the United States Constitution. 527 U.S. 581 (1999). Under Respondent's arguments, it could deny Medicaid services to Baptists or to black persons. But the civil rights laws and the Constitution of this country can never be "waived" by any state agency because the Supremacy Clause requires that Respondent must administer the Medicaid program in compliance with the Medicaid Act and other laws, including the ADA, enforcing waiver participants' civil rights.

Respondents claim that because they held workshops telling waiver participants that they were about to commit an illegal act, the act is somehow legitimized. Federal Medicaid regulations contain different requirements for giving notice of reductions in Medicaid services. 42 C.F.R. 431.210 means something. Its very specific requirements are mandatory before services are reduced or terminated and

Respondent failed to meet those standards. The proper remedy is to require the agency to start over and do it right this time. Failing to hold Respondent accountable for compliance with 42 C.F.R. 431.210 will simply perpetuate and reward Respondents' violations of the due process rights of our most vulnerable citizens who are the least capable of protecting themselves from such abuse.

Respondent's reliance on a federal district court case from Washington State is also misplaced. Respondent's Brief at 16. *M.R. v. Dreyfus*, WL 588511 (W.D. Wash. 2011). The plaintiffs in *M.R.* objected to the use of an assessment tool used to reduce services. However, Respondent ignores the fact that Washington had a process for disputing the number of hours awarded when an individual needs more. Id. Each waiver participant received an appealable individual assessment before reductions occurred, unlike this case, wherein no such assessment was made prior to reducing the services. Plaintiffs in that case also failed to produce evidence of risk of institutionalization, unlike the Appellant in this case. Id. Also unlike the system implemented by Respondent, which places the same cap on personal care, companion and nursing services, regardless of the severity of disability, the Washington system awarded more hours to persons who have more severe conditions. Id. The changes in *M.R. v. Dreyfus* were considered and enacted by the state legislature. The reductions at issue in this case were never approved by the South Carolina General Assembly. They were submitted to CMS after the legislature ended its session and implemented before the 2011 Session began. The legislature never had an opportunity to authorize the executive branch's alteration of the use of funds as allocated in the state budget. *Jackson, supra.* HHS is an agency in the executive branch of state government, but it does not have the authority to fundamentally alter how MR/RD Medicaid waiver services are provided when its decisions violate the ADA, thereby disregarding decisions by not only the legislative branch, but also the judicial branch of government.

A 2008 audit of the South Carolina MR/RD Medicaid waiver program sharply criticized the agencies for denying choice and failing to eliminate barriers caused by the near monopoly of DSN Boards and DDSN in providing waiver services. Record at 455. Ignoring the findings of that audit, on

January 1, 2010, Respondent eliminated or reduced primarily services provided by qualified providers that are not DSN Boards, while astronomically increasing rates paid to DSN Boards and DDSN for institutional services and increasing the number of persons in the waiver. Respondent's Brief at 19 (letter from CMS). During FY 2010, DHHS actually increased the payment rate paid to DDRSN for ICF/MR respite services by 70%, all the while claiming that the home-based service reductions were unavoidable due to claims of "severe budget reductions," while sitting on millions of dollars of "excess funds" and federal Medicaid stimulus funds. This was an "improper modification of legislation" by the executive branch. *Jackson v. Sanford*, Case No. 26918, (S.C. Sup. Ct. January 24, 2011). As the Supreme Court held in *Edwards v. State*: "Governor Sanford must execute the Budget as enacted by the General Assembly." 383 S.C. 82, 678 S.E.2d 412 (S.C. 2009).

Then, soon after claiming that these reductions were necessitated by a $2.1 million deficit, DDSN went to the South Carolina Budget and Control Board (SCBCB) and asked for permission to spend more than $6 million it was holding in an excess funds account to buy more real estate for local boards. Record at 686, 697 to 700. This deal was sealed by an agreement to split this excess funds account nearly in half with SCBCB. Record at 690. In addition to this excess funds account, DDSN had received, at the time the reductions were announced, more than $30 million in federal Medicaid stimulus funds. Record at 158 to 164. Most of these federal Medicaid stimulus funds paid to South Carolina were transferred to a rainy day fund, instead of being used to maintain Medicaid home and community based services. Id., *Karen W. v. Sanford* at 134. Respondent's claim that caps were placed on the services at issue in this appeal because of budget reductions is simply a sham. Indeed, as the United States District Court for South Carolina found, the services at issue cost less than the institutional services that will be required if Richard's needs are not met in the community. *Peter B. v. Sanford.* The agency acted outside of the scope of its authority, and in violation of the ADA, by taking funds the legislature had appropriated to provide home and community based services and (1) using those funds to increase payments to DDSN and DSN boards for institutional ICF/MR respite services and (2) diverting those

funds to the State's General Reserve Fund and a rainy day fund. Record at 158 to 164.

Respondent's argument "reasonable medical standards" must have been used because Appellant may think highly of his new service coordinator, is completely illogical and irrelevant. Respondent's Brief at 7. There is no evidence in the record that the DDSN service coordinator even contacted Richard's physician. There is also no evidence in the record that Richard, his physician or his guardian were even informed about how many hours the service coordinator was requesting. The hearing officer determined in the 2009 "fair hearing" that the number of hours he was receiving at that time were medically necessary. (Hearing officer failed to include 2009 documents in record on appeal.) Such an admission cannot be overcome by Respondent's presumption that the service coordinator must have considered the physician's orders because there is no evidence in the record she reviewed those records and she testified that she was not competent to review medical records. Record at 34 and 41. Richard's physician determined that he needs 2,240 hours a year, in addition to 52 days per year. (2009 documents not included in record on appeal.) Hearing officer Loomis agreed that these hours and days were medically necessary. Id. There is no credible medical evidence in the record to support the reduction to 172 hours per month of respite services, a decision made by a DDSN employee with no medical training, who had not reviewed his physician's orders or even inquired about the employment obligations of his parents. The decision violated the 2009 order and was arbitrary and capricious and it has no factual basis. The record shows that waiver service reductions were made with no medical assessment.

Respondent argues that because Appellant enjoys volunteering at a nursing home, he should subject himself to institutionalization because he might like it. Brief at 9. This is no more logical than saying that doctors who enjoy working with cancer patients should try radiation, because they might like it. A prison chaplain may enjoy visits with inmates, but he would probably not enjoy being locked up with them. The "other options" to which Respondent refers are institutional placement in an ICF/MR for respite or attending a congregate workshop, but the ADA and Olmstead protect Richard from such atrocious experiences. Appellant presented affidavits from his physician stating that it would be unsafe

for him to be subjected to such placements and his DDSN psychological services provider agreed. Record at 780 to 785. The record contains reports and audits showing DDSN has failed to protect persons in these facilities from sexual assault, financial exploitation and neglect. Record at 257, 289 to 290 and 383. The federal magistrate in *Peter B.* recognized that:

> The Court does not mean to insult the hard work of the defendants or the individual care providers that accomplish it, but it would be an oversight of this decision not to also emphasize the fairly serious deficiencies of various institutional facilities, revealed in a state agency audit, which include unsanitary conditions; abuse; neglect; and exploitation... Institutions can be places of both great compassion and unspeakable horror. These are not insignificant considerations when measuring the irreparable harm and opportunity cost of a *de facto* involuntary institutionalization of a person otherwise content and healthy in community.

As to Respondent's argument that ex parte communications were allowable, any "adjudicator" who needs to find out what the posture of a party is should do so in the presence of all parties. The information obtained from DDSN was not simply related to scheduling a hearing or some procedural matter. The very fact that this communication took place and the Office on Appeals and Hearings did not provide notice of it to all parties is an indicator of bias.

When a party fails to comply with a judge's ruling, the judge retains jurisdiction over the case to determine why the court's orders were not followed. The power to hold parties who refuse to comply with an order of the court are inherent in the Court. All courts have the inherent power to punish for contempt. *Curlee v. Howle,* 277 S.C. 377, 287 S.E.2d 915 (1982); *State v. Passmore,* 363 S.C. 568, 611 S.E.2d 273 (Ct.App.2005). This power is essential to the preservation of order in judicial proceedings and the due administration of justice. *Id.* Under Respondent's reasoning, all the hearing officer could do was to hope her order would be carried out. Rewarding the Respondent for its contumacy by requiring Appellant, an person who has profound disabilities and limited resource, to start over from the beginning when the agency chooses to ignore an order is wrong.

Respondent admits that it did not object to the incorporation by reference of the 2009 record. Respondent's Brief at 12. According to Respondent, the hearing officer reviewed the 2009 record. Id. It

is legal error for the hearing officer to omit from the record on appeal the transcript, exhibits and records in this proceeding. Rule 36 of the South Carolina Rules of Procedure for the Administrative Law Court requires that the record must consist of (1) All pleadings, motions, and intermediate rulings; (2) All evidence received or considered...(6) The transcript of the testimony taken during the proceeding. The hearing officer failed to include all evidence received or considered and the transcripts of testimony taken during the proceeding which was incorporated by reference, whether or not this appeal is a continuation or an entirely new appeal.

The agency also claims that it has no responsibility for complying with the 2009 order. Respondent claims, without providing any evidence in support, that upon remand to DDSN the service coordinator took into account the orders of Dr. Joseph. Respondent's Brief at 13. Respondent admits that the service coordinator and the Appellant were "probably trying to work out the array of services allowed under the waiver, when the Appellant appealed." But the record documents bad faith by Respondent in failing to inform the hearing officer it had submitted an amendment to CMS at the time oral arguments were heard in the first hearing and it had no intention of complying with her order. Respondent failed to appeal that order and this Court should prohibit the agency from reducing Appellant's services below the level ordered by the first hearing officer. Appellant's due process rights have been violated thereby and the decision of the hearing officer should be reversed because Appellant has provided credible medical evidence that the services ordered by the first hearing officer are medically necessary and the ADA and *Olmstead* prohibit any reduction which would place Appellant at risk of institutionalization.

Courts across the country, including the United States District Court for South Carolina, have determined that CMS approval of reductions does not make them legal, as that federal agency does not have the authority to override congressional intent of the ADA. See *Peter B. v. Sanford.* In its brief, Respondent erroneously informed this court in its brief that a "final ruling in the Crabtree case could be

subject to the 6th circuit's ruling in Rosen." Respondent's Brief at 16. Crabtree v. Goetz. Record at 753 to 761. That is not factual. In that case, waiver participants in Tennessee were receiving up to 24 hours of care a day, seven days a week. Id. The State of Tennessee had passed a state statute approving the cuts and CMS had approved an amendment to the waiver allowing the reductions. Id. The district court issued a preliminary injunction preventing the state from reducing waiver services and the case was dismissed on January 22, 2010. No. 3:08-0930 (M.D. Tenn. January 22, 2010).

In *Marlo M. v. Cansler*, the federal district court prohibited the State of North Carolina from reducing services where the plaintiffs receive care and supervision in their own apartments twenty-four hours a day. 679 F.Supp.2d 635 (E.D.N.C. 2010). A temporary injunction was issued just three days after the lawsuit was filed in the federal court and a preliminary injunction was ordered a month later, finding that such reductions would violate the ADA and Omstead. Similarly, in New York, the federal court required the state in 2009 to provide additional funding and services sufficient to enable persons living in boarding homes to move to apartments. *Disability Advocates, Inc. v. Paterson*, 598 F. Supp. 2d 289. See http://documents.nytimes.com/disability-advocates-inc-v-david-a-paterson.

Respondent correctly states that *Radaszewski v. Maram* is favorable to Richard, but erroneously suggests that *Radaszewski* has not been decided on the merits. 383 F.3d 599 (7th Cir. 2004). A bench trial was held in Illinois in September 2007 and on May 9, 2008, the district court issued a permanent injunction requiring the state to continue to provide Radaszewski 16 hours a day of RN services, in addition to 336 hours a year of respite nursing services. 1:01-cv-09551 Document #: 175 Filed: 05/09/08. Appellant's counsel could find no evidence, eight years after decision in *Fisher v. Oklahoma Health Care Association* that the case was ever "fully tried," but that 10th Circuit case has been cited in 19 United States district court decisions, 12 decisions of United States Circuit Courts and four cases in two different states. 335 F.3d 1175 (10th Cir. 2003). The State of Illinois opted to use taxpayer funds to provide services the young man needs instead of going to trial and continuing to appeal a losing case.

The best Respondent can do is to come up with a case decided against the state where its counsel believes there is a "good chance for an on-point circuit court decision in *Cota v. Maxwell-Jolly*." 688 F.Supp. 980 (N.D. Calif. 2010). (Harry Cota, the lead plaintiff in that case died on March 7, 2011.) That case is stayed pending appeal to the Ninth Circuit. Case 4:09-cv-03798-SBA Document 201 Filed11/22/10. However, that Circuit has held in three Medicaid rate reduction cases that there is a strong public interest in maintaining Medicaid services. *Maxwell-Jolly v. Independent Living Center of Southern California*, 572 F.3d 644, 659 (9th Cir. 2009); *Maxwell-Jolly v. Santa Rosa Memorial Hospital*, 09-17633 (9th Cir. May 27, 2010); and Maxwell-Jolly v. the California Pharmacists' Association, 563 F.3d 847, 849, 853 (9th Cir. 2009). The State of California has appealed these cases to the United States Supreme Court, which has granted cert. In *Independent Living Center*, the Ninth Circuit held that "...there is a robust public interest in safeguarding access to health care for those eligible for Medicaid, whom Congress has recognized as the most needy in the country." Supra at 659. In *Dominguez v. Schwarzenegger*, the Ninth Circuit upheld the district court's grant of a preliminary injunction where Medicaid participants claimed that their access to needed services would be denied if the state were allowed to reduce reimbursement rates for home-based services. 596 F.3d 1087 (9th Cir. 2010).

Most applicable and important to this Court, however, is the order of Judge Michelle Childs, who adopted in toto the findings and recommendations of Magistrate Judge Bruce Howe Hendricks. *Peter B. v. Sanford*, C.A. 6:10-cv-00767-JMC (SCDC February 1, 2011). In that case, the federal court issued a preliminary injunction prohibiting Respondent in this case from implementing the January 1, 2011 reductions which are the subject of this appeal. *See also* Magistrate's R&R dated November 24, 2010. The court determined that the plaintiffs who claim that the January 1, 2010 reductions in MR/RD Medicaid waiver services violate the ADA are likely to prevail on the merits and that an injunction was in the public interest. In particular, Judge Hendrisk's description of the harm that would be suffered by plaintiff Chip E. is like the injury Richard would experience, as his condition is very similar:

> He is the highest functioning of the three plaintiffs and, maybe, precisely for this reason, the prospect of institutionalization is most terrorizing to him. The threat of irreparable injury to Chip exists exactly in the lost opportunity that community living offers...This is precisely the sort of injury incidental to the prejudice of segregation, which the and person imposes. "Institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life." *Id.* Where such an experience can be avoided, without significant alteration of the *status quo*, the United States Supreme Court has stated, it should be... His experience in an institution would come with all of the adjunct humiliations that violation of personal space and person imposes.

The Hearing Officer erred as a matter of law and fact in finding that the Respondent has not violated the ADA and *Olmstead* by placing Richard at risk of institutionalization. The HHS hearing officer made nothing more than an unsupported and conclusory finding that the reductions at issue in this case do not violate *Olmstead.* He based this decision on the fact that Appellant lives near his parents who provide some of his care. Record at 12 to 31. However, federal regulations prohibit consideration of resources provided to an adult Medicaid beneficiary by a parent. 42 CFR 435.602. Respondent's witness, Dawn Shealy, testified that she determined that Richard does not need additional respite hours because his mother only works part time. Record at 39. But Richard's mother, who is no longer able to lift him, works eight part time jobs, because she has to be home during the middle of the day to take care of her son. Record at 63. Federal courts, including the United States District Court of South Carolina have held that even a risk of institutionalization is sufficient to invoke the protections of the ADA and *Olmstead.* That court dismissed Respondent's argument that institutionalization is "speculative," based on affidavits presented by the plaintiffs and their physicians:

> The court finds that this evidence demonstrates that institutionalization is sufficiently likely; and therefore, the issuance of a preliminary injunction is warranted. Defendants would have the court wait until Plaintiffs are actually removed from their current living arrangements. However, the standard requires a finding of likelihood, not absolute certainty. Further, the harm to be prevented will have already been done should the court adopt Defendant's position to wait until the effects of the service reductions are certain.

Peter B. v. Sanford, supra. The Magistrate's Report in that case addressed this issue:

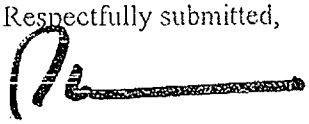
> To echo the briefs of the plaintiffs and the *amici*, cases involving ADA integration claims have consistently recognized that even the risk of institutionalization is sufficient to establish a

violation of Title II and certainly to justify preliminary relief. *See Fisher v. Oklahoma Health Care Authority*, 335 F.3d 1175, 1184 (10th 2003) (holding that Medicaid participants not currently institutionalized but at "high risk for premature entry into a nursing home" could bring claim for violation of the integration mandate); *Brantley v. Maxwell-Jolly*, 656 F. Supp. 2d 1161, (N.D. Cal. 2009); *Mental Disability Law Clinic v. Hogan* 2008 WL 6:10-cv-00767-JMC -BHH Date Filed 11/24/10 Entry Number 71,15 4104460, at *15 (E.D.N.Y. Aug. 28, 2008) (stating "even the risk of unjustified segregation may be sufficient under *Olmstead*). The case law is clear that plaintiffs need not wait to be institutionalized before relief is sought.

As did the plaintiffs in *Peter B.*, Richard has submitted reliable evidence "in the form of affidavits from ...treating physicians and testimony of ... current caregivers that supported their allegation that a reduction in services would cause dramatic changes in [his] current living conditions." Id. In this case, affidavits of Richard's treating physician were submitted which affirm that he ("Richard would be at risk of institutionalization if the needed home-based services are not provided." Affidavit of Dr. Thomas, Record at 784.) As Judge Hendricks recognized: "The opinion of a responsible treating physician in determining the appropriate conditions for treatment ought to be given the greatest of deference." Citing Olmstead, 527 U.S. at 610.Indeed, Richard himself signed an affidavit describing his need for services and stating that he would "have to live in an institution" without these services. Record at 787. On the other side, Respondent has provided absolutely no medical evidence from any qualified person to determine the medical necessity of these services or that he would not be at risk of institutionalization without them. Without testimony or a statement from a physician who is willing to put his license on the line if he is wrong, the only "speculation" in this case is that of the Respondent whose witness with no medical training testified that Richard is not at risk if these services are not continued.

For the reasons set forth in Appellant's brief and the record on appeal, Appellant prays that this Court reverse the decision of the lower tribunal, finding that the services ordered after the 2009 fair hearing are medically necessary, that those services have not been provided with reasonable promptness and that the ADA and *Olmstead* require that those services be provided.

Respectfully submitted,



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April 13, 2011

THE STATE OF SOUTH CAROLINA
Administrative Law Court

APPEAL FROM THE SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

10-MISC-042
The Honorable W. Jefferson Bryson

Docket No. 10-ALJ-08-0774-AP

Richard Stogsdill.....Appellant,

v.

South Carolina Department of Health and Human Services,.....Respondent.

CERTIFICATE OF FILING AND SERVICE

I, Patricia L. Harrison, Attorney for Appellant, certify that I have this day, April 13, 2011 filed one copy of the foregoing *Reply Brief of Appellant* with the S.C. Administrative Law Court. I further certify that I have also this day served one copy of the foregoing *Reply Brief of Appellant* upon Respondent to their counsel of record by US mail with sufficient postage attached.

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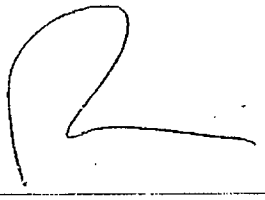

Patricia L. Harrison

FILED
APR 14 2011
SC ADMIN. LAW COURT

THE STATE OF SOUTH CAROLINA
IN THE ADMINISTRATIVE LAW COURT

Appeal from the Division of Hearings and Appeals
South Carolina Department of Health and Human Services

Docket Number: 10-ALJ-08-0774-AP

R. S.

Appellant,

vs.

South Carolina Department of Health and Human Services,

Respondent.

BRIEF OF RESPONDENT

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ISSUES

In the Respondent's view, the issue on appeal is whether there is substantial evidence in the record to sustain the Decision of the Hearing Officer, that:

1. The changes in the Waiver were lawfully made;
2. Adequate due process was afforded to the Appellant;
3. A previous Administrative Decision relating to Appellant was carried out insofar as the changes in the Waiver permitted, and adequate consideration of the attending physician's orders can be assumed;
4. That the integration mandate of the Olmstead case was not violated.

STATEMENT OF THE CASE

The Appellant in this matter is a Medicaid-eligible individual, who has been receiving services under the South Carolina Mental Retardation/Related Disabilities (MR/RD) Waiver. Under this Waiver, beneficiaries can be provided a mix of services through the Department of Disabilities and Special Needs (SCDDSN). Waivers are mechanisms within the Medicaid Program under which, by having certain generic requirements of the Medicaid program "waived," States are able to provide services to individuals in ways not allowed under the regular Medicaid Program. On January 1, 2010, the five-year renewal of the MR/RD Waiver, as approved by the Centers for Medicare and Medicaid Services (CMS), went into effect. The renewed Waiver included a cap or limit on some services and excluded others.

The SCDDSN is responsible for the day-to-day operation of this Waiver. The Department of Health and Human Services (Department, DHHS, Respondent) is the agency that administers the South Carolina Medicaid Program, and so, is also responsible for the overall administration of the Waiver. This appeal is directly from a SCDHHS Decision sustaining the action of the SCDDSN reducing services to the Appellant. The reduction was the result of the limitations set forth in the renewed Waiver.

Prior to the Waiver changes, the Appellant was receiving a combined 69 hours of Personal Care

Aide and Companion Care services per week and about 36 hours of Respite Care per week. Personal Care Aide II (PCAII) services consist of hands-on personal care that a person needs to accomplish their activities of daily living such as bathing, toileting, dressing and eating. Adult Companion Services are similar to PCAII services but include an aspect of community integration. Respite Care can be a range of services, including personal care but is designed to provide services when the normal caregiver is absent or needs relief.

The Waiver capped any combination of PCAII and Adult Companion services at 28 hours per week. The normal cap for Respite Services under the new Waiver is 68 hours per month (or almost 16 hours per week), but exceptions can be granted for up to 240 hours per month (or about 56 hours per week). Under these new limits, the Appellant's services were reduced to 28 hours of PCAII-type services (including Adult Companion services) per week and 68 monthly hours of Respite Care. After the initial cuts, the Appellant's Service Coordinator applied for an increase in Respite Care, and Appellant was granted a total of 172 hours of Respite Care per month (or about 40 hours per week). See, Respondent's Exhibit #1 at page 88 of the Record.

Also, in this case, in accordance with the new Waiver, the Appellant's Occupational and Speech Therapies were discontinued. After Reconsideration was denied (page 845 of the Record), the Appellant appealed the reductions and the elimination of services to the DHHS Appeals Division. In his Decision of September 14, 2010 the Department's Hearing Officer sustained the Departments' actions. On or about October 20, 2010, the Appellant appealed to the Administrative Law Court.

ARGUMENTS

Scope of Review -- The "Substantial Evidence Rule"

Thus, this case is before the ALC as an appeal of an agency action. As such, the ALC sits in an appellate capacity under the Administrative Procedures Act (APA), rather than as an independent finder of fact. In South Carolina, the provisions of the Administrative Procedures Act -- specifically S.C. Code Ann. §1-23-380(A)(5) & (B) -- require the ALC to apply the "substantial

evidence" rule. Under that rule:

> (5) The court may not substitute its judgment for the judgment of the agency as to the weight of the evidence on questions of fact. The court may affirm the decision of the agency or remand the case for further proceedings. The court may reverse or modify the decision if substantial rights of the appellant have been prejudiced because the administrative findings, inferences, conclusions, or decisions are:
> (a) in violation of constitutional or statutory provisions;
> (b) in excess of the statutory authority of the agency;
> (c) made upon unlawful procedure;
> (d) affected by other error of law;
> (e) clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; or
> (f) arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

The well-settled case law in this State has interpreted the rule to mean that an agency decision will not be set aside simply because reasonable minds may differ on the judgment. Lark v. Bi-Lo, 276 S.C. 130, 276 S.E.2d 304 (1981). The fact that the record, when considered as a whole, presents the possibility of drawing two inconsistent conclusions from the evidence does not prevent the agency's finding from being supported by substantial evidence. Substantial evidence is that which, after considering the entire record, would allow reasonable minds to reach the conclusion that the administrative agency reached. Spartanburg Regional Medical Center v. Oncology and Hematology Associates of South Carolina, LLC 387 S.C. 79, 690 S.E.2d 783, (S.C., 2010) citing Grant v. S.C. Coastal Council, 319 S.C. 348, 353, 461 S.E.2d 388, 391 (1995) (citation and internal quotation marks omitted).

In applying the substantial evidence rule, the factual findings of the administrative agency are presumed to be correct. Kearse v. State Health and Human Services Finance Comm'n, 318 S.C. 198, 456 S.E.2d 892 (1995). Furthermore, the reviewing court is prohibited from substituting its judgment for that of the agency as to the weight of the evidence on questions of fact. Lee County School Dist. Bd. Of Trustees v. MLD Charter School Academy Planning Committee, 371 S.C. 561, 641 S.E.2d 24 (2007). Finally, the party challenging an agency action has the burden of proving convincingly that the agency's decision is unsupported by substantial evidence. Waters v. South Carolina Land Resources Conservation Comm'n, 321 S.C. 219, 467 S.E.2d 913 (1996), citing Hamm v. AT&T, 302 S.C. 210, 394 S.E.2d 842 (1994).

Of course, the ALC may always reverse or remand a decision, which is affected by an error of law. Callahan v. Beaufort County School Dist., 375 S.C. 92, 651 S.E.2d 311 (2007). However, in reviewing the errors of law asserted by the Appellant, the ALC does need to give deference to the Department's interpretation of its own rules and the relevant federal rules and manual provisions applied. Hampton Nursing Center v. State Health and Human Services Finance Commission, 303 S.C. 143, 399S.E. 2d 434 (Ct. App. 1990).

Application of the Substantial Evidence Rule in this Case

I. **Substantial evidence supports the Hearing Officer's conclusions that the changes in the Waiver were lawfully made.**

A. The Hearing Office was correct in determining that the Waiver changes complied with the rules on Medicaid Waivers.

Section 1915(c) of the Social Security Act [42 USC §1396n(c)] permits states to waive the requirement that persons with mental retardation or a related disability live in an institution in order to receive certain Medicaid services. "[The program] allow[s] states to experiment with methods of care, or to provide care on a targeted basis, without adhering to the strict mandates of the Medicaid system." See Bryson v. Shumway, 308 F. 3d 79 (1st Cir. 2002), cited in Doe v. Kidd, 501 F.3d 348 (4th Cir. 2007). Clearly, under S.C. Code Ann. §44-6-5 et seq. the DHHS is the single state agency designated to administer the South Carolina's Medicaid Program. §1902(a)(5) [42 USC §396a(a)(5)] and 42 CFR §431.10.

Under the statutes, then, the Respondent, the designated Medicaid agency, has the statutory authority to enter into a Waiver agreement with the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers the Program. Attached is the letter from CMS approving the amended Waiver. Attached also, is the first page of the Wavier that describes most of the new limitations in services, also effective on that date. (These documents were referenced in the Respondent's Prehearing Brief, but were omitted from the Record.)

The major changes include, as mentioned above, the new limits on Personal Care Aide Services (PCA), Adult Companion Services (ACS), and Respite Care. Speech Language pathology [sic],

Occupational and Physical Therapy are among the services to be eliminated. The elimination of "daily" respite is a reimbursement change, which does not eliminate the service. Thus, facially, the Departments have properly exercised their authority to amend the Waiver, and CMS, the responsible federal agency has approved the change.

Additionally, in the case of these reductions, the SCDDSN held six (6) statewide workshops in the September and October preceding the reductions. The workshops were well attended by both advocates and beneficiaries. The purpose of the workshops was to alert the public of the proposed changes. See the testimony of Jacob Chorey at pages 30 & 31 of the Record. At the time of the workshops, the Waiver application had been sent to CMS (August 31, 2009). In November, the Waiver was approved with no substantive changes in the limits at issue here.

Later, a general notice was sent out to all SCDDSN clients notifying them of the pending changes and urging them to work closely with their SCDDSN Service Coordinators (case managers) to mediate the impact of the new service limits. Service coordinators were trained in the changes. See, Testimony of Mr. Chorey at page 46 of the Record. Then, specific notices were sent to the beneficiaries, who were directly impacted.

Service Coordinators affirmatively contacted and are continuing to work with the effected clients in order to help rearrange services to get needed coverage within the new Waiver limits.

B. The Waiver is not violative of the amount duration and scope provisions of the Medicaid Act.

42 CFR §440.230 Sufficiency of amount, duration, and scope, states as follows:

> (a) The [State Medicaid] plan must specify the amount, duration, and scope of each service that it provides for--
> (1) The categorically needy; and
> (2) Each covered group of medically needy.
> (b) Each service must be **sufficient in amount, duration, and scope** to reasonably achieve its purpose.
> (c) The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under Sec. Sec. 440.210 and 440.220 to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition.

(d) The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures. (Emphasis added)

This section has recently been interpreted by a few courts. For example, there is the recent case of Freeman v. State of Washington Department of Social and Health Services, 2010 WL 3720285 (W.D. Wash, Sept. 17, 2010). In that case Plaintiffs raised the issue of insufficiency under §440.230(b) brought about by a general, statewide, reduction in Personal Care Aide Services, one of the services being provided to this Appellant . In deciding that the Plaintiffs could not show that the reduction violated the standard, the court referenced the earlier case of Alexander v. Choate, 469 U.S. 287, 105 S. Ct. 712, 83 L.Ed.2d 661 (1985). In that case the Supreme Court said:

> [M]edicaid programs do not guarantee that each recipient will receive the level of health care precisely tailored to his or her particular needs. Instead, the benefit provided through Medicaid is a particular package of health care services... That package of services has the general aim of assuring that individuals will receive necessary medical care, but the benefit provided remains the individual services offered-not "adequate health care."

Freeman, at 11.

Thus, §440.230(b) means adequacy of the service as a whole. Even if the Hearing Officer could have found that the services to this specific Appellant have been insufficient, he would not have been able, under §440.230(b) to generalize to the adequacy of the services provided within the Waiver program.

C. Services have been provided with reasonable promptness, even assuming that the provision of services is included in the reasonable promptness provisions.

Sec. 1902(a)(8) [42 USC §1396a(a)(8)] provides as follows:

> A State plan for medical assistance must—
>
> (8) provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals;

In his Decision, the Hearing Officer specifically found that the services were provided with reasonable promptness. There seems to be a split among the federal circuits with respect to the meaning of the "reasonable promptness" provision, and this and other legal issues were

preserved in the Decision for future review. Some courts have held that the reasonable promptness provision only means prompt payment for services received and, by implication, not assuring that the services themselves are rendered. See, Equal Access for El Paso, Inc. v. Hawkins, 562 F.3d 724 (5th Cir.2009); Brown v. Tenn. Dep't of Finance & Admin., 561 F.3d 542, 544-45 (6th Cir.2009); Doe v. Kidd, 501 F.3d 348, 355-56 (4th Cir.2007) and Bruggeman v. Blagojevich, 324 F. 3d 906 (7th Cir. 2003). A few circuits and district courts have gone in the other direction and have treated the Medicaid Act as requiring a state to provide certain actual medical services. Bryson v. Shumway, 308 F.3d 79, 81, 88-89 (1st Cir.2002); Doe v. Chiles, 136 F.3d 709, (11th Cir.1998); Boulet v. Cellucci, 107 F.Supp.2d 61 (D.Mass.2000).

The controversy stems from the definition of "medical assistance" in 42 USC §1396d(a), which now reads as follows:

> (a) The term "medical assistance" means payment of part or all of the cost of the following care and services **or the care and services themselves, or both.**

Before the Hearing Officer's Decision in this matter, the underlined and bolded part was added by the Patient Protection and Affordable Care Act (ACA, Pub.L 111-145) effective March 23, 2010. Although the legislative history does indicate that this amendment was intended to correct any misunderstandings of the meaning of the term, it is still for courts to determine the retroactive effect, if any, of the amendment. In any case, any misunderstandings are not relevant here because the Hearing Officer had substantial evidence to find that services themselves had been provided with reasonable promptness. It is the amount of the services that is at issue here.

D. Reasonable medical standards were used.

The Program Coordinator from the District Office received an application from the actual Service Coordinator to increase the Respite Care to make up for the reduction in PCAII Services. The application was from the new Service Coordinator, Ms. Yankowitz. It appears from the Record, at page 70, that the Appellant and his parents think highly of this new Service Coordinator.

The Service Coordinator had recommended 228 hours of respite services per month (Record, page 39). Presumable this was considering the attending physician's orders, as was required in

the previous Administrative Decision. The Service Coordinator's request was within the limits created by the new Waiver.

E. The efficiency, economy and quality standards have been met

> Sec. 1902. [42 U.S.C. 1396a] (a) A State plan for medical assistance must—
> (30)(A) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and 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; and...

Cases about §1902(a)(30)(A) are always about reimbursement rates, not about reduction in services. See, Independent Living Center of Southern California, Inc. v. Maxwell-Jolly, 374 Fed.Appx. 690 (9th Cir., 2010) Certiorari Granted in Part by Maxwell-Jolly v. California Pharmacists Ass'n, 131 S.Ct. 992 (2011), in which Pharmacies sued the director of Department of Health Care Services, challenging California law that imposed 5% reduction in reimbursement rate for prescription drugs provided under Medi-Cal fee-for-service program. See also, Connecticut Ass'n of Health Care Facilities, Inc. v. Rell, 2010 WL 2232693 (D.Conn., 2010), in which Connecticut froze nursing home rates.

We cannot find that this issue was raised at the hearing level, but in any event, this case is about a reduction in services, not a reduction in rates. We cannot find in the Record allegation that the rates are insufficient to attract enough PCA providers so that participants in the Waivers can have access to adequate services which, we believe, is what would have to be shown to prove that §1902(a)(30)(A) has been violated.

What pages 697 through 700, referenced by the Appellant, do show is that both the previous Waiver and the current Waiver (pages 698-700 of the Record) offer a variety of services that can be mixed and matched to a persons needs. Just as a hypothetical example, at page 63 of the Record, the Appellant's mother testified that he enjoys volunteering at the local long term care, which is part of the hospital. In certain cases, Respite Care can be provided at a long term care

facility (nursing home). See the chart at page 699 of the Record. Obviously, that would have to be explored by the Service Coordinator, but if the Appellant were to stay at the long term care facility for some of the Respite Care for the benefit of his caregivers, he would also have the added benefit of interaction with the patients with whom he enjoys volunteering. This is just another way of looking at the Chart. However, it illustrates how the Appellant continues to rely on the services that have historically been provided and has not been willing to explore with his Service Coordinator other options for meeting his needs.

II. Although there were problems in the notice regarding the reductions, the substantial evidence in the Record shows those defects were not fatal as the Appellant did get adequate due process.

In addition to the issues set forth in the Appellant's appeal request and answered in the Respondent's Pre-Hearing Brief, the Appellant has asserted that the SCDDSN's initial notice to the Appellant about the reduction in services was defective because it did not comply with the following regulation:

> §431.210 Content of notice.
>
> A notice required under Sec. 431.206 (c)(2), (c)(3), or (c)(4) of this subpart must contain--
> (a) A statement of what action the State, skilled nursing facility, or nursing facility intends to take;
> (b) The reasons for the intended action;
> (c) The specific regulations that support, or the change in Federal or State law that requires, the action;
> (d) An explanation of--
> (1) The individual's right to request an evidentiary hearing if one is available, or a State agency hearing; or
> (2) In cases of an action based on a change in law, the circumstances under which a hearing will be granted; and
> (e) An explanation of the circumstances under which Medicaid is continued if a hearing is requested.

Specifically, the Appellant complains that the notice does not adequately describe the action taken by the agency. However, it appears that the Appellant was exactly aware of the actions

being taken on his case when he appealed. See, the Notice of Appeal at page 830 and following of the Record.

Ultimately, the "regulations that support... the action" are set forth in the general description of the home and community based waivers in 42 CFR §440.180 of the Medicaid Regulations:

> 440.180 Home or community-based services.
>
> (a) Description and requirements for services. ``Home or community-based services'' means services, not otherwise furnished under the State's Medicaid plan, that are furnished under a waiver granted under the provisions of part 441, subpart G of this chapter.
> (1) These services may consist of any or all of the services listed in paragraph (b) of this section, as those services are defined by the agency and approved by CMS.
> ..... (emphasis added)

Obviously, that is a very general, over-arching and abstract concept, and, thus it is much more meaningful for a beneficiary to be apprised of the particular service and service limits in the waiver that apply to the particular action being taken by the agency. Obviously that took place at some time during the process, because the Appellant knew exactly what was being reduced and eliminated and what to appeal.

As to the Appellant's complaints that his parents were warned that they would be responsible for the cost of services provided during the pendency of the appeal, the cited 42 CFR §435.602(a) is an eligibility rule which is included in Part 435, Eligibility, of 42 CFR, Subpart G entitled General Financial Requirements and Options:

> Sec. 435.602 Financial responsibility of relatives and other individuals.
>
> (a) Basic requirements. Subject to the provisions of paragraphs (b) and (c) of this section, in determining financial responsibility of relatives and other persons for individuals under Medicaid, the agency must apply the following requirements and methodologies:
> (1) Except for a spouse of an individual or a parent for a child who is under age 21 or blind or disabled, the agency must not consider income and resources of any relative as available to an individual.
> (2) In relation to individuals under age 21 (as described in section 1905(a)(i) of the Act), the financial responsibility requirements and methodologies that apply include considering the income and resources of parents or spouses whose income

and resources would be considered if the individual under age 21 were dependent under the State's approved AFDC plan, whether or not they are actually contributed, except as specified under paragraphs (c) and (d) of this section. These requirements and methodologies must be applied in accordance with the provisions of the
State's approved AFDC plan.

(3) When a couple ceases to live together, the agency must count only the income of the individual spouse in determining his or her eligibility, beginning the first month following the month the couple ceases to live together.

(4) In the case of eligible institutionalized spouses who are aged, blind, and disabled and who have shared the same room in a title XIX Medicaid institution, the agency has the option of considering these couples as eligible couples for purposes of counting income and resources or as eligible individuals, whichever is more advantageous to the couple.

The rule deals with what is to be included in the calculation of Medicaid eligibility. The Medicaid Fair Hearing regulations do allow the agency to recoup the cost of services maintained during the pendency of an appeal:

Sec. 431.230 Maintaining services.

(a) If the agency mails the 10-day or 5-day notice as required under Sec. 431.211 or Sec. 431.214 of this subpart, and the recipient requests a hearing before the date of action, the agency may not terminate or reduce services until a decision is rendered after the hearing unless--

(1) It is determined at the hearing that the sole issue is one of Federal or State law or policy; and

(2) The agency promptly informs the recipient in writing that services are to be terminated or reduced pending the hearing decision.

(b) If the agency's action is sustained by the hearing decision, the agency may institute recovery procedures against the applicant or recipient to recoup the cost of any services furnished the recipient, to the extent they were furnished solely by reason of this section.

Ex parte communication was not done by the Hearing Officer, but some preliminary communication took place between SCDDSN and the Director of the Appeals Division and cannot be shown to be prejudicial to the case.

SECTION 1-23-360: Communication by members or employees of agency assigned to decide contested case.
Unless required for the disposition of ex parte matters authorized by law, members or employees of an agency assigned to render a decision or to make

> findings of fact and conclusions of law in a contested case shall not communicate, directly or indirectly, in connection with any issue of fact, with any person or party, nor, in connection with any issue of law, with any party or his representative, except upon notice and opportunity for all parties to participate. An agency member:
> (1) May communicate with other members of the agency; and
> (2) May have the aid and advice of one or more personal assistants.
> Any person who violates the provisions of this section shall be deemed guilty of a misdemeanor and upon conviction shall be fined not more than two hundred fifty dollars or imprisoned for not more than six months.

The person identified by the Appellant as having violated this provision was, at the time, the Director of the Division of Appeals and Hearings. He was not the person assigned to make the findings of fact and conclusions of law in this case. Even if he had been the person, it goes against reason that the adjudicator cannot find out what the posture of the case is before issuing a Notice of the Hearing. In fact, there is no indication in the record of the purpose of Mr. Crouch's contact with DDSN, but he was the person responsible for assigning the cases and it is reasonable to assume that he needed some background before doing so.

III. **There is substantial evidence in the record to find that a previous order regarding the Appellant was a DHHS Final Administrative Decision, which could not be fully effectuated because of the Waiver changes, and, even so, did not require the Respondent to follow the orders of attending the physician, only consider them in planning for care.**

A. The previous Final Administrative Decision.

We believe that the Decision in the 2009 case of [Appellant] v. SCDHHS, 09-MISC-017 was a final Order, which the Hearing Officer expected to be carried out. The Respondent did not object to the incorporation of the previous case, and it appears that the Hearing Officer in this case did review it. However, the Hearing Officer declined to apply it dispositively to the Appellant's need for care at this time. We believe that the previous case ended with the Remand and the Hearing Officer did not retain jurisdiction of the case for further review.

Also, during the time the previous Order was being implemented, the new Waiver required all services to be reevaluated, taking into consideration the new limits. We believe that the evidence substantiates the Hearing Officer's decision to examine the reduction in services to the Appellant

occasioned by the new wavier limits. Furthermore, it appears that upon remand to the DDSN, the Appellant's case was reevaluated and reauthorized by the new Service Coordinator, taking into account the orders of the Appellant's attending physician, Dr. Joseph. See, the new Service Coordinator's Application for additional services at page 103 and following of the Record. The Service Coordinator and the Appellant were probably trying to work out the array of services allowed under the Waiver, when the Appellant appealed.

B. Problems with complete deference to attending physician's orders.

The concept of Medical Necessity is introduced in the Medicaid regulations as an element to avoid services being provided in such quantity that it takes undue advantage of the Medicaid Program. In 42 CFR:

> Sec. 433.304 Definitions.
>
> As used in this subpart--
> Abuse (in accordance with Sec. 455.2) means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not **medically necessary** or that fail to meet professionally recognized standards for health care. (Bolding added.)

Medical necessity can, therefore, be a limiting element on Medicaid Services.

> Sec. 440.230 Sufficiency of amount, duration, and scope.
>
> (a) The plan must specify the amount, duration, and scope of each service that it provides for--
> (1) The categorically needy; and
> (2) Each covered group of medically needy.
> (b) Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.
> (c) The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under Sec. Sec.
> 440.210 and 440.220 to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition.
> (d) The agency may place appropriate limits on a service based on such criteria as **medical necessity** or on utilization control procedures.
> (Bolding added.)

To their credit, treating physicians are natural advocates for their patients, and that is as it should be and central to the doctor/patient relationship. However, in their advocacy for their patients, treating physicians are often unmindful of the true availability and cost of services ordered. Furthermore, although their training is extensive, not every physician is aware of the evidence-based approaches that have been shown to be effective in the area of home-based or community services. Every order from a treating physician should be given the utmost consideration and attention by State agency staff charged with authorizing services, but services varying widely from the normal scope which experience has shown to be safe, should not be authorized in disregard of the need for sound stewardship of State and Federal funds.

We believe there is a split in the federal circuits as to the control of the attending physician in determining what services are "medically necessary." In the fourth circuit, we believe that the decisions of the treating professionals (the State's or the individual's private provider) are not necessarily controlling. See, Thomas S. v. Flaherty, 902 F.2d 250 (4th 1990), as quoted in Williams v. Wasserman, 164 F. Supp. 2d 591 (D. Md. 2001) a case in which the court denied Olmstead (see below) relief to the Plaintiffs, indicating that to do so would cause a fundamental alteration of the State's program. We believe that in this federal circuit, at least, the treating professional's opinion will certainly be among those considered to determine that professional judgment was exercised. However, the question of medical necessity is an issue of fact, which if left to the attending simply forecloses the issue and makes it not subject to scrutiny by the administering agencies or courts.

The Respondent understood the unreported district court case of Moore v. Medows, 2009 WL 4884029 (N.D. Ga. 2009), cited by Appellant, to be about who gets to determine medical necessity for service, the patients' attending or the State. The district court said the patient's attending's order were dispositive. We believe that the circuit court disagreed and remanded the case. We further believe that upon remand, the district court sustained the attending physician's original orders but because the orders were not unreasonable and untainted by fraud. The case is, as reported by the Appellant, on appeal to the 11th Circuit.

Finally, even if the attending physician's order were dispositive about what is medically necessary for this Waiver participant, that would not override the specified programmatic limits on the services available. Waiver services, particularly, are designed to "...complement and/or

supplement the services that are available to participants through the Medicaid State Plan and other federal, state and local public programs as well as the supports that families and communities provide." See paragraph 1 on Page 1 of the MR/RD Waiver document, attached.

IV. There is substantial evidence in the Record to show that integration mandate of Olmstead was not violated.

In further explication of the Appellant's argument that the U.S. Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999) interpreted the Americans with Disabilities Act in such a way as to require his services to continue, undiminished, the Appellant cites extensive caselaw.

As we understand the Appellant's basic argument, it is that the Supreme Court in Olmstead said that if the person wants to live in the community and the State's treating professionals think he can and the State can reasonably accommodate such a placement, then the person should be supported in the community. The proposed cuts in services to the Appellant, could lead to his having to be institutionalized, and, therefore, the cuts should be prohibited. First of all, the Appellant is living in the community, and it is speculative as to whether the reduction in services will cause him to be institutionalized. Secondly, even if it is true that he would be institutionalized, the State's responsibility under Olmstead (to support a person in the community) is not boundless. Olmstead, at 603. If the accommodation would fundamentally alter the State's program, the State does not have to make the accommodation.

Nationwide, there have been many recent lawsuits, based on Olmstead, against States for reducing Waiver and regular Medicaid services in the face of budget problems. Having made an attempt to review the cases, the Respondent cannot find that, in the context of budget cuts such as many states are now facing, that the federal courts have finally spoken with any consensus on the issue. Can the State, in the face of budget cuts, reduce an individual's waiver (for example) services in the community, even if there is a chance that the reductions will lead to institutionalization? It would appear that most or all of the cases are in some stage of litigation, and have not yet been finalized.

Probably, the case most favorable to the Respondent is Rosen v. Goetz, 410 F. 3d 919 (6th Cir., 2005). In that case, the federal circuit court lifted a district court's injunction against service reductions imposed by the State. The court said:

> When a State [Tenn.] to its credit achieves the status of becoming one of the most generous providers of Medicaid services in the nation, it may occasionally happen that the zero-sum fiscal realities of administering a state budget will prohibit the State from sustaining that level of support. If that should happen, it is not for the federal courts to compel the State to maintain non-mandatory Medicaid programs that it no longer can support.
> Rosen, at 933.

However, it is believed that the district court is still monitoring Tennessee's disengagement with their statewide Medicaid Waiver program, and will continue to be involved in all related state actions. In his post-hearing Brief, the Appellant cites Crabtree v. Goetz, an unreported case for which the Westlaw cite is 2008 WL 5330506 (M.D. Tenn., 2008). This was another Tennessee case in which the district court granted a preliminary injunction preventing the State from implementing Medicaid service cuts. As far as we know the merits of the case, more than was necessary to dispose of the preliminary injunction have not been heard. Presumably, the injunction or the district court's final ruling in the Crabtree case could be subject to the 6th circuit's ruling in Rosen.

The language in Fisher v. Oklahoma Health Care Association, 335 F. 3d 1175 (10th Cir. 2003) and Radeszewski v. Maram, 383 F. 3d 599 (7th Cir. 2004) is very favorable to the Appellant, but the Respondent understands both of those cases to be ones in which the circuit court was reversing a summary judgment, saying that the court below decided the cases on the pleading without taking sufficient facts and arguments. The circuit court wanted the cases to be fully tried because the Plaintiffs had set forth a case that, under the ADA, could potentially be decided in their favor.

However, in M.R., et al v. Dreyfus, WL 588511 (W.D. Wash., 2011), the court examined the standards for whether Olmstead had been violated. In Dreyfus, as in the present case, a reduction in personal care service hours occasioned by a State budget problem had occurred.

The court distinguished the Fisher, case in which the institutionalization of the Appellants was certain, from cases like the Dreyfus reduction in services in which institutionalization was speculative. In Dreyfus, the district court declined to impose an injunction. Again, the merits of the case are yet to be fully heard.

We reviewed the Marlo M. v. Cansler case, WL 148849 (E.D.N.C, 2010) but, again, as the Appellant states it resulted in preliminary injunctions. It is true however, that in the Marlo case as in most of the cases cited by the Appellant, courts have found that the Plaintiffs have put forth initial cases that were likely to succeed on the merits. That, of course, along with the likelihood of irreparable harm and the balance of equities, is one of the requirements that a Plaintiff has to meet in order to be granted a preliminary injunction. However, the cases are still pending for full hearings on the merits.

It also appears to the Respondent that a good chance for an on-point circuit court decision favorable to the Appellant is in the ninth circuit. However, in the northern district of California, in the case of Cota v. Maxwell-Jolly, 688 F. Supp. 2d 980 (N. D. Calif., 2010), the court enjoined eligibility and medical necessity restrictions on Adult Day Health Care. We cannot find that appeal has been taken or that the case is otherwise resolved.

Recently, in South Carolina another temporary injunction was issued in the case of P.B., J. E. and M.M. v. Sanford, et al., C.A. No.:6-CV-00767-JMC. The issues in that case are very similar to the issues here. For two (2) of those Plaintiffs, the services were reduced as a result of the South Carolina's Waiver Amendment. Pending the resolution of the matter, the Department was temporarily enjoined from reducing the services. There are, of course, many issues to be argued in that case, and the outcome is, again, not certain. We believe that the temporary order in that case need not determine the decision in this court.

It may be some time before federal courts achieve consensus on these issues. Obviously, the Respondent's position is that Olmstead does allow states to reduce services when there only a possibility of institutionalization as opposed to a certainty. Furthermore, it is the Respondent's

position that courts will ultimately decide that to exceed established program limits would be a "fundamental alteration" of the State's program.

CONCLUSION

Unlike some Medicaid services, such as nursing home services and hospital services, Waiver services are optional. They do not have to be provided in order for the State to maintain a viable Medicaid Program. Until recently, the State has been able to offer these Waiver services without limitation, and, at times, it is believed that the services authorized have exceeded those which were reasonable or medically necessary. See, the testimony of Ms. Shealy at page 16 and beginning at page 25 of the Record.

In light of the federal courts' inability to reach a consensus on these issues, we respectfully request that this Administrative Law Court sustain the Hearing Officer's Decision in this case and allow the Appellant and his new Service Coordinator to craft an acceptable array of Waiver services within the established Waiver limits.

Respectfully Submitted,

Richard G. Hepfer
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Attorney for the Respondent

March 14, 2010
Columbia, South Carolina

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St., Suite. 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

November 9, 2009

Emma Forkner, Director
South Carolina Department of Health & Human Services
Department of Health & Human Services
1801 Main Street
Columbia, SC 29201

Dear Ms. Forkner:

I am pleased to inform you that your request to renew South Carolina's Home and Community-Based Waiver for Persons with Mental Retardation or Related Disabilities, as authorized under provisions of section 1915(c) of the Social Security Act, has been approved. This waiver renewal has been assigned control number 0237.R04, which should be used in future correspondence. The waiver renewal is effective January 1, 2010 through December 31, 2014.

Specifically, you submitted a renewal request on August 31, 2009 to continue to provide the following waiver services: Adult Day Health Care; Personal Care 1 & 2; Residential Habilitation; Respite; Extended State Plan Adult Dental; Adult Vision; Audiology Services; Extended State Plan Prescribed Drugs; Adult Attendant Care Nursing; Adult Companion Services; Adult Day Health Care Nursing; Adult Day Health Care Transportation; Behavior Support Services; Career Preparation Services; Community Services; Day Activity; Employment Services; Environmental Modifications; Nursing Services; Personal Emergency Response System (PERS); Private Vehicle Modifications; Psychological Services; Specialized Medical Equipment, Supplies & Assistive Technology and Support Center Services.

The following estimates of utilization and cost of waiver services have been approved:

	Unduplicated Recipients	Factor D	Total Waiver Costs
Year 1 (1/1/10 – 12/31/10)	6300	$51,869	$278,661,600
Year 2 (1/1/11 – 12/31/11)	6700	$52,350	$298,042,800
Year 3 (1/1/12 – 12/31/12)	7100	$53,607	$323,085,500
Year 4 (1/1/13 – 12/31/13)	7500	$56,320	$359,812,500
Year 5 (1/1/14 – 12/31/14)	7900	$59,078	$398,815,700

We appreciate the effort and cooperation provided by your staff during our review of this request. If you have any questions, please feel free to contact Kimberly Adkins-McCoy at (404) 562-7159.

Sincerely,

Mary Kaye Justis, RN, MBA
Acting Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:
Due to the State of South Carolina's budget situation, SCDDSN opted to make minor adjustments to the MR/RD waiver program. SCDHHS and SCDDSN worked together for many months to consider possible changes administratively allowed within federal regulations. To obtain public input, SCDDSN conducted a survey of waiver participants, parents and other interested stakeholders. Additionally, staff from both agencies hosted a well-attended public meeting. The information gained guided SCDDSN toward making necessary budgetary adjustments including the following:

Services for which limits will be implemented:
• Specialized Medical Equipment, Supplies and Assistive Technology:
a) lower the monthly limit of liquid nutrition (for those without a feeding tube) to 2 cases per month;
b) limit the cost per wheel chair to $8,000 total and allow only 1 chair every 5 years;
• Nursing: limit services up to 56 hours per week for LPN or 42 hours per week for RN;
• In-home Respite: limit services up to 68 hours per month;
• Personal Care 2: limit services up to 28 hours per week. (Note: The participant is limited to a combined total of 28 hours per week for PC2, Adult Companion and/or Adult Attendant);
• Personal Care 1: limit service to 6 hours per week;
• Adult Companion Care: limit services up to 28 hours per week. (Note: participant is limited to a combined total of 28 hours of companion, PC2 and/or attendant care per week);
• Adult Attendant Care: limit services up to 28 hours per week. (Note: participant is limited to a combined total of 28 hours of companion, PC2 and/or attendant care per week).

Services to be removed:
Physical Therapy
Occupational Therapy
Speech Language pathology
Day Habilitation (replaced with Day Activity)
Supported Employment (replaced with Employment Services)
Prevocational Habilitation (replaced with Career Preparation)

Service to be added:
Personal Emergency Response System (previously covered under Specialized Medical Equipment)

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

R. S., Appellant, vs. South Carolina Department of Health and Human Services, Respondent.	Docket No. 10-ALJ-08-0774-AP **CERTIFICATE OF SERVICE**

I hereby certify that I am a Paralegal for the Respondent in the above-captioned matter and that on the 14th day of March, 2011, in Columbia, South Carolina, I served a copy of the forgoing Brief of Respondent on the following person by depositing the same in the United States Mail, postage paid, and addressed as follows:

Ms. Patricia L. Harrison
Attorney at Law
611 Holly St.
Columbia, SC 29205

Linda Hillian
Paralegal
Office of General Counsel
SC Department of Health and
Human Services

THE STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

APPEAL FROM THE SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

10-MISC-042

The Honorable W. Jefferson Bryson

Docket No.10-ALJ-08-0774-AP

Richard Stogsdill, Appellant,

v.

South Carolina Department of Health and Human Services, Respondent.

INITIAL BRIEF OF APPELLANT

Patricia L. Harrison
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Columbia, SC 29205
803/256-2017

ATTORNEY FOR APPELLANT

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ISSUES ON APPEAL

1. Did the Respondent err as a matter of law in failing to give the greatest of deference to Richard's treating physician?

2. Does the record support the hearing officer's findings about the number of hours Richard was entitled to receive when he filed his appeal, his conclusion that Respondent considered the orders of Richards' physician in determining his need for respite and his conclusion that the predictions of Richard's health care professionals are "speculative," or are these findings and conclusions clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record?

3. Did Respondent violate Richard's due process rights by failing to provide a notice of reduction or termination of services meeting the requirements of 42 CFR 431.210, reducing or terminating services during the appeal in violation of 42 CFR 431.230, purging the Record on Appeal in violation of Rule 36 of the South Carolina Rules of the Administrative Law Court, improperly limiting Appellant's access to the records in the file and generally violating the procedural due process requirements of 42 U.S.C. 1396a(a)(3), 42 CFR 431.205 et. seq. and Article IVX of the United States Constitution and are these violations subject to repetition?

4. Was the order of the hearing officer made upon unlawful procedure or affected by other error of law because the Director of the Office of Hearings and Appeals participated in ex parte communications with DDSN employee Jacob Chorey and/or counsel for Respondent?

5. Did Respondent violate provisions of the Medicaid Act and the applicable regulations promulgated by CMS, by not providing services with reasonable promptness, not requiring comparable services to be provided in the amount, duration and scope necessary to meet the goals of the program and not applying reasonable medical standards?

6. Has Respondent violated the Americans with Disabilities Act (ADA) and the Department of Justice regulations contained at 42 U.S.C. 12132 and 28 C.F.R. 35.130(d), which require public entities to administer and deliver government services to qualified disabled persons in "the most integrated setting" possible?

STATEMENT OF THE CASE

This case arises out of an appeal of Respondent's denial of medical assistance which Richard Stogsdill's physician determined to be medically necessary to avoid placement in a more restrictive congregate setting. Richard filed an appeal on February 13, 2009 pursuant to 42 U.S.C. 1396a(a)(3) and the South Carolina Administrative Procedures Act at 1-23-380. (DHHS Office of Hearings and Appeals omitted all records dated between February 13, 2009 and January 11, 2010 from the Record on Appeal. The letter requesting this appeal is not included in the Record on Appeal). In that letter, he objected to DDSN prohibiting him from using his hours so as to have two caregivers at times when he has to be transferred.

OT, PT and speech services from the MR/RD Medicaid waiver. (This record was omitted from the Record on Appeal). In this letter, Richard objected to the failure to comply with Ms. Loomis' November 16, 2009 order, violation of the ADA and various provisions of the Medicaid Act, including, but not limited to the failure to comply with its notice requirements. Id.

On January 12, 2010, the director of DDSN upheld the Respondent's action. R. at 845. DDSN informed Richard's family that they would be responsible for payment for services provided to him during the appeal unless he won his appeal. R. at 88.

On January 11, 2011, Richard requested a review of this decision by letter to Mr. Vastine Crouch, who was the Director of the SCDHHS Office of Hearings and Appeals (DHHSOHA). R. at 843. A hearing was held on May 11, 2010 by a new hearing officer, Jefferson Bryson. The DHHS hearing officer issued a final order on September 14, 2011 upholding the reductions, concluding that the opinions of Richard's treating physician and other health care professionals "must be speculative" and that Respondent had not violated the integration mandate of *Olmstead*. R. at 14. He held that Respondent had violated the notice requirements of the Medicaid Act, but that this violation was "cured" by the "Reconsideration process." Id. This order was received by the Appellant on September 22, 2010 and this appeal was filed in the South Carolina Administrative Law Court on October 20, 2010.

STANDARD OF REVIEW

Richard seeks injunctive relief. "Actions for injunctive relief are equitable in nature." *Shaw v. Coleman*, 373 S.C. 485, 492, 645 S.E.2d 252, 256 (Ct.App.2007). *See also* Jean Hoefer Toal, et al., *Appellate Practice in South Carolina* 193 (1999). In actions in equity this Court may find facts in accordance with its own view of the preponderance of the evidence. *Shaw* at 492. This Court may reverse or modify an order that is in violation of constitutional or statutory provisions; in excess of the statutory authority of the agency; made upon unlawful procedure; affected by other error of law; clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; or arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion. S.C. Code Ann. 1-23-380(5) (Supp. 2009).

Richard claimed that Respondent had erroneously denied his request for Personal Care Attendant (PCA), Adult Companion Services and Respite Services. He also appealed the failure to enlist sufficient providers, the expenditure of funds intended for services to purchase large workshops, the failure to promulgate regulations and the failure to comply with the mandates of the United States Supreme Court in *Olmstead v. L.C.*, 525 U.S. 1054 (1998).

In an interlocutory order dated November 16, 2009, DHHS hearing officer Bonnie D. Loomis made findings of fact that Richard had requested additional PCA Services and that his physician had determined that he requires two personal care aides for eight hours a day (16 hours total). Order at 4 and 5. She determined that DDSN made a mathematical error in determining Richard's need for PCA services and that Richard was without standing to object to the reduction of services. Order at 4 and 6. Ms. Loomis then remanded the issue of Richard's PCA services and specifically ordered the agency to take into account the order of his treating physician. Order at 7. Ms. Loomis determined that the number of Respite hours Appellant's physician had ordered was appropriate. That order required DDSN to determine the number of hours of Adult Companion Services Richard requires, taking into consideration his need for socialization. Ms. Loomis denied Appellant's due process claim and claim for failure to promulgate regulations. Order at 10 and 11. This was an unappealable interlocutory order. Appeals Case 09-MISC-017, November 16, 2009.

Before December 30, 3009, DDSN determined that Richard needs 15 hours a week of Adult Companion Services. R. at 88 and 787. Respondent failed to comply with the November 16, 2009 Order to reevaluate Richard's need for PCA services, giving consideration to Dr. Joseph's order. In December, Richard learned that instead of complying with that Order, DDSN intended to reduce his PCA, Adult Companion and Respite hours, without giving consideration to his physician's order. He also learned that DDSN intended to terminate his right to receive occupational therapy (OT), physical therapy (PT) and speech and language services. R. at 88. However, neither DDSN nor Respondent provided Richard with any written notice of its intention to reduce, suspend or terminate waiver services. R. at 10.

On December 30, 2009, Richard, through his counsel, sent a letter to the Director of DDSN asking for reconsideration of this decision to reduce his PCA, Adult Companion and Respite hours and to eliminate

FACTS

Richard is a person who has severe disabilities which are "related disabilities" for purposes of qualification for the MR/RD Medicaid waiver program, which is administered by the South Carolina Department of Disabilities and Special Needs (DDSN) under a contract with Respondent. However, Respondent may not delegate to DDSN the authority to issue policies, rules or regulations on program matters. 42 CFR 431.10(d)(1).

Richard is 23 years old. He has severe cerebral palsy. R. at 783. Although he is profoundly physically impaired, Richard has normal intelligence. R. at 58 and 786. He attended school until he was 21, where he was fully integrated into his school community, socializing primarily with peers who do not have disabilities. R. at 59. He was "brought up with normal people, normal kids..." Id. At school, Richard provided an aide by the school district during the entire school day. R. at 60.

For a while, Richard attended a program at South Carolina Vocational Rehabilitation, but they were unsuccessful in placing Richard and terminated his services. (Testimony of Nancy Stogsdill at 2009 hearing.) DDSN has terminated the speech, OT and PT services which Richard received at school. R. at 67. As a result of the loss of these services, Richard's muscles have atrophied. R. at 68, 73 and 74. He has lost the ability to hold a cup, to use his thumb on the computer, to hold a book and turn pages since these therapies were terminated. Id. Richard's ability to speak has also deteriorated since he left school. R. at 69.

When Richard was attending school, his mother worked full-time as a bookkeeper and his father travels in his work. R. at 61. His mother was forced to quit her full time job when Richard's supports were reduced in order to help with his care. R. at 61 and 62. She is unable to lift Richard because of injury to her back. R. at 63. Now his mother has taken on a number of part time jobs to accommodate his schedule while trying to make financial ends meet. R. at 63. His mother leaves her house around seven a.m. to go to work and returns to help Richard mid-day. R. at 64, 80. Then she returns to work and usually does not get home until 5:30 or 6:00. R. at 81. Her work day is longer than the 37 ½ hours most full time state employees work. After that, her "second shift" job begins: helping to take care of her 23 year old son, trying to keep him out of an institution.

Richard is 5'5" tall and weighs between 115 and 120 pounds. R. at 61. He cannot sit up straight. R. at 60 and 62.When he is in his bed, Richard cannot use his phone or punch the emergency button. R. at 62. His cerebral palsy causes "horrible spasms" which hurt Richard to the point that he "sweats and moans...to the point of tears." R. at 74. When he is suddenly hit with these spasms, Richard has to be taken out of his wheelchair and stretched on his bed. Id. He sometimes crumbles without warning at the onset of these spasms, falling forward. R. at 60 and 75. His arms and legs have to be strapped into his wheelchair because of these uncontrolled movements. R. at 60.

Richard lives in an apartment next to his parent's home. He requires two persons to get him out of bed, toilet, shower and dress him. R. at 60 and 783. He requires assistance taking his medications and requires a regular toileting schedule to prevent life-threatening gastrointestinal obstructions. R. at 783. Once Richard is transferred from his bed by two caregivers, he can drive his motorized wheelchair and can use one or two fingers on his left hand to manipulate his computer. R. at 59. After his food is prepared and cut into small pieces by someone else, Richard can feed himself. Id. Richard volunteers at the fine arts center, using his two fingers that work to hand out programs. He welcomes people and takes tickets. R. at 62. Richard also visits and reads to patients at the local hospital. Id.

According to Dr. Joseph, who has been Richard's treating physician for 22 years, the reason his health has been relatively good is because of the excellent care he has received in his own home, allowing him to remain outside of an institutional setting. R. at 72 and 783. If Richard were required to attend a congregate workshop or to move to an institution, his condition would deteriorate. R. at 783. Because of the exercise Richard receives in his current living arrangement and the therapies he has received at home, he has been able to avoid expensive and painful surgeries. R. at 783. According to Dr. Joseph, Richard needs Adult Companion Services prevent regression of his social skills and to maintain good mental health. R. at 784. Sixteen hours of PCA services are needed a day (2 persons for 8 hours a day), just to meet his basic needs for activities of daily living (bathing, dressing, shaving, toileting, purchasing and preparing food, transferring to and from the bed to his wheelchair, etc.). R. at 783. If Richard were forced into an institution, Dr. Joseph has determined that he "would expect to see a marked decline in both his physical and mental condition because

of the trauma he would experience from being segregated from his community and being forced to live in a congregate setting." R. at 785.

Richard's provider of psychological services has worked with persons who have disabilities for 30 years. R. at 780. She has reported that he exhibits anxiety and "depressive symptoms," which have increased due to his increasing level of dependence on his parents and his inability interact with his non-disabled peers since he left school. R. at 780 to 781. His needs cannot be met effectively by attending a DDSN congregate workshop, where he would be surrounded by persons who have cognitive deficits. R. at 781. At the workshop, participants must sit at assigned tables, in assigned seats. R. at 64. His mother testified that it "would be unbearable for Richard" to be forced to spend his days in a room with fifty or sixty disabled persons in a workshop, some who have no control over their behavior and anger. R. at 65. Not only would Richard be at risk of harm from assault, most persons who attend the workshop could not communicate with him due to their cognitive disabilities. Id.

According to his mother, who previously served on the local DSN Board and is familiar with their services: "mentally he would be devastated to have to go to a workshop..." and he would regress because of the stigmatization he would feel if forced to attend the workshop. R. at 65 and 66. Evidence was presented at the 2009 hearing by a nurse and Richard's treating physician of the inappropriateness of Richard attending a workshop. (Transcript of 2009 hearing was omitted from the Record on Appeal.) Richard's psychologist agrees with his treating physician that his mental and physical health would decline if he were forced to attend a congregate workshop, where he would be placed with persons who have aggressive behaviors. R. at 65 and 781. Richard would also be vulnerable to being assaulted, because he is unable to defend himself. Id.

Providing the services at home that Richard's physician has ordered would delay institutionalization and would allow him to remain in the least restrictive setting in the community. Id. The Adult Companion Services his physician has determined that Richard needs would cost approximately the same amount as his attending a DDSN workshop. R. at 782. Even if Richard were to attend the workshop, he would still require PCA services, because he is unable to get out of bed, shower, dress, use the toilet, fix his meals or transport himself to the workshop without total assistance. Likewise, once the day program ended in the afternoon,

Richard would be totally reliant on others for every activity of daily living.

Effective January 1, 2010, DDSN placed caps on Adult Companion, PCA and Respite Services and totally eliminated speech and language, physical therapy and occupational therapy services from the MR/RD Medicaid waiver program. R. at 88. Under the new rules, persons living at home can receive no more than 28 hours a week of PCA and Adult Companion Services (combined). R. at 88. Respite hours under the new rules are limited to 68 hours a month, unless DDSN grants an exception, in which case up to 240 hours a month of respite may be authorized. These changes were made by the Respondent without promulgating regulations or changing any law. DHHS obtained approval from CMS by informing that federal agency that these reductions were necessary due to severe budget reductions. At the time these changes were submitted to CMS, DDSN asked the S.C. Budget and Control Board to spend $7.8 million, with $2.6 million of those funds transferred to three local DSN Boards to buy large buildings to be used as workshops. R. 680 to 695.

Under the new rules, DDSN will provide Richard with unlimited respite services in an ICF/MR, the most restrictive and expensive setting in the DDSN system, as these institutional services were not reduced. (An ICF/MR is a nursing home for persons who have mental retardation or a related disability.) Under the new plan, DDSN increased the rate of reimbursement for these institutional services by 70%, while the reimbursement rate for other home-based services was reduced. R. at 697 to 700. These ICF/MR respite services, which cost $270 per day, replaced daily home-based respite which had cost only $53.06 per day. R. at 697. When asked how Richard would react to being sent to a DDSN Regional Center to receive Respite Services, his mother testified: "He would object violently. I mean he would – he wouldn't understand why we were doing it. He -- I mean he would think that, what happened, you know, what did I do? Why am I being punished?" R. at 79.

According to DDSN, in 2009, the waiver services Richard was receiving at home cost $37,364.45 a year ($102.36 per day). (Exhibit 5 from July 7, 2009 hearing, which was not included in the Record on Appeal.) Institutional services in a DDSN ICF/MR cost $320 per day. R. at 795. In an audit of DDSN's MR/RD Medicaid waiver program which DHHS released in 2006, it reported Medicaid paying up to $170,837.00 per year ($468.04 per day) for waiver services provided to an individual waiver participant who

lived in a congregate group home. R. at 264. $158,921 of these costs were found to be allowable by CMS "because of enhanced staffing needs, and the cost to serve these individuals would be high regardless of where they are placed." R. at 266. But persons who choose to remain in their homes or apartments are denied these same "enhanced" services.

Neither Respondent nor DDSN provided any written notice of reduction, suspension or termination of Richard's services. In an effort to discourage waiver participants from appealing, DDSN threatened parents that they would be billed the cost of services if the appeal was lost. R. at 88. CMS regulations specifically prohibit States from requiring parents to pay for Medicaid services provided to an adult child. 42 CFR 435.602.

Richard participated as a plaintiff in a petition for original jurisdiction filed in the South Carolina Supreme Court in December 2009, requesting an injunction to prohibit the January 1, 2010 reductions in services. R. 134. This Court may take judicial notice that the Supreme Court denied he petition for original jurisdiction without ruling on the merits. Within weeks, on January 11, 2010, Richard's DDSN service coordinator sent a notice to his providers of PCA Services and durable medical goods instructing them to terminate Richard's services because he had "moved out of state." R. at 788 and 789. DDSN did not provide Richard with these termination notices. He learned of the notice of termination of his services from his private service providers. R. at 69 to 70, 790. Respondent failed to provide Richard with any written notice meeting the requirements of 42 C.F.R. 431.210. Richard filed a request for reconsideration with SCDDSN on December 30, 2009. (This request for reconsideration was not included by DHHS in the Record on Appeal, but is referenced on page 845.) The very next day, January 12, 2010, Dr. Beverly Buscemi, Director of DDSN upheld the agency's decision to further reduce Richard's PCA, Companion and Respite services. R. at 845. Dr. Buscemi's response stated: As you may know, limits or caps have been placed on services in the MR/RD Waiver. Approval for these limits or caps was obtained from the Centers for Medicaid and Medicare Services (CMS). These approved limits cannot be exceeded and must be applied to all MR/RD Waiver participants. (Emphasis added.) R. at 845.

On January 12, 2010, Richard requested review of Dr. Buscemi's decision by filing a letter with

Vastine Crouch, the Director of the DHHS Office on Hearings and Appeals. R. at 843. He appealed the reduction in waiver services, the termination of daily respite as a waiver option, the elimination of speech, OT and PT services, the agency's failure to apply reasonable medical standards in determining medical necessity, the violation of due process, the failure to promulgate regulations, violation of the ADA integration mandate and misuse of federal stimulus funds. Id.

On January 18, 2010, Richard's DDSN service coordinator completed a "Respite Assessment" documenting that he requires extensive supervision, with visual supervision every 15 minutes. R. age 98. His parents are also responsible for caring for elderly parents and they have no extended family members to help them with Richard or their parents. R. at 100. This assessment noted that the waiver provides no coverage for Richard on the weekends and that he is incontinent and requires catheter care. R. 101 and 102. On March 1, 2010, the District Director of DDSN modified Richard's Respite hours to 172 per month, which is a reduction from the hours contained in his January 2009 plan of care and found by Ms. Loomis and Richard's physician to be appropriate.

On February 18, 2010, Jacob Corey, the DDSN MR/RD Medicaid Program Coordinator, sent an ex parte memorandum to Mr. Crouch. informing him that DDSN had "increased" the number of hours of respite provided to Richard. R. at 88. He informed Mr. Crouch in this memo that the waiver amendments had been approved by CMS. As to the number Adult Companion hours Richard was receiving, this memo informed Mr. Crouch that the family was "working that out" when Richard filed his appeal with DHHS. Mr. Chorey informed Mr. Crouch in this ex parte memo that the family had been advised that they would be responsible for the cost of services if they lose their appeal. Id. At some point, this memo was provided to counsel for Respondent, because it was submitted at the 2010 HHS fair hearing as an exhibit, but Richard's counsel was not notified when these ex parte communications took place. Although Mr. Chorey informed Mr. Crouch that DDSN had increased Richard's Respite hours, the change was actually a reduction from the number of hours Respondent was required to provide during the appeal - hours that DDSN and hearing officer Loomis had determined to be medically necessary. Several weeks after sending this memo to Mr. Crouch, DDSN informed Richard's service coordinator that 172 hours of respite had been approved on March 1, 2010. R. at

97. DDSN did not provide Richard with notice of this reduction in service.

A second "fair hearing" was held before DHHS hearing officer Jefferson Bryson on May 11, 2010, more than year after Richard requested an increase in the number of hours of services contained in his 2009 plan of care. At the fair hearing, Respondent again failed to provide even a scintilla of medical evidence from a qualified medical source to contradict the opinions of Richard's treating physician or the findings of medical necessity of Ms. Loomis, who ordered Respondent to continue to provide the number of Respite hours contained in the 2009 plan of care (2,240 hours per year, in addition to 52 days per year. The number of hours was documented in Exhibit 5 of brief filed July 7, 2009, which was not included in the Record on Appeal.) Ms. Shealy, who holds a BA in Sociology and admitted having no medical training, testified that Richard's physician was not contacted. R. at 36. Ms. Shealy testified under oath that before the January 2010 "staffing," she thought that Richard had been authorized to receive 37 hours of respite. R. at 30, 32. The 2009 plan of care, which was still in effect because of Richard's appeal, required DDSN to provide 2,240 units of hourly respite each year (an average of 43 hours per week), in addition to 52 units of daily respite (24 hours a day) each year. (Exhibit 5 attached to Appellant's July 7, 2009 Brief which was omitted from the Record on Appeal.) The assessment by Ms. Shealy in no way represented an "increase" in respite hours above what Richard was entitled to receive, as had been represented by DDSN to Mr. Crouch.

In the order issued by Ms. Loomis on November 16, 2009, the hearing officer directed Respondent to determine the need for services in consideration of the opinions of his physicians. Respondent admitted that Richard's physician had not been contacted. R. at 36. In fact, Ms. Shealy testified that "we didn't review any medical records." Id.

In an order dated September 14, 2010, the DHHS hearing officer upheld the decision of DDSN to reduce Richard's MR/RD Medicaid waiver services, despite his treating physician's determination that these services are medically necessary. R. at 13. The order did not address the primary issue raised in Richard's original appeal, i.e., that the services DDSN was providing in 2009 were insufficient and that he needed more services. The hearing officer did not address the failure to give deference to Richard's treating physician, or the specific Order of Ms. Loomis to reevaluate Richard's PCA services, giving consideration to the order of

his physician. The September 14, 2010 order held that Respondent has not violated Richard's due process rights, because it had "cured" any violation of the notice requirements contained in the Medicaid Act, through the "Reconsideration process." R. at 14. That order determined, without addressing the fundamental alteration criteria established by the United States Supreme Court, that Respondent is not in violation the ADA and *Olmstead v. L.C.* R. at 14. 525 U.S. 1054 (1998).[1]

Audits by the South Carolina Legislative Council and DHHS and studies by South Carolina Protection & Advocacy for Persons with Disabilities have documented the serious risk of harm in DDSN congregate facilities, and a federal magistrate judge recently determined that these conditions are relevant in evaluating violations of the integration mandate. R. at 231, 289, 366 and 458. This Court may take judicial notice of the Magistrate Report and Recommendations dated November 24, 2010 attached as Exhibit 1.

ARGUMENTS

1. **Did the Respondent err as a matter of law in failing to give the greatest of deference to Richard's treating physician?**

It is undeniable that, even after being ordered by a DHHS hearing officer to do so, Respondent gave no deference to the orders of Richard's treating physician. Since 1999, it has been well settled law that medical necessity must be determined by the individual's treating physician. In his concurring opinion in *Olmstead v. L.C.*, United States Supreme Court Justice Kennedy held that States are obligated to give the opinions of the treating physician the "greatest of deference." 527 U.S. 581 (1999). Justice Kennedy cautioned States against placing persons like Richard in settings where they would receive "too little assistance and supervision," warning them not to treat people with disabilities in "integrated settings devoid of the services and attention necessary for their condition." *Id.* The legislative history of the Medicaid Act demonstrates Congressional intent to give deference to the opinion of the treating physician. That history documents that "(t)he physician is to be the key figure in determining utilization of health services." S.Rep.

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[1] The criteria established in *Olmstead* for determining whether the integration mandate has been violated are (1) is the person complaining a qualified person with disabilities, (2) has the state determined that the needs of the individual may be met in the community, (3) does the individual oppose receiving treatment in the community and (4) can the requested services be provided without a fundamental alteration in the State's programs.

No. 404, 89th Cong., 1st Sess., 46, Reprinted in [1965] U.S.Code Cong. & Admin.News pp. 1943, 1986. See also, *Beal v. Doe*, 432 U.S. 438 (1977). The state cannot be the "final arbiter" of medical necessity and that role must be played by the treating physician, except in those rare occasions where there is Medicaid fraud or the treating physician's opinion is not within the reasonable standards of medical care." *Moore ex rel. Moore v. Medows*, 674 F.Supp.2d 1366 (N.D.Ga. 2009). (*Moore v. Medows* is on appeal to the 11th Circuit, oral arguments held on November 22, 2010). In *Moore*, the federal district court prohibited the State from reducing a waiver participant's nursing services from 94 hours a week to 84 hours a week. Id. See also *Hunter v. Medows*, Case No. 1:08cv2930-TWT (N.D.Ga. Nov. 3, 2008).

Certainly, where a physician's opinion departs substantially from accepted standards the Courts will not blindly enforce that physician's orders, but that is not the case here. No responsible physician has ever suggested that Richard requires fewer hours of supervision than Dr. Joseph has ordered. In its pre-hearing brief, Respondent misconstrued *Thomas S. v. Flaherty*, to the hearing officer, claiming that the 4th Circuit dismissed the now well established rule that the individual's treating physician must be given the greatest of deference in determining medical necessity. 902 F.2d 250 (4th 1990). In their brief, Respondents failed to inform the tribunal that the "treating physicians" in *Thomas S.* were actually the State's own physicians, not the physicians chosen by the plaintiffs - and that the Court held that the State's treating physicians were simply dead wrong. In *Thomas S.*, the 4th Circuit determined that the State's physicians were subjecting patients to unconstitutional treatment state institutions. In this pre-Olmstead case, the court held that the opinions of the State's physicians, "may not be conclusive" because they were applying standards which "substantially departed from accepted standards." Id. at 252. In Richard's case no responsible physician is claiming that Dr. Joseph's ordered treatment departs from accepted standards. Indeed, leaving Richard without supervision substantially departs from accepted standards. 42 CFR 435.602(a)(1) prohibits Respondent from considering income or resources of a parent in determining eligibility for services. Respondent has failed to produce <u>any</u> medical evidence, credible or not.

It is well established in the record and uncontradicted by the Respondent that Richard needs two caregivers to lift him. R. at 783. The record shows that due to his spasticity, Richard requires total assistance

with bathing, dressing, toileting, brushing his teeth, grooming, purchasing food, preparing meals and doing laundry. R. at 783. Without hands on care with ambulation and positioning, he will develop decubitus ulcers which would likely jeopardize his general health status and be more costly to the State. R. at 783. Richard's treating physician, Dr. Joseph determined, based on his experience treating Richard for many years, that Richard is not an appropriate candidate for a congregate program. R. at 784. Dr. Joseph determined that Richard needs 16 hours a day of PCA services to remain in his home (two persons, eight hours a day) and there is no evidence in the record that this is order "departed from accepted standards" of medical care. R. at 784. Richard also needs five hours a day of Adult Companion Services to prevent regression in his social skills and to maintain good mental health. Id. Dr. Joseph determined in 2010 that these services are needed in addition to the 172 hours of Respite Services, which authorized in May of 2010. According to Dr. Joseph, if Richard were to be placed in an institution, he would experience a marked decline in both his mental and physical health. R. at 784 to 785. Dr. Joseph provided a well reasoned explanation for the services he ordered. Id. Richard would experience "trauma" from being segregated from the community and being forced to live in a congregate setting. R. at 785. Richard's psychological services provider, agrees with his physician that placement in a congregate setting would increase Richard's anxiety and depression. R. at 782. In addition to the uncontradicted opinion of Dr. Joseph, at the hearing in 2009, a nurse who provided PCA services to Richard testified about the medical necessity of these services. (Transcript of 2009 hearing was omitted from the records transmitted by HHS to the Administrative Law Court.) The only medical evidence in this case supports Dr. Joseph's orders.

Deferring to the reasonable opinions of treating physicians is also required by the South Carolina Medical Practice Act. In South Carolina, the act of determining medical necessity or appropriateness of proposed medical care, so as to affect the diagnosis or treatment of a patient located in South Carolina, is the practice of medicine, as defined by Section 40-47-40 of the 1976 Code of Laws of South Carolina, and that act can only be performed by a physician licensed to practice medicine in this State. Making determinations of medical necessity and determining appropriateness of medical care "requires independent medical judgment that is reserved to physicians, especially determinations to deny, reduce, or terminate health

care services or to deny payment for a health care service because that service is not medically necessary." Feb. 5-7, 2001 order of the SC Board of Medical Examiners at T:\ORDERS\07\Moore\07cv631\msjtwt2.wpd .

Respondent totally ignored the November 16, 2009 order requiring Respondent to have Richard's need for services be determined by qualified individuals and to consider the opinion of his treating physician. R. 126. Ms. Loomis concluded that the "People Providing Input" in Richard's first appeal were not "fitted (as by training or experience)" for the care planning process. R. at 126. In the November 2009 Order, the hearing officer concluded that it was necessary to have "qualified individuals" to determine Richard's need for waiver services. R. at 126. (The November 2009 Order was omitted from the Record on Appeal provided by DHHS). Instead of correcting this legal error, Respondent allowed Ms. Shealy, who is a DDSN employee who had never met Richard or reviewed any medical record determine whether he received up to the amount allowable under the new caps (240 hours a month of Respite Services). She testified at the hearing as follows:

Q.	What happens when Richard wakes up? Can he get out of bed?
Shealy	I don't know. I don't know.
Q.	Okay. Can he toilet himself?
Shealy	I don't know. I don't think so. I know that in the justification the service coordinator had said that the mother does have to get up with him periodically for toileting. But I...
Q.	Can Richard feed himself?
Shealy	I don't know.
Q.	Can Richard take a shower by himself?
Shealy	I don't know.
Q.	Can he get out of - could he get out of the house if the house was on fire?
Shealy	I don't know.
Q.	Okay. What medical reports did you review to determine that 172 hours was sufficient?
Shealy	We didn't - I didn't review any medical records.
Q.	Okay. Have you, have you communicated with his physician?
Shealy	No.

R. at 36. When asked "What medical training do you have?" Ms. Shealy responded "I don't have any medical training." R. at 33. According to her testimony, Ms. Shealy's job does not involve the review of medical necessity for services. R. at 35. She holds a BA degree in Sociology. She was "not sure" whether the risk of Richard developing decubitus ulcers was considered in determining how many respite hours he needs.

R. at 41.

This Court should hold Respondent in contempt for failing to comply with the November 16, 2009 Order requiring qualified persons to determine medical necessity and for violating federal and state law which requires deference to be given to the treating physician. Appellant requests that this Court order Respondent to pay Appellant fees and costs resulting from this contempt and these violations and to pay for the cost of services for which Richard and/or his parents have paid out-of-pocket.

2. **Does the record support the hearing officer's findings about the number of hours Richard was entitled to receive when he filed his appeal, his conclusion that Respondent considered the orders of Richards' physician in determining his need for respite and his conclusion that the predictions of Richard's health care professionals are "speculative," or are these findings and conclusions clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record?**

The September 14, 2010 order adopted in toto the ex parte memo Jacob Chorey sent to Mr. Crouch as factual findings of the number of hours Richard was entitled to receive at the time of the proposed reductions. R. at 10. This finding is factually and legally erroneous. Appellant's brief submitted on July 9, 2009 included his budget which showed the number of hours approved on January, 2009 which included 2,240 units of hourly respite and 52 days a week of daily respite and 3,458 units per year of PCA services. (This brief and attachments thereto were not included in the Record on Appeal.). R. at 125. Subsequently, DDSN determined that Richard required additional PCA hours. The parties agree that upon remand, DDSN determined that Richard was entitled to receive 15 hours a week of Adult Companion Services.

In that order, the hearing officer concluded that "the attending physician's orders were promptly considered in the request for an exception to the Respite limits..." R. at 14. However, the clear testimony of Ms. Shealy was that she did not consider Richard's medical records. R. at 34 and 36. No evidence in the record supports this conclusion.

The conclusion of the hearing officer that the predictions of Richard's physicians and other medical professionals are "speculative" is not supported by any reliable, probative or substantial evidence in the record. In order to refute the opinion of a physician, Respondent must submit medical evidence offered by a physician who is prepared to defend his opinion and who is subject to licensing and disciplinary standards established by the South Carolina Board of Medical Examiners. Respondent submitted no medical testimony

or report to refute Dr. Joseph. On the other hand, Dr. Joseph's recommendations are clearly supported by DDSN billing for PCA and Respite services for years (if these services contained in Richard's2009 plan of care are not medically necessary, Respondent has committed Medicaid fraud), testimony from nurse Todd (in the first fair hearing), affidavits from Richard's psychological service providers and testimony of his mother.

3. **Did Respondent violate Richard's due process rights by failing to provide a notice meeting the requirements of 42 CFR 431.210, reducing or terminating services during the appeal in violation of 42 CFR 431.230, purging the Record on Appeal in violation of Rule 36 of the South Carolina Rules of the Administrative Law Court, improperly limiting Appellant's access to the records in the file and generally violating the procedural due process requirements of 42 U.S.C. 1396a(a)(3), 42 CFR 431.205 et. seq. and Article IVX of the United States Constitution and are these violations subject to repetition?**

The Fourteenth Amendment of the United States Constitution, the Due Process Clause, prohibits state and local governments from depriving persons of life, liberty, or property without certain steps being taken to ensure fairness. Article I, Section 22 of the South Carolina Constitution states " [t]he fundamental requirements of due process under the United States Constitution and the South Carolina Constitution include notice, an opportunity to be heard in a meaningful way, and judicial review." 42 CFR 431.201 defines notice as "a written statement that meets the requirements of § 431.210." 42 CFR 431.210 clearly requires the state to provide a written notice that specifies the regulation or change in law that authorizes the action taken by the state. Respondent failed to provide such notice to Richard in violation of 42 CFR 431.210.

Federal regulations provide that when action is taken without meeting the notice requirements of 42 CFR 431.210, the remedy is to require the State to reinstate the services. 42 CFR 431.231(c)(1). The written notice must be sent to the waiver participant at least ten days prior to the proposed action. 42 CFR 431.211. The federal regulations do not require the State to provide whatever notice it deems to be adequate. It requires the State to provide very specific information in a written notice sent to any Medicaid participant before the State reduces, suspends or terminates a Medicaid service. When these regulations are violated, the agency must begin from the beginning and notify the participant in writing, not only of the reasons for the action, but of the regulation or change in law which authorizes the action, so that the participant can prepare his case. The repeated violation of these notice requirements document that this due process violation is subject to repetition, yet it evades review. The hearing officer erred as a matter of law in determining that

this violation of law was somehow "cured" because Respondent was provided with "adequate notice." R. at 12. Medicaid's implementing regulations set forth very detailed requirements for written notice related to the right to appeal which require DHHS to provide not only the reasons for the reduction, suspension or termination of benefits, but also the specific regulations or change in Federal or State law which requires the action. 42 U.S.C. 1396a(a)(3), 42 C.F.R. 431.206(b)-(c), 431.210. The remedy for defective service is to require Respondent to comply with the law, and to provide Appellant with a notice that meets the very specific requirements of 42 CFR 431.205 and 210.

In addition to failing to provide the required notice, DDSN improperly attempted to intimidate Richard's family to discourage their filing an appeal by falsely informing them that they would be responsible for the cost of services provided during the appeal if he lost the appeal. Not only is it illegal to demand payment from parents of an adult Medicaid beneficiary, this threat constituted intimidation aimed at discouraging Richard from exercising his right to due process. 42 CFR 435.602(a).

Then Respondent violated 42 CFR 431.230 by reducing Richard's respite services from the amount he was entitled to receive at the time of his first request for a fair hearing, by again having an unqualified person assess his need for services without considering the orders of his treating physicians. Itisdifficult to imagine more convincing evidence that this violation is subject to repetition, while evading review. Respondent intentionally misled the tribunal, in an ex parte communication no less, by claiming to have increased his respite hours through Ms. Shealy's assessment. At all times during this appeal, and currently, Richard is entitled to receive 2,240 hours a year of hourly respite and 52 days a year of daily respite.

Although the details are not available in the Record on Appeal, simply because DHHS failed to include the transcript of the first hearing in the Record on Appeal, this Court should consider that DHHS and DDSN failed to make the record available to him before the first hearing and sent his counsel on a wild goose chase to Camden, knowing that the file was in Columbia. Because Ms. Loomis' order is interlocutory, that issue is preserved for appeal. The Record on Appeal does not contain the transcript, pleadings and other documents the department is clearly required by Rule 36 of the South Carolina Rules of the Administrative Law Court to send to the Court and the Appellant.

Appellant requests that this Court consider sanctions for violating Appellant's due process rights, including the payment of fees and costs incurred during two years of appeals, without the fundamental issue raised by Appellant in 2009 having ever been addressed - i.e. his need for additional services, over and above the amount provided in 2009.

4. **Was the order of the hearing officer made upon unlawful procedure or affected by other error of law because the Director of the Office of Hearings and Appeals participated in ex parte communications with DDSN employee Jacob Chorey and/or counsel for Respondent?**
It is evident from the record that the Director of the DHHS OHA was participating in improper ex-parte communications with Jacob Chorey, the MR/RD Waiver Program Coordinator at DDSN. As is discussed above, in this communication, Mr. Chorey did not inform Ms. Crouch that DDSN was actually decreasing, during an appeal, the number of hours Richard was entitled to receive even before he filed his first appeal. A fair hearing decision must be based exclusively on evidence introduced at the hearing and the pleadings. 42 CFR 431.244. It is apparent from this memo that ex parte communications were underway.

Since Appellant is not entitled to conduct depositions or to file motions to produce in fair hearings, Appellant requests an order commanding Respondent, DDSN and the local DSN Board to produce all evidence of ex parte communications, including emails, memos, correspondence and any other evidence of ex parte communications.

5. **Did Respondent violate provisions of the Medicaid Act and the applicable regulations promulgated by CMS, by not providing services with reasonable promptness, not requiring comparable services to be provided in the amount, duration and scope necessary to meet the goals of the program and not applying reasonable medical standards?**

(a) Reasonable Promptness.

In 2009, Appellant filed an appeal requesting additional home-based waiver services which his physician had determined to be medically necessary in order to prevent institutionalization or placement in another congregate setting. 42 U.S.C. 1396a(a)(8) of the Medicaid Act requires that the state provide "medical assistance ... with reasonable promptness to all eligible individuals." *Doe v. Kidd*, 501 F.3d 348, 354 (2007). Federal regulations direct state agencies to determine an applicant's eligibility for Medicaid within ninety days of the date of application and to "[f]urnish Medicaid promptly to recipients without any delay caused by the agency's administrative procedures." 42 C.F.R. 435.911, 435.930. Id. As the Fourth

Circuit noted in *Doe*: "...the relevant federal and state regulations and manuals define reasonable promptness as forty-five days or ninety days, depending on the applicant." *See, e.g.*, 42 C.F.R. 435.911; South Carolina Medicaid Manual, cited at J.A. 242; United States Department of Health & Human Services Center for Medicaid and State Operations, Olmstead Update No: 4. Id. at 356.

Despite the first hearing officer having issued an order in 2009 requiring DDSN to have Richard's need for PCA services evaluated by a qualified person, giving consideration to the opinions of his treating physician, Respondent arbitrarily, capriciously, willingly and knowingly ignored that order and the well-supported treatment decisions of Richard's physician and has failed to provide the needed services with reasonable promptness in violation of 42 USC 1396a(a)(8). *Doe v. Kidd, Supra.*

Richard's treating physician determined that he needs the number of hours and days of respite services contained in his January 2009 plan of care and Ms. Loomis ordered that those services were needed. Instead of providing those Respite services with reasonable promptness, Respondent again violated Richard's right to have his need for services be determined by qualified persons and actually reduced his Respite services. Respondent has violated Richard's right to receive services with reasonable promptness and he requests that this Court order Respondent to order the agency to provide those services ordered by Richard's treating physician immediately and to pay his costs and fees incurred in enforcing the interlocutory order and the 42 CFR 431.230.

(b) *Comparability and Amount, Duration and Scope*

The "comparability" requirement of the Medicaid Act is set forth at 42 U.S.C. 1396a(a)(10)(B). The Medicaid Act requires States to provide "comparable services when individuals have comparable needs." Id. The comparability requirement may be violated when beneficiaries with the same level of need are treated differently. *Jenkins v. Wash. Dep't of Health & Human Servs.*, 160 Wn.2d 287, 157 P.3d 388 (2007). In that case, Medicaid beneficiaries asked the court to prohibit the State Medicaid Agency from enforcing a regulation that reduced a beneficiary's maximum authorized personal care service hours if the beneficiary happened to live with his or her care provider. *Id.* at 290. Individuals who did not live with their care providers, like individuals in South Carolina who live in congregate settings, did not receive a

reduction in the level of supervision they were receiving. *Id.* The reduction applied automatically in *Jenkins*, and did not require the agency to evaluate a beneficiary's individual circumstances. *Id.* at 292. The Washington Supreme Court concluded that the State had violated the comparability requirement because the rule treated beneficiaries in the same classification differently. *Id.* at 300. In that case, the Court held that "[N]o reduction is justified unless an individual determination is made supporting that *reclassification* ." (emphasis added)). Id. Richard has the same level of need as persons living in congregate homes and ICF/MR facilities, but he is treated differently simply because he lives in the community. Respondent did not reduce the amount, duration or scope of supervision provided to persons who live in group homes or ICF/MR facilities due to the its "budget crisis." DDSN chose to balance its budget by eliminating home based services, while dramatically increasing the rates it pays to DDSN and its local Boards for institutional services.

The 'comparability' requirement of the Medicaid Act mandates comparable services for individuals with comparable needs and is violated when some recipients are treated differently than others where each has the same level of need." *V.L.*, -- F. Supp. 2d at --, 2009 WL 3486708 at *6. Because the plan implemented by DHHS fails to take into account the specific circumstances and needs of the individual, it must fail. Id. (comparability requirement violated where eligibility criteria for in-home services failed to measure the individual needs of the disabled or elderly persons for a particular service). Each Medicaid service must be sufficient in amount, duration and scope to reasonably achieve the important purpose of preventing waiver participants from being forced into institutional settings. 42 CFR 432.230. DHHS must provide categorically needy persons services that are equal in amount, duration and scope for all recipients in the group. 42 C.F.R. 440.240. "Categorically Needy" includes persons, like Richard, who are eligible for Medicaid and who meet the financial eligibility requirements for SSI or are considered under section 1619(b) of the Social Security Act to be SSI recipients. S.C. Administrative Code 126-350.

The Respondent has failed to provide comparable services to persons living at home as they provide to persons living in DDSN funded congregate settings. DDSN provides OT, PT and speech and language services to persons living in ICF/MR facilities. It provides intensive staffing, costing up to $170,837 a year to

some persons living in group homes. R. at 264. Persons living at home are allocated significantly lesser funding , making it impossible under the waiver to obtain the services they need and forcing families to fight local DSN Boards, which have a financial incentive to deny services. R. at 263. In 2003, for example, DDSN paid $65,567 per year for "high needs" individuals living in congregate settings. Id. Yet, it pays a band payment of only $12,544 per year for persons living at home. Id. Richard's services at home cost $37,364, according to a budget DDSN prepared in January 2009. (Exhibit 5 attached to a brief Appellant submitted in this case on July 7, 2009 was omitted from the Record on Appeal.) This allocation system discriminates against persons who have more severe disabilities, like Richard, who do not want to be forced into an institution in order to receive comparable services. The local DSN Board that receives Richard's band payment has an incentive to create barriers to his obtaining the services he needs. R. at 502 to 508. DDSN will provide Richard an unlimited number of days of ICF/MR respite services, and actually increase the reimbursement rate for these services by 70% during FY 2010. R. at 697 to 700.

(c) Reasonable Medical Standards.

It was obvious from Ms. Shealy's testimony that no reasonable standards were not used to determine Richard's need for Respite Services. In spite of a court order (November 2009) finding that Richard needs 2, 240 hours of hourly Respite services, and 52 daily units per year, totaling an average of 67 hours per week, this individual who does not even know whether Richard can get out of bed or toilet himself came to the conclusion that he only needs 172 hours a month of Respite Services. (The number of hours Richard was receiving under his 2009 plan is set forth in Exhibit 5 of the July 7, 2009 brief.) Hearing officer Loomis issued an order finding that those services were appropriate and medically necessary. Ms. Shealy testified that she came to the conclusion that Richard only needs 172 hours a month of Respite because his mother works part time. R. at 38. Richard's mother testified that she leaves for work at seven a.m., returns home to help Richard mid-day for half an hour, then returns to work until 5:30 or 6:00 p.m. R. at 80 to 81. State employees are considered to be "full time" if they work 37 ½ hours per week. Richard's mother has two full time jobs. According to the DDSN service coordinator, Richard's mother spends more than double the hours state employees work each week in her second full time job, i.e. spending 90 hours a week taking care of her son.

R. at 101. The decision to reduce Richard's services was completely arbitrary and capricious and not based on reasonable standards.

The Medicaid Act requires that all participating states use "reasonable standards (which shall be comparable for all groups) . . . for determining ...the extent of medical assistance under the plan which . . . are consistent with the objectives" of the program. 42 U.S.C. § 1396a(a)(17). States generally have "broad discretion" under this provision to set standards for determining the amount of medical assistance to be afforded. *See State of Wash. Dept. of Soc. and Health Servs. v. Bowen*, 815 F.2d 549, 555 (9th Cir. 1987). Nevertheless, a state may violate this requirement where it seeks to impose eligibility requirements that fail to reasonably measure the individual's need for a particular service. *V.L. v. Wagner*, --- F. Supp. 2d ---, 2009 WL 3486708 at *6, *9 (N.D. Cal., Oct. 23, 2009) (enjoining California Department of Social Services from implementing new eligibility criteria for In-Home Supportive Services that did not measure "the individual need of a disabled or elderly person for a particular service."). Citing *Watson v. Weeks*, 436 F.3d. 1152, 1162 (9th Cir. 2006). In *Crabtree v. Goetz*, the federal district court in Tennessee granted a preliminary injunction where the State instituted caps on home-based waiver services without conducting individualized assessments or a cost analysis. *Crabtree v. Goetz*, 2008 WL 5330506, at *30 (M.D.Tenn.2008). In *Crabtree*, as in South Carolina, CMS had approved the amendments/reductions to the waiver program which were found by the federal court to violate federal law. In *Marlo M. v. Cansler*, the federal district court in North Carolina prohibited the State from reducing home based services

Reasonable standards must include having qualified persons determine medical necessity. Because Respondent allows persons who have no medical training to determine medical necessity, in violation of the South Carolina Medical Practice Act and *Olmstead*, its procedures are inherently unreasonable. As discussed above, Respondent has absolutely refused to apply reasonable standards to determine Richard's need for services.

(d) Efficiency, economy and quality of care.

Balancing South Carolina's budget on the backs of people like Richard, while drastically increasing the rate paid for ICF/MR services and the utilization rate of those institutional services, must fail because

Respondent has violated 42 U.S.C.1396a(a)(30)(A). That statute requires a state that accepts federal Medicaid funds to "safeguard against unnecessary utilization of" Medicaid services and 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 . . . at least to the extent that such care and services are available to the general population." The plan increases the most expensive and restrictive services in the DDSN system. Respondent failed to even conduct an economic analysis before adopting a plan which it admits will increase the costs and utilization of ICF/MR Respite services. The amendments increase the cost of ICF/MR Respite services from $157 per day to $270 per day. R. at 697 to 700. It increases the number of persons using these services by more than 400% and increases the average number of days spent in an ICF/MR for respite services by 50% These institutional respite services were projected to cost $103,318 during the year before the waiver amendments were adopted, but were projected to cost $1,122,660 during the first year of the amendments, an increase of more than a million dollars spent on institutional services. Id. The average cost per waiver participant prior to the amendments was $36,209 (Factor D). R. at 697. After the amendments, the average annual cost per waiver participant was projected to be $44,232, an increase of $8,023 per waiver participant. R. at 699.

The services that were discontinued or reduced were provided primarily by private providers, instead of DSN Boards. R. at 56. The services that were increased are provided by DDSN and its local DSN Boards. CMS has criticized DDSN for having most MR/RD waiver services provided by DSN Boards. R. at 503. A 2007 audit by DHHS likewise criticized DDSN for the low number of non-DSN Board providers. R. 504. The 2008 audit by the South Carolina Legislative Audit Council criticized DDSN for providing financial benefits to DSN Boards that are not provided to private providers. R. at 505. There is no evidence that DDSN reduced its band payments to local Boards when these services were reduced on January 1, 2010, thus there could have been no "savings" by reducing the services being provided by private providers. The reductions simply would have provided the local boards a windfall. This maintenance of a monopoly, which has been criticized by CMS and the South Carolina Legislative Audit Council does not promote the efficient utilization of Medicaid funds. It is likely to drive waiver participants into more expensive hospital and

institutional settings in violation of 42 U.S.C. 1396a(a)(30).

Under 42 U.S.C. 1396a(a)(30), payment rates must be "consistent with efficiency, economy, and quality of care and . . . sufficient to enlist enough providers so that care and services are available under the plan." The amendments increased payments to DSN Boards and DDSN, which are the sole providers of ICF/MR services. The changes further imposed barriers to competition which will decrease the number of providers and will limit care and services under the plan.

6. **Has Respondent violated the Americans with Disabilities Act (ADA) and the Department of Justice regulations contained at 42 U.S.C. 12132 and 28 C.F.R. 35.130(d), which require public entities to administer and deliver government services to qualified disabled persons in "the most integrated setting" possible?**

In *Olmstead v. L.C.*, the Supreme Court recognized the rights persons who have disabilities to be integrated into the community, rather than segregated and isolated with other persons who have disabilities. 527 U.S..581 (1999). In its analysis, the plurality pointed to the historic significance of the ADA: Congress enacted the ADA in order to "provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities." 42 U.S.C. § 12101(b)(1) cited in *Olmstead* at 589. The Court went on to examine the reasoning driving the enactment of the ADA and noted that in passing the statute, Congress recognized that "historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a pervasive social problem." 42 U.S.C. § 12101(a)(2) cited in *Olmstead* at 588-589. Appellant provided uncontradicted evidence that failing to provide the waiver services his physician determined he needs would isolate him and he would be involuntarily segregated with other disabled persons if he were required to attend a DDSN workshop or to be admitted to an ICF/MR facility to receive respite services. As documented above, the amendments resulted in a tremendous increase in the utilization of ICF/MR Respite services, with four times the number of waiver participants resorting to ICF/MR facilities for Respite Services each person using these services spending 50% longer in an ICF/MR than they would have spent before the waiver amendments. R. at 697 to 700.

This is the same kind of unjustified and stigmatizing isolation and segregation that was prohibited by

the United States Supreme Court in *Brown v. Board of Education* and *Olmstead*. 74 S.Ct. 686, 98 (1954). Many years ago, that Court declared that "separate is not equal." Id. at 493. The opportunity to live and learn in the community with non-disabled persons is an important right that is protected by the integration mandate of the ADA. Richard's rights established under the ADA, the Rehabilitation Act and *Olmstead* are being violated by forcing him into receiving congregate services, where the State will profit from his meager earnings. Proviso 24.1 of the FY 2010 budget provides that revenues derived from production contracts at workshops are paid to DDSN.

Congress directed the Attorney General of the United States to issue regulations to implement the ADA, based on regulations issued under Section 504 of the Rehabilitation Act. See 42 U.S.C. § 12134; 28 C.F.R. § 35.190(a); Executive Order 12250, 45 Fed. Reg. 72995 (1980), reprinted in 42 U.S.C. § 2000d-1. These regulations require public entities to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d). The preamble of this "integration mandate" explains that "the most integrated setting" is the one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible." 28 C.F.R. § 35.130(d), App. A, at 571 (2009). The United States Supreme Court recognized that it must give respect to the interpretation of DOJ in interpreting the ADA. *Olmstead* at 583.

Separating Richard from his friends and family who live in his chosen community, isolating him in a large congregate and segregated workshop, where he would be warehoused with other persons who have disabilities, and forcing him into a Regional Center ICF/MR, like Midlands Center constitutes discrimination. Once Richard set forth evidence that he is a disabled person, that the state has determined that his needs can be met in the community and that he does not object to placement in the community, then the burden shifted to the Respondent to prove that the services his physician has determined that he needs to remain outside of an institution cannot be provided without a "fundamental alteration" in the way South Carolina delivers services. Respondent failed to meet that burden and the hearing officer failed to apply the law as required by the integration mandate as directed by the United Stats Supreme Court in *Olmstead*. The integration mandate is violated where the state chooses to administer services by allocating resources to more restrictive settings.

Disability Advocates, Inc. v. Paterson, 598 F.Supp. 289, 318 (E.D.N.Y. 2009) and *Disability Advocates, Inc. and the United States of America v. Paterson*, Case No. 1:03-cv-3209 (E.D.N.Y. March 1, 2010).

As in *Marlo M. v. Cansler*, "There is no question Plaintiffs, who have been successfully living in their own homes for numerous years, are deemed eligible for community-based living by the State's experts." *Marlo M. v. Cansler,* Case 5:09cv00535, Order filed January 15, 2010 at 3 of 5 (Document 35). Also, as in that case "[t]ermination of funding by Defendants will force Plaintiffs from their present living situation, in which they are well integrated into the community, into group homes or institutional settings." *Id.* at 4 of 5. Like the Plaintiffs in *Marlo*, the services Plaintiffs request can be provided "at overall costs savings per year (compared) to alternative placements." Id. at 5 of 5. Obviously, providing services that have been provided for years cannot be considered to be a fundamental alteration. Applying these criteria, a South Carolina Federal Magistrate Judge recently determined that the waiver amendments adopted in January of 2010 violated the ADA.

CONCLUSION

For the reasons set forth above, Appellant requests that this Court reverse the 2010 decision of the HHS Hearing Officer. Appellant requests an order directing Respondent to immediately provide the number of Respite hours ordered in the November 16, 2009 order and to provide the other services Richard's treating physician has determined to be appropriate and medically necessary. Appellant requests that this Court review and correct the factual findings and conclusions of law as set forth above. Appellant requests an order concluding that the Respondent has violated *Olmstead* and the South Carolina Medical Practice Act by basing treatment decisions on the opinions of persons not qualified to make treatment decisions. Decisions about medical necessity require the order of a physician. Appellant requests an order finding that the treatment decisions of a reasonable treating physician must be followed. Appellant requests either an order finding that the agencies have violated the ADA or, in the alternative, an order clearly stating that this Court does not have jurisdiction over matters related to the ADA so that Appellant may pursue those claims without objection from Respondent as to jurisdiction in the federal court. Judicial economy would be served by such an order.

Appellant asks that this court determine that Respondent has failed to provide services with reasonable promptness and that this Court's order require Respondent to provide those services determined in the treating physician's 2010 affidavit to be medically necessary. R. at 783. Appellant requests an order requiring Respondent to pay Appellant's legal fees and the costs of this action and to reimburse Appellant for out-of-pocket costs, the amount to be determined at a hearing or by agreement, because Respondent improperly reduced Appellant's services from the hours determined in the 2009 order to be medically necessary.

Respectfully submitted,

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Columbia, South Carolina
February 13, 2011

IN THE STATE OF SOUTH CAROLINA

In The Court of Appeals

APPEAL FROM THE ADMINISTRATIVE LAW COURT
Carolyn C. Matthews, Administrative Law Judge

Case 10-ALJ-08-0774-AP

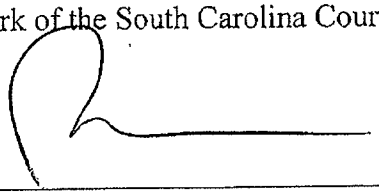
Richard Stogsdill ..... Appellant,

v

South Carolina Department of Health and Human Services ..... Respondent.

AMENDED CERTIFICATE OF SERVICE

Patricia L. Harrison, attorney for Appellant, certifies that she has served a Appellant's Initial Brief in the above captioned case on The South Carolina Department of Health and Human Services by hand delivery to 1801 Main Street on May 10, 2013 and by US Mail to the Office of General Counsel, SC Dept of Health and Human Services ,PO Box 8206, Columbia, SC 29202, with a copy mailed to the Clerk of the South Carolina Court of Appeals on May 10, 2013.



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THE STATE OF SOUTH CAROLINA
Administrative Law Court

APPEAL FROM THE SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

10-MISC-042
The Honorable W. Jefferson Bryson

Docket No. 10-ALJ-08-0774-AP

Richard Stogsdill.....Appellant,

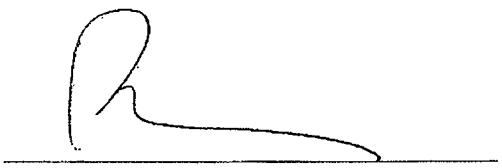
v.

South Carolina Department of Health and Human Services,.....Respondent.

CERTIFICATE OF FILING AND SERVICE

I, Patricia L. Harrison, Attorney for Appellant, certify that I have this day, February 14, 2011 filed one copy of the foregoing *Initial Brief of Appellant* with the S.C. Administrative Law Court. I further certify that I have also this day served one copy of the foregoing *Initial Brief of Appellant* upon Respondent to their counsel of record by hand delivery.

Office of General Counsel
SC Dept of Health and Human Services
1801 Main Street
Columbia, SC 29202



Patricia L. Harrison

FILED

FEB 14 2011

SC ADMIN. LAW COURT

THE STATE OF SOUTH CAROLINA
Administrative Law Court

APPEAL FROM THE SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

10-MISC-042
The Honorable W. Jefferson Bryson

Docket No. 10-ALJ-08-0774-AP

Richard Stogsdill.....Appellant,

v.

South Carolina Department of Health and Human Services,.....Respondent.

EXHIBIT 1

Peter B. v. Sanford

Report and Recommendations of Federal Magistrate Judge

Dated November 24, 2010

FILED

FEB 14 2011

SC ADMIN. LAW COURT

PLEADINGS

IN THE DISTRICT COURT OF THE UNITED ST
FOR THE DISTRICT OF SOUTH CAROLIN...
GREENVILLE DIVISION

Peter B., Jimmy "Chip" E. and Michelle M.,	)	Civil Action No. 6:10-767-JMC-BHH
Plaintiff,	)	
vs.	)	REPORT AND RECOMMENDATION OF MAGISTRATE JUDGE
Marshall C. Sanford, Emma Forkner, Beverly Buscemi, Kelly Floyd, The South Carolina Department of Health and Human Services and The South Carolina Department of Disabilities and Special Needs,	)	
Defendants.	)	

The plaintiffs have brought this action seeking declaratory and injunctive relief for violation of Title II of the Americans with Disabilities Act of 1990 (ADA), 42 U.S.C. § 12132; Section 504 of the Rehabilitation Act of 1973 (Section 54); and 42 U.S.C. § 1983. This matter is before the Court on the plaintiffs' motion for injunctive relief pursuant to Fed. R. Civ. P. 65(b).[1] [Doc. 12.] The defendants have filed numerous responses [Docs. 18, 19, 28, 47, 70], and the plaintiffs have replied [Doc 44]. The plaintiffs ask the Court to enjoin the defendants from reducing or terminating certain medical and personal-care services, the absence of which would allegedly force the plaintiffs from their homes and communities into disability institutions and other like facilities. In addition to the full briefing of the parties, the

[1] There is also a motion to dismiss and a motion to amend Complaint pending in this case. Those outstanding matters remain under consideration and will be resolved shortly.

Court allowed and considered the *amici curiae* brief filed by Protection and Advocacy for People with Disabilities, Inc., the South Carolina Chapter of the National Academy of Elder Law Attorneys, and South Carolina Legal Services in support of the plaintiffs' motion. Moreover, a hearing on the motion was held before the Court, on September 28, 2010.

Based upon the parties' respective representations at both hearing and on motion, the Court has allowed this case some opportunity to be resolved through changed circumstances at the state level. [Doc. 28.] It has become apparent over time that a resolution is now in order.

BACKGROUND

The plaintiffs are three individuals who have varying degrees of severe mental retardation and/or related disabilities. Peter B. has mental retardation, hydrocephalus, diabetes and coronary heart disease. (See Pl. Exs. 1, 3.) Chip E. has normal intelligence and severe cerebral palsy and a speech disorder. (See Pl. Ex. 9.) Michelle M. has autism, profound mental retardation, cerebral palsy, a bipolar disorder and is unable to speak. (See Pl. Ex. 4.)

The defendant South Carolina Department of Disabilities and Special Needs ("DDSN") provides services to individuals, like the plaintiffs, with developmental disabilities such as mental retardation and autism, and to some individuals with head-and-spinal-cord injuries. *See* S.C. Code § 44-21-10 *et seq.* The vast majority of DDSN's funding derives from the federal Medicaid program, passed through to DDSN from the state Medicaid agency, defendant South Carolina Department of Health and Human Services ("DHHS").

Medicaid funds are used by both of these defendants to provide services to individuals in long-term institutions and to enable individuals to live in the community with appropriate supports. *See generally* 42 U.S.C. §§ 1396a & 1396n(c). Because some conditions of federal Medicaid law are waived in order to provide certain groups of people with disabilities services in the community rather than in institutions, these programs are referred to as "waivers." *See generally Doe v. Kidd*, 501 F.3d 348, 359 (4th Cir. 2007). In other words, qualifying individuals may either choose to live, and receive care, in a state institutional facility or they may "waive" that opportunity and elect to live in the surrounding community, with the aid of in-home medical and personal-care services. Importantly, using Medicaid funds for waiver services, rather than for institutional care, enables eligible recipients to remain in less restrictive settings in compliance with the United States Supreme Court's decision in *Olmstead v. v. L.C. ex rel. Zimring*, 527 U.S. 538 (1999), discussed below.

Defendant DDSN operates the waiver relevant to this action: the Mental Retardation and Related Disabilities Waiver (MR/RD Waiver). The MR/RD Waiver is for persons who (1) have an intellectual disability (mental retardation) or a related disability, (2) are eligible for Medicaid, and (3) who need home and community based services in order to live in the community. *See generally* DDSN MR/RD Waiver Manual, Chap. 1.6. All individuals on the waiver must require a threshold level of care that is similar to that required to receive services in a nursing home. *See Doe v. Kidd*, 501 F.2d at 351. Notwithstanding, they live in a variety of settings. *Id.* at 351-352. Some of these settings are small community-based facilities, like a Community Training Home (CTH), which provide residential services. *See*

id. Some of the settings are homes owned or rented by the individual or a family member. Individuals, who live in their own home or the home of a friend or family member, receive a variety of services to meet their care needs.

In late 2009, DHHS, which is the single state agency responsible for the Medicaid program, sought and received the approval of the United States Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS) to amend the waiver to limit or cap certain services. (Def. Ex. 3, Attach A.) The defendants represent that the amendments to the waiver were born out of the indisputably difficult economic climate of severe state budget reductions and further were intended to eliminate disparities between people with similar disability needs and to reduce superfluous and redundant services. (Forkner Aff. ¶ 5-7.) Effective as of January 1, 2010, the amended waiver placed a service use cap, or flat cap, on the number of hours an individual could receive for particular services: Personal Care I and II, Adult Attendant Care, Adult Companion Care, Nursing, and in-home Respite services. *Id.*

The summary of the capped services, relevant here, are as follows: Personal Care II services were capped at 28 hours per week, or four hours per day. Respite services were also capped, at 68 hours per month, or slightly over two hours per day.

Importantly, these caps affected two of the plaintiffs, Chip E. and Michelle M. (Lacy Aff. at 3-5.) The precise kind and level of services provided each of the plaintiffs both prior to, and after, the waiver amendments has been the source of some disagreement between the parties and the subject of numerous and disparate representations in declarations and

briefs of the same. Corralling the data has been less than a straight-forward process. This is the Court's best estimation and summary of the evidence, concerning each plaintiff respectively.

Jimmy (Chip) E.

Service	Before 1/1/2010	After 1/1/2010 (proposed/actual)
Personal Care II	52 hours per week	28 hours per week
In-home Respite	112 hours per month	68 hours per month

(Pl. Reply at 6-8, Attach. 1 at 22, 37, 47, 49, 51, Attach. 12.)

Michelle M.

Service	Before 1/1/2010	After 1/1/2010 (proposed/actual)
Personal Care II	56 hours per week	28 hours per week
In-home Respite	28 hours per week[2]	30 hours per week
Institutional respite[3]	0	0

(Pl. Reply at 11, Attach. 4 at 81, 93, 95.)

Much energy could be devoted to outlining the services allegedly now available to the plaintiffs and the ostensible alternatives, available or not, depending on the arguments

[2] The defendants put forward evidence that the plaintiff had up to 240 hours per month. (See Lacy Aff.) The plaintiffs have responded that she was never provided that many hours and that the 30 hours per week allotted in May 2010, was an increase of only 2 hours. (Pl. Reply at 11, Attach. 4 at 81.)

[3] The defendants originally submitted testimony that she was provided 2 weeks of institutional respite per year. The plaintiffs have rejoined that no such service has ever been available. (Pl. Reply, Attach. 4 at 81.)

of the parties. The plaintiffs have done a persuasive job of establishing the hours they have received and the defendants, aside from their original representations, have done little to effectively counter, either in their filings or at hearing. The Court, therefore, has largely adopted the plaintiffs' evidence concerning services and hours provided, whether discussed specifically herein or not. To the Court, it is sufficient to say that there has been a diminution in service hours for both Chip and Michelle, which, as will be discussed, their treating physicians find significant. More to the point, it is this reduction in hours that the plaintiffs contend will drive them to an institution against their will and hope and in violation of the Americans with Disabilities Act.

The third plaintiff, Peter B., receives services in a DDSN residential placement, as part of a Supervised Living Program II (SLP II). The care needs for individuals in DDSN residential placements are met through the residential habilitation service, during periods of the day when the individual is receiving residential habilitation services. For example, if individuals receiving residential habilitation need assistance with their meals, then the residential habilitation provider is responsible for seeing the need is met. (See Lacy Aff. at 2 & Attach. B.) Those, like Peter, receiving residential habilitation have not had caps placed on the number of hours of Personal Care they can receive, unlike those individuals who live in their own homes. *See id.*; Attach. A. However, Peter contends that 12 hours of "one-on-one" services were terminated as duplicative and not covered by Medicaid. (See generally Lucy Aff. at 2-3.) The termination of those services occurred in July 2009. *Id.* Like Michelle and Chip, Peter contends that the elimination of these services will effectively result in

forced and undesired institutionalization.

Lastly, the Court would acknowledge that the plaintiffs have commenced administrative actions concerning these same services, which are at varying stages of resolution. Most notably, it appears that Peter's appeals have been denied. [See Doc. 70.] The Court will address the effect of these proceedings to the extent relevant, but, as will be discussed, finds them to be largely non-dispositive or otherwise non-preclusive of this Court's consideration.

DISCUSSION

This is a fact intensive and messy case. From its procedural and statutory dimensions to its medical ones, it is substantial. In its review, the Court has attempted to narrow the necessary attention to be applied. Of course, the individual circumstances and incidents of the plaintiffs' particularized needs tend to additionally layer the inquiry. The whole thing is a delicate matter and, certainly for the plaintiffs, much would seem to hang in the balance. They have an unquestionably powerful story, which has moved the undersigned, in sympathy, if not in the specific formation of this decision's many contours. Sympathetic considerations, however, are largely outside this Court's purview. As always, there is a legally correct answer to the dilemma posed, which this recommendation attempts to approximate, in general result if not perfect detail. The care the plaintiffs require is complicated, burdensome, and inexact. In some respects, there is no easy answer to their situations. But certainly, if anyone knows what might be the best, among many less than perfect alternatives, it is the plaintiffs, their families, and their physicians. To credit those

accounts, earnestly, seems in keeping with the manner in which these cases are to be considered. *See Olmstead*, 527 U.S. at 610 (Kennedy, J., concurring) ("The opinion of a responsible treating physician in determining the appropriate conditions for treatment ought to be given the greatest of deference.") The defendants do much good for the disabled persons of our larger community and the Court is aware of the appropriate bases, economic and otherwise, which have motivated the decisions at issue here on behalf of a much larger populace than the individuals prosecuting this case. With that said, and based on the following, as considered in light of the hearing, both in its argument and evidence, and the many briefs of the parties and *amici*, the Court has concluded that a preliminary injunction should lie.

"A preliminary injunction is an extraordinary and drastic remedy." *Munaf v. Geren*, 553 U.S. 674, 128 (2008) (internal quotations omitted). Rule 65 of the Federal Rules of Civil Procedure governs the issuance of Preliminary Injunctions. Pursuant to Rule 65, "a temporary restraining order may be granted . . . only if it clearly appears from specific facts shown . . . that immediate and irreparable injury, loss, or damage will result to the applicant." In its recent opinion in *Winter v. Natural Resources Defense Council, Inc.*, 129 S.Ct. 365, 374-76 (2008), the United States Supreme Court articulated clearly what must be shown to obtain a preliminary injunction, stating that the plaintiff must establish "[1] that he is likely to succeed on the merits, [2] that he is likely to suffer irreparable harm in the absence of preliminary relief, [3] that the balance of equities tips in his favor, and [4] that an injunction is in the public interest." *Id.* at 374. Critically, all four requirements must be satisfied. *Id.*

Indeed, the Supreme Court in *Winter* rejected a standard that allowed the plaintiff to demonstrate only a "possibility" of irreparable harm because that standard was "inconsistent with our characterization of injunctive relief as an extraordinary remedy that may only be awarded upon a clear showing that the plaintiff is entitled to such relief." *Id.* at 375-76.

Before the Supreme Court's decision in *Winter*, the standard articulated in *Blackwelder Furniture Co. of Statesville v. Seilig Manufacturing Co.*, 550 F.2d 189 (4th Cir.1977), governed the grant or denial of preliminary injunctions in the Fourth Circuit. *See Direx Israel, Ltd. v. Breakthrough Med. Corp.*, 952 F.2d 802, 811-14 (4th Cir.1991); *Rum Creek Coal Sales, Inc. v. Caperton*, 926 F.2d 353, 359-60 (4th Cir.1991);

In *Real Truth About Obama, Inc. v. Federal Election Com'n*, 2009 WL 2408735 (4th Cir. August 5, 2009), the Fourth Circuit expressly concluded that the *Blackwelder* standard stood "in fatal tension with the Supreme Court's 2008 decision in *Winter*." *Id.* at *3. That decision, however, was vacated by the United States Supreme Court for reasons unrelated to the Fourth Circuit's discussion concerning preliminary injunctions. *See Real Truth About Obama, Inc. v. Federal Election*, 130 S. Ct. 2371, 2371 (U.S. 2010) (vacating and remanding for further consideration in light of *Citizens United v. Federal Election Com'n*, 130 S.Ct. 876 (U.S. 2010)).

It seems that the vacated Fourth Circuit decision still remains some good indication of how this Circuit would view application of *Winter*. In *Real Truth* the Fourth Circuit, stated that a plaintiff must now show that he will "likely succeed on the merits" regardless of whether the balance of hardships weighs in his favor. *Id.* Moreover, the standard for

likelihood of success on the merits requires more than simply showing that "grave or serious questions are presented" for litigation. *Id.* Second, the plaintiff must make a clear showing that he will likely be irreparably harmed absent preliminary relief. *Id.* That the plaintiff's harm might simply outweigh the defendant's is no longer sufficient. *Id.* Moreover, this showing of irreparable injury is mandatory even if the plaintiff has already demonstrated a strong showing on the probability of success on the merits. *Id.* Third, the Court is admonished to pay "particular regard" to the "public consequences" of any relief granted. *Id.* Lastly, there no longer exists any flexible interplay between the factors; all four elements of the test must be satisfied. *Id.* A failure to establish any of the elements necessary for relief is, therefore, fatal to the request for a temporary restraining order. *Winter*, 129 S.Ct. at 374.

Applying the standard in *Winters*, the Court finds that the plaintiffs have established entitlement to a preliminary injunction. Each element will be considered in turn.

Likelihood of Success on the Merits

Title II of the Americans with Disabilities Act of 1990 (ADA), prohibits discrimination by public entities against individuals with disabilities. *See* 42 U.S.C. § 12132. The United States Supreme Court has held that prohibited discrimination under the ADA includes "unnecessary segregation" and "unjustified institutional isolation of personal disabilities." *Olmstead v. L.C.*, 527 U.S. 581, 600-02 (1999). The Supreme Court's determination was based, in part, on the Department of Justice regulation, usually referred to as the "integration mandate," which requires states to administer services "in the most integrated

setting appropriate to the needs of the qualified individuals with disabilities." 28 C.F.R. § 35.130(d) (amended at 75 F.R. 56164-01, adding a section "h" to § 35.130). The most integrated setting appropriate is defined as "a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible." *Olmstead*, 527 U.S. 581, 592 (citing 28 C.F.R. pt. 35, App. A. p. 450, redesignated App. B at 75 F.R. 56164-01). In other words, it is discrimination, on account of a person's disability, to create obstacles to their ability to live normally in their community.

In *Olmstead v. L.C.*, the United States Supreme Court found a violation of the ADA, ruling in favor of disabled individuals seeking to reside in the community, rather than in a segregated facility. *Olmstead*, 527 U.S. at 607. The Court emphasized the Preamble of the ADA and the accompanying Congressional finding that "society has tended to isolate and segregate individuals with disabilities" and that the issue continues to be a "serious and pervasive social problem." *Id.* at 600. The Court held that the integration mandate of the ADA governed the plaintiffs' claims. *See Olmstead*, 527 U.S. at 588.

> States are required to provide community-based treatment for persons with mental disabilities when the State's treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities.

Id. at 607.

To state a claim under Title II of the ADA based on a violation of the integration mandate, the plaintiff must prove that (1) the State's treatment professionals have

determined that community-based services are appropriate; (2) the disabled individual does not oppose treatment; and (3) the provision of community-based services can be reasonably accommodated, taking into account the resources available to the state and the needs of other disabled individuals.[4] *Olmstead*, 527 U.S. at 587. Critically, a State's failure to provide services to a qualified person in a community-based setting as opposed to a nursing home or institution presents a violation of Title II of the ADA. *See id.*; *Fisher v. Oklahoma Health Care Auth.*, 335 F.3d 1175, 1181-82 (10th Cir. 2003) (imposition of cap on prescription medications placed on participants in community-based program at high risk for premature entry into nursing homes in violation of the ADA).

At this juncture, the plaintiffs have presented evidence demonstrating that their services are being terminated by defendants in violation of the ADA sufficient to justify interim equitable relief. The defendants, focused almost exclusively on the irreperability of the harm alleged, have not really made much argument regarding the plaintiff's likelihood of success on the merits. The Court will consider each element of the substantive claim, in turn.

In regards to the first, there is no dispute between the parties that the plaintiffs, who have been successfully living in their own homes for numerous years, are deemed eligible for community-based living by the State's experts. Concerning the second element, the

[4] Under the specific paradigm of the ADA, the elements of the claim have been articulated as follows: (1) is a "qualified individual with a disability;" (2) was either excluded from participation in or denied the benefits of a public entity's services, programs, or activities or was otherwise discriminated against by the public entity; and (3) such exclusion, denial of benefits, or discrimination was by reason of his disability. *See Townsend v. Quasim*, 328 F.3d 511, 517 (9th Cir. 2003).

very existence of this lawsuit, and every representation of the plaintiffs made herein, attests to a complete lack of any objection to community-based living; that is their plain and affirmative desire – to live in their communities.

Lastly, whether the provision of community-based services can be reasonably accommodated, taking into account the resources available to the State and the needs of other disabled individuals, the plaintiffs have put forward evidence that in all material respects it is less costly to provide the community-based, in-home services than institutional ones. (Compare Pl. Ex. 10 with Ex. 11.) To wit, capped respite services for Michelle M. were enjoyed at a cost of $70/day compared with the alternative provision of those same services in an institution at $320/day. (Pl. Exs. 4, 5, 23.) Likewise, the record reveals that Peter B.'s requested one-on-one companion services cost less than $200/week before their elimination under the amendments and that the alternative offer by the state to enroll him in a Workability workshop would cost more than $220/week.[5] (Pl. Ex. 1 at 4.) Similarly, the services Chip E. has been receiving during 2010 cost $39,424.25, approximately one-third of the cost of institutional services. [See Doc. 44-10 at 269.] The same institutional services would cost approximately $116,000.00 a year. [See Doc. 44-11.] As to all potential disabled persons affected by the amendments, the plaintiffs have put forward evidence that the number of waiver participants and the likely length of time for such participants in institutional facilities would increase, with a concomitant increase in overall and service-

[5] These figures were represented by the plaintiffs to the Court. Their exact source is not clear. Regardless, the record does, in the least, admit to a greater cost for alternative services than the ones requested by Peter B. (Pl. Ex. 1 at 4.)

specific costs. (Compare Pl. Ex. 10 with Ex. 11.)

Olmstead, instructs that the State is exempted from the integration mandate only where a "fundamental alteration" of the States' services or programs is required. *Olmstead*, 527 U.S. at 591-92. Not only do the plaintiff's not request any alteration, fundamental or otherwise, but they beg for a returned *status quo*, which is apparently cheaper for the State, and better for the individuals, than the amendments. The Court cannot understand, and the defendants have not explained, how the requested community-based services could be "reasonably accommodated" any better. *See Olmstead*, 527 U.S. at 587.

The defendants' only real rejoinder is that, as of this moment, actual institutionalization of the plaintiffs has not occurred and that there exists no credible-risk of it, such that any argument concerning cost differential is effectively speculative and premature. The argument seems simultaneously to go to the merits consideration and the irreparability of the harm alleged. The defendant argues it as to the latter. The Court will make some comment in both sections, but principally, here, under the merits analysis.

To echo the briefs of the plaintiffs and the *amici*, cases involving ADA integration claims have consistently recognized that even *the risk* of institutionalization is sufficient to establish a violation of Title II and certainly to justify preliminary relief. *See Fisher v. Oklahoma Health Care Authority*, 335 F.3d 1175, 1184 (10th 2003) (holding that Medicaid participants not currently institutionalized but at "high risk for premature entry into a nursing home" could bring claim for violation of the integration mandate); *Brantley v. Maxwell-Jolly*, 656 F. Supp. 2d 1161, (N.D. Cal. 2009); *Mental Disability Law Clinic v. Hogan*, 2008 WL

4104460, at *15 (E.D.N.Y. Aug. 28, 2008) (stating "even the risk of unjustified segregation may be sufficient under *Olmstead*"). The case law is clear that plaintiffs need not wait to be institutionalized before relief is sought.

Illustratively, the Eastern District of North Carolina recently granted emergency injunctive relief, prohibiting the State from reducing home-based services to persons who had a dual diagnosis of mental retardation and mental illness, just three days after the plaintiffs in that case filed their complaint alleging violation of the ADA; there, the plaintiffs were at risk of having to move from independent apartments to group home or institutional facilities. *See Marlo M. v. Cansler*, 679 F. Supp. 2d 635 (E.D.N.C. Jan. 17, 2010). While the plaintiffs had not been institutionalized at the time of the filing of the complaint, the district court concluded that a likelihood of success on the merits existed because the plaintiffs had shown that the State's termination of funding *threatened* to force the plaintiff's from their then present living situations into group homes or institutional settings. *Id.* at 638; *see also Ball v. Rogers*, 2009 WL 1395423, at *5 (D. Ariz. April 24, 2009) (holding that failure to provide plaintiffs with needed services threatened plaintiffs with institutionalization, prevented them from leaving institutions, and in some instances forced them into institutions in order to receive their necessary care in violation of the ADA and Rehabilitation Act); *Hogan*, 2008 WL 4104460, at *15 ("[E]ven the risk of unjustified segregation may be sufficient under Olmstead"); *M.A.C. v. Betit*, 284 F.Supp. 2d 1298, 1309 (D. Utah 2003) (adopting *Fisher's* position that a plaintiff need not currently be institutionalized to bring suit).

Specifically, here, the plaintiffs have put forward the following evidence concerning

the risk of institutionalization posed by the elimination of various services. Concerning Peter B., his treating physician has documented Peter's physical and psychological deterioration since the elimination of the requested services (Reel Aff. ¶ 7-9) and has expressed the opinion that "if the services are not restored, Peter risks loss of the ability to live independently in a community setting and he will likely be placed in an institutional setting because of a decline in his physical and mental condition," *id.* ¶ 10. Likewise, Michelle M.'s treating physician, based upon Michelle's parents inability to assist and here, otherwise, absolute reliance on in-home services to keep her out of a facility, has further indicated that if relevant services were reduced, "Michelle would be likely to have to return to an institution." (Patterson Aff. ¶¶ 9, 10.) Chip E.'s treating physician has made comparable representations. [See generally Doc. 44-2.] These opinions have been given significant weight. *See Olmstead*, 527 U.S. at 610; *Crabtree v. Goetz*, 2008 WL 5330506, at *25 (M.D. Tenn. Dec. 19, 2008).

The defendants contend that the claim of Peter B.'s particular demand is betrayed insofar as he has been without the requested services since July 2009 and, yet, no institutionalization has been required. But, this is not conflicting medical testimony. Rather, it is an unsupported attempt to correlate the two events. The defendants cite administrative findings that the plaintiff has not met his burden to associate his weight loss with the diminution in one-on-one services. (Def. Resp. at 14.) But, besides the irrelevancy of the administrative conclusion regarding evidence which may or may not now be before this Court, Peter has, in fact, submitted evidence, here, that his weight loss is so related; that

it will dangerously affect his diabetes; and that those conditions will force institutionalization. (Reel Aff. ¶ 7-10.) The defendants have offered some evidence of Peter's fluctuating weight over the years. (Moore Aff. ¶ 4.) But, this does not precisely refute the opinion of Peter's treating physician that Peter's condition will continue to deteriorate such that institutionalization is inevitable. (Reel Aff. ¶ 7-9.) That evidence is uncontradicted. And, the Court would credit it.

The defendants further argue that the plaintiffs' claims are not "ripe" because SCDDSN has agreed to provide services at current levels to Michelle M. and Chip E. while their administrative appeals are pending in the South Carolina Administrative Law Court. It is true that federal courts may issue declaratory judgments only in cases of actual controversy. 28 U.S.C. § 2201. The defendants emphasize that the controversy must be "ripe" for judicial resolution, and that in the context of an administrative case, there must be "an administrative decision [that] has been formalized and its effects felt in a concrete way by the challenging parties." *Charter Federal Sav. Bank v. Office of Thrift*, 976 F.2d 203, 208 (4th Cir. 1992). In a similar South Carolina ADA/Medicaid decision, however, the United States Court of Appeals for the Fourth Circuit expressly indicated that the administrative proceedings pending in the State courts were irrelevant to the federal claims. *See Doe v. Kidd*, 501 F.3d 348, 353 n.1 (4th Cir. 2007). The court stated:

> There have been state administrative proceedings in Doe's case since she noted her appeal to this Court. We do not consider the outcome of these proceedings because the outcome has no effect, preclusive or otherwise, on the issues Doe raises before this Court.

Id.

Moreover, in this case, the "formalized" administrative decision is the January amendments themselves, which of their own force exercise legal and binding effect over the plaintiff's circumstances. *See Abbott Laboratories v. Gardner*, 387 U.S. 136, 149-50 (1967) (finding regulations themselves to be "final agency action"), *overruled on other grounds by Califano v. Sanders*, 430 U.S. 99 (1977)). The fact that the plaintiffs have challenged the amendments' specific application in the form of an administrative appeal, in addition to the judicial case here, does not make the actual regulatory amendments any less "formalized." The amendments were effective as of January 1, 2010, and there was no act of an administrative court necessary to formalize them any further. And certainly, the defendants cannot expect the plaintiffs, psychologically frail in the first instance, to rely on the vagaries of a promise that services will continue during the pendency of appeal. This lawsuit is their right, as far as the Court can tell.

The plaintiffs have met the burden to establish the three elements of their ADA integration claim. The Court would recommend, therefore, that the plaintiffs have shown a likelihood of success on the merits.[6]

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[6] The Court has had some concern over the objection of the defendants that the one-on-one services requested by Peter B. are not properly allowable Medicaid services. Frankly, the defense has not been thoroughly briefed. As far as the Court can tell, the issue in the State administrative proceedings has largely turned on the perceived duplicative nature of those services to other services. [Docs. 19-1, 70-1, -2; Lacy Aff. at 2.] As to that point, the defendants' showing here is unavailing. The plaintiffs have submitted evidence that the one-on-one services are essential and not redundant. (See Reel Aff. ¶¶ 7-10.) It is true that the administrative law court appears to have agreed that the services were non-waiver services [Doc. 19-1], but the Court does not believe, and the defendants have not argued, that that determination is somehow binding here. Moreover, the adjudication that the services are non-waiver in quality does not appear to be dispositive. As the *amici* explains, the waiver program is merely an optional tool, which states can use to provide

Irreparable Harm

The evidence at this point is strong that the plaintiffs will suffer regressive consequences if moved, even temporarily. The plaintiffs have behavioral and special needs, and benefit from a stable environment and personalized treatment. Information in the record indicates that they each have conditions or behaviors which make them poor candidates for group housing.

As a threshold legal matter, numerous federal courts have recognized that the reduction or elimination of public medical benefits irreparably harms the participants in the programs being cut. *See Beltran v. Myers*, 677 F.2d 1317, 1322 (9th Cir.1982) (holding that possibility that plaintiffs would be denied Medicaid benefits sufficient to establish irreparable harm); *Newton-Nations v. Rogers*, 316 F. Supp. 2d 883, 888 (D. Ariz. 2004) (citing *Beltran* and finding irreparable harm shown where Medicaid recipients could be denied medical care as a result of their inability to pay increased co-payment to medical service providers); *Edmonds v. Levine*, 417 F. Supp. 2d 1323, 1342 (S.D. Fla. 2006) (finding that state Medicaid agency's denial of coverage for a off-label use of prescription pain medication

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services in the community and to save money on providing institutional care. In other words, use of waivers is simply one way a state may meet the integration mandate of the ADA. "Medicaid can be an important resource to assist states in fulfilling their obligations under ADA. The [Home and Community-Based Services (HCBS)] waiver program in particular is a viable option for states to use to provide integrated community-based long-term care services and supports to qualified Medicaid eligible recipients." HCBS Waivers – 1915(c), at http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/05_HCBSWaivers-Section1915%28c%29.asp (last viewed Nov. 22, 2010). In other words, the status of the one-on-one services as non-waiver does not seem to absolve the defendants of their obligation to provide services to the plaintiff, which would keep in him the community as mandated by *Olmstead*. Again, the issue has been thinly treated and may be better traced at a later procedural moment in this case. For now, the Court has no reason to conclude either that the one-on-one services are non-waiver or, to the extent that they are, that such a determination matters.

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would irreparably harm plaintiffs). In other words, institutionalization, as a result of a denial of benefits, constitutes, legally speaking, the kind of harm which equitable relief is suited to enjoin.

More concretely, the plaintiffs have put forward evidence, specifically, of the kind of injury they would face. As discussed, the decline in Peter B.'s mental and physical condition since the termination of his companion services has already been documented. (Pl. Exs. 1, 3, 14.) Soon after Peter B.'s companion services were terminated, his anxiety and depression increased. (See Pl. Exs. 1, 14.) He lost nine pounds between the time that his companion services were terminated and the filing of this lawsuit. *Id.* This physical deterioration is likely to exacerbate his diabetic condition without the supervision of his specialized diet and exercise provided by his companion service provider. (Reel Aff. ¶ 7-10.) Peter's behavior support specialist and psychological services provider, Lennie Mullis, has indicated that Peter's ability to maintain employment, predicated on community living, is essential to his personal identity and mental health. (Mullis Aff. at 2.) The deterioration in his health, as previously cited, will jeopardize his ability to work, which will lead to both "depression and withdrawal." *Id.* at 2-3.

The plaintiffs have also put forward evidence that Michelle M. is likely to suffer the same unexplained physical injuries she experienced when she was previously institutionalized. (Pl. Exs. 4, 5.) There, she mysteriously fell, resulting in the loss of teeth; was clawed on her neck and side to the point of scarring; broke her toe; fell into depression; lost weight; and had difficulty sleeping. (Pl. Ex. 4 ¶¶ 14-19.) The plaintiffs have offered

evidence that she would be at risk of choking from aspiration due to the elimination of speech and language services. (Pl. Ex 5.) In a congregate setting, there is evidence that Michelle M. will be at risk for infections, particularly of her stoma where she is fed through a tube into her stomach. (Pl. Exs. 5, 14.) It has been represented, and unrefuted, that Michelle M. pulls out her feeding tube when she tries to stand up while being fed. (Pl. Ex. 14.) She will likely have to be restrained in a chair if she is placed in an institution. Lastly, because of Michelle M.'s behavioral issues and loud outbursts, she is at great risk in a congregate setting of abuse by other residents, as well as by frustrated and frequently poorly trained staff members. (Pl. Exs. 5, 14.) These are not compensable injuries.

Lastly, the threat of irreparable injury to Chip E. is slightly more difficult to summarize. He is the highest functioning of the three plaintiffs and, maybe, precisely for this reason, the prospect of institutionalization is most terrorizing to him. (Pl. Ex. 9 ¶ 12.) The threat of irreparable injury to Chip exists exactly in the lost opportunity that community living offers. The evidence reveals that Chip is significantly involved with the Clinton High School Football team in substantive ways, all of which would be forfeited upon institutionalization. (Chip Aff. ¶ 6 .) This is precisely the sort of injury incidental to the prejudice of segregation, which the *Olmstead* mandate contemplates and seeks to redress. *See Olmstead*, 527 U.S. at 600-01 ("[C]onfinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.") His experience in an institution would come with all of the adjunct humiliations that violation of personal space

and person imposes. "Institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life." *Id.* Where such an experience can be avoided, without significant alteration of the *status quo*, the United States Supreme Court has stated, it should be.

The Court does not mean to insult the hard work of the defendants or the individual care providers that accomplish it, but it would be an oversight of this decision not to also emphasize the fairly serious deficiencies of various institutional facilities, revealed in a state agency audit, which include unsanitary conditions; abuse; neglect; and exploitation. [Doc. 44-10 at , 287, 308-09.] Institutions can be places of both great compassion and unspeakable horror. These are not insignificant considerations when measuring the irreparable harm and opportunity cost of a *de facto* involuntary institutionalization of a person otherwise content and healthy in community.

These various forms of psychological and physical harms posed by institutionalization have been recognized as irreparable and sufficient to justify injunctive relief. *See Marlo*, 2010 WL 148849, at *2; *Crabtree v. Goetz*, 2008 WL 5330506, at *30 (M.D. Tenn. Dec., 19, 2008). The Court would agree, on the record here. The cited opinions of the plaintiffs' treating physicians, which are entitled to deference, *see Olmstead*, 527 U.S. at 610; *Crabtree*, 2008 WL 5330506, at *25, create more than a mere "possibility" of irreparable harm, and instead suggest that such harm is "likely," *Winters*, 129 S. Ct. at 375-76. And the unfavorable resolution of Peter's administrative appeal, which the defendant emphasizes

as reason to deny an injunction here [see Doc. 70], is actually additional evidence of the likelihood that the plaintiffs' rights in necessary services will not be protected and that they will be forced into institutional facilities but for Court action, now.

For all these reasons, the plaintiffs have established a likelihood of irreperable harm.

Balance of Harms

In contrast to the irreparability of the harm facing the plaintiffs, the harm to the defendants if an injunction is granted is at most slight. With an injunction, the defendants will only have to maintain the same level of funding they have provided to the plaintiffs for years and which, in the instances, of Michelle M. and Chip E., they maintain even now. Further, and as already detailed, the record indicates that maintaining the plaintiffs' current level of community based services actually presents an overall cost *savings* per year to alternative placements. To all of this, the defendants have made little rejoinder. They have not attempted to explain how the injunction would peculiarly burden them in any respect, much less to some degree more than the consequences posed to the plaintiffs in the absence of the same. The relief requested is temporary in nature; commensurate with what the defendants have largely been providing the plaintiffs even subsequent to the amendments; and demands no sort of systemic alteration. The request is for the *status quo* not some new buffet of benefit or other "fundamental alteration."

In all of its consideration, the Court does not mean to suggest that the call has been an obvious one. The defendants' objections largely sound in reasonableness and legal basis. Both the timeliness of this lawsuit and the urgency of the harm alleged, are matters

CONCLUSION

Wherefore, it is RECOMMENDED that the plaintiffs' Motion for Injunctive Relief [Doc. 12] be GRANTED and the defendants be ordered to maintain and/or return services in the quality, kind, and volume enjoyed by the plaintiffs prior to January 1, 2010, and, in the case of Peter B., prior to July 2009.

IT IS SO RECOMMENDED.

s/Bruce Howe Hendricks
United States Magistrate Judge

November 24, 2010
Greenville, South Carolina

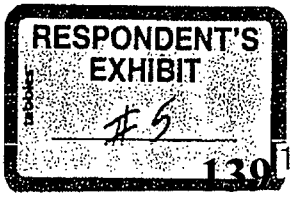
STATE OF SOUTH CAROLINA COUNTY OF RICHLAND	)	BEFORE THE APEALS DIVISION OF THE STATE DEPARTMENT OF HEALTH AND HUMAN SERVICES
Richard Stogsdill, Petitioner, -v- State Department of Health and Human Services, Respondent.	)	POST-HEARING BRIEF 10-MISC-42 (MR/RD)

TO: Mr. W. Jefferson Bryson, Hearing Officer, Division of Appeals and Hearings, South Carolina State Department of Health and Human Services, Post Office Box 8206, Columbia, SC 29202-8206 AND Ms. Patricia Harrison, Law Office of Patricia L. Harrison, 611 Holly Street, Columbia, SC 29205

Background

As noted in the Petitioner's recent Brief, he is certainly an accomplished young man. He is also a Medicaid-eligible individual, who has been receiving services under the South Carolina Mental Retardation/Related Disabilities (MR/RD) Waiver. Under this Waiver, beneficiaries can be provided a mix of services through Department of Disabilities and Special Needs (SCDDSN). Waivers are mechanisms within the Medicaid Program under which by "waiving" certain generic requirements of the Medicaid program States are able to provide services to individuals in ways not allowed under the regular Medicaid Program. On January 1, 2010, the five-year renewal of the MR/RD Waiver, as approved by the Centers for Medicare and Medicaid Services (CMS), went into effect. The renewed Waiver included a cap or limit on some services and excluded others.

The SCDDSN is responsible for the day-to-day operation of this Waiver. The Department of Health and Human Services (Department, DHHS, Respondent) is the agency that administers the South Carolina Medicaid Program, and so, is also responsible for the overall administration of the Waiver. This appeal is directly from a SCDDSN Reconsideration of a reduction in services to the Petitioner. The reduction was the result of the limitations set



forth in the renewed Waiver. The Reconsideration upheld the original reduction, thus, this appeal is before the Appeals Division of the SCDHHS. In this case, the hearing was held on Tuesday, May 11, 2010 at which time the Hearing Officer asked for briefs on the legal issues raised in the appeal and as further put forth at the hearing.

The Respondents, Departments, incorporate herewith the arguments set forth in their Pre-hearing Brief filed on May 6, 2010. In addition, the Respondents offer the following brief argument on the legal issues.

As to the incorporation of the previous case, Stogsdill v. SCDHHS, 09-MISC-017, the Respondent would not object to reference to the facts and holdings in that case, but believes that the case ended with the Remand and the Hearing Officer did not retain jurisdiction of the case for further review. We believe that upon remand to the DDSN, Mr. Stogsdill's case was reevaluated and reauthorized by the local board, taking into account the orders of Dr. Thomas C. Joseph. Then, the new waiver required all services to be reevaluated, taking into consideration the new limits. This case is about the reduction in services to the Petitioner occasioned by the new wavier limits. Facts and law in the previous case should be referenced only insofar as they are relevant to the present dispute.

Position of the Departments on the Legal Issues to be Briefed

1. Due Process:

In addition to the issues set forth in the Petitioner's appeal request and answered in the Respondent's Pre-Hearing Brief, the Petitioner has asserted that the SCDDSN's initial notice to Mr. Stogsdill about the reduction in services was defective because it did not comply with the following regulation:

> §431.210 Content of notice.
>
> A notice required under Sec. 431.206 (c)(2), (c)(3), or (c)(4) of this subpart must contain--
> (a) A statement of what action the State, skilled nursing facility, or nursing facility intends to take;
> (b) The reasons for the intended action;
> (c) The specific regulations that support, or the change in Federal or State law that requires, the action;
> (d) An explanation of--
> (1) The individual's right to request an evidentiary hearing if one /

is available, or a State agency hearing; or

(2) In cases of an action based on a change in law, the circumstances under which a hearing will be granted; and

(e) An explanation of the circumstances under which Medicaid is continued if a hearing is requested.

Specifically, the Petitioner complains that the notice does not set forth the specific "regulations that support...the action."

Ultimately, the "regulations that support... the action" are set forth in the general description of the home and community based waivers in 42 CFR §440.180 of the Medicaid Regulations:

440.180 Home or community-based services.

(a) Description and requirements for services. ''Home or community-based services" means services, not otherwise furnished under the State's Medicaid plan, that are furnished under a waiver granted under the provisions of part 441, subpart G of this chapter.

(1) These services may consist of any or all of the services listed in paragraph (b) of this section, as those services are defined by the agency and approved by CMS.

..... (emphasis added)

Obviously, that is a very general, over-arching and abstract concept, and, thus it is much more meaningful for a beneficiary to be apprised of the particular service and service limits in the waiver that apply to the particular action being taken by the agency. It is also much more concretely contestable than the general statement in the actual federal regulations. Under the wording of the federal regulation at 42 CFR §431.210, would it not have been permissible to simply have set forth the general statement in 440.180, referenced above? Would that have given the beneficiary a better understanding of the action taken by the agency?

2. Olmstead and the ADA.

In further explication of the Petitioner's argument that the U.S. Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999) interpreted the Americans with Disabilities Act in such a way as to require his services to continue, undiminished, the Petitioner cites addition caselaw.

As we understand the Petitioner's basic argument, it is that the Supreme Court in Olmstead said that if the person wants to live in the community and the State's treating professionals

think he can and the State can reasonably accommodate such a placement, then the person should be supported in the community. The proposed cuts in services to the Petitioner, could lead to his having to be institutionalized, and, therefore, the cuts should be prohibited. First of all, the Petitioner is living in the community, and it is speculative as to whether the reduction in services will cause him to be institutionalized. Secondly, even if it is true that he would be institutionalized, the State's responsibility under Olmstead (to support the person in the community) is not boundless. Olmstead, at 603. If the accommodation would fundamentally alter the State's program, the State does not have to make the accommodation.

Having made an attempt to review the cases, the Respondent cannot find that, in the context of budget cuts such as many states are now facing, that the federal courts have finally spoken on the issue. Can the State, in the face of budget cuts, reduce an individual's waiver (for example) services in the community, even if there is a chance that the reductions will lead to institutionalization? It would appear that most or all of the cases are in some stage of litigation, and have not yet been finalized.

Probably, the case most favorable to the Respondent is Rosen v. Goetz, 410 F. 3d 919 (6th Cir., 2005). In that case, the federal circuit court lifted a district court's injunction against service reductions imposed by the State. The court said:

> When a State [Tenn.] to its credit achieves the status of becoming one of the most generous providers of Medicaid services in the nation, it may occasionally happen that the zero-sum fiscal realities of administering a state budget will prohibit the State from sustaining that level of support. If that should happen, it is not for the federal courts to compel the State to maintain non-mandatory Medicaid programs that it no longer can support. Rosen, at 933.

However, it is believed that the district court is still monitoring Tennessee's disengagement with their statewide Medicaid Waiver program, and will continue to be involved in all related state actions. The Petitioner cites Crabtree v. Goetz, an unreported case for which the Westlaw cite is 2008 WL 5330506 (M.D. Tenn., 2008). This was another Tennessee case in which the district court granted a preliminary injunction preventing the State from implementing Medicaid service cuts. As far as we know the merits of the case, more than was necessary to dispose of the preliminary injunction have not been heard. Potentially, the injunction or the district court's final ruling in the Crabtree case could be subject to the ruling in Rosen.

The language in Fisher v. Oklahoma Health Care Association, 335 F. 3d 1175 (10th Cir. 2003) and Radeszewski v. Maram, 383 F. 3d 599 (7th Cir. 2004) is very favorable to the Plaintiff, but the Respondent understands both of those cases to be ones in which the circuit court was just reversing a summary judgment. In other words, the circuit court was saying that the court below decided the cases on the pleading without taking sufficient facts and arguments. The circuit court wanted the cases to be fully tried because the Petitioners had set forth a case that, under the ADA, could potentially be decided in their favor.

The Respondent understood the unreported district court case of Moore v. Medows, 2009 WL 4884029 (N.D. Ga. 2009) to be about who gets to determine medical necessity for service, the patients' attending or the State. The district court said the patient's attending's order were dispositive. We believe that the circuit court disagreed and remanded the case. We further believe that upon remand, the district court sustained the attending physician's original orders but for slightly different reasons.

We reviewed the Marlo M. v. Cansler case, WL 148849, but, again, as the Petitioner states they resulted in preliminary injunctions, which mean that the cases could be heard fully at a later time if they are not settled or otherwise resolved. It is true however, that in this case as in most of the cases cited by the Petitioner, courts have found that the Plaintiffs have put forth initial cases that were likely to succeed on the merits. That, of course, along with the likelihood of irreparable harm and the balance of equities, is one of the requirements that a Plaintiff has to meet in order to be granted a preliminary injunction. Presumably, the cases are still pending for final hearings on the merits.

It also appears to the Respondent that a good chance for an on-point circuit court decision favorable to the Petitioner is in the ninth circuit. In the northern district of California, in the case of Cota v. Maxwell-Jolly, 688 F. Supp. 2d 980 (N. D. Calif., 2010), the court enjoined eligibility and medical necessity restrictions on Adult Day Health Care. Appeal would be to the ninth circuit.

Therefore, since:

1) there is no settled law on the issue of whether the State can, notwithstanding Olmstead and the ADA, reduce these services under an approved waiver;
2) the Petitioner received adequate notice of the reductions;
3) the Departments have applied reasonable standards of medical necessity in authorizing services for Mr. Stogsdill;
4) the Departments have complied with standards of promptness; and
5) the Departments' service reductions have nothing to do with Federal Stimulus Funds;

the Respondents' actions in this matter must be sustained.

Wherefore, the Respondent respectfully asks that the services currently authorized to be provided to the Petitioner be evaluated in terms of the needs of the Petitioner, within the legitimate limitations included in the new waiver.

Respectfully Submitted,

Richard G. Hepfer
Deputy General Counsel
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Post Office Box 8206
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hepfer@scdhhs.gov
Attorney for the Respondent

Columbia, South Carolina
June 14, 2010

South Carolina Department of
Health & Human Services

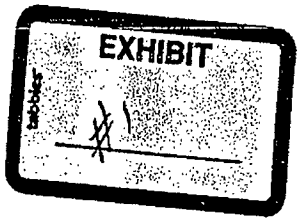
Emma Forkner • Director
Mark Sanford • Governor

March 19, 2010

CERTIFIED MAIL

Patricia L. Harrison, Esquire
611 Holly Street
Columbia SC 29205

RE: Fair Hearing of Richard Stogsdill v. SCDHHS
Appeals' Case # 10-MISC-042 (MR/RD)



- NOTICE OF HEARING -

Dear Ms. Harrison:

We have received your request for a fair hearing and have scheduled the hearing for **Tuesday, May 11, 2010, at 3:00PM, in the Ninth Floor Conference Room of the Jefferson Square Building, 1801 Main Street (corner of Main and Laurel), Columbia, South Carolina.** The hearing will be about the reduction in PC2 and Companion hours, and the allocation of Respite services provided to Richard Stogsdill under the Mental Retardation and Related Disabilities Waiver, and, whether you can establish that the agency's authority to determine and allocate services under the Waiver is in violation of Federal or State laws, rules, or regulations governing the administration of Medicaid services..

The rules for the hearing are enclosed in this letter. The rules and facts by which the Respondent denied the services will be forthcoming.

You should be ready to say why you think DHHS' decision is wrong. In presenting his case, you may look at his case file, call your own witnesses, ask questions of DHHS' witnesses, and give the Hearing Officer any papers you think are important. If you wish to review his file, please contact the caseworker in the county office.

If either, or both, parties intend to offer documents as evidence for entry into the record, then it will be necessary for that party(ies) to make copies of the documents so that the other party and the Hearing Officer may each have a copy of the document(s). Further, should either party as a part of their testimony intend to refer to a particular paragraph or section of a policy or procedure manual, directive, memorandum, etc., then it will be necessary for the party(ies) to make copies in duplicate of these referenced sections.

Division of Appeals and Hearings
Post Office Box 8206 • Columbia, South Carolina 29202-8206
(803) 898-2600 • Fax (803) 255-8206

Also, should either party intend to utilize charts, graphs, visual aids, etc., as a part of their presentation, then it will be necessary for that party to have these items photocopied on 8 1/2 x 11 inch paper so that they may be easily integrated into the case record.

If you cannot meet on the date above or have questions, and you live in the Columbia area, you may contact me at 898-2600; otherwise, if you live outside the Columbia area, you may contact me toll-free at 1-800-763-9087.

Sincerely,

W. Jefferson Bryson, Hearing Officer
Division of Appeals and Hearings

WJB/sbs

Enclosure

cc: Dr. Kathi Lacy, Ph.D., Associate State Director, Policy, SCDDSN
Kara Lewis, Bureau of Community Long Term Care Services, SCDHHS
Richard Hepfer, Deputy General Counsel, SCDHHS

PATRICIA L. HARRISON
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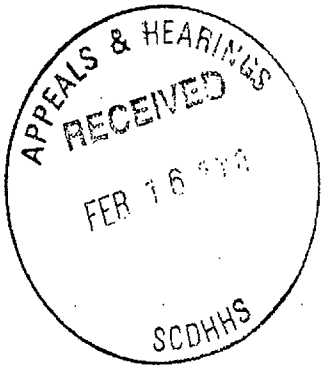
611 HOLLY STREET
COLUMBIA, SOUTH CAROLINA 29205

TELEPHONE (803) 256-2017 FAX (803) 256-2213

February 11, 2010

Mr. Vastine Crouch
Division of Appeals and Hearings
SC Department of Health and Human Services
PO Box 8206
Columbia, South Carolina



RE: Appeal of Richard Stogsdill

Dear Mr. Crouch:

I am writing to appeal the reductions of MR/RD Medicaid waiver services of Richard Stogsdill and the elimination of Occupational Therapy, Physical Therapy and daily respite services. The notification received from Dr. Buscemi is attached. We are requesting that Richard's services be continued during this appeal and that all waiver services reasonably prescribed by his treating physician be provided with reasonable promptness.

Specifically, Richard appeals.

1. The reduction of waiver services, including, but not limited to PCA services, adult companion services and respite.

2. Termination of daily respite as a waiver option;

3. Elimination of speech and language services, physical therapy and occupational therapy as waiver services;

4. The agencies' failure to apply reasonable medical standards to determine the medical necessity for services;

5. The violation of due process rights established under federal and constitutional law and regulations implementing the Medicaid Act, including, but not limited to notice and standard of promptness requirements established by CMS;

6. The failure to promptly determine eligibility for and to provide waiver services prescribed by Richard's treating physician;

7. Violation of the Olmstead decision and directives provided by CMS subsequent to that decision, which require services to be provided in the least restrictive setting;

8. Failure of SCDDSN and SCDHHS to utilize federal stimulus funds to maintain Richard's eligibility for Medicaid waiver services.

Please direct all communications to my office.

Cordially,

Patricia L. Harrison

cc: Nancy Stogsdill

Beverly A. H. Buscemi, Ph.D.
State Director
David A. Goodell
Associate State Director
Operations
Kathi K. Lacy, Ph.D.
Associate State Director
Policy

SOUTH CAROLINA Department OF Disabilities AND Special Needs

RECEIVED JAN 13 2010

COMMISSION
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Richard C. Huntress
Vice Chairman
Otis D. Speight, MD, MBA, CPE
Secretary
W. Robert Harrell
Nancy L. Banov, M.Ed.
Susan K. Lait
Deborah C. McPherson

3440 Harden Street Ext (29203)
PO Box 4706, Columbia, South Carolina 29240
V/TTY: 803/898-9600
Toll Free: 888/DSN-INFO
Website: www.ddsn.sc.gov

January 12, 2010

Ms. Patricia L. Harrison
611 Holly Street
Columbia, SC 29205

RE: Richard Stogsdill

Dear Ms. Harrison

We received your December 30, 2009 correspondence regarding Richard Stogsdill's Mental Retardation/Related Disabilites (MR/RD) Waiver services.

As you may know, limits or caps have been placed on services in the MR/RD Waiver. Approval for these limits or caps was obtained from the Centers for Medicaid and Medicare Services (CMS). These approved limits cannot be exceeded and must be applied to all MR/RD Waiver participants.

While we understand and appreciate the hardship these changes may cause, we are not at liberty to exceed the established limits. Therefore, I must uphold the decision to reduce Personal Care II, Companion, and Respite Services.

We understand that you have requested that Richard's Personal Care, Companion, and Respite Services continue while your reconsideration and appeal is being considered.

Thank you for the opportunity to respond to your concerns. We encourage you to continue to work with Richard's Service Coordinator to access services that will best meet his needs. If you wish to pursue this matter further, you have the right to request an appeal with the SC Department of Health and Human Services. The appeals process is attached for your information.

Sincerely,

Beverly A. H. Buscemi PhD

Beverly A.H. Buscemi, Ph.D.
State Director

APPEALS & HEARINGS
RECEIVED
FEB 16 2010
SCDHHS

Attachment
C: Kimberely Bennett, Kershaw County DSN Board
Vicki Coleman, District I
Kara Lewis, DHHS

SCDDSN RECONSIDERATION PROCESS AND SCDHHS MEDICAID APPEALS PROCESS

The SC Department of Disabilities and Special Needs (SCDDSN) is responsible for the day-to-day operations of the Mental Retardation/Related Disabilities (MR/RD) Waiver and the Head and Spinal Cord Injury (HASCI) Waiver. A request for reconsideration of an adverse decision **must be** sent in writing to the State Director at SCDDSN, P. O. Box 4706, Columbia, SC 29240. The SCDDSN reconsideration process **must be** completed in its entirety before seeking an appeal from the South Carolina Department of Health and Human Services (SCDHHS).

A formal request for a reconsideration must be made in writing within thirty (30) calendar days of receipt of written notification of the adverse decision. The request must state the basis of the complaint, previous efforts to resolve the complaint and the relief sought. The reconsideration request must be dated and signed by the consumer, representative, or person assisting the consumer in filing the request. If necessary, staff will assist the consumer in filing a written reconsideration.

Note: In order for waiver benefits/services to continue during the reconsideration/appeal process, the consumer/representative's request for reconsideration must be submitted within ten (10) calendar days of the written notification of the adverse decision. If the adverse action is upheld, the consumer/representative may be required to repay waiver benefits received during the reconsideration/appeal process.

The State Director or his designee shall issue a written decision within ten (10) working days of receipt of the written reconsideration request and shall communicate this decision to the consumer/representative. If the State Director upholds the original adverse action/decision, the reason(s) shall be specifically identified in the written decision.

If the consumer/representative fully completes the above reconsideration process and is dissatisfied with the results, the consumer/representative has the right to request an appeal with the SCDHHS. The purpose of an administrative appeal is to prove error in fact or law. The consumer/representative must submit a written request to the following address no later than thirty (30) calendar days from the receipt of the SCDDSN written reconsideration decision.

Division of Appeals and Hearings
SC Department of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206

The consumer/representative must attach copy of the written reconsideration notifications received from the SCDDSN regarding the specific matter on appeal. In the appeal request the consumer/representative must clearly state with specificity, which issue(s) the consumer/representative wishes to appeal.

Unless the request is made to the above address within thirty (30) calendar days of the receipt of the SCDDSN written reconsideration decision, the SCDDSN decision will be final and binding. An appeal request is considered filed at the above address if postmarked by the thirtieth (30^{th}) calendar day following receipt of the SCDDSN written reconsideration decision. The consumer/representative shall be advised by the SCDHHS Division of Appeals and Hearings as to the status of the appeal request.

STATE OF SOUTH CAROLINA	)	BEFORE THE APEALS DIVISION
	)	OF THE STATE DEPARTMENT OF
COUNTY OF RICHLAND	)	HEALTH AND HUMAN SERVICES
	)	
	)	
	)	
Richard Stogsdill,	)	
	)	
Petitioner,	)	
	)	PREHEARING
-v-	)	BRIEF
State Department of Health	)	
and Human Services,	)	10-MISC-42 (MR/RD)
	)	
Respondent.	)	
	)	

TO: Mr. W. Jefferson Bryson, Hearing Officer, Division of Appeals and Hearings, South Carolina State Department of Health and Human Services, Post Office Box 8206, Columbia, SC 29202-8206 AND Ms. Patricia Harrison, Law Office of Patricia L. Harrison, 611 Holly Street, Columbia, SC 29205

Background

The Petitioner in this matter is a Medicaid-eligible individual, who has been receiving services under the South Carolina Mental Retardation/Related Disabilities (MR/RD) Waiver. Under this Waiver, beneficiaries can be provided a mix of services through Department of Disabilities and Special Needs (SCDDSN). Waivers are mechanisms within the Medicaid Program under which by "waiving" certain generic requirements of the Medicaid program States are able to provide services to individuals in ways not allowed under the regular Medicaid Program. On January 1, 2010, the five-year renewal of the MR/RD Waiver, as approved by the Centers for Medicare and Medicaid Services (CMS), went into effect. The renewed Waiver included a cap or limit on some services and excluded others.

The SCDDSN is responsible for the day-to-day operation of this Waiver. The Department of Health and Human Services (Department, DHHS, Respondent) is the agency that administers the South Carolina Medicaid Program, and so, is also responsible for the overall administration of the Waiver. This appeal is directly from a SCDDSN Reconsideration of a reduction in services to the Petitioner. The reduction was the result of the limitations set forth in the renewed Waiver. The Reconsideration upheld the original reduction; thus, this appeal

is before the Appeals Division of the SCDHHS. In this case a hearing has been set for Tuesday, May 11, 2010.

General Position of the Departments

1. The Petitioner and its agent the Department of Disabilities and Special Needs, have the authority to amend the Waiver and set reasonable limits on the services offered.

Section 1915(c) of the Social Security Act [42 USC §1396n(c)] permits states to waive the requirement that persons with mental retardation or a related disability live in an institution in order to receive certain Medicaid services. "[The program] allow[s] states to experiment with methods of care, or to provide care on a targeted basis, without adhering to the strict mandates of the Medicaid system." See Bryson v. Shumway, 308 F. 3d 79 (1st Cir. 2002), cited in Doe v. Kidd, 501 F.3d 348 (4th Cir. 2007).

Under the statute, then, the Departments in this case have the statutory authority to enter into a Waiver agreement with the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers the Program. Attached is the letter from CMS approving the amended Waiver. Also attached is the first page of the Wavier that describes most of the new limitations in services, also effective on that date.

The Major Changes include the new limits on Personal Care Aide Services (PCA), Adult Companion Services (ACS), and Respite Care. Speech Language pathology [sic], Occupational and Physical Therapy are among the services to be eliminated. The elimination of "daily" respite is a reimbursement change, which does not eliminate the service.

Thus, facially, the Departments have properly exercised their authority to amend the Waiver, and CMS, the responsible federal agency has approved the change.

Additionally, in the case of the SCDDSN reductions, six (6) statewide workshops were held in the September and October preceding the reductions. The workshops were well attended by both advocates and beneficiaries. The purpose of the workshops was to alert the public of the proposed changes. At the time of the workshops, the Waiver application had been sent to CMS (August 31, 2009). In November, the Waiver was approved with no substantive changes in the limits at issue here.

On December 1, 2009, a general notice was sent out to all SCDDSN clients notifying them of the pending changes and urging them to work closely with their SCDDSN Service Coordinators (case managers) to mediate the impact of the new service limits. Later in

December, specific notices were sent to the beneficiaries, who were directly impacted. The Notices complied with the requirements of §431.210. Services continued at the pre-limit levels for those individuals who sought reconsideration within the regulatory ten (10) day period.

Service coordinators affirmatively contacted and are continuing to work with the effected clients in order to help rearrange services to get the most coverage within the new Waiver limits.

2. The Departments have applied reasonable standards of medical necessity in authorizing services for Mr. Stogsdill.

The concept of Medical Necessity is introduced in the Medicaid regulations as an element to avoid services being provided in such quantity that it takes advantage of the Medicaid Program. In 42 CFR:

> Sec. 433.304 Definitions.
>
> As used in this subpart--
> Abuse (in accordance with Sec. 455.2) means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not **medically necessary** or that fail to meet professionally recognized standards for health care. (Bolding added.)

Medical necessity can, therefore, be a limiting element on Medicaid Services.

> Sec. 440.230 Sufficiency of amount, duration, and scope.
>
> (a) The plan must specify the amount, duration, and scope of each service that it provides for--
> (1) The categorically needy; and
> (2) Each covered group of medically needy.
> (b) Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.
> (c) The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under Sec. Sec. 440.210 and 440.220 to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition.
> (d) The agency may place appropriate limits on a service based on such criteria as **medical necessity** or on utilization control procedures.
> (Bolding added.)

To their credit, treating physicians are natural advocates for their patients, and that is as it should be and central to the doctor/patient relationship. However, in their advocacy for their patients, treating physicians are often unmindful of the true availability and cost of services ordered. Furthermore, although their training is extensive, not every physician is aware of the evidence-based approaches that have been shown to be effective in the area of home-based or community services. Every order from a treating physician should be given the utmost consideration and attention by State agency staff charged with authorizing services, but services varying widely from the normal scope which experience has shown to be safe, should not be authorized.

There is a split in the federal circuits as to the control of the attending physician in determining what services are "medically necessary." In the fourth circuit, we believe that the decisions of the treating professionals are not necessarily controlling. See, Thomas S. v. Flaherty, 902 F.2d 250 (4th 1990), as quoted in Williams v. Wasserman, 164 F. Supp. 2d 591 (D. Md. 2001) a case in which the court denied Olmstead (see below) relief to the Plaintiffs, indicating that to do so would cause a fundamental alteration of the State's program. We believe that in this federal circuit, at least, the treating professional's opinion will certainly be among those considered to determine that professional judgment was exercised. However, the question of medical necessity is an issue of fact, which if left to the attending simply forecloses the issue and makes it not subject to scrutiny by the administering agencies.

Furthermore, even if the attending physician's order were dispositive about what is medically necessary, for this Waiver client that would not override the specified programmatic limits on the services available. Waiver services, particularly, are designed to "...complement and/or supplement the services that are available to participants through the Medicaid State Plan and other federal, state and local public programs as well as the supports that families and communities provide." See paragraph 1 on Page 1 of the MR/RD Waiver document, attached.

3. The Departments have complied with standards of promptness.

It appears that an assessment was timely completed with Mr. Stogsdill and services, within the limits set forth in the new Waiver, were approved in mid-January. This is in addition to the efforts of the DDSN in publicizing the Waiver reductions mentioned above.

4. In amending the Waiver, the Departments have complied with the Americans with Disabilities Act (ADA) Section 504 of the Rehabilitation Act and the Supreme Court's holding in and Olmstead v L.C. ex rel. Zimring, 527 U.S. 581 (1999).

Under Olmstead, States are required to provide community-based treatment for persons with mental disabilities when the State's treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities. Olmstead, at 587.

First of all, Olmstead dealt with deinstitutionalization of individuals who wanted to be integrated into community living. The Petitioner in this case is already living in the community. It is speculative at best to assume that this reduction in services will lead to his institutionalization.

However, even if he does, in the future, experience difficulty, "[t]he State's responsibility, once it provides community-based treatment to qualified persons with disabilities, is not boundless," Olmstead at 603. In the Olmstead case, the Court was considering the Justice Department's regulations and general approach in enforcing the ADA. It found that courts must consider the totality of the expenses and programs undertaken by the State when evaluating the fundamental alteration defense. More generally, the States retain the right, as explained in the implementing regulations not to "take any action that [they] can demonstrate would result in a fundamental alteration in the nature of a service, program, or activity or in undue financial and administrative burdens." 28 C.F.R. § 35.150(a)(3). The concept of "fundamental alteration is further explained, in part, below:

> Sec. 35.130 General prohibitions against discrimination.
>
> (a) No qualified individual with a disability shall, on the basis of disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any public entity.
>
> (b)
>
> .....
>
> (7) A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.

"Sensibly construed, the fundamental-alteration component of the reasonable-modifications regulation would allow the State to show that, in the allocation of available resources, immediate relief for the plaintiffs would be inequitable, given the responsibility the State has undertaken for the care and treatment of a large and diverse population of persons with mental disabilities." Olmstead, at 604.

In evaluating a fundamental-alteration defense, the [court] must consider, in view of the resources available to the State, not only the cost of providing community-based care to the litigants, but also the range of services the State provides others with mental disabilities, and the State's obligation to mete out those services equitably. Olmstead, at 597.

Thus the courts have acknowledged the fundamental alteration defense in applying the rules in Olmstead. In this case the Departments have recently applied for renewal of the MR/RD Waiver, which has been approved by CMS. The DDSN has responsibility for providing services to the developmental disabled population of the State. In order to equitably apportion services, the Department must be allowed to reasonably limit otherwise "boundless" services.

5. The Departments' service reductions have nothing to do with Federal Stimulus Funds.

Federal Stimulus Funds were authorized by Congress in the American Recovery and Reinvestment Act (ARRA), enacted on February 17, 2009. H.R. 1, 111th Cong., Pub.L. No. 111-5 (1st Sess.2009). Under ARRA, in order to receive enhanced FMAP, a state may not restrict eligibility "standards, methodologies, or procedures" beyond those in effect on July 1, 2008. See, § 5001(f)(1) of ARRA. Gray Panthers of San Francisco v. Schwarzenegger, 2009 WL 2880555, (N.D. Cal. 2009)(emphasis added).

Petitioners apparently claim that the changes set to take effect in South Carolina's Medicaid Waiver program on January 1, 2010, are in violation of Section 5001 of ARRA. However, since it is manifestly the limitations on services that are the subject of this action, the restrictions of ARRA do not apply

These allegations were raised in a Petition for the South Carolina Supreme Court to take original jurisdiction and grant an injunction against the Departments' imposition of the Waiver limitations, which were to go into effect on January 1, 2010. The Petition and request for an injunction were filed on December 30, 2009, and responded to on December 31, 2009 by the Departments. In an Order, issued on February 4, 2010, the Supreme Court denied the Petition and declined to grant the injunction, thereby allowing the Wavier limitations to go into effect on January 1, 2010.

Conclusion

The Departments properly amended this Waiver, and properly evaluated Mr. Stogdill for services within the new limits that would allow him to remain safely in his current living situation. Therefore, the Departments respectfully request that the Hearing Officer render a Decision:

APPEALS & HEARINGS RECEIVED MAY 06 2010

1) Affirming the DDSN's proposed Service Plan for the Petitioner under the new Waiver limits;

2) Dismissing the Petitioner's Appeal; and

3) Such other remedies as justice should demand.

Respectfully Submitted,

Richard G. Hepfer
Deputy General Counsel
Office of General Counsel
Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206
Voice: (803) 898-2791
Fax (803) 255-8210
hepfer@scdhhs.gov
Attorney for the Respondent

Columbia, South Carolina
May 6, 2010

Beverly A. H. Buscemi, Ph.D.
State Director
David A. Goodell
Associate State Director
Operations
Kathi K. Lucy, Ph.D.
Associate State Director
Policy

SOUTH CAROLINA Department OF Disabilities AND Special Needs

RESPONDENT'S EXHIBIT #3

COMMISSION
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Susan K. Lait
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3440 Harden Street Ext (29203)
PO Box 4706, Columbia, South Carolina 29240
V/TTY- 803/898-9600
Toll Free: 888/DSN-INFO
Website: www.ddsn.sc.gov

To: Service Coordinator Suzanne Yankowitz
DSN Board / Qualified Provider Agency The ARC

From: Dawn Shealy
District I

Date: March 1, 2010

The Respite Limit Exception has been received for Richard Stogsdill

After reviewing the request and all supporting documentation the team has made the following decision (s):

___ Approval of _____ hours monthly.

X Modified to 172 hours monthly.

___ Denied

The WTS will be updated to reflect the approved amount.

If you have any questions please contact me at (864) 938 -3356 or dshealy@ddsn.sc.gov.

South Carolina Department of Disabilities and Special Needs
Mental Retardation/Related Disabilities Waiver
Respite Assessment

Participant Name: Richard Stogsdill

Social Security Number: [redacted]

Age: [redacted]

DSN Board/Provider: The Arc of SC

Service Coordinator/Early Interventionist Name: Suzanne Yankowitz

Participant's Primary Caregiver(s):

Name: Nancy Stogsdill Relationship: mother Age: 61

Name: ____ Relationship: Father Age: 60

Name: ____ Relationship: ____ Age: __

Participant's Primary Diagnosis (check only one):

☐ MR ☐ RD-Autism ☑ RD-Other CP ☐ Other ____

Additional Diagnosed Conditions (check all that apply):

☐ Blindness
☑ Cerebral Palsy
☐ Brain or neurological damage
☐ Chronic brain syndrome
☐ Chemical dependence
☐ Deafness
☐ Epilepsy or seizures
☐ Mental illness (e.g. Psychosis, Schizophrenia, etc.)
☐ Situational mental health problems
☐ Other ____

Is this participant on the SCDDSN Critical Circumstance list? ☐ Yes ☐ No

Part I. Supervision Needs

☐ Requires occasional/little support during the day (outside of visual supervision for 1-3 hour periods)

☐ Requires limited support and supervision (within the same room or nearby, outside of visual supervision for 1 hour periods)

☑ Requires extensive, moderately intense support and supervision (within the same room or nearby, outside of visual supervision for 15 minute periods)

☐ Requires pervasive, continuous, highly intense support and supervision (direct, continuous visual contact)

Comments: ____

Part II: Caregiver Stress:

Service Coordinator/Early Interventionist: Please provide this section of the assessment to the caregiver(s) for them to complete and return to you. This may be completed over the phone, during a home visit, or by mailing it to the caregiver. This section is designed to determine the amount of stress the parent/caregiver/guardian(s) is/are experiencing.

Caregiver(s): The information requested below may seem personal; but, we must understand the stress that you may be experiencing in order to provide you with relief. The following is a list of statements which reflect how people may feel when taking care of another person. After each statement, indicate how often you feel this way (i.e. never, sometimes or always) by placing a check mark in the corresponding box. There are no right or wrong answers.

QUESTION	Never	Sometimes	Always
1. How often do you feel that you don't have enough time for yourself?			✓
2. How often do you feel stressed and overwhelmed between caring for yourself and your family and trying to meet other responsibilities?			✓
3. Are you afraid of what the future holds for your relative if something were to happen to you or your family?			✓
4. Do you feel you do not or will not have enough money to care for your participant?			✓
5. Do you feel your health has suffered because of the care you provide to your family?			✓
6. Do you feel you don't have as much privacy as you would like because of your relative?			✓
7. Do you feel you will be unable to take care of your relative much longer?			✓
8. Do your responsibilities for yourself and your family make you feel out of control?		✓	
9. Do you feel that you do not have enough time for each member of your family?			✓

Part II Score: 34 (See Respite Service Chapter for Instructions)

Part III: Request for Respite and General Information

1. Does/do the primary caregiver(s) have any health/medical/mental health issues? If yes, explain. ☑ Yes ☐ No
   mrs. Stogsdill has back problems from lifting Richard and as she is getting older she does not have as much strength

2. If respite is needed to enable the primary caregiver(s) to work/attend school, indicate what other resources have been explored to meet this need and the primary caregiver's work/school schedule.
   PCA II. services, and Adult Companion

3. Is the primary caregiver responsible for providing care for other individuals (e.g. elderly parent(s), other children, another disabled participant, etc.)? If yes, for whom? ☑ Yes ☐ No
   mr. and mrs. Stogsdill are caregiving for elderly parents

4. What is the household composition?

   Number of Adults: 3 Age(s): 32, 61, 60

   Number of Children: __ Age(s): ____

5. Are there friends, neighbors, church members and/or extended family members who assist in caring for the participant? If yes, who? ☐ Yes ☑ No

6. Are there opportunities for [caregiver] spouses to spend time together without having to provide direct care for this participant? If yes, how often and who assists? ☐ Yes ☑ No ☐ N/A

7. Are there any needs that the participant has on his/her Support Plan that are not being met? If so, please list. ☑ Yes ☐ No
   Speech Therapy, Occupational Therapy and Physical Therapy

8. What services is the participant currently receiving (through any funding source)?

   ☐ OT/PT/Speech
   ☐ Attends Public School
   ☐ Adult Day Health Care
   ☐ Prevocational/Day Services
   ☐ Participant is homebound
   ☐ EI Services
   ☑ Personal Care (amount/frequency): 55 hrs/week
   ☐ Nursing (amount/frequency): ____
   ☐ Family Support funds for ____
   ☑ Assistive Technology
   ☑ Companion Services
   ☑ Behavior Support/Psychological Services
   ☐ Day Care
   ☐ Applied Behavior Analysis (ABA Therapy)
   ☐ Summer Camp

9. If skilled tasks are required during respite for this participant (e.g. medication administration, tube feedings, suctioning, etc.), what is the plan for these tasks to be completed by a qualified family member or Nurse?
   Medication is placed in a pill box and set out for the family member or nurse to administer

10. Is/are the primary caregiver(s) being paid to provide Personal Care services to the participant? ☐ Yes ☑ No

11. How much time every day/week is/are the caregiver(s) responsible for caring for the participant (excluding sleep time)?

90 hours/week

12. Does/do the caregiver(s) experience sleepless nights or is/are he/she/they unable to sleep consistently due to the care of their participant? If yes, explain. ☐ Yes ☐ No

Richard will call out to his parents during the night if he needs to use the bathroom or is not feeling well.

13. Have there been any changes of circumstances in the participant's home that have added additional stressors (e.g. death of parent, death of spouse, divorce, relocation, etc.)? If yes, explain. ☐ Yes ☑ No

14. Has/have the caregiver(s) experienced any loss of income due to caring for the participant? ☑ Yes ☐ No

15. Has [one of] the caregiver(s) had to quit his/her job or reduce his/her hours in order to care for the participant? ☑ Yes ☐ No

Total Units of Respite Care *requested* (by the participant/caregiver) per month: 228 hrs.

Total Units of Respite Care recommended (by the Service Coordinator) per month: 228

Include justification for or against requested number of weekly units: 57 hrs.

Suzanne D Yankouts
Signature of Person Completing Assessment

1/18/10
Date

incontent - requires catheter care

non-Ambulatory - electric w/c

water walker, + other medical equipment.

Richard Stogsdill is a 22 year old man with a diagnosis of Cerebral Palsy. Richard is non ambulatory and relies on the assistance if others to complete all activities of daily living and personal hygiene. Richard's parents are the primary caregivers and provide assistance to help Richard complete activates of daily living and hygiene tasks at the end of the day and throughout the night. Richard will call out to his parents during the night to go to the bathroom or if he does not feel well. Mr. and Mrs. Stogsdill have both had to alter their work schedules in order to ensure that there is someone with Richard at all times.

Mrs. Stogsdill has stated that as she is getting older she finds it more difficult to transfers Richard easily and has back problems as a result of the years of transferring him. Mr. and Mrs. Stogsdill also care for elderly parents and are required to go to their residences, which are not local, to ensure that their needs are being met as well. Mr. and Mrs. Stogsdill have not been able to visit with family and friends or have a vacation for them as they need to make sure that Richard is cared for. On the weekends, there is no support for Richard in the house so Mr. and Mrs. Stosgdill must ensure that one of them is home with Richard or take Richard with them where ever they go. Richard has expressed wanting to spend more time on the weekends with other people and to be able to go out and do activities that are being held and so he can meet people his own age.

South Carolina Department of Disabilities and Special Needs
Mental Retardation/Related Disabilities Waiver
Request for Respite Limit Exception

40 hrs wk = 172 month

Participant's Name: Richard Stogsdill *SS#*: [redacted]

Service Coordination Provider: The Arc of SC

Service Coordinator: Suzanne Yankowitz *Phone*: (803) 748-5020

Indicate the category (Select One) that describes the reason for the exception request. Based on the category selected, provide or submit the information required for consideration of the request.

☐ **Caregiver hospitalized or receiving medical treatment**

☐ Documentation from the caregiver's physician of his/her condition and anticipated treatment and/or recovery schedule must be submitted. If commute time must be considered, please indicate the location where treatment will be provided and round-trip distance from the caregiver's home.

Also document reason that secondary caregiver (if applicable) is unable to temporarily fulfill primary caregiver's duties.

☐ The SC Annual Assessment (and/or other documents) must clearly and specifically reflect the care and supervision needs of the person for whom respite is requested. The needs of the person must justify the additional respite requested in consideration of all natural and paid support already received by person.

☐ **Need for constant hands-on/direct care and supervision due to medically complex condition OR severe disability**

☐ The SC Annual Assessment (and/or other documents) must clearly and specifically reflect the person's medically complex condition or severe disability.

Medically complex means that the person has a serious medical condition resulting in substantial physical impairment or disability requiring comprehensive care management defined as extensive hand-on assistance or total care on a routine basis.
The person needs extraordinary supervision and observation

OR

The person needs frequent and/or life saving administration of specialized treatments.

Severe disability means that the person has substantial physical or behavioral impairment or disability such that the degree of impairment or disability requires extensive hands on assistance or total care on a routine basis.

☐ The SC Annual Assessment (and/or other documents) must clearly and specifically document the care and supervision needs of the person for whom

respite is requested. The needs of the person must justify the additional respite requested in consideration of all natural and paid support already received by person.

☐ **Seasonal relief during the summer (June, July and August) for a school student over age 12 whose caregiver/guardian works and for whom Support Center services are not available**

- ☐ Assure that person attended school and is between 13 and 21 years of age.
- ☐ Verification that Support Center services are not available
- ☐ Statement of caregiver employment status, including work hours and commuting time
- ☐ The SC Annual Assessment (and/or other documents) must clearly and specifically document the care and supervision needs of the person for whom respite is requested. The needs of the person must justify the additional respite requested in consideration of all natural and paid support already received by person.

Amount of Respite Requested: [redacted]

List all services this person receives:
PCA II, Adult Companion, Assitive Technology

Provide a two week schedule that shows how/when services and supports (including natural supports) are provided. Include the anticipated schedule for Respite: For example:

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
PC2: 8A-10A RSP: 10A-8P NS: 8P-8A	PC2: 7A-8A DAY SVS:8A-3P RSP: 3P-10P NS: 10P-7A	PC2: 7A-8A DAY SVS:8A-3P RSP: 3P-10P NS: 10P-7A	PC2: 7A-8A DAY SVS:8A-3P RSP: 3P-10P NS: 10P-7A	PC2: 7A-8A DAY SVS:8A-3P RSP: 3P-10P NS: 10P-7A	PC2: 7A-8A DAY SVS:8A-3P RSP: 3P-10P NS: 10P-7A	PC2: 8A-10A RSP: 10A-8P NS: 8P-8A

recom. 40 hours) = 172 hrs month of respite
keep respite as is during wk 31 hours
requesting 11 hrs S+S reduce to 9 hours
for both S+S

Sunday [redacted], NS 9p-8a

Monday PCA 7a-8:30a [redacted] PCA 1:30p-6:00p PCA 3:30p-6p [redacted], NS 9p-7a

Tuesday PCA 7a-8:30a AC 9a-1p [redacted], PCA 3:15p-6:00p, [redacted], NS 9p-7a

Wednesday PCA 7a-8:30a [redacted] PCA 1:30p-6p, [redacted], NS 9p-7a

Thursday PCA 7a-8:30a AC 9a-1p [redacted], PCA 3:15p-6p, [redacted], NS 9p-7a

Friday PCA 7a-8:30a AC 9a-1p [redacted], PCA 3:15p-6p, [redacted] NS 9p-7a

Saturday [redacted] NS 9p-8a

31 + 8 = 39 = 40

Sunday
Monday
Tuesday
Wednesday
Thursday
Friday
Saturday

Same as above

31 (a)

Justification ***(Describe how the requested hours would meet a documented need and the consequences of the service not being provided)*:** ____

Suzanne D. Yankouty
Service Coordinator

1/18/10
Date

Suzanne D. Yankouty
Service Coordination Supervisor

1/18/10
Date

Suzanne D. Yankouty
Executive Director/Designee

1/18/10
Date

MR/RD Form REXCP (10/09)

DDSN Approval

District Office

Amount of Respite Approved: Modified to 172 HRS monthly

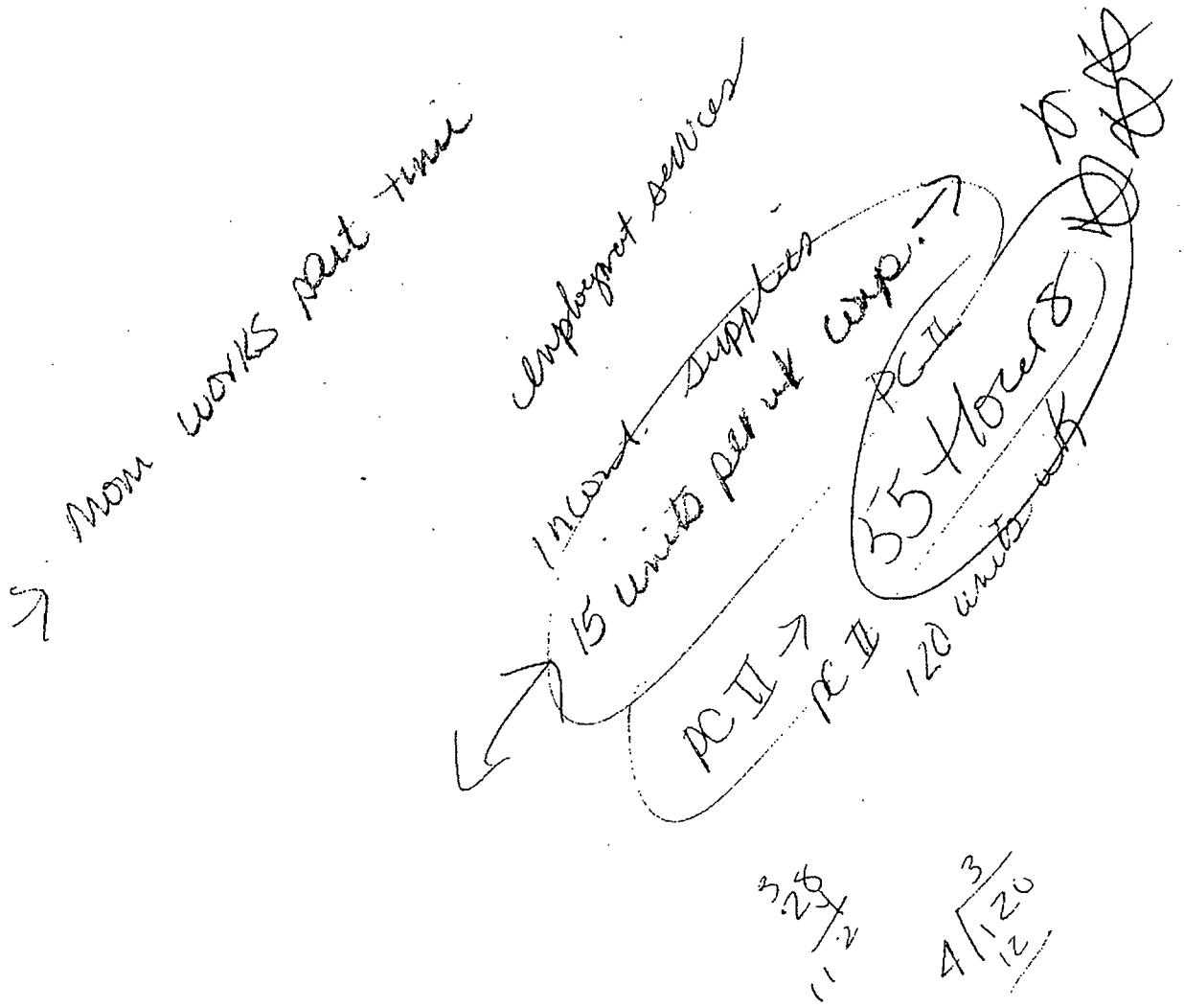
District Director

2/1/10
Date

MR/RD Form REXCP (10/09)

Richard Stogsdill is a [redacted] and relies on the assistance if others to complete all activities of daily living and personal hygiene. Richard's parents are the primary caregivers and provide assistance to help Richard complete activates of daily living and hygiene tasks at the end of the day and throughout the night. Richard will call out to his parents during the night to go to the bathroom or if he does not feel well. Mr. and Mrs. Stogsdill have both had to alter their work schedules in order to ensure that there is someone with Richard at all times.

Mr. and Mrs. Stogsdill have not been able to visit with family and friends or have a vacation for them as they need to make sure that Richard is cared for. On the weekends, there is no support for Richard in the house so Mr. and Mrs. Stosgdill must ensure that one of them is home with Richard or take Richard with them where ever they go. Richard has expressed wanting to spend more time on the weekends with other people and to be able to go out and do activities that are being held and so he can meet people his own age.



SOUTH CAROLINA DEPARTMENT OF
DISABILITIES AND SPECIAL NEEDS

FAX

TO: Jacob Chorley

FROM: Dawn Shealy

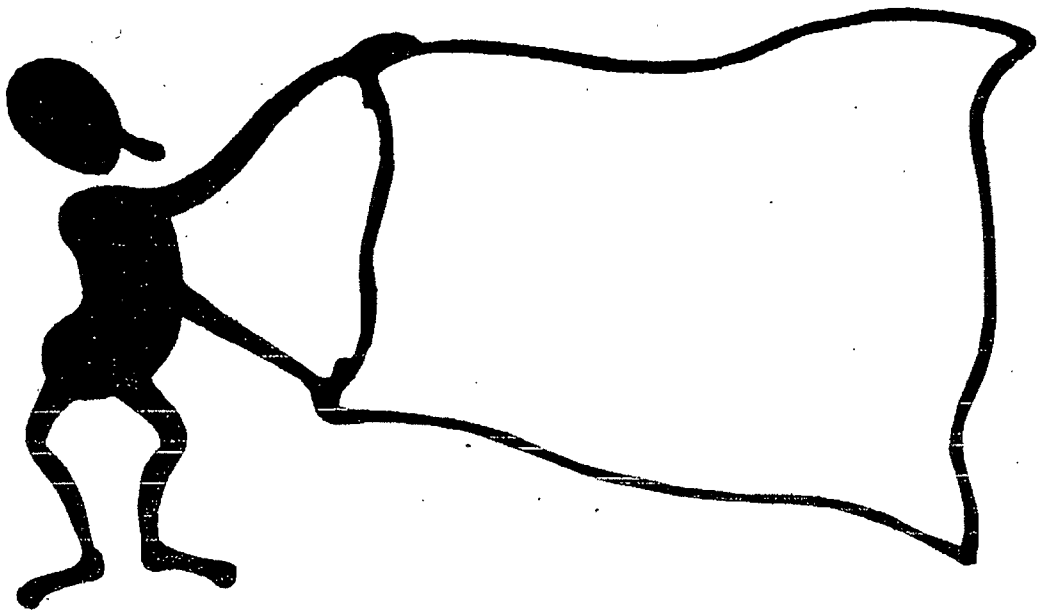
FAX #:

FAX #: (864) 938-3435

TELEPHONE:

DATE: 5/7/10

MESSAGE



THIS FAX HAS A TOTAL OF _____ PAGES
INCLUDING THE COVER SHEET.

Hwy 76 East - P.O. Box 239 - Clinton, S.C. 29325

The Arc

The Arc of South Carolina
Advocating for the rights of citizens with special needs since 1957

To: Dawn Shealy
Fax Number: (864) 938-3435

Phone: 803-748-5020
Fax (803) 445-1024

Date: 1/28/10

Regarding: Richard Stogsdill
Total Pages including Cover Sheet: 11

Comments:

CONFIDENTIALITY NOTICE

The documents accompanying this telecopy transmission contain confidential information belonging to the sender. The information is intended only for the use of the individual named above. If you have received this fax in error, please notify this office at (803) 748-5020, to arrange for the return of the original document.

Eugene A. Laurent, Ph.D.
State Director
David A. Goodell
Associate State Director
Operations
Kathi K. Lacy, Ph.D.
Associate State Director
Policy

SOUTH CAROLINA Department of Disabilities AND Special Needs

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Vice Chairman
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Susan K. Lait
Deborah C. McPherson

3440 Harden Street Ext (29203)
PO Box 4706, Columbia, South Carolina 29240
V/TTY: 803/898-9600
Toll Free: 888/DSN-INFO
Website: www.ddsn.sc.gov

To: DDSN Board Executive Directors
Contracted Providers of Service Coordination and Day Services
Service Coordination Supervisors
Day Services/Program Directors

From: Angela Syphertt AD 1/09
Director of Service Coordination and Plan Development
Jerry Junkins JJ 1/09
Program Coordinator, Day Services

Date: November 6, 2009

RE: Community Supports Waiver and New Day Services Information Sessions

---

As requested by the Service Coordination Committee, information sessions are being provided to clarify issues and questions regarding the Community Supports Waiver and Day Services We apologize for the short notice, but the goal is to convene Day Program and Service Coordination supervisory staff as close to the end of November 2009 as possible in order to meet implementation deadlines. Please note the following dates/locations for the sessions:

Pee Dee Region November 17, 2009
Pee Dee Center
Staff Development Training Room 1
Conference Room
714 National Cemetery Road

Piedmont Region November 20, 2009
Whitten Center,
Regional Center Annex,/Health Services
Conference Room

Midlands Region November 30, 2009
DDSN Central Office
Conference Room 251

Coastal Region December 3, 2009
DDSN District II Office, Room 2
Coastal Center

NOTE: Sessions for all locations listed above will be from 10:00 am to 12:00 pm.

Participants will be responsible for taking the information back to their agency for appropriate implementation and training staff. It is not necessary to register for the sessions; however, send only staff as previously mentioned above due to limited space. If the date and time designated for your region is not convenient, you may attend another date/time.

Thank you.

ALS/als

cc: Felita Martino Kim Miller Rufus Britt John King

RESPONDENT'S EXHIBIT #4

DISTRICT I
P.O. Box 239
Clinton, SC 29325-5328
Phone: (864) 938-3497

Midlands Center - Phone: 803/935-7500
Whitten Center - Phone: 864/833-2733

9995 Miles Jamison Road
Summerville, SC 29485
Phone: 843/832-5576

DISTRICT II
Coastal Center - Phone: 843/873-5750
Pee Dee Center - Phone: 843/664-2600
Saleeby Center - Phone: 843/332-4104

CSW and Day Services Information

November 30. 2009
Midlands Region – Central Office
10:00-12:00 PM

Name	Agency
[illegible]	Dillon
WENDY DERRICK	BURTON Center
Lorraine Rosa	Marlboro DSN
Molly Lutzyniuk	Delmarva
Suzanne Jankowitz	The ARC of SC
Caryn Troxler	Delmarva
[illegible]	Babcock Cent
Meg Ivey	Aiken DSN
Karen Brazell	"
Tyjah Burt	"
Renee Staggs	Tri County Ind Cntr
Nikki Bratcher	Chester-Lancaster DSN
Vivian M Rivera	Cliffwoods Academy
Ruby Norman	Kershaw DSN B
[illegible] (DSC)	Kershaw DSNB
Mary Criddine	District II
Shirley Kennedy	Fairfield DSNB
Leslie Adkins	Palmetto
Derlene Williams	"
BECKY SWEARINGEN	FAIRFIELD DSN

CSW and Day Services Information

November 30. 2009
Midlands Region – Central Office
10:00-12:00 PM

Name	Agency
Missy O'Cain	Calhoun DSN
[illegible]	Babcock Center
Lori Moms	Rich/Lex DSN Board
Veronica Lewis	Kershaw
Tyran Burt	Aiken Co Dept of Disabilities
Karen Bracell	Aiken Co Dept.
Dawn Shelley	District I / DDSN

STATE OF SOUTH CAROLINA)	BEFORE THE APPEALS DIVISION OF THE SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
COUNTY OF RICHLAND)	
Richard Stogsdill,)	
Petitioner,)	BRIEF ON APPLICABILITY OF ADA SECTION 504, *OLMSTEAD* AND VIOLATION OF DUE PROCESS RIGHTS OF RICHARD STOGSDILL
vs.)	
South Carolina Department of)	
Health and Human Services,)	10 MISC 42 (MR/RD)
Respondent)	

APPEALS & HEARINGS
RECEIVED
JUN 01 2010
SCDHHS

TO: Mr. W. Jefferson Bryson, Hearing Officer, Division of Appeals and Hearings, South Carolina State Department of Health and Human Services and Richard Hepfer, Esq., Attorney for SCDHHS

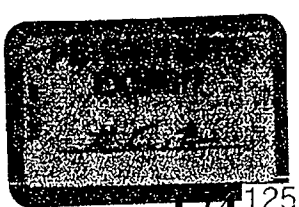
FACTS

Richard Stogsdill finished high school at age 21. While in school, Richard received physical therapy, occupational therapy and speech and language services. When Richard turned age 21, the South Carolina Department of Vocational Rehabilitation (VR) evaluated Richard and, at the time of his 2009 fair hearing, he was receiving services from VR. He was no longer receiving services through the school system.

Richard's approved plan of care dated January 21, 2009 included 2,240 units a year of hourly respite services, in addition to 52 units of "daily respite" (24 hours each day). In total, Richard's plan contained the equivalent of 67 hours per week of respite services, but these services could be used on an annual basis. So, for example, if his mother had surgery or needed to attend business out-of-town, Richard could use respite services to cover all times during the day when he was not receiving other waiver services, even though the number of hours exceeded 67 hours that particular week, so long as he did not exceed his annual allocation.

2009 Appeal

This matter was initiated by Richard Stogsdill's request for a fair hearing, which was filed with SCDDSN on February 13, 2009, with an appeal to SCDHHS taken on April 1, 2009. Petitioner requests that the testimony and records from that appeal be incorporated by reference into the record in this appeal. A hearing was held on June 29, 2009 before a SCDHHS hearing officer, which resulted in an order dated November 16, 2009, remanding Richard's appeal to SCDDSN. That order addressed issues related to Richard's need for personal care attendant services, respite services and adult companion services as is set forth below.



Personal Care Attendant Services. In the November 16, 2009 order, the hearing officer made finding of fact that SCDDSN failed to solicit input from Richard's treating physician in determining his need for personal care attendant services. Order dated November 16, 2009 at 5. The hearing officer made findings of fact that Richard's physician, who had treated Richard "since he was a young child," determined that he required a minimum of two personal care aides for eight hours per day (sixteen hours total per day of personal care attendant services.) Id at 5 to 7. The hearing officer concluded that SCDDSN erred in failing to solicit input from Richard's treating physician in determining how many personal care hours were medically necessary. Id. at 7. In that order, the hearing officer also concluded that :

> The "People Providing Input" were not "fitted (as by training or experience)" for the care planning purpose.

The hearing officer found that it was necessary to have 'qualified individuals' to determine Richard's need for personal care services. Id. at 7. The order takes notice that there was no 'licensed medical or nursing care provider' whose treatment opinions were considered in developing Richard's plan of care. The hearing officer ordered SCDDSN to consider Dr. Joseph's June 29, 2009 affidavit in determining whether Richard is entitled to receive additional personal care services, taking into consideration medical necessity and utilization control procedures. 42 C.F.R. 440.230.

Respite Services. The hearing officer determined on November 16, 2009 that "the level of respite services authorized in the 2009 plan of care was appropriate." November 16, 2009 Order at 8. (See also finding of fact at page 5 of order: "Petitioner's treating physician stated in his June 29, 2009 affidavit that the level of respite services included in the 2009 plan was appropriate, and I so find.") This finding was not appealed by Respondent.

Adult Companion Services. The hearing officer determined in the November 16, 2009 order that Adult Companion Services are "non-medical care, supervision and *socialization*, provided to a functionally impaired adult." Order at 8. That order concluded that "...the DDSN Service Coordinator should have recognized the need for Adult Companion services as articulated by Petitioner and Petitioner's guardian and included an appropriate level of such services in the January 2009 annual care plan for Petitioner." Order at 9. The hearing officer remanded Richard's appeal to DDSN "for additional care planning that takes Petitioner's and Petitioner's guardian's clear statements about socialization into account." Id.

On remand, SCDDSN assessed Richard's needs and determined that Richard needed 15 hours a week of Adult Companion Services to meet his need for socialization and 55 hours a week of personal care attendant services (approximately half the number of personal care hours recommended by Richard's physician). The record is silent as to how SCDDSN determined that Richard required fewer hours of personal care services than had been ordered by his physician. The record does show, however, that Richard was receiving 67 hours a week of respite services (daily and hourly combined), an amount determined by SCDDSN in 2009 to be appropriate and

confirmed by Richard's physician to be necessary, in addition to 55 hours of personal care services and 15 hours of adult companion services per week.

Amendment of MR/RD Medicaid Waiver Was Not a Change in Law

In December of 2009, SCDDSN notified waiver participants by a general letter sent to all participants of the program that some services would be reduced and others would be eliminated effective January 1, 2010. The agency provided training at local DSN Boards. The changes to the MR/RD Medicaid waiver program were not based on a change of state law or regulation. Indeed, SCDDSN and SCDHHS have not promulgated regulations for the operation of the MR/RD Medicaid waiver program. No action was taken by the South Carolina General Assembly to approve these drastic modifications to the MR/RD Medicaid waiver program.

Emma Forkner, the Director of SCDHHS, waited until after the General Assembly had adjourned for the year before requesting permission from CMS (the federal Medicaid agency) to amend the MR/RD Medicaid waiver. On June 11, 2009, Ms. Forkner wrote a letter asking CMS (the federal Medicaid agency) to eliminate some MR/RD Medicaid waiver services and requested permission to place caps on other services. She informed CMS in this letter that SCDHHS had been "working diligently" with SCDDSN to develop the waiver amendment since October 2008. These changes were not approved by the South Carolina General Assembly, indeed, there is no evidence in the record that the members of the General Assembly were ever informed of her intent to drastically reduce waiver services. Ms. Forkner requested an implementation date for the proposed MR/RD Medicaid waiver amendments prior to the return of the General Assembly. CMS granted her request to amend the MR/RD Medicaid waiver effective January 1, 2010.

"Input" from the public and affected organizations and parties was not obtained until after the decision was made to reduce services. At no time did SCDDSN or SCDHHS perform a cost analysis to consider the costs of alternatives services which would be needed once waiver caps were put into place. The correspondence from Interim Director of SCDDSN, Dr. Eugene A. Laurent, to local DSN Boards tells another story about public involvement before SCDHHS decided to eliminate physical therapy, occupational therapy and speech and language services and reductions in personal care services, respite and adult companion services. Petitioner's Exhibit 20. In this memo, titled "Apology," on June 9, 2009, Dr. Laurent admits that these changes were made without involving the County DSN Boards or even informing them that the proposal was going to the Commissioners of SCDDSN. Dr. Laurent states: "Again, the executive staff and I apologize. We will do better." Id. Emma Forkner sent her letter to CMS two days later, on June 11, 2009, requesting reductions in the MR/RD Medicaid waiver.

In addition to having no basis is a change of state law, the amendments to the MR/RD Medicaid waiver which took effect on January 1, 2010 were not based on any change in federal law. In fact, during the time Ms. Forkner and her staff had been "working diligently" on the waiver, the federal government passed the American Recovery and Reinvestment Act (ARRA) which provided SCDDSN $34 million in additional federal stimulus dollars to maintain Medicaid programs and jobs for workers affected by state budget reductions. During FY 2009, SCDDSN receive an additional $50 million in federal stimulus dollars. The purposes of Section 5001 of the ARRA was (1) to provide fiscal relief to States in a period of economic downturn,

and (2) to protect and maintain State Medicaid programs during the period of economic downturn including by helping to avert cuts to provider paymnet rates and benefits or services..." ARRA Section 5001(f0(3). Most of these federal stimulus funds received by SCDDSN were paid to the "Medical Care Maintenance of Effort Fund," which was a rainy day fund, instead of using the funds for the intended purpose of maintaining Medicaid services.

CMS has never denied a State's request to amend a Medicaid waiver, according to *Knowles v. Horn,* 3:08-cv-1492-K (ND Texas 2010). In that case, the federal district court noted that CMS has "never denied a single waiver application in the past ten years." Citing *Grooms v. Maram*, 563 F. Supp. 2d 840, 857 (N.D. Ill. 2008). Other states have not considered CMS' approval of a request to reduce services as determinative of whether the changes violated either the Medicaid Act or the ADA and Section 504.

Failure to Provide Notice Meeting Requirements of 42 C.F.R. 431.210

Richard never received a written notice that his services would be reduced or terminated after Ms. Forkner decided to eliminate some waiver services and to place caps on other waiver services. There is no evidence in the record showing that Respondent ever provided Richard with a written notice of reduction/termination of services meeting the clear mandates of 42 C.F.R. 431.210. That regulation does not allow compliance by providing generic notices without informing waiver participants of the regulations and/or change in state or federal law that justifies the change in services. Providing a general notice to all waiver participants and training sessions on the reductions established by Emma Forkner, director of SCDHHS, without a change in law or regulation, simply does not satisfy due process or these regulatory requirements. This regulation requires Respondent to provide a written individual notice that includes the *specific regulations* that support the change in services or the change in Federal or State law that requires the action. No such written notice was ever sent to Richard Stogsdill.

When Richard received a verbal warning from the local DSN Board of that agency's intent to reduce his waiver services, he filed a request for a reconsideration with SCDDSN on December 30, 2009 to avoid having his services reduced without prior notice, as the local Board was threatening to do. Dr. Buscemi, Director of SCDDSN denied Richard's request and informed him that her agency intended to reduce his services, without citing a regulation, or a change in state or federal law to support her decision. The only explanation given was that CMS approved the reductions and the "approved limits" cannot be exceeded.

Termination of Richard's Personal Care Attendant, Specialized Medical Equipment, Supplies and Assistive Technology Benefits

On January 11, 2010, the local DSN Board sent a notice of termination of Richard's services to the providers of Richard's services, but not to Richard. Richard's Service Coordinator, who is an employee of the Kershaw County DSN Board, sent the providers of his Medicaid services, equipment and supplies these notices of termination of his services. *See* SCDDSN MR/RD Medicaid Waiver Notice of Termination of Service. The reason the SCDDSN Service Coordinator gave for terminating Richard's services was "Participant moved out of state." Richard's mother testified that he has lived in the same residence for years. The record is devoid of evidence that Richard moved from his home of many years, much less out of the state.

Applicable Legal Standards

Because Respondent failed to comply with 42 C.F.R. 431.210, Richard has been left to guess at what legal standard the SCDHHS Office of Appeals and Hearings will apply in deciding his appeal. This violates Richard's due process rights contained in the United States Constitution and the clear mandate of 42 C.F.R. 431.205.

The Office of Hearings and Appeals claims that it is not bound to consider the order of the United States Supreme Court in *Olmstead v. L.C.*, or the Americans with Disabilities Act (ADA) or Section 504 of the Rehabilitation Act. 527 U.S. 581 (1999). SCDHHS seems to suggest that the hearing officer can base his decision on state agency policy, which has not been promulgated as a regulation or enacted as a statute. It is unclear upon what regulation or law that Office considers relevant in this appeal. There is no legal basis for refusing to allow Richard to make arguments and to present evidence that Respondent has violated the United States Supreme Court order in *Olmstead,* Congressional statutory directives established in the ADA and Section 504 and the integration mandate contained in the federal regulations implementing the ADA and Section 504. See also Executive Order 12250, 45 Fed. Reg. 72995 (1980), reprinted in 42 U.S.C. 2000d-1. The Attorney General issued 28 C.F.R. 35.130(d), requiring public entities to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." The preamble to these regulations contemplates that "the most integrated setting" is one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible, and that persons with disabilities must be provided the option of declining to accept a particular accommodation. 28 C.F.R. 35.130(d), App. A., at 571 (2009). Richard must be given the opportunity to present evidence that these federal mandates have been violated.

In deciding a fair hearing appeal, the hearing officer must give greatest weight to the applicable federal statutes, which are contained in the Medicaid Act, the ADA and Section 504. Of second most importance are the federal regulations contained in 42 C.F.R. 430 et seq. and the regulations implementing the ADA and Rehabilitation Act promulgated by the United States Department of Justice. Thirdly, the hearing officer must consider directives of CMS, the agency responsible for administering federal Medicaid programs, and the United States Department of Justice, the federal agency with oversight responsibility for the ADA and Rehabilitation Act.

The hearing officer may consider State law only where it does not conflict with federal laws, regulations or directives of CMS and the United States Department of Justice. State regulations, where they do not conflict with federal law, may then be considered, with agency policies having the least weight. Where State law, regulations or policies conflict with federal law, regulations or directives, they are preempted by the Supremacy Clause of the United States Constitution. State regulation § 126-399 titled "Conflict Between State and Federal Regulations" also correctly provides that "When the requirements of the State and the Federal regulations are not in agreement, the requirements of the Federal regulations shall prevail."

States are not required to participate in the Medicaid home and community based waiver programs, however, once a state accepts federal funding for these programs, it must comply with all federal statutes, regulations and directives of federal agencies. *Doe v. Kidd,* 501 F.3d 348, 354 (4th Cir. 2007), *cert.* denied,. 128 S. Ct. 1483 (2008). Respondent must comply with federal regulations contained in Subpart E of Title 42 C.F.R. 431.200 et seq., as well as other federal

laws and regulations. A hearing must be provided to any person whose claim for services is denied or when the participant claims that the "agency has taken an action erroneously." 42 C.F.R. 431.220(a(2). Richard alleges that Respondent took action erroneously by failing to consider the directives of *Olmstead,* the ADA and Section 504. At the hearing, the Medicaid participant must be allowed to "Present an argument without undue interference..." 42 C.F.R. 431.242.

In a pre-hearing brief, counsel for Respondent argued that the agencies were in compliance with the Americans with Disabilities Act (ADA), the Rehabilitation Act (Section 504) and the American Recovery and Reinvestment Act (ARRA). Obviously, Respondent's counsel considers the ADA, Section 504 and the ARRA to be relevant to this appeal. It was legal error to refuse to allow Richard to present evidence at an evidentiary hearing to show that reduction in his services is prohibited by the ADA, Section 504 and the ARRA. Courts around the country have prohibited Medicaid agencies from reducing services based on violations of the Medicaid Act, ADA and Section 504.

Moore v. Medows

In our sister state of Georgia, in *Moore v. Medows,* the district court granted the plaintiff's motion for summary judgment when the state reduced Anna Moore's nursing services from 94 to 84 hours a week. Case 1:07-cv-00631-TWT (N.D. Ga. December 9, 2009). The Eleventh Circuit remanded, however, the district court again upheld Moore's claim, requiring the state to maintain the Medicaid services Moore needs to remain at home. In that case, like the present case, the state argued that the reductions should be upheld because CMS approved the Georgia Pediatric Program. The district court disagreed, requiring the Georgia Medicaid Program to continue Moore's nursing services at 94 hours a week.

Marlo M. v. Cansler

Just across South Carolina's northern border, in North Carolina, in *Marlo v. Cansler*, the federal court prohibited the state from reducing the around-the-clock services the plaintiffs received in their own homes. Case 5:09-cv-00535-BO (E.D.N.C. December 14, 2009 and January 17, 2010), 2010 WL 148849. As in South Carolina, the state attempted to reduce services alleging budget reductions. However, the United States Department of Justice filed an Amicus brief supporting plaintiffs' claims that reductions of their services would violate the ADA and Section 504. Exhibit 22. The federal court refused to allow the state to reduce home-based services based on violations of the ADA and Section 504. The district court first granted an emergency temporary restraining order, then granted a preliminary injunction prohibiting the state from reducing home-based services.

Crabtree v. Goetz

In *Crabtree v. Goetz*, the State of Tennessee sought to impose limitations on waiver services through an act passed by its legislature. No. 3:08-0939, 2008 WL 5330506 (M.D. Tenn. Dec. 19, 2009), 6 2008 WL 5330506, * 30. The *Crabtree* plaintiffs were individuals with serious disabilities who, like Richard, need extensive care and assistance. They filed suit against Tennessee state Medicaid officials, alleging that they were violating Title II of the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act (Section 504) because they (1) failed to provide services in the most integrated setting appropriate; and (2) employed methods of administration that result in discrimination on the basis of disability.2

Before the reductions, waiver participants in Tennesse were provided with up to 24 hours a day, seven days a week of home health and nursing services. Relying upon *Olmstead*, the court recognized that "[u]nder the ADA," the opinion of a responsible treating physician must be given "the greatest of deference." The Court also found that the reductions were not allowable because the State had made no individualized assessment of the Plaintiffs' needs before making the cuts. The judge in *Crabtree* rejected the State's contention that continuing to provide services to Plaintiffs in the community would be a fundamental alteration to the TennCare program. It reasoned that the cost of continuing home health and nursing care for the 22 plaintiffs would "be only a fraction of the $50 million that Defendants identify as necessary for the changes Tennessee proposes." The Court ordered that the Defendants (1) refrain from imposing the cuts, (2) conduct individualized assessments of the Plaintiffs to determine the specific needs of each Plaintiff, including the amount of time required to meet those needs, and the extent to which family or other natural supports are available, and whether the needs could be satisfied in the community at less cost than Defendants are presentlypaying; and (3) determine whether nursing homes will in fact provide the services. The court was not swayed by the fact that CMS had approved the waiver service reductions in refusing to allow reductions to services.

Fischer v. Oklahoma Health Care Auth.

In *Fisher* v. *Oklahoma Health Care Auth.*, the plaintiffs, like Richard, were receiving Medicaid-funded medical care through a Medicaid home and community based waiver program. 335 F.3d 1175, 1177(10th Cir. 2003). When the State decided to limit the number of prescription medications that participants could receive, plaintiffs sought a preliminary injunction, arguing that the change in policy violated the integration mandate of Title II because it would force them out of their homes and into institutions. *In Fisher,* the court concluded that the ADA's integration mandate applies equally to those individuals already institutionalized and to those at risk of institutionalization. The Tenth Circuit held that "*Olmstead* does not imply that disabled persons who, by reason of a change in state policy, stand imperiled with segregation, may not bring a challenge to that state policy under the ADA's integration regulation without first submitting to institutionalization." *Fisher*, 335 F.3d at 1182. The threat that Richard needs these services to remain out of an institutional setting is not "speculative." He can take care of none of his personal care needs because of his disability and requires around-the-clock care which his parents are unable to provide. (Nor do parents of an adult child have a legal duty to provide care for the child.) Under the reasoning of *Fisher*, Richard does not have to endure the hardship of moving to an institution before exerting his ADA and Section 504 rights.

Radaszewski v. Maram

In *Radaszewski v. Maram*, the plaintiff received around-the-clock services, including 16 hours a day of nursing services until he turned 21. 383 F.3d 599 (7th Cir. 2004). The adult Medicaid waiver program he transitioned to at age 21 contained caps that would not provide the 16 hours a day of nursing services he needed. He alleged violation of the ADA and Section 504's integration mandate. The Seventh Circuit reversed the lower court's dismissal, finding "the integration mandate may well require the state to make reasonable modifications to the form of existing services in order to adapt the to community-integrated settings." 383 F.3d at 611. On remand, the district court determined that the state's failure to fund at-home, private duty nursing

was disability discrimination and the court ordered the state to cover the 16 hours of nursing services Radaszewski had been receiving before reaching age 21. Despite the fact that the state had rules prohibiting the provision of these services, the district court found that home and community based services could be provided to the plaintiff as a reasonable accommodation and it rejected the states's claim that this would result in a fundamental alteration in the program. As in *Radaszewski,* there is "little doubt" that Richard can be cared for at home, because he has been receiving care at home all his life.

Due Process Violations

SCDHHS must continue Richard's services until a notice meeting the specific requirements of 42 C.F.R. 431.231 is provided to Richard and he is provided a hearing at which has ability to present his argument without undue interference is granted. At the hearing in May 2010, Richard was required to guess at what statutory or regulatory basis the change of services was based upon. In fact, counsel for Respondent filed a brief just days before the hearing arguing that Respondent had met requirements of the ADA and the Rehabilitation Act, then at the hearing, the hearing officer refused to allow Richard to present evidence or argument that these same federal laws have been violated. This was a clear violation of Richard's due process rights guaranteed by the United States Constitution, as well as by *Goldberg v. Kelly*, 397 U.S. 254 (1970). If the ADA and Rehabilitation Act were not within the jurisdiction of the hearing officer, why did the agency's counsel base his arguments on these federal laws?

The ADA, Section 504 and the Supreme Court's decision in *Olmstead* are very relevant to this case. To prevail, Richard must show that he is a "qualified individual" with a disability, the State's treating professionals have determined that community placement is appropriate, that Richard does not oppose treatment in the community and that the services Richard requests can be provided without a "fundamental alteration" of the state's services and programs. It is undeniable that Richard is a qualified individual, SCDDSN has determined for years that his needs can be met in the community and it is unquestioned that he does not oppose community treatment. The only issue in this case is whether the State can prove that providing these services would cause a "fundamental alteration" in the way the State delivers services. In considering the fundamental alteration defense, the tribunal may consider the resources of the State and the needs of others who have comparable disabilities. *Olmstead*, *supra*.

Just last year, the Office of Hearings and appeals agreed with Richard's physician that he needs 67 hours a week of respite services (43 hours per week, in addition to 52 units of "daily respite" - a period of 24 hours). SCDDSN evaluated Richard on remand and determined that he requires 55 hours a week of personal care services, in addition to 15 hours a week of adult companion services. Respondent claims that these services must be capped, without an individualized assessment of need, due to budget reductions. Richard must be provided with the opportunity at a fair hearing to present evidence and arguments showing that the "budget reduction" explanation of Respondent is a pretext and that, in fact, the reductions in services will actually result in greater costs to the State. *Disability Advocates, Inc. v. Paterson,* 598 F.Supp.2d 289. Richard's services (55 hours/week pca, 15 hours/week acs and 67 hours a week of respite) cost $249 per day, compared to the cost of an ICF/MR of $320 per day. Exhibits 15 and 33. The hearing officer erred in prohibiting Richard from presenting evidence showing that Respondent and SCDDSN improperly transferred stimulus funds to a rainy day account, that at the time these

service reductions were approved and that SCDDSN had $7.8 million in an excess funds account in September 2009 that could have used to prevent the reductions, but was instead improperly used to purchase real estate.

Richard should also be allowed to introduce evidence that the "budget reduction" explanation was not legitimate because SCDDSN has not reduced the capitated payments made to local DSN Boards. There can be no "savings" where the band payments made to local DSN Boards were not reduced when the home based service caps were imposed. Richard should be allowed to demonstrate that the amendments were purposefully to maintain the monopoly DSN Boards have maintained for years by reducing access to services provided by private providers.

Respectfully submitted,

Patricia L Harrison
611 Holly Street
Columbia, South Carolina 29205

Attorney for Richard Stogsdill

May 1, 2010

Columbia, South Carolina

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

July 13, 2009

Ms. Bonnie D. Loomis, Hearing Officer
SC Department of HHS
c/o Pincus and Loomis, LLC
3306 Millwood Ave.
Columbia, SC 29205

Re: Richard Stogdill v. DHHS Case #09-MISC-017

Dear Ms. Loomis:

Enclosed for your consideration, is the Department's Post-hearing Brief in this matter. Please take this letter as my certification that a true and correct copy of this Brief, with the attachments has been sent to Ms. Patricia Harrison, 611 Holly Street, Columbia, SC 29205.

If there are questions, please do not hesitate to contact me. My direct line is (803) 898-2791.

Sincerely,

Richard G. Hepfer
Deputy General Counsel

Enclosure

cc: Ms. Patricia Harrison, Attorney for Petitioner
Ms. Tana Vanderbilt, Attorney for DDSN
Mr. George Maky, Div. of CLTC Waiver Mangmt.

Office of General Counsel
P. O. Box 8206 Columbia South Carolina 29202-8206
(803) 898-2795 Fax (803) 255-8210

STATE OF SOUTH CAROLINA COUNTY OF RICHLAND Richard Stogsdill, Petitioner, -v- State Department of Health and Human Services, Respondent.	)	BEFORE THE HEARING OFFICER OF THE STATE DEPARTMENT OF HEALTH AND HUMAN SERVICES POST-HEARING BRIEF OF RESPONDENT 09-MISC-017

TO: Ms. Bonnie D. Loomis, Hearing Officer, South Carolina Department of Health and Human Services, c/o Pincus and Loomis, LLC, 3306 Millwood Ave., Columbia, SC 29205 AND Ms. Patricia L. Harrison, 611 Holly Street, Columbia, SC 29205.

Background:

On June 29, 2009, a hearing in this matter was held in the Kershaw County Board of Disabilities and Special Needs at 1619 Jefferson Davis Highway, northeast of the City of Camden, South Carolina. The Petitioner is a Medicaid beneficiary eligible to receive Medicaid covered services. The Respondent (DHHS) is the State agency that administers the South Carolina Medicaid Program. In this case, the Petitioner receives his services through a Home and Community Based Waiver called the "South Carolina MR/RD Medicaid Waiver" (Waiver). Day-to-day operation of the Waiver has been delegated to the South Carolina Department of Disabilities and Special Needs (DDSN).

The hearing was on an appeal of a reconsideration determination by the DDSN. On March 3, 2009,

Mr. Robert W. Barfield, the then Acting Director of DDSN, rendered that determination deciding that:

1) The DDSN had provided Mr. Stogsdill with reasonably prompt services;

2) The DDSN had provided care that was compliant with the orders of Mr. Stogsdill's physician;

3) The DHHS, not DDSN, was responsible for recruiting and enlisting Personal Care Service providers and therefore could not remedy that portion of the reconsideration request; and

4) The remaining issues were not relevant to Mr. Stogdill's specific case.

The Petitioner's original request and Mr. Barfield's determination are again attached, for convenience. As is his right, the Petitioner appealed Mr. Barfield's decision to the DHHS, the State Medicaid Agency, and the above mentioned hearing ensued. The Petitioner's Appeal is also attached.

Exchange of Post-hearing Briefs:

Some time had passed since the original request for reconsideration and the appeal to this forum, and the Petitioner was, due to the passage of time, compelled to raise issues not contemplated in his original appeal. The Hearing Officer kindly allowed the Petitioner to more fully explain those issues (and, presumably, expound upon the original issues) in a Post-hearing Brief to which the Respondent, as also allowed, now responds.

Criteria by which to Analyze the Issues:

The Petitioner has raised a number of issues. Some of the issues are theories about why the law compels DDSN to provide services and DHHS to ensure that services are provided to Mr. Stogsdill. Others of the issues raised by the Petitioner are apparently presented to show that funds wasted because of inefficiencies in State Government would be better spent on the Petitioner's home care. The Respondent respectfully suggests that both the new issues and the issues raised in the original

appeal be analyzed according to the following criteria:

Standing:

In order to bring an action against an agency in South Carolina, an individual must: 1) have suffered an injury-in-fact; 2) there must be a causal relationship between the injury and the agency conduct complained of; and 3) it must be likely that the relief requested will redress the injury. Sea Pines Ass'n for the Protection of Wildlife, Inc. v. S.C Dep't of Natural Res., 345 SC 594, 550 S.E. 2d 287 (2001). In that case, the residents complained that the Department of Natural Resources' decision to kill deer on Hilton Head Island would decrease the Plaintiff's opportunity to watch and enjoy wildlife. The South Carolina Supreme Court determined that their injury-in-fact due to the thinning of the herd was too conjectural to give them standing to contest the Department's decision. Of course, we do understand that South Carolina recognizes a public interest exception to this requirement of standing, but here the Petitioner has neither shown a breach of duty, nor a public interest which is clearly affected.

Therefore, we suggest that the initial question before the Hearing Officer is: How was the Petitioner aggrieved? What is his injury-in-fact? In a lot of ways the Petitioner starts his appeal against the Respondent's actions at the wrong end of the causal chain. He complains that the Respondent breached a statutory or regulatory duty (as he understands it), before he establishes his standing to complain of the breach. Unless he is bringing a declaratory judgment or some such action, the initial question has to be: How was he aggrieved? Administrative appeals are about how the agency action aggrieved the Petitioner. The Petitioner strenuously urges numerous theories by which he is entitled to the right, before he establishes that the right has been withheld. Assuming that a right has been withheld, it might then be appropriate to delve into questions about whether the Respondent has exceeded or violated its grant of authority.

Did the Respondent Breach a Duty?

The Petitioner asserts, without going into much detail, that the Respondent has a duty to operate according to the Petitioner's interpretation of the statutes and regulations. Often, the meaning of the statutes and regulations are at least in question and at most, diametrically opposed to the Petitioner's view. The issues raised by the Petitioner can be analyzed in terms of whether there is a clear duty. We would like to show that the law does not lead to the conclusions that the Petitioner would urge.

Relevance:

In South Carolina, relevancy is central to the law of evidence. Under 401 of the Rules of Evidence:

> "Relevant evidence" means evidence having any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence.

Relevancy requires a logical relationship between the proposed evidence and a fact to be established. Levy v. Outdoor Resorts of South Carolina, Inc., 304 S.C. 427 (1991). The core issue in this case is whether Mr. Sogsdill's needs were being met with the 50+ hours of Personal Care Aide and other services he is receiving. Strictly speaking, under the Medicaid Fair Hearing Regulations at 42 CFR §431.200 et seq., the DHHS is required to provide an evidentiary hearing to anyone whose services have been denied, or suspended, terminated, or reduced. 42 CFR §431.200. If indeed, Mr. Stogsdill's services were denied, or suspended, terminated, or reduced, then in this case the most weight (or relevance) should be assigned to the evidence that tends to show whether that action on the part of the agency was correct according to his needs. In the Respondent's view, that means looking at the situation to see what levels of service are reasonably needed.

Issues Raised at the Hearing:

The Need for Adult Companion Services: The Petitioner asserts that this has been a pending request

which has not been dealt with, and, therefore, should be cognizable in this hearing. However, the evidence indicates otherwise. The testimony of the Service Coordinator, Kimberly Bennett indicated that in addition to the hours of Personal Care Aide services, the Petitioner has been attending Vocational Rehabilitation training during the day. The testimony also indicated that the training would be ending shortly. The Affidavit of the counselor, Lennie Mullis, indicates that an assessment had been requested by the Kershaw DSN Board, and the assessment was performed on June 3, 2009. Part of the recommendation of the counselor was that Mr. Stogsdill begin to receive Adult Companion Services now that his Vocational Rehabilitation training was ending. Certainly that assessment should be taken into account in Mr. Stogsdill's care planning. If not clear to the Kershaw County staff, then that could certainly be made clear in the Hearing Officer's Decision.

However, even if the Kershaw County staff and the Service Coordinator, Ms. Bennett, had already had a copy of the assessment, which they did not, it could hardly be expected that with the hearing pending and the transitional nature of Mr. Stogsdill's care, that the Service Coordinator and her supervisors would have a chance to review the counselor's assessment for the purpose of care planning. Therefore, there has been insufficient time for a deliberate decision to have been made on Mr. Stogsdill's need for Adult Companion Services, and he does not have standing to raise the issue, because he has not been aggrieved by an agency decision. Certainly, it would not be amiss for the Hearing Officer's Decision to encourage or even require the County Board to take the assessment into account during Mr. Stogsdill's next care plan.

Due Process Concerns: The Petitioner complains that the Respondent and it agents violated 42 CFR §441.302(d) by not offering Adult Companion Services as a feasible alternative. The Petitioner further complains that Dr Kathy Lacy, the Associate Director of DDSN, withheld the MR/RD Waiver document from the Petitioner. The Petitioner finally complains that his attorney was not given timely access to his file in the Kershaw County office to adequately prepare for the hearing.

42 CFR §441.302(d) is set forth below:

(d) Alternatives--Assurance that when a recipient is determined to be likely to require the level of care provided in a hospital, NF, or ICF/MR, the recipient or his or her legal representative will be--

(1) Informed of any feasible alternatives available under the waiver; and

(2) Given the choice of either institutional or home and community-based services.

The Respondent believes that the plain meaning of this part of the regulation is that at the time a recipient shows the need for institutional care, alternatives under the waiver should be explained so the individual can decide whether to choose Wavier or institutional services. The Respondent can not read this section to mean that every discrete service has to be continuously explained to the recipient. That is not to say that appropriate services should not be discussed and explained during care planning, but as explained above, the Adult Companion Service has only just become an issue now that Mr. Stogsdill is ending his Vocational Rehabilitation training.

Dr. Lacy's letter is attached to the Petitioner's Post-hearing Brief as Exhibit 2. The Exhibit speaks for itself, but does not on its face seem to be a denial that a document containing the definition of Adult Companion Services exists. Furthermore, it appears that the document was provided to the Petitioner since portions of it are attached to his Post-hearing Brief, at Exhibit 1.

Apologies are certainly in order if the Respondent, its agents, or its attorney inconvenienced the Petitioner's attorney in her efforts to obtain documents. However, the remedy for any undue hardship encountered in preparing his case, is not to grant the basic relief requested by the Petitioner, but to cure any disadvantage caused by the hardship. This the Hearing Officer has done by granting the Petitioner additional time to prepare a Post-hearing Brief in which he argued additional issues, more fully explained the original issues, and submitted additional documents.

Cost Concerns: The Respondent has not raised any cost concerns. Indeed, any programmatic cost concerns to the MR/RD Waiver involve aggregate cost of the overall program as compared to the cost of the comparable institutional service. Obviously, that does not mean that superfluous services may be approved for the convenience of individual recipients or their families. Minimal medically

necessary service must be provided. Furthermore, it is the nature of a Waiver to apply pressure on the State to be fiscally responsible in authorizing services, for if, in the aggregate, the cost for the MR/RD Waiver services exceeds the cost of comparable institutional services, the Waiver cannot operate, and will not be approved by the federal governing agency. See the regulations at 42 CFR §441.354. Therefore, the Respondent asserts that the information presented at the hearing about the cost of individual ICF/MR services (testimony of Mr. Barfield), the indications about the diversion of funds to the workshops and purchases of real property and the cost which the State may have recently borne as a result of the Gubernatorial indiscretions are not relevant to this case.

Issues Raised Initially:

The Respondent's initial Brief contains the basic responses to the Petitioner's remaining issues, and the Respondent craves reference to that document. However, insofar as the issues were expanded upon and clarified at the hearing and in the Petitioner's Post-hearing Brief, the Respondent offers the following responses:

Reasonable Promptness: Again, it is true that §1902(a)(8) of the Social Security Act [42 USC §1396a(a)(8)] requires States to "...provide that all individuals wishing to make an application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals." The procedural posture of Doe v. Kidd 501 F.3d 348 C.A.4 (S.C., 2007) was set forth in the Respondent' original Brief. Again, the Respondent would direct the Hearing Officer's attention to the split among the circuits in the meaning of prompt furnishing of medical assistance, i.e., does it mean provision of services or the prompt readiness to pay for those services? Finally, the Respondent would like to point out one critical distinction between the Doe case and Mr. Stogdill's appeal: In the Doe case, the services in question were already approved in her plan of care. Doe, at 353-4. Here, there is no agreement about the services needed. Indeed, prior to the hearing, there was not even any indication that specific services had been requested and denied, or whether services

have been suspended, reduced or terminated. The core issue is whether the Petitioner needs the services requested and authorized, not whether approved services have not been provided promptly.

Reduction of Services: Again, there is no doubt that, under §1902(a)(3) of the Act, Medicaid beneficiaries have the right to a hearing if their services have been reduced suspended or terminated. However, in this case, it is questionable that such reduction occurred. In fact, the Service authorizations submitted at the hearing and attached as Exhibit 5 of the Petitioner's Post-hearing Brief, indicate that services have actually increased from 200 units of service per week (70 from Active Nursing and 130 from Home Remedies) to 210 units per week (90 from Active Nursing and 130 from Home Remedies).

Services Ordered by Physician: Again, physician's orders should be given great weight when determining the level of services authorized for a client. However, as Respondent said in its initial Brief and as the Affidavit of Dr. Joseph illustrates, physicians are natural advocates for their patients and, understandably, in an effort to make sure their patients receive adequate services, sometimes err on the side of excess. Having heard the testimony of Ms. Stogsdill and Mr. Stogsdill's aide, Mr. Todd, it appears to the Respondent that better use of assistive devices could easily reduce or eliminate the need for two (2) Personal Care Aides to be present at all times and substitute an Adult Companion for some of the times now covered by Personal Care Aides or Respite Care. Again, the Respondent does not believe that the law in this circuit favors the view that the attending physician's order (or the counselor's recommendations, for that matter) is necessarily dispositive about what care is needed. Certainly, the Service Coordinator and the supervisors and the other participants in the care planning (including the Petitioner's guardian) should give great weight to the wishes of the doctor, but the plan of care, as developed by that team is the controlling document. If there is an issue about the sufficiency of a particular services or services, redress is through the appeals process.

Provider Recruitment: Again, the State Medicaid Agency is responsible for enlisting sufficient

provider coverage so that its programs, as a whole, reasonably achieve their purposes. This issue was not explored in any depth at the hearing, except for the Service Coordinator's testimony that she had adequate care providers to tend to the needs of all of her other clients, and did not have significant difficulty obtaining approved coverage for Mr. Stogsdill. Again, if anything is in issue here, it is the quantity of services appropriate.

Olmstead: In the Petitioner's Post-hearing Brief, it appears that this issue may apply to this case only as an illustration as to why the attending physician's order should be dispositive. Again, the *Olmstead* decision stands for the principle that individuals should be provided sufficient supports to allow them to live in the community if their treating professions agree that they can and the provision of such supports does not fundamentally alter the State's method of providing services. Olmstead v L.C. 119 S. Ct. 2176 (1999). In Olmstead, as the Respondent understands it, the view of the treating professionals may be dispositive as to whether the recipient in question can live in the community, as opposed to an institution. There is no indication in Olmstead that the views of the treating professionals are dispositive as to the specific services to be provided in the community. Mr. Stogsdill lives in the community. If Mr. Stogsdill has standing at all, it is to question what specific level and quantity of services he should receive.

Promulgation of Regulations and Reasonable Standards: The DHHS' regulations are at S.C. Code Ann. R. 126.125 et seq. DDSN's are at S.C. Code Ann. R. 88-105 et seq. Again, the DHHS regulations generally describe the Medicaid Program as administered in South Carolina. The DDSN regulations describe aspect of its programs. Again, the regulations do not include every detail of the Programs or prescribe or limit the discretion of the individuals who manage the services. Neither the statute submitted by the Petitioner at the hearing (S.C. Code Ann. §44-20-220) nor the press account of the lawsuit by Protection and Advocacy mean that the detailed standards by which individual cases are analyzed must be in regulation. Presumably, if the lawsuit is successful DDSN will issue more detailed regulations.

Since there is no showing that the authorization of services for Mr. Stogsdill has been reduced, and since there has been insufficient time for Mr. Stogsdill's Service Coordinator and the other members of the care team to review the recent assessment of the counselor and the preferences of Mr. Stogsdill's attending physician, Mr. Stogsdill does not technically have standing to bring this action. Nevertheless, in the interests of judicial economy, and because there have obviously been some misunderstandings about Mr. Stogsdill's need for services, the Respondent respectfully requests that the Hearing Officer:

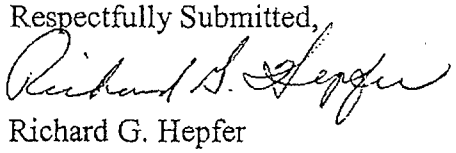
1) Inquire into the matter and issue an Order sustaining the DDSN's reconsideration determination of March 3, 2009 issued by then Acting Director Robert W. Barfield;

2) Specify what services, if any, the credible evidence in this case has shown to be minimally necessary for Mr. Stogdill to live in the community;

3) Specify, if appropriate, what should be considered by the care team and the appropriate weight to be accorded to the professional recommendations and testimony about the situation submitted at the hearing.

4) Grant such other resolution of this matter as justice may demand.

Respectfully Submitted,



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July 13, 2009

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July 7, 2009

Monet Pincus, Esquire
Pincus Loomis Law
3306 Millwood Ave.
Columbia, SC 29205

Re: Richard Stogsdill
Case # 09 MISC 017

Dear Ms. Pincus:

Enclosed is the brief which I filed with you and served upon Respondent's counsel yesterday electronically, I have reformatted the brief to add page numbers and added attachments.

Please advise if you need anything further from Appellant at this time.

Cordially,

Patricia L. Harrison

Richard Stogsdill, Appellant	)	HHS Office of Appeals and Hearings
vs.	)	Brief of Appellant in Response to Questions Presented by Hearing Officer
The South Carolina Department of Health and Human Services, Respondent	)	09 MISC 017

APPELLANT APPEALED NOT ONLY THE IMPROPER DENIAL OF SERVICES, BUT ALSO THE ARBITRARINESS OF DDSN'S PROCESS FOR DETERMINING WHAT SERVICES APPELLANT IS ENTITLED TO RECEIVE

Appellant appealed the failure of Respondent to provide community based MR/RD Medicaid waiver services as determined to be necessary by his treating physician. As discussed in Richard's complaint filed with the South Carolina Department of Health and Human Services (HHS), these services are subject to change and must be provided in a timely manner. Federal law requires Respondent to provide waiver services with "reasonable promptness." 42 U.S.C. 1396a(a)(8). Federal Courts, including the United States Court of Appeals for the Fourth Circuit, have defined "reasonable promptness" as meaning within 90 days from the date of the request. *Doe v. Chiles*, 136 F.3d 709 (11th Cir. 1998); *Doe v. Kidd*, 501 F.3d 348 (4th Cir. 2007). Where the health and safety of a Medicaid participant is at risk, "reasonable promptness" may require immediate action:

> Where the need for such a change is very urgent (e.g., as in the case of abuse in a person's current living arrangement), then "reasonable promptness" could mean "immediate."

Olmstead Update No. 4 at http://www.freedomclearinghouse.org/olmstead/olmsteadltr4.htm.

Appellant has appealed the failure of Respondent to promulgate regulations or to establish reasonable standards for determining which MR/RD Medicaid waiver services a participant shall receive. Congress intended that decisions about the provision of services would be made based on medical necessity. The Supreme Court emphasized the importance of the treating physician in making decisions about what services are provided. *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999). Respondent is required to provide a hearing not only when services are not provided with reasonable promptness, but also when "Any recipient ...requests it because he or she believes that the agency has taken an action erroneously." 42 C.F.R. 431.220(2). Appellant clearly stated in his appeal that he believes that Respondent has erred by failing to establish reasonable standards to determine what services are needed for him to remain in the community and to provide those services which are deemed to be medically necessary with reasonable promptness.

APPELLANT PROPERLY APPEALED THE FAILURE TO PROVIDE COMMUNITY BASED SERVICES, WHICH INCLUDED, BUT ARE NOT LIMITED TO PERSONAL CARE SERVICES, RESPITE SERVICES AND ADULT COMPANION SERVICES

In January of 2009, Appellant requested community based services to allow him to participate as a valued member of his community and to prevent his placement in an ICF/MR. The United States Supreme Court requires that the State provide services in the least restrictive setting where provision of such services would not "fundamentally alter" the way the State delivers services. *Olmstead, Supra.* Justice Kennedy, in his concurring opinion, specifically addresses the role of the treating physician in making treatment decisions. *Id.*

The following year, Congress proclaimed in the Developmental Disabilities Act of 2000 that individuals must be provided with access to needed community services, individualized supports and other forms of assistance that promote independence, productivity, and integration and inclusion. (Public Law No. 106-402, 42 U.S.C. §15001 et. seq.)

It was not necessary in this appeal for Appellant to identify these services by using the same labels that Respondent uses in the unpublished MR/RD Medicaid Waiver Document. That Document is the contract between CMS, the federal Medicaid agency and Respondent. It defines each service which Respondent must make available to all MR/RD waiver participants in Appendix B. Exhibit 1. But the information contained in that document was not provided to Appellant prior to the filing of this appeal, nor was Appellant's Service Coordinator even aware of the existence of Adult Companion services or the State's duty to provide these services. It was the duty of the Service Coordinator to inform Appellant of all feasible services under the MR/RD Medicaid waiver.

Richard's guardian testified that she requested services which meet the definitions of Personal Care services, Adult Companion services and Respite services. She testified that the Kershaw Center never required her before this appeal was filed to put Richard's requests in writing or to use the specific labels which Respondent applies to these services. She testified that Richard was never informed by the Service Coordinator about all of the services in the MR/RD Medicaid waiver. The Service Coordinator did not even know that Adult Companion Services existed. In fact, when Appellant requested a copy of the MR/RD Medicaid waiver

document in which Adult Companion Services and other Medicaid waiver services are defined, Dr Kathi Lacy, the Associate State Director of the South Carolina Department of Disabilities and Special Needs falsely responded that no such document existed. In a letter dated February 4, 2009, Dr. Kathi Lacy responded to Appellant's request for the MR/RD Waiver document, denying that the agency had possession of any contract between HHS and CMS (the federal Medicaid agency):

> We received your letter dated January 19, 2009. Related to your request, DDSN does not have a copy of any contract between South Carolina's Medicaid agency, SC Department of Health and Human Services (SCDHHS) and the federal Medicaid agency, CMS.

Exhibit 2.

The MR/RD waiver document defines each and every MR/RD Medicaid waiver service in detail in Appendix B of the requested document. Exhibit 1. The Waiver Document is the document under which Respondent has delegated authority to administer the MR/RD Waiver program to DDSN. Federal law requires the State to inform individuals likely to require nursing home or ICF/MR care about "any feasible alternatives available under the waiver" and to give the individual the "choice of either institutional or home and community-based services. 42 U.S.C. § 1396n(c)(2); 42 C.F.R § 441.302 (d). Richard was given the choice of ICF/MR of waiver services and he selected community based waiver services instead of institutional services in an ICF/MR (a facility operated by DDSN which provides similar services to a nursing home). See discussion of ICF/MR in *Doe v. Kidd, supra.* However, Respondent violated 42 U.S.C. § 1396n(c)(2) and 42 C.F.R § 441.302 (d) by not assuring that its agent, DDSN and that agency's

local DSN boards inform Appellant and other waiver participants of all of the "feasible alternatives" contained in the waiver, including Adult Companion Services. Even more egregious was the knowing refusal by the Associate Director of DDSN to prevent Appellant from obtaining the document which defines these services. DDSN comes to this tribunal with unclean hands and its deceit should not be rewarded by requiring MR/RD Waiver participants to know and understand the lingo used by DDSN and Respondent to describe services.

Adult Companion services, Personal Care services and Respite services fall clearly within the scope of the verbal request Appellant made through his legal guardian in January of 2009 for community services. The appeal Richard filed on April 1, 2009, after DDSN denied Richard's request for reconsideration, includes all community based services for which his treating physician determines him to need which are included in the MR/RD Medicaid waiver. In his appeal, Richard stated that his medical needs include, but are not limited to 82 units per day of Personal Care services. Identification of that specific service did not limit his appeal to Personal Care services. Respondent was on notice that Appellant was requesting these and other waiver services which would be identified as being needed by his treating physician. No one at HHS, DDSN or the Kershaw Center made any effort to contact Appellant's treating medical providers to determine what services are medically necessary. None of these agencies consulted any qualified medical professional before summarily denying Appellant's request for services.

In his appeal, Appellant clearly objected to the arbitrary policies used by DDSN and Respondent to determine what services would and would not be provided under the MR/RD

Medicaid waiver and the Respondent's failure to obtain medical evidence of the need for these services. In fact, Respondent provided absolutely no basis, other than the Service Coordinator asking her supervisor, who in turn asked some unidentified bureaucrat at DDSN whether they could deny Richard's request for waiver services.

Dr. Thomas C. Joseph has been Appellant's treating physician since he was an infant. Appellant provided evidence in the form of an affidavit signed by Dr. Joseph stating that Richard needs eight hours a day of personal care services, with two persons providing this service to assure his safety. (For a total of sixteen hours, or 64 units of Personal Care hours.) Exhibits 3 and 4. Richard's caregiver, David Todd, provided testimony to support his physician's opinion that it would be unsafe for one person to transfer Richard. Dr. Joseph determined that Appellant also needs five hours a day of adult companion services. He also determined that Appellant continues to need the Respite services contained in his annual budget dated 1/21/09 (which includes 52 daily units per year and 2,240 hourly units per year). Exhibit 5.[1]

Evidence was submitted showing that the cost of these services is not greater than the costs of some individuals for whom DDSN provides residential services. See affidavit of William Barfield. All of the requested services are currently provided under the waiver. There is no evidence that providing these services would "fundamentally alter" the way in which services are delivered through the MR/RD Medicaid waiver in South Carolina.

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[1] Evidence was presented at the hearing that the requested Personal Care and Adult Companion services are in addition to, and not a substitute for, the Respite hours which are needed by Richard's caregivers. This issue is not in dispute.

In addition, Appellant provided the uncontradicted opinion of his DDSN certified Behavior Support/Psycological Services provider that these services are necessary. Exhibit 6. This opinion supports that of Appellant's treating physician.

Respondent provided no medical evidence to support its determination that these services are not medically necessary. The only testimony presented by Respondent was that of Appellant's Service Coordinator, who admitted that she has no medical training. Richard's Service Coordinator admitted that she did not know that Adult Companion Services are services included in the MR/RD Medicaid waiver.

In the absence of any credible medical evidence to show that Appellant does not need the requested MR/RD Medicaid waiver services, any decision to deny these services would be arbitrary and capricious. This tribunal should require Respondent to provide 64 units a day of Personal Care services and five hours a day of Adult Companion Services, as requested by Appellant. In addition, HHS should be required to promulgate regulations to establish reasonable standards to determine how requests for MR/RD Waiver services will be approved. Otherwise, Richard and other MR/RD Waiver participants will be subjected to endless appeals each time his needs change. This violates the "reasonable promptness" requirement of the Medicaid Act contained in 42 U.S.C. 1396a(a)(8), as well as the requirement to administer the program in the best interests of the participants. 42 U.S.C. 1396a(a)(19).

RESPONDENT HAS VIOLATED APPELLANT'S RIGHT TO PROCEDURAL DUE PROCESS

Federal requirements that Respondent must follow in these proceedings are set forth in Subpart E of CMS regulations contained at 42 C.F.R. 431.200 et. seq. Specifically, CMS has mandated that Respondent provide a hearing system which meets the due process requirements established by the United States Supreme Court in *Goldberg v. Kelly*, 397 U.S. 254 (1970). In addition, CMS requires States to comply with those other requirements contained in Subpart E of the Code of Federal Regulations mentioned above. These are the regulations promulgated by CMS after notice and receipt of public comment. Respondent is bound by these regulations, which were enacted to codify 42 U.S.C. 1396a(a)(3), the section of the Medicaid Act grants Medicaid participants the right to a fair hearing.[2] The Medicaid Act also requires the State to administer the Medicaid program in the "best interests" of the participants. 42 U.S.C. 1396a(a)(19).

It would be impossible for Appellant to predict and object to all due process violations Respondent might make during the course of the appeal. Requiring Appellant to file a separate appeal each time Respondent violates due process requirements during an existing appeal contradicts the clear intent of Congress to administer the program in the best interests of the participants.

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[2] One commentator has noted that this provision is contained in "Section 1396a (which) is generally regarded to be the longest sentence in the English language." Barry R. Furrow et al., Health Law §§ 12-1, at 2 n.2 (2d ed. 2000).

Federal fair hearing regulations specifically provide that appellants, such as Richard, must be given an opportunity to "Examine at a reasonable time before the date of the hearing and during the hearing: the content of the Applicant's case file and all documents and records to be used by the State or local agency ...at the hearing." 42 C.F.R. 431.242. Counsel for Appellant called the lawyer representing the Respondent on June 24, 2009 and asked to review Appellant's file.[3] Respondent provided Appellant only four documents: which are attached as Exhibit 7. None of these documents provide any medical justification for denying Appellant's request for services.

Respondent's counsel advised counsel for Appellant that the Kershaw Center Service Coordinator had possession of the Appellant's file. On June 25, 2009, Appellant's counsel called the Kershaw Center and informed the agency that she would travel to Camden to review the file. On the morning of June 26, 2009, before leaving Columbia to travel to Camden to review the file, counsel again called the Kershaw Center to notify the agency that she would be there to review the file that afternoon. Only after Appellant's counsel arrived in Camden, did she receive a phone call from the director of the Kershaw Center advising her that Richard's file had been transferred to the State Office of the Department of Disabilities and Special Needs. Counsel immediately returned to Columbia that afternoon, where she was provided Respondent's file that is approximately six inches thick and was provided less than 90 minutes to review the file.

3

Respondent violated Appellant's procedural due process right by failing to make Appellant's file available for review by his legal counsel at a reasonable time before the hearing. Appellant had instructed the Kershaw Center, in writing, not to release any information in his file without prior written notice. No one at the Kershaw Center, DDSN nor HHS informed the Appellant that his records were being removed from Camden and transferred, without his consent, to the State Offices of DDSN in Columbia in violation of the Health Insurance Portability and Accountability Act (HIPAA).

DDSN and local boards have consistently claimed that they are separate legal entities. In *Young v. South Carolina Department of Disabilities* and Special Needs, the South Carolina Supreme Court held that DDSN is a separate legal entity from local DSN boards:

> The plain language of the statutes and ordinances establishes the Board as a separate entity from DDSN ...

374 S.C. 360, 649 S.E.2d 488 (S.C. 2007). Respondent violated the procedural due process rights of Appellant in this game of "keep away" with Appellant's file. In playing this game, the Kershaw Center clearly violated Appellant's rights under The Health Insurance Portability and Accountability Act (HIPAA), which requires all agencies involved to protect Appellant from any unauthorized release of protected health care information.

HHS "has taken an action erroneously" in upholding DDSN's denial of Appellant's request for services and impeding his ability to prepare for his fair hearing. (42 C.F.R.

431.220(2)). This denial of due process rights, coupled with the absolute failure of Respondent to produce evidence in support of its denial of services, supports Appellant's right to a favorable decision in this case.

In addition, this tribunal should recognize the failure of Respondent to promulgate reasonable standards which are based on medical necessity in its decision. Respondent should be required to promulgate, after publication and opportunity for public comment, standards which require the Respondent to give weight to the opinions of treating physicians.

Respectfully submitted,

Patricia L. Harrison
Attorney for Appellant
611 Holly Street
Columbia, South Carolina 29205

Columbia, South Carolina

July 6, 2009

Received July 7, 2009

Richard Stogsdill, Appellant	)	HHS Office of Appeals and Hearings
vs.	)	Case # 09-MISC-017
The South Carolina Department of Health and Human Services, Respondent.	)	

CERTIFICATE OF SERVICE

The undersigned does hereby certify that service of the attached **Brief of Appellant in Response to Questions Presented by Hearing Officer**, in the above referenced action was made upon counsel of record by hand delivery at the below listed address this 7th day of July, 2009.

Patricia L. Harrison

Delivered to:

Hearing Officer Monet Pincus
Pincus Loomis Law
3306 Millwood Ave.
Columbia, SC 29205

Richard Hepfer, Esquire
SC Department of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206

Exhibit 1

South Carolina MR/RD Medicaid Waiver Document*

*Appendices at Pages 19 through 81 not included

South Carolina's

Medicaid Waiver

#0237.90

UNDER THE AUTHORITY OF
SECTION 1915 (c) OF THE SOCIAL SECURITY ACT

FOR PERSONS WITH

MENTAL RETARDATION AND RELATED DISABILITIES

10/01/04 – 09/30/09

SECTION 1915 (c) WAIVER FORMAT

1. The State of South Carolina requests a Medicaid home and community-based services waiver under the authority of section 1915 (c) of the Social Security Act. The administrative authority under which this waiver will be operated is contained in Appendix A.

   This is a request for a model waiver.

   a. _____ Yes b. _X_ No

   This waiver is requested for a period of (check one):

   b. _X_ 5 years (renewal waiver)

2. This waiver is requested in order to provide home and community-based services to individuals who, but for the provision of such services, would require the following level(s) of care, the cost of which could be reimbursed under the approved Medicaid State plan:

   b. _X_ Intermediate care facility for mentally retarded or persons with related disabilities (ICF/MR)

3. A waiver of section 1902(a)(10)(B) of the Act is requested to target waiver services to one of the select group(s) of individuals who would be otherwise eligible for waiver services:

   f. _X_ mentally retarded and persons with related disabilities

4. A waiver of section 1902 (a)(10)(B) of the Act is also requested to impose the following additional targeting restrictions (specify):

   e. _X_ Not applicable

5. Except as specified in item 6 below, an individual must meet the Medicaid eligibility criteria set forth in Appendix C-1 in addition to meeting the targeting criteria in items 2 through 4 of this request.

6. This waiver program includes individuals who are eligible under medically needy groups.

   a. _____ Yes b. _X_ No

7. A waiver of §1902 (a)(10)(C)(i)(III) of the Social Security Act has been requested in order to use institutional income and resource rules for the medically needy.

   a. ___ Yes b. ___ No c. _X_ N/A

8. The State will refuse to offer home and community-based services to any person for whom it can reasonably be expected that the cost of home or community-based services furnished to that individual would exceed the cost of a level of care referred to in item 2 of this request.

a. _X_ Yes b. ___ No

9. A waiver of the "statewideness" requirements set forth in section 1902(a)(1) of the Act is requested.

a. ___ Yes b. _X_ No

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

11. The State request that the following home and community-based services, as described and defined in Appendix B-1 of this request, be included under this waiver:

d. _X_ Personal care services

e. _X_ Respite care

f. _X_ Adult day health

g. _X_ Habilitation

_X_ Residential habilitation

_X_ Day habilitation

_X_ Prevocational services

_X_ Supported employment services

h. _X_ Environmental modifications

k. _X_ Specialized medical equipment, Supplies and Assistive Technology

n. _X_ Adult companion services

s. _X_ Extended State Plan services (Check all that apply):

_X_ Physical therapy services

_X_ Occupational therapy services

_X_ Prescribed drugs

X Other Services (specify):

1. Speech-Language pathology
2. Audiology services
3. Adult Dental services
4. Adult Vision services

t. X Other Services (specify):

1. Psychological services
2. Nursing services
3. Private Vehicle Modifications
4. Behavior Supports services

12. The State assures that adequate standards exist for each provider of services under the waiver. The State further assures that all provider standards will be met.

13. An individual written plan of care will be developed by qualified individuals for each individual under this waiver. This plan of care will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written plan of care. The plan of care will be subject to the approval of the Medicaid agency. FFP will not be claimed for waiver services furnished prior to the development of the plan of care. FFP will not be claimed for waiver services, which are not included in the individual written plan of care.

14. Waiver services will not be furnished to individuals who are inpatients of a hospital, NF, or ICF/MR.

15. FFP will not be claimed in expenditures for the cost of room and board, with the following exception(s) (check all that apply):

a. X When provided as part of respite care in a facility approved by the State that is not a private residence (hospital, NF, foster home, or community residential facility).

b. X Meals furnished as part of a program of adult day health services.

For the purposes of this provision, "board" means 3 meals a day, or any other full nutritional regimen.

16. The Medicaid agency provides the following assurances to CMS:

a. Necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. Those safeguards include:

1. Adequate standards for all types of providers that furnish services under the waiver (see Appendix B);

2. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver (see Appendix B). The State assures that these requirements will be met on the date that the services are furnished; and

3. Assurance that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

b. The agency will provide for an evaluation (and periodic reevaluations, at least annually) of the need for a level of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future (one month or less), but for the availability of home and community-based services. The requirements for such evaluations and reevaluations are detailed in Appendix D.

c. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, and is included in the targeting criteria included in items 3 and 4 of this request, the individual or his or her legal representative will be:

1. Informed of any feasible alternative under the waiver; and

2. Given the choice of either institutional or home and community-based services

d. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to persons who are not given the choice of home or community-based services as an alternative to institutional care indicated in item 2 of this request, or who are denied the service(s) of their choice, or the provider(s) of their choice.

e. The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures of the level(s) of care indicated in item 2 of this request under the State plan that would have been made in that fiscal year had the waiver not been granted.

f. The agency's actual total expenditure for home and community-based and other Medicaid services under the waiver and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals in the institutional setting(s) indicated in item 2 of this request in the absence of the waiver.

g. Absent the waiver, persons served in the waiver would receive the appropriate type of Medicaid-funded institutional care that they require, as indicated in item 2 of this request.

h. The agency will provide CMS annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of the persons served on the waiver. The information will be consistent with a data collection plan designed by CMS.

i. The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as CMS may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller Generals, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

The State conducts a single audit in conformance with the Single Audit Act of 1984, P.L. 98-502

a. _X_ Yes b. ___ No

17. The State will provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-neutrality. The results of the assessment will be submitted to CMS at least 90 days prior to the expiration of the approved waiver period and cover the first 24 months (new waivers) or 48 months (renewal waivers) of the waiver.

a. ___ Yes b. _X_ No

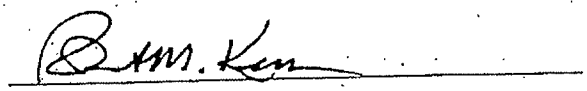
18. The State assures that it will have in place a formal system by which it ensures the health and welfare of the individuals served on the waiver, through monitoring of the quality control procedures described in this waiver document (including Appendices). Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that plans of care are periodically reviewed to ensure that the services furnished are consistent with the identified needs of the individuals. Through these procedures, the State will ensure that quality of services furnished under the waiver and the State plan to waiver persons served on the waiver. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

19. An effective date of **October 1, 2004** is requested.

20. The State contact person for this request is Kara Lewis, who can be reached by telephone at (803) 898-2710.

21. This document, together with Appendices A through G, and all attachments, constitutes the State's request for a home and community-based services waiver under section 1915(c) of the Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver (including Appendices and attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid agency. Upon approval by CMS, this waiver request will serve as the State's authority to provide home and community services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid agency.

Signature: 

Print Name: Robert M. Kerr

Title: Director

Date: June 22, 2004

APPENDIX A – ADMINISTRATION

LINE OF AUTORITY FOR WAIVER OPERATION

Check One:

_X_ The waiver will be operated by the South Carolina Department of Disabilities and Special Needs (SCDDSN), a separate agency of the State, under the supervision of the Medicaid agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

APPENDIX B – SERVICES AND STANDARDS

APPENDIX B-1: DEFINITION OF SERVICES

The State requests that the following home and community-based services, as described and defined herein, be included under this waiver. Provider qualifications/standards for each service are set forth in Appendix B-2.

d. _X_ Personal care services:

_X_ Assistance, either hands-on (actually performing a personal care task for a person) or cuing so that the person performs the task by him/herself, in the performance of IADLs or ADLs. ADLs include eating, bathing, dressing, toileting, transferring, and maintaining continence. IADLs capture more complex life activities and include personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, to include informing a client that it is time to take medication as prescribed by his/her physician or handing a client a medication container, and money management to consist of delivering payments to a designated recipient on behalf of the client. Personal care services can be provided on a continuing basis or on episodic occasions. Skilled services that may be performed only by a health professional are not considered personal care services. Using this revised definition, authorizations to providers will be made at two different payment levels. The higher level will be call Personal Care 2 and will be used when the majority of care is related to activities of daily living. The lower level, Personal Care 1, will be authorized when most of the needed care is for instrumental activities of daily living.

1. Services provided by family members (Check one):

   _X_ Payment will not be made for personal care services furnished by a member of the individual's family per State Medicaid policy.

2. Supervision of personal care providers will be furnished by (Check all that apply):

   _X_ A registered nurse or a licensed practical nurse, licensed to practice nursing in the State, when the service requires hands-on assistance with activities of daily living.

   _X_ Other (specify): High school diploma or equivalent required when the service requires no hands-on assistance with activities of daily living.

3. Frequency or intensity of supervision (Check one):

   _X_ Other (specify): As indicated in provider contracts.

4. Relationship to State plan services (check one):

_X_ Other service definition (specify): Personal care services provided under the approved State plan for individuals 21 years of age and younger, and provided under the waiver for individuals 21 years of age and older.

e. _X_ Respite care:

_X_ Services 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. FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence,

Respite care will be provided in the following location(s) (check all that apply):

_X_ Individual's home or place of residence

_X_ Foster home

_X_ Medicaid certified ICF/MR

_X_ Group home

_X_ Licensed respite care facility

_X_ Other community care residential facility approved by the State that is not a private residence (Specify type): Community Residential Care Facility

_X_ Licensed Nursing Facility

f. _X_ Adult day health:

_X_ Services furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. The State intends to limit services to individuals with medically complex conditions; or individuals who would not likely benefit from either day habilitation, prevocational habilitation, or supported employment services. Authorization of services will be based on the recipient's need for the service as identified and documented in the individual's plan of care. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Physical, occupational and speech therapies indicated in the individual's plan of care are not furnished as component parts of this service.

Transportation between the individual's place of residence and the adult day health center will be provided as a component part of adult day health services. The cost of this transportation is included in the rate paid to providers of adult day health services. (Check one):

1. X Yes 2. ___ No

Qualifications of the providers of adult day health services are contained in Appendix B-2.

g. X Habilitation:

X Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. This service includes:

X Residential habilitation: Residential habilitation services include the care, skills training and supervision provided to individuals in a non-institutional setting. The degree and type of care supervision, skills training and support of individuals will be based on the plan of care and the individual's needs. Services include 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. Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code. Payment for residential habilitation does not include payments made, directly or indirectly, to members of the individual's immediate family. Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid. Documentation which shows Medicaid payment does not cover these components is attached to Appendix G.

X Day habilitation: Assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the individual resides. Services shall normally be furnished 4 or more hours per day on a regularly scheduled basis, for 1 or more days per week unless provided as an adjunct to other day activities included in an individual's plan of care.

Day habilitation services shall focus on enabling the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition, day habilitation

services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

_X_ Prevocational services not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602 (16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401 (16 and 17)). Services are aimed at preparing an individual for paid or unpaid employment, but are not job-tasks oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs).

Check one:

_X_ When compensated, individuals are paid at less than 50 percent of the minimum wage.

Activities included in this service are not directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the individual's plan of care as directed to habilitative, rather than explicit employment objectives.

Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

_X_ Supported employment services, which consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported employment is conducted in a variety of settings; particularly work sites in which persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waivers services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

2. Payments that are passed through to users of supported employment programs; or

3. Payments for vocational training that is not directly related to an individual's supported employment program.

The State will require prior institutionalization in a NF or ICF/MR before a recipient is eligible for expanded habilitation services (prevocational, educational and supported employment).

1. ___Yes 2. _X_ No

With the exception of Supported Employment, transportation will be provided between the individual's place of residence and the site of the habilitation services, or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

1. _X_ Yes 2. ___ No

The State requests the authority to provide the following additional services, not specified in the stature. The State assures that each service is cost-effective and necessary to prevent institutionalization. The cost neutrality of each service is demonstrated in Appendix G. Qualifications of providers are found in Appendix B-2.

h. _X_ Environmental modifications:

_X_ Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence, and without which, the individual would require institutionalization. Home is defined as non-government subsidized living quarters, and modifications to any government-subsidized housing (i.e., group homes or community residential care facilities) are not permitted. Such adaptations may include the installation

of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems, which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home, which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. **Adaptations that add square footage to the home are excluded from this benefit.** All services shall be provided in accordance with applicable State or local building codes. Approval of a request for environmental modification is a multi-step process. The modification is initially determined by the service coordinator/**early interventionist** based on the recipient's need as documented in the plan of care. Three bids for the modification are obtained by the service coordinator/**early interventionist** and submitted with documentation of the need. This information is reviewed by South Carolina Department of Disabilities and Special Needs (SCDDSN) staff for programmatic integrity and cost effectiveness. To ensure cost neutrality, the environmental modification service must be within the lifetime monetary cap of $7,500 per recipient, and the recipient's actual total expenditure for home and community based and other Medicaid services under the waiver will not exceed the cost of care in an ICF/MR. **The service coordinator/early interventionist will assist in identifying all appropriate resources, both waiver and non-waiver. Should it become necessary, the SC/EI will assist with transitioning the client into institutional placement.**

k. X Specialized Medical Equipment, Supplies and Assistive Technology:

X Specialized medical equipment, supplies and assistive technology to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

n. X Adult Companion services:

X Non-medical care, supervision and socialization, provided to a functionally impaired adult individual. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care but may entail hands on assistance or training to the recipient in performing activities of daily living and independent living skills. Providers may also perform light housekeeping tasks, which are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the plan of care, and is not purely diversional in nature. Reimbursement will not be made to any family members residing in the same residence as the individual.

s. X Extended State Plan services:

The following services, available through the approved State plan, will be provided, except that the limitations on amount, duration and scope specified in the plan will not apply. Services will be as defined and described in the approved State plan. The provider qualifications listed in the plan will apply, and are hereby incorporated into this waiver request by reference. These services will be provided under the State plan until the plan limitations have been reached. Documentation of the extent of services and cost-effectiveness are demonstrated in Appendix G. (Check all that apply):

X Physical therapy services

X Occupational therapy services

X Prescribed drugs: An additional two (2) prescribed drugs over the State plan limit will be allowed under the waiver

X Other State plan services (specify):

1. Speech-Language Pathology: The service will be defined and described in the approved State plan. The availability of this service is not limited by any age restriction and will not duplicate any services available to adults in the State plan.

2. Audiology services: The service will be defined and described in the approved State plan. The availability of this service is not limited by any age restriction and will not duplicate any services available to adults in the State plan.

3. Adult Dental services: The service will be defined and described in the approved State plan. The availability of this service is not limited by any age restriction and will no duplicate any services available to adults in the State plan.

4. Adult Vision services: The service will be defined and described in the approved State plan. The availability of this service is not limited by any age restriction and will not duplicate any services available to adults in the State plan.

t. X Other waiver services which are cost-effective and necessary to prevent institutionalization (specify):

1. Psychological Services: Services focused upon assessment of needs and counseling/therapy designed to address specific needs in areas such as cognitive and/or affective skills. These services include initial assessment for determining need for and appropriateness of psychological services, psychological testing, goal-oriented counseling/therapy focused on issues related to seriously inappropriate sexual behavior (e.g., those behaviors which could lead to criminal sexual misconduct).

2. Nursing Services: Continuous or intermittent care provided to the individual in accordance with the plan of care as deemed medically necessary by a physician. Services are provided by licensed nurses within the scope of the State's Nurse Practice Act. **To ensure cost-neutrality the maximum number of hours authorized for nursing services may not exceed the sub-acute hospital care rate. The Service Coordinator/Early Interventionist will assist in identifying all appropriate resources, both waiver and non-waiver. Should it become necessary, the Service Coordinator/Early Interventionist will assist with transitioning the client into institutional placement.**

3. Private Vehicle Modifications: Modifications to a privately owned vehicle used to transport the waiver recipient, and for any equipment needed by the recipient which makes the vehicle accessible to the recipient. Modification to any government- subsidized vehicle is not permitted. To ensure cost-neutrality, the private vehicle modification service must be within a monetary cap of **$7,500 per vehicle and a lifetime cap of 2 vehicles.** The approval process for vehicle modifications is initially determined by the Service Coordinator or Early Interventionist based on the recipient's needs as identified and documented in the plan of care, and the availability of a privately owned vehicle that would be used for transportation on a routine basis. The criterion used in assessing a recipient's need for this service are: 1) The parent or family member cannot transport the individual because the individual cannot get in or out of the vehicle; 2) The individual can drive but cannot get in or out of the vehicle and a modification to the vehicle would resolve this barrier. Bids for the service are obtained and submitted along with the documentation of the need to SCDDSN. Each request is reviewed programmatically and fiscally before approval is given. The approval process is the same for any privately owned vehicle modification, regardless of ownership.

4. Behavior Support Services: Services which use current empirically validated practices to identify causes of, intervene to prevent, and appropriately react to problematic behavior. These services include initial assessment for determining need for and appropriateness of behavior support services; behavioral assessment (i.e., functional assessment and/or analysis) that includes direct observation, interview of key persons, collection of objective data; analysis of behavioral/functional assessment data to determine the function of the behaviors (and later to assess success of intervention and any needed modifications) and behavioral intervention based on the functional assessment that is primarily focused on prevention of the problem behavior(s) based on their function.

APPENDIX B-2: PROVIDER QUALIFICATIONS

A. LICENSURE AND CERTIFICATION CHART

The following chart illustrates the requirements for the provision of each service under the waiver. Licensor, Regulation, State Administrative Code are referenced by citation. Standards not addressed under uniform State citation are attached.

Service	Provider Type	License	Certification	Other Standard
d. Personal care services	Personal care provider			Attachment 1-Minimum qualifications; Medicaid Enrolled Providers.
e. Respite care	Respite provider; Foster Home; Licensed Respite Care Facility; Medicaid certified ICF/MR; Group home; Community Residential Care Facility; Nursing Facility	Code of laws of SC, 1976 as amended: 44-20-170 through 44-10-1000; 44-20-10 et seq.,; 44-21-10 et seq., 44-7-110 et seq.; SCDHEC Regulation Number NF61-17		Attachment 2-Minimum qualifications; Medicaid Enrolled Providers
f. Adult day health	Adult day care provider	Code of Laws of SC, 1976 as amended: 44-7-260.		Medicaid Enrolled Providers
g. Habilitation	Residential habilitation provider; Day habilitation provider; Prevocational services provider; Supported employment services provider	Code of Laws of SC, 1976 as amended: 40-20-170 through 44-10-1000; 44-20-10 et seq.; and 44-21-10 et seq.; SC Licensing regulations: Mo. 61-103		Medicaid Enrolled Providers
h. Environmental modifications	Licensed Contractor	Code of Laws of SC, 1976 amended: 40-59-15 et. Seq.		Medicaid Enrolled Providers
k. Specialized medical equipment, supplies and Assistive technology	Durable Medicaid Equipment provider			Medicaid Enrolled Providers
n. Adult companion services	Adult Companion provider			Attachment 3-Minimum qualifications; Medicaid Enrolled Providers.

Service	Provider Type	License	Certification	Other Standard
s.1. Physical therapy services	Licensed Physical Therapist	Code of Laws of SC, 1976 as amended; 40-45-10 et seq.		Medicaid Enrolled Providers
s.2. Occupational therapy services	Licensed Occupational Therapist	Code of Laws of SC, 1976 as amended; 40-36-10 et seq.		Medicaid Enrolled Providers
s.3. Prescribed drugs	Licensed Pharmacist	Code of Laws of SC, 1976 as amended; 40-43-30 et seq.		Medicaid Enrolled Providers
s.4. Speech-Language Pathology	Licensed Speech Pathologist	Code of Laws of SC, 1976 as amended; 40-67-10 et seq.		Medicaid Enrolled Providers
s.5. Audiology services	Licensed Audiologist	Code of Laws of SC, 1976 as amended; 40-67-10 et seq.		Medicaid Enrolled Providers
s.6. Adult Dental services	Licensed Dentist, Board Certified Oral Surgeon, or Dental Hygienist	Code of Laws of SC; 1976 as amended; 40-15-70 et seq.		Medicaid Enrolled Providers
s.7. Adult Vision services	Licensed Optometrist, Ophthalmologist, or Optician	Code of Laws of SC, 1976 as amended; 40-37-10 et seq.; 40-38-10 et seq.; or 40-47-5 et seq.		Medicaid Enrolled Providers
t.1. Psychological services	Psychological services provider	Code of Laws of SC, 1976 as amended; 40-55-20 et seq.; 40-75-5 et seq.		Attachment 4-Minimum qualifications; Medicaid Enrolled Providers
t.2. Nursing Services	Licensed Practical Nurse or Registered Nurse	Code of Laws of SC, 1976 as amended; 40-33-10 et seq.		Medicaid Enrolled Providers
t.3. Private vehicle modifications	Private vehicle modification provider			Attachment 5-Minimum qualifications; Medicaid Enrolled Providers
t.4. Behavior support services	Behavior support provider			Attachment 6-Minimum qualifications Medicaid Enrolled Providers

B. ASSURANCE THAT REQUIREMENTS ARE MET

The State assures that the standards of any State licensure or certification requirements are met for service or for individuals furnishing services provided under the waiver.

C. PROVIDER REQUIREMENTS APPLICABLE TO EACH SERVICE

For each service for which standards other than, or in addition to State licensure or certification must b met by providers, the applicable educational, professional, or other standards for service provision or fo service providers are attached to this Appendix, tabbed and labeled with the name of the service(s) t which they apply.

When the qualifications of providers are set forth in State or Federal law or regulation, it is not necessar to provide copies of the applicable documents. However, the documents must be on file with the Stat Medicaid agency, and the licensure and certification chart at the head of this Appendix must contain th precise citation indicating where the standards may be found.

D. FREEDOM OF CHOICE

The State assures that each individual found eligible for the waiver will be given free choice of a qualified providers of each service included in his or her written plan of care.

APPENDIX G – FINANCIAL DOCUMENTATION

APPENDIX G – 1

COMPOSITE OVERVIEW

COST – NEUTRALITY FORMULA

Level of Care: ICF/MR

FACTOR	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5
C	5,200	5,400	5,600	5,800	6,000
D	$34,713	$34,713	$35,360	$36,050	$36,209
D'	$7,211	$7,355	$7,502	$7,652	$7,805
G	$98,181	$100,144	$102,148	$104,190	$106,274
G'	$1,890	$1,928	$1,966	$2,006	$2,046

UNDUPLICATED INDIVIDUALS:

YEAR 1 of RENEWAL	5,200
YEAR 2 of RENEWAL	5,400
YEAR 3 of RENEWAL	5,600
YEAR 4 of RENEWAL	5,800
YEAR 5 of RENEWAL	6,000

Factor C is computed as follows:

_X_ The State will make waiver services available to individuals in the target group up to lesser of the number of individuals indicated as Factor C for the waiver year, or the number authorized by the State legislature for that time period.

The State will inform CMS in writing of any limit, which is less than Factor C for that waiver year.

Factor D

LOC: ICF/MR

Demonstration of Factor D estimates: Waiver Year 1

Waiver Service Column A	# Undup. Recip Column B	Avg. # Units/User Column C	Avg. Unit Cost/Basis Column D	Total Column E
PT	52	22	$40.00/Hour	$45,760
OT	52	22	40.00/Hour	45,760
Speech	52	33	40.00/Hour	68,640
Psychological services	26	33	66.00/Hour	56,628
Audiology	52	11	40.00/Hour	22,880
Behavior Supports	52	33	60.00/Hour	102,960
Special Equip./Supplies	1,248	N/A	2,500.00/Per Item	3,120,000
Day Hab.	1,872	198	42.00/Day	15,567,552
Prevocational Hab.	2,080	198	42.00/Day	17,297,280
Supported Employment	312	88	20.43/Hour	560,926
Residential Hab.-Daily	2,704	319	150.00/Day	129,386,400
Residential Hab.-Hourly	52	176	16.50/Hour	151,008
Adult Day Health	26	198	38.00/Day	195,624
Personal Care 1	52	440	10.05/Hour	229,944
Personal Care 2	520	550	12.80/Hour	3,660,800
Prescription Drugs	2,288	22	36.75/Per Item	1,849,848
Environmental Mods.	78	N/A	7,500.00/Per Item	585,000
Respite Non-Inst. Day	572	27.5	50.00/Day	786,500
Respite Non-Inst. Hour	208	330	6.25/Hour	429,000
Respite Inst. ICF/MR	26	22	148.23/Day	84,788
Adult Companion	104	440	10.80/Hour	494,208
Adult Dental	832	2	102.00/Per Visit	169,728
Adult Vision	572	2	70.00/Per Visit	80,080
Nursing LPN	182	1,320	20.00/Hour	4,804,800
Nursing RN	26	660	30.00/Hour	514,800
Private Vehicle	26	N/A	7,500.00/Per Item	195,000
Grand Total (sum of Column E):				$180,505,914
Factor C:				5,200
Factor D (Per Capita Average): Divide by C:				$34,713
Average Length of Stay:				11.00 months

APPENDIX G – 2

actor D

LOC: ICF/MR

Demonstration of Factor D estimates: Waiver Year 2

Waiver Service Column A	# Undup. Recip Column B	Avg. # Units/User Column C	Avg. Unit Cost/Basis Column D	Total Column E
PT	54	22	40.00.Hour	$47,520
OT	54	22	40.00/Hour	47,520
Speech	54	33	40.00/Hour	71,280
Psychological services	27	33	66.00/Hour	58,806
Audiology	54	11	40.00/Hour	23,760
Behavior Supports	54	33	60.00/Hour	106,920
Special Equip./Supplies	1296	N/A	2,500.00/Per Item	3,240,000
Day Hab.	1,944	198	42.00/Day	16,166,304
Prevocational Hab.	2,160	198	42.00/Day	17,962,560
Supported Employment	324	88	20.43/Hour	582,500
Residential Hab.-Daily	2,808	319	150.00/Day	134,362,800
Residential Hab.-Hourly	54	176	16.50/Hour	156,816
Adult Day Health	27	198	38.00/Day	203,148
Personal Care 1	54	440	10.05/Hour	238,788
Personal Care 2	540	550	12.80/Hour	3,801,600
Prescription Drugs	2,376	22	36.75/Per Item	1,920,996
Environmental Mods.	81	N/A	7,500.00/Per Item	607,500
Respite Non-Inst. Day	594	27.5	50.00/Day	816,750
Respite Non-Inst. Hour	216	330	6.25/Hour	445,500
Respite Inst. ICF/MR	27	22	148.23/Day	88,049
Adult Companion	108	440	10.80/Hour	513,216
Adult Dental	864	2	102.00/Per Visit	176,256
Adult Vision	594	2	70.00/Per Visit	83,160
Nursing LPN	189	1,320	20.00/Hour	4,989,600
Nursing RN	27	660	30.00/Hour	534,600
Private Vehicle	27	N/A	7,500.00/Per Item	202,500
Grand Total (sum of Column E):				$187,448,449
Factor C:				5,400
Factor D (Per Capita Average): Divide by C:				$34,713
Average Length of Stay:				11.00 months

APPENDIX G – 2

'actor D

LOC: ICF/MR

Demonstration of Factor D estimates: Waiver Year 3

Waiver Service Column A	# Undup. Recip Column B	Avg. # Units/User Column C	Avg. Unit Cost/Basis Column D	Total Column E
PT	56	22	40.00.Hour	49,280
OT	56	22	40.00/Hour	49,280
Speech	56	33	40.00/Hour	73,920
Psychological services	28	33	66.00/Hour	60,984
Audiology	56	11	40.00/Hour	24,640
Behavior Supports	56	33	60.00/Hour	110,880
Special Equip./Supplies	1,344	N/A	2,500.00/Per Item	3,360,000
Day Hab.	2,016	198	42.84/Day	17,100,357
Prevocational Hab.	2,240	198	42.84/Day	19,000,397
Supported Employment	336	88	20.84Hour	616,197
Residential Hab.-Daily	2,912	319	153.00/Day	142,125,984
Residential Hab.-Hourly	56	176	16.83/Hour	165,876
Adult Day Health	28	198	38.00/Day	210,672
Personal Care 1	56	440	10.25/Hour	252,560
'ersonal Care 2	560	550	13.06/Hour	4,022,480
rescription Drugs	2,464	22	36.75/Per Item	1,992,144
Environmental Mods.	84	N/A	7,500.00/Per Item	630,000
Respite Non-Inst. Day	616	27.5	51.00/Day	863,940
Respite Non-Inst. Hour	224	330	6.38/Hour	471,610
Respite Inst. ICF/MR	28	22	151.19/Day	93,133
Adult Companion	112	440	10.80/Hour	532,224
Adult Dental	896	2	102.00/Per Visit	182,784
Adult Vision	616	2	70.00/Per Visit	86,240
Nursing LPN	196	1,320	20.00/Hour	5,174,400
Nursing RN	28	660	30.00/Hour	554,400
Private Vehicle	28	N/A	7,500.00/Per Item	210,000
Grand Total (sum of Column E):				$198,014,382
Factor C:				5,600
Factor D (Per Capita Average): Divide by C:				$35,360
Average Length of Stay:				11.00 months

APPENDIX G – 2

Factor D

LOC: ICF/MR

Demonstration of Factor D estimates: Waiver Year 4

Waiver Service Column A	# Undup. Recip Column B	Avg. # Units/User Column C	Avg. Unit Cost/Basis Column D	Total Column E
PT	58	22	42.00.Hour	$53,592
OT	58	22	42.00/Hour	53,592
Speech	58	33	42.00/Hour	80,388
Psychological services	29	33	69.30/Hour	66,320
Audiology	58	11	42.00/Hour	26,796
Behavior Supports	58	33	63.00/Hour	120,582
Special Equip./Supplies	1,392	N/A	2,500.00/Per Item	3,480,000
Day Hab.	2,088	198	43.70/Day	18,066,629
Prevocational Hab.	2,320	198	43.70/Day	20,074,032
Supported Employment	348	88	21.26/Hour	651,066
Residential Hab.-Daily	3,016	319	156.06/Day	150,145,950
Residential Hab.-Hourly	58	176	17.17/Hour	175,271
Adult Day Health	29	198	39.90/Day	229,106
Personal Care 1	58	440	10.46/Hour	266,939
Personal Care 2	580	550	13.32/Hour	4,249,080
Prescription Drugs	2,552	22	38.59/Per Item	2,166,597
Environmental Mods.	87	N/A	7,500.00/Per Item	652,500
Respite Non-Inst. Day	638	27.5	52.02/Day	912,691
Respite Non-Inst. Hour	232	330	6.50/Hour	497,640
Respite Inst. ICF/MR	29	22	154.22/Day	98,392
Adult Companion	116	440	11.34/Hour	578,794
Adult Dental	928	2	107.10/Per Visit	198,778
Adult Vision	638	2	73.50/Per Visit	93,786
Nursing LPN	203	1,320	20.00/Hour	5,359,200
Nursing RN	29	660	30.00/Hour	574,200
Private Vehicle	29	N/A	7,500.00/Per Item	217,500
Grand Total (sum of Column E):				$209,089,421
Factor C:				5,800
Factor D (Per Capita Average): Divide by C:				$36,050
Average Length of Stay:				11.00 months

Factor D

LOC: ICF/MR

Demonstration of Factor D estimates: Waiver Year 5

Waiver Service Column A	# Undup. Recip Column B	Avg. # Units/User Column C	Avg. Unit Cost/Basis Column D	Total Column E
PT	60	22	$44.10.Hour	$58,212
OT	60	22	44.10/Hour	58,212
Speech	60	33	44.10/Hour	87,318
Psychological services	30	33	72.77/Hour	72,042
Audiology	60	11	44.10/Hour	29,106
Behavior Supports	60	33	66.15/Hour	130,977
Special Equip./Supplies	1,440	N/A	2,500.00/Per Item	3,600,000
Day Hab.	2,160	198	44.57/Day	19,061,698
Prevocational Hab.	2,400	198	44.57/Day	21,179,664
Supported Employment	360	88	21.68/Hour	686,822
Residential Hab.-Daily	3,120	319	159.18/Day	158,428,670
Residential Hab.-Hourly	60	176	17.51/Hour	184,906
Adult Day Health	30	198	41.90/Day	248,886
Personal Care 1	60	440	10.67/Hour	281,688
Personal Care 2	600	550	13.58/Hour	4,481,400
Prescription Drugs	2,640	22	40.52/Per Item	2,353,402
Environmental Mods.	90	N/A	7,500.00/Per Item	675,000
Respite Non-Inst. Day	660	27.5	53.06/Day	963,039
Respite Non-Inst. Hour	240	330	6.63/Hour	525,096
Respite Inst. ICF/MR	30	22	157.30/Day	103,818
Adult Companion	120	440	11.91/Hour	628,848
Adult Dental	960	2	112.46/Per Visit	215,923
Adult Vision	660	2	77.18/Per Visit	101,878
Nursing LPN	210	1,320	20.00/Hour	5,544,000
Nursing RN	30	660	30.00/Hour	594,000
Private Vehicle	30	N/A	7,500.00/Per Item	225,000
Grand Total (sum of Column E):				$217,252,605
Factor C:				6,000
Factor D (Per Capita Average): Divide by C:				$36,209
Average Length of Stay:				11.00 months

APPENDIX G – 3

METHODS USED TO EXCLUDE PAYMENTS FOR ROOM AND BOARD

The purpose of this Appendix is to demonstrate that Medicaid does not pay the cost of room and board furnished to an individual under the waiver.

A. The following service(s), other than respite care*, are furnished in residential settings other than the natural home of the individual (e.g., foster homes, group homes, supervised living arrangements assisted living facilities, personal care homes, or other types of congregate living arrangements) (Specify):

1. Residential Habilitation

2. Institutional - ICF/MR Respite

*Note: FFP may be claimed for the cost of room and board when provided as part of respite care in a Medicaid certified NF or ICF/MR, or when it is provided in a foster home or community residential facility that meets State standards specified in this waiver.

B. The following service(s) are furnished in the home of a paid caregiver. (Specify):

Day or hourly based Non-institutional Respite Care.

Attached is an explanation of the method used by the State to exclude Medicaid payment for room and board.

Continual monitorship of financial data is maintained to assure that room and board costs are excluded from reimbursement.

APPENDIX G – 4

METHODS USED TO MAKE PAYMENT FOR RENT AND FOOD EXPENSES OF AN UNRELATED LIVE-IN CAREGIVER.

Check one:

X The State will not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who lives with the individual(s) served on the waiver.

APPENDIX G – 5

FACTOR D' LOC: ICF/MR

NOTICE: On July 25, 1994, CMS published regulations which changed the definition of Factor D' The new definition is:

"The estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program."

Include in Factor D' the following:

The cost of all State plan services (including home health, personal care and adult day health care) furnished in addition to waiver services WHILE THE INDIVIDUAL WAS ON THE WAIVER.

The cost of short-term institutionalization (hospitalization, NF, or ICF/MR) which began AFTER the person's first day of waiver services and ended BEFORE the end of the waiver year IF the person returned to the waiver.

Do NOT include the following in the calculation of Factor D':

If the person did NOT return to the waiver following institutionalization, do NOT include the costs of institutional care.

Do NOT include institutional costs incurred BEFORE the person is first served under the waiver in this waiver year.

If institutional respite care is provided as a service under this waiver, calculate its cots under Factor D. Do not duplicate these costs in your calculations of Factor D'.

Factor D' is computed as follows:

_X_ Based on CMS Form 372 for years 2001-2002 of waiver #0237.90.

APPENDIX G – 6

FACTOR G

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor G as:

"The estimated annual average per capita Medicaid cost for hospital, NF, ICF/MR care that would have been incurred for individuals served in the waiver, were the waiver not granted."

Provide data ONLY for levels of care indicated in item 2 of this waiver request.

Factor G is computed as follows:

_X_ Based on trends shown by CMS Form 372 for years 2001-2002 of waiver #0237.90 which reflec costs for an institutionalized population at this LOC.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D Do not duplicate these costs in our calculation of Factor G.

FACTOR G'

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor G' as:

"The estimated annual average per capita Medicaid costs for all services other than those included in Factor G for all individuals served in the waiver, were the waiver not granted."

Include in Factor G' the following:

"The cost of all State Plan services furnished WHILE THE INDIVIDUAL WAS INSTITUTIONALIZED.

The cost of short-term hospitalization (furnished with the expectation that the person would return to the institution) which began AFTER the person's first day if institutional services."

If institutional respite care is provided as a service under this waiver, calculate its cost under Factor D. Do not duplicate these costs in your calculation of Factor G'.

Factor G' is computed as follows:

_X_ Other (specify): Based on CMS Form 372 Report for years 2001-2002 for waiver #0237.90.

AVERAGE PER CAPITA EXPENDITURES BY FISCAL YEAR:

YEAR 1:	**$1,890 X 1.00 = $1,890**
YEAR 2:	**$1,890 X 1.02 = $1,928**
YEAR 3:	**$1,928 X 1.02 = $1,966**
YEAR 4:	**$1,966 X 1.02 = $2,006**
YEAR 5:	**$2,006 X 1.02 = $2,046**

APPENDIX G – 8

DEMONSTRATION OF COST NEUTRALITY

LOC: **ICF/MR**

YEAR 1	FACTOR D:	$34,713	FACTOR G:	$98,181
	FACTOR D':	$7,211	FACTOR G':	$1,890
	TOTAL:	$41,924	TOTAL	$100,071
YEAR 2	FACTOR D:	$34,713	FACTOR G:	$100,144
	FACTOR D':	$7,355	FACTOR G':	$1,928
	TOTAL:	$42,068	TOTAL	$102,072
YEAR 3	FACTOR D:	$35,360	FACTOR G:	$102,148
	FACTOR D':	$7,502	FACTOR G':	$1,966
	TOTAL:	$42,862	TOTAL	$104,114
YEAR 4	FACTOR D:	$36,050	FACTOR G:	$104,190
	FACTOR D':	$7,652	FACTOR G':	$2,006
	TOTAL:	$43,702	TOTAL	$106,196
YEAR 5	FACTOR D:	$36,209	FACTOR G:	$106,274
	FACTOR D':	$7,805	FACTOR G':	$2,046
	TOTAL:	$44,014	TOTAL	$108,320

Exhibit 2

February 4, 2009 letter from Dr. Kathi Lacy to Nancy Stogsdill

Stanley [illegible]
State Dir.
Robert W. [illegible]
Deputy S[illegible]
Administra
David A. [illegible]
Associate S[illegible]
Operations
Kathi K. Lacy, Ph.D.
Associate State Director
Policy

3440 Harden Street Ext (29203)
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Kelly Hanson Floyd
William F. Bishop

February 4, 2009

Ms. Nancy G. Stogsdill
1 Hunt Cup Lane
Camden, SC 29020

Dear Ms. Stogsdill:

We received your letter dated January 19, 2009. Related to your request, DDSN does not have a copy of any contract between South Carolina's Medicaid agency, SC Department of Health and Human Services (SCDHHS) and the federal Medicaid agency, CMS. However, in order to be of assistance to you, I am forwarding your request to Mr. Bryan Kost at SCDHHS by copy of this letter. I am confident Mr. Kost will assist you in every way possible.

Thank you.

Sincerely,

Kathi Lacy

Kathi Lacy, Ph.D.
Associate State Director, Policy

CC: Mr. Bryan Kost

DISTRICT I
P.O. Box 239
Clinton, SC 29325-0328
Phone: (864) 938-3497

Midlands Center Phone: 803/935-7500
Whitten Center Phone: 864/833-2733

DISTRICT II
9995 Miles Jamison Road
Summerville, SC 29485
Phone: 843/832-5576

Coastal Center Phone: 843/873-5750
Pee Dee Center - Phone: 843/664-2600
Saleeby Center - Phone: 843/332-4104

Exhibit 3

Affidavit of Thomas C. Joseph, MD, included in Appellant's Fair Hearing Exhibits

Exhibit 4

Prescription by Dr. Joseph Requiring two persons to transfer Appellant

PEDIATRIC ASSOCIATES, P.A.
PEDIATRIC AND ADOLESCENT MEDICINE

THOMAS C. JOSEPH, M.D.
DEA # AJ6868965

MARGUERITE M. CARLTON, M.D.
DEA # BC1043708

1346 HALE STREET
CAMDEN, SC 29020

THEODORE E. KALUTZ, M.D.
DEA # AK9332482

CHRISTINE B. SELLERS, M.D.
DEA # BS4092033

1165 HIGHWAY 1, S.
SUITE 100
LUGOFF, SC 29078

803-432-1931 / 803-432-1932

NAME Richard Daigle

ADDRESS DOB 8-23-81 DATE 4-29-05

℞ (Please Print)

VOID VOID VOID

Exhibit 5

Annual Budget of Richard Stogsdill

KERSHAW COUNTY BOARD OF DISABILITIES & SPECIAL NEEDS
ESTIMATED ANNUAL COST OF SERVICES AS OF: 1/21/2009

Consumer Name: RICHARD STOGSDILL

Service	Service Unit	Cost per Unit	Total Units	Total Cost
Service Coordination	month	132.50	12	1,590.00
Assistive Technology	1	1.00	935	935.05
Personal Care	15 minutes	3.70	3,458	12,794.60
Respite Daily	day	66.40	52	3,452.80
Respite Hourly	hour	8.30	2,240	18,592.00

Total Estimated Cost $ 37,364.45

for Aug 27 - Feb 28

- ~~next~~ thru end of Feb -
- to start ~~last~~ about Voc Rehab.
about plans
~~Voc~~ Rehab
V. to Catawba. MR/RD waiver card.

PLEASE NOTE: THESE ARE BUDGETED SERVICES AND THE COST OF THE BUDGETED ~~SERVICES~~ LISTED HERE ARE ESTIMATES AND ARE BASED ON STATEWIDE AVERAGE COSTS

Exhibit 6

Assessment and Affidavit of Lennie Mullis

CONFIDENTIAL ASSESSMENT

CLIENT NAME: Richard Stogsdill

ADDRESS: 1 Hunt Club Lane, Camden, SC 29020

DATE OF BIRTH: [redacted]

DATE OF EVALUATION: 6/03/09

MEDICAID#[redacted]

DIAGNOSIS: Related Disability

PHYSICAL LIMITATIONS: Cerebral Palsy, Mobilizes with a power wheel chair

MEDICATIONS:
Backlafan
Vitamin C

REASON FOR REFERRAL: Richard Stogsdill was referred for a psychological counseling assessment due to possibly displaying symptoms of depression.

BACKGROUND INFORMATION:
Richard Stogsdill is a twenty-two year old Caucasian male whom resides with his mother and father in Camden, SC. Richard graduated Camden High School in 2007. Richard is currently employed at Vocational Rehabilitation, Monday – Friday.

INTERVIEW:
Consultant had the pleasure of interviewing Richard Stogsdill on Wednesday, June 3, 2009 at his home. Richard has Cerebral Palsy and mobilizes with a power wheel chair. Richard was eager to talk and rapport was easily established and maintained throughout the interview. Richard discussed his current situation. Richard lives at home with his mother, and father. Richard resides in a separate part of the house and receives PCA services for ADL skills (i.e. bathing, dressing, toileting, hygiene, etc.)

Richard is aware of his need for physical assistance from others. Richard is knowledgeable of his physical restrictions. Consultant feels that Richard may experience anxiety as a result of his physical limitations with regards to working and or participating in social situations.
Richard continued his discussion with consultant by expressing his feelings of needing peers, work, and social activities. Richard is very aware that his friends from school are now working or off at college and he indicates that he is left in a transitional state. Richard feels that his parents are over protective and feels that he should be able to have more independence. Richard magnifies and intensifies his parents concerns and supervision. This in turn may create additional feelings of stress, anxiety, and or depression.
Richard enjoys meeting and being with people. He is a very social person. Richard does not anticipate that people may not be as honest or as trustworthy as they may present and therefore he may be at risk for being easily persuaded and or influenced by others.
Richard is able to articulate his feelings and feels that counseling would be helpful.

ASSESSMENT RESULTS:
Richard Stogsdill is a twenty-two year old male with whom resides in Camden, SC, with his parents. Richard has cerebral palsy. Richard displays symptoms of stress with regards to having physical limitations and not having many work or social opportunities in Camden, SC.

RECOMMENDATIONS:
As a result of the assessment consultant suggest the following:

1. Referral to the Disability Action Counsel for community skill development and social awareness
2. Utilizing Clemson Extension services as additional community supports.
3. Assessing possibilities of volunteer work in assisted living facilities for the elderly.

Consultant also recommends counseling to address the following objectives:

to decrease feelings of stress /anxiety
to increase self esteem

to increase communication skills
to increase social awareness

RECOMMENDATIONS:
Consultant recommends counseling to address the following objectives:

to increase communication and social skills with others:
(1) participating in regularly scheduled social activities
(2) participating in a daily exercise program (i.e recommended through OT – to increase endurance and strength)
(3) participating in a weekly support group

to decrease feelings of stress/anxiety
(1) relaxation training (with musical and or relaxation tapes)

to increase communication skills
(1) daily journaling (by typing or verbalization)
(2) art – computer
(3) Participation in theatre and or performing art classes

to increase social skills and to increase self-esteem
(1) participate in counseling activities, which allow for Richard to make appropriate choices in social situations.
   a. Short term goals
   b. Socially excepted limitations
(2) participating in counseling activities that allow Richard to role-play consequences in social situations.
(3) participating in counseling activities that allow Richard the opportunity to state expectations of himself and others (with regards to social situations.)

Counseling is recommended for 4 units per month, or 2 hours monthly, for the next six months.

Lennie Schlager Mullis
Psychological Consultant
WP 9974
6/09

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF KERSHAW	)	
	)	AFFIDAVIT OF LENNIE S. MULLIS

1. I am an approved provider of behavior support and counseling for persons who receive services from the South Carolina Department of Disabilities and Special Needs.

2. I hold a Masters in Science in psychology and Bachelors of Science in psychology and have worked with persons who have mental retardation for 30 years.

3. Prior to becoming a certified provider of behavior support and counseling services for the South Carolina Department of Disabilities and Special Needs, I was the executive director of a local DSN Board and I am familiar with all of the services offered through the MR/RD Medicaid waiver.

4. My sole responsibility in this case is to advocate for Richard Stogsdill and I have no conflicting obligations to any member of his family.

5. I was asked by the Kershaw County Disabilities and Special Needs Board to perform a psychological assessment on Richard Stogsdill because of reports that he may be exhibiting depressive symptoms.

6. I performed this assessment of Richard Stogsdill on June 3, 2009.

7. At the time of my assessment, Richard had graduated from high school and he was attending a work program at Vocational Rehabilitation five days a week.

8. Based on my assessment, I determined that Richard is experiencing anxiety as a result of his physical limitations and is frustrated that he is not able to continue his education with his peers.

9. Richard's anxiety and depressive symptoms have been magnified by the fact that his peers are leaving home and going off to college.

10. Since I met with Richard, the services which were being provided by the South Carolina Department of Vocational Rehabilitation have been reduced and it is likely that they will be terminated soon because that agency was not able to place Richard in a job.

11. Richard has depended primarily on the support of his parents, who are getting older and are not physically or mentally able to continue to provide care at the level they provided prior to his reaching age 21.

12. Richard's anxiety has been increased by his level of dependence upon his parents and it is expected that this problem will increase now that Richard has no opportunity to interact

with non-disabled peers in the community, as he did when he was attending school.

13. Richard has a history of seizures and these seizures may be exacerbated by stress or sleep deprivation. When Richard was attending school and having social opportunities to interact with his peers, these seizures were under control.

14. Based on my assessment, I recommended:

X	participation in volunteer work
X	participation in regularly scheduled social activities
X	participation in a daily exercise program
X	participation in a weekly support group
X	relaxation training
X	daily journaling and art therapy
X	participation in theatre or performing art classes
X	social interaction training.

15. These goals could not be met effectively by placing Richard in a day program operated by the South Carolina Department of Disabilities and Special Needs and placing Richard in such a setting would be inappropriate to meet his medical and psychological needs.

16. Attending a congregate day program, where Richard would be surrounded by persons who have greater cognitive deficits, would be likely to increase Richard's anxiety and depression.

17. It is foreseeable that Richard's mental and physical health would decline if he were required to attend a workshop.

18. The goals Richard has set could be met, however, by providing a combination of adult companion services, personal care services and respite, all of which are services offered through the MR/RD Medicaid waiver.

19. Providing these services would be more cost effective to the State than placing Richard in an ICF/MR facility.

20. Some of the individuals in DDSN workshops exhibit aggressive behaviors and Richard would be unable to defend himself from such individuals, placing him at risk of harm.

21. In my opinion, placing Richard in a workshop would endanger his mental and physical health and welfare.

22. A combination of adult companion services, personal care services and respite services are needed to protect Richard's health and welfare and to provide respite so that his parents can continue to provide supports in his home to delay institutionalization.

23. Providing 76 hours per month of adult companion services would cost approximately the same amount as the cost for Richard to attend the DDSN workshop.

24. Richard's treating physician is most capable of determining the number of hours of personal care which are needed to protect his health and welfare and to allow him to remain in the community.

Further deponent sayeth not.

Lennie S. Mullis

Lennie Mullis is a person who is known to me and I recognize her voice. On ___ June, 2009, Lennie Mullis affirmed by telephone that she has read and affirmed this affidavit, that the above statements are true to the best of her knowledge and that the signature above is her own.

Sworn to before me this 28th day of June, 2009 by telephone.

Notary Public for South Carolina

Exhibit 7

Documents Provided to Appellant as Respondent's Exhibits to be Presented at Fair Hearing

S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MR/RD WAIVER

AUTHORIZATION FOR SERVICES
TO BE BILLED TO SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

TO: Active Nursing
930 Oswego RD Sumter, SC 29153

RE: Richard Stogsdill [redacted]
Recipient's Name Date of Birth

1 Hunt Club Lane Camden, SC 29020
Address

(803) 432-5587
Phone Number

Medicaid # [redacted]

Social Security # [redacted]

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Prior Authorization # RW 2810319

Personal Care Services
___ Personal Care I (PC I) S5130
✓ Personal Care II (PC II) T1019
Number of Units Per Week to be Provided: 70 (one unit = 15 minutes)
Start Date: 2/4/09

Service Tasks Requested:

- ☑ Assistance with personal care activities such as bathing, dressing, toileting, brushing teeth, grooming, shampooing hair, caring for skin, etc.
- ☑ Assistance with meals such as feeding, shopping for food, preparing/cooking meals, post-meal cleanup, etc.
- ☑ Assistance with home care/light housekeeping tasks such as sweeping, light laundry, bed making, changing bed linens, etc.
- ☐ Monitoring conditions such as temperature, checking pulse rate, observation of respiratory rate, checking blood pressure, monitoring medications, etc.
- ☑ Assistance with exercise, ambulation, positioning, etc.
- ☑ Transportation and/or escort services

Please note: Physician's order must be attached for individuals under age 21. MR/RD Form 15 may be used.

Service coordinator/early interventionist: KCBDSN

Name / Address / Phone # (Please Print): (803) 432-4841
PO Box 310 Camden, SC 29021

Kimberly Bowman 2/4/09
Signature of Person Authorizing Services Date

MR/RD Form A-3 (1/05)

S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MR/RD WAIVER

AUTHORIZATION FOR SERVICES
TO BE BILLED TO SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

TO: Active Nursing Services
930 Oswego Rd Sumter, SC 29153

RE: Richard Stovall [redacted]
Recipient's Name / Date of Birth

1 Hunt Coop Lane Camden, SC 29020
Address

(803) 432-5587
Phone Number

Medicaid # [redacted]

Social Security # [redacted]

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Prior Authorization # B W 2 8 0 3 9

Personal Care Services

____ Personal Care I (PC I) S5130
✓ Personal Care II (PC II) T1019
Number of Units Per Week to be Provided: 90 (one unit = 15 minutes)
Start Date: 3/5/09

Service Tasks Requested:

- ✓ a. Assistance with personal care activities such as bathing, dressing, toileting, brushing teeth, grooming, shampooing hair, caring for skin, etc.
- ✓ b. Assistance with meals such as feeding, shopping for food, preparing/cooking meals, post-meal cleanup, etc.
- ✓ c. Assistance with home care/light housekeeping tasks such as sweeping, light laundry, bed making, changing bed linens, etc.
- ☐ d. Monitoring conditions such as temperature, checking pulse rate, observation of respiratory rate, checking blood pressure, monitoring medications, etc.
- ✓ e. Assistance with exercise, ambulation, positioning, etc.
- ✓ f. Transportation and/or escort services

Please note: Physician's order must be attached for individuals under age 21. MR/RD Form 15 may be used.

Service coordinator/early interventionist: Name / Address / Phone # (Please Print):

Kimberly Bennett (803)
PO Box 310 Camden, SC 29021

Kimberly Bennett 3/4/09
Signature of Person Authorizing Services Date

MR/RD Form A-3 (1/05)

S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MR/RD WAIVER

AUTHORIZATION FOR SERVICES
TO BE BILLED TO SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

TO: Home Remedies
2030-H-Lyttleton St. Camden SC 29020

RE: Richard Stogsdill, [redacted]
Recipient's Name Date of Birth

Hunt Club Lane Camden, SC 29020
Address

(803) 432-5587
Phone Number

Medicaid # [redacted]

Social Security # [redacted]

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Prior Authorization # R W 2 8 0 3 9

Personal Care Services
___ Personal Care I (PC I) S5130
✓ Personal Care II (PC II) T1019
Number of Units Per Week to be Provided: 130 (one unit = 15 minutes)
Start Date: 8/27/08

Service Tasks Requested:

- ✓ Assistance with personal care activities such as bathing, dressing, toileting, brushing teeth, grooming, shampooing hair, caring for skin, etc.
- ✓ Assistance with meals such as feeding, shopping for food, preparing/cooking meals, post-meal cleanup, etc.
- ✓ Assistance with home care/light housekeeping tasks such as sweeping, light laundry, bed making, changing bed linens, etc.
- ☐ Monitoring conditions such as temperature, checking pulse rate, observation of respiratory rate, checking blood pressure, monitoring medications, etc.
- ✓ Assistance with exercise, ambulation, positioning, etc.
- ✓ Transportation and/or escort services

Please note: Physician's order must be attached for individuals under age 21. MR/RD Form 15 may be used.

Service coordinator/early interventionist: Name / Address / Phone # (Please Print):

KCBDSN 432-4841
PO Box 310 Camden, SC 29021

[signature] 1/13/09
Signature of Person Authorizing Services Date

MR/RD Form A-3 (1/05).

S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
MR/RD WAIVER

AUTHORIZATION FOR SERVICES
TO BE BILLED TO SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

TO: Home Remedies
2330-A-Lyttleton St. Camden, SC 29020

RE: Richard Staggsdill [redacted]
Recipient's Name / Date of Birth

1 Hunt Club Lane Camden, SC 29020
Address

(803) 432-5587
Phone Number

Medicaid # [redacted]

Social Security # [redacted]

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Prior Authorization # RW 18 10 3 9

Personal Care Services
____ Personal Care I (PC I) S5130
__✓__ Personal Care II (PC II) T1019
Number of Units Per Week to be Provided: 130 (one unit = 15 minutes)
Start Date: 2/26/09

Service Tasks Requested:

- [✓] Assistance with personal care activities such as bathing, dressing, toileting, brushing teeth, grooming, shampooing hair, caring for skin, etc.
- [✓] Assistance with meals such as feeding, shopping for food, preparing/cooking meals, post-meal cleanup, etc.
- [✓] Assistance with home care/light housekeeping tasks such as sweeping, light laundry, bed making, changing bed linens, etc.
- [ ] Monitoring conditions such as temperature, checking pulse rate, observation of respiratory rate, checking blood pressure, monitoring medications, etc.
- [✓] Assistance with exercise, ambulation, positioning, etc.
- [✓] Transportation and/or escort services

Please note: Physician's order must be attached for individuals under age 21. MR/RD Form 15 may be used.

Service coordinator/early interventionist: Name / Address / Phone # (Please Print):

KCBDSN 432-4841
PO Box 310 Camden, SC 29021
Kimberly Bennett 2/25/09
Signature of Person Authorizing Services / Date

MR/RD Form A-3 (1/05)

STATE OF SOUTH CAROLINA COUNTY OF RICHLAND Richard Stogsdill, Petitioner, -v- State Department of Health and Human Services, Respondent.	)	BEFORE THE HEARING OFFICER OF THE STATE DEPARTMENT OF HEALTH AND HUMAN SERVICES PREHEARING BRIEF 09-MISC-017

TO: Ms. Monet S. Pincus, Hearing Officer, South Carolina Department of Health and Human Services, c/o Pincus and Loomis, LLC, 3306 Millwood Ave., Columbia, SC 29205 AND Ms. Patricia L. Harrison, 611 Holly Street, Columbia, SC 29205.

Background:

The Petitioner is a Medicaid beneficiary eligible to receive Medicaid covered services. In this case, the Petitioner receives his services through a Home and Community Based Waiver called the "South Carolina MR/RD Medicaid Waiver" (Waiver). Administration of this Waiver is the responsibility of the South Carolina Department of Health and Human Services (DHHS), but day-to day operations of the Waiver has been delegated to the South Carolina Department of Disabilities and Special Needs (DDSN). When a Medicaid applicant or recipient does not agree with a final determination of the DDSN, the managing agency, appeal is to the Appeals and Hearings Division of the DHHS, and the DHHS is the Respondent.

The DDSN decision appealed in this matter was rendered on March 3, 2009 by Mr. Robert W. Barfield, the then Acting Director of DDSN. This final decision of DDSN was essentially a reconsideration of several alleged failures of DDSN in providing care to Mr. Stogsdill. In the Petitioner's request for reconsideration (Exhibit 1 to Petitioner's Appeal Notice, which is attached) the issues brought to the Acting Director for reconsideration were as follows:

1) That DDSN failed to provide Mr. Stogsdill medically necessary services with reasonable promptness;

2) That DDSN failed to provide services to Mr. Stogdill in accordance with the opinions of his treating physician;

3) That DDSN failed to enlist sufficient providers to enable services to be provided in the appropriate amount; and

4) That DDSN failed to promulgate regulations which comply with the *Olmstead* case and instead fund restrictive residential settings regardless of the individual's need for services.

In his Decision (Exhibit 2 of the Appeals Notice), the Acting Director found that:

1) The DDSN had provided Mr. Stogsdill Personal Care Services since April 2008;

2) The DDSN provided care that was consistent with the orders of his physician;

3) The DHHS was responsible for recruiting and enlisting Personal Care Service providers; and

4) The remaining issues were not relevant to Mr. Stogdill's specific case.

Arguments:

On or about April 1, 2009, the Petitioner appealed the Acting Director's Decision to the Appeals and Hearings unit of the DHHS (Attached). We believe that the essential elements of the Petitioner's appeal can be summarized and responded to, as follows:

Reasonable Promptness: (Item 6 of Petitioner's Appeal Notice) It is true that §1902(a)(8) of the Social Security Act [42 USC §1396a(a)(8)] requires States to "...provide that all individuals

wishing to make an application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals." In Doe v. Kidd 501 F.3d 348 C.A.4 (S.C.),2007, Doe appealed among other issues, the district court's decision to dismiss as moot her § 1983 claim that DDSN and DHHS violated the Medicaid Act by providing her with temporary respite services instead of providing her, with reasonable promptness, the residential habilitation services approved in her 2003 plan of care.

That issue is still on remand to the South Carolina district court and there is some question about whether the reasonable promptness standard requires States to do other than to promptly stand ready to pay for services. See, Bruggeman ex rel. Bruggeman, 324 F. 3d 906 (7th Cir. 2003), Westside Mothers v. Olszewski, 454 F. 3d 532 (6th Cir. 2006), and Mandy R. v. Owens, 464 F. 3d 1139 (10th Cir. 2006). However, there is no need to reach such fine points of the law in this case. Mr. Stogsdill entered the MR/RD Waiver in April of 2008, and was promptly provided services. The amount of the services appropriate may be at issue, but here is no doubt that he began receiving services promptly and those services were promptly paid for.

Reduction of Services: (Items 8, 9 & 10 of Petitioner's Appeal) There is also no doubt that, under §1902(a)(3) of the Act, Medicaid beneficiaries have the right to a hearing if their services have been reduced suspended or terminated. However, in this case no such reduction occurred. In Exhibit 3 of Petitioner's Appeal, the Petitioner sets forth the DDSN Service Coordinator's determination to award 3,458, 15 minute units of service to the Petitioner per week, and then asserts that Exhibit 4, which authorizes 70, 15 minute units a month later was a reduction. Clearly, the first Exhibit was a mistake. A simple calculation (3,458/4=864.5hours of service per week) shows that the Authorization is absurd, since there are only 168 hours in a 7-day week. Therefore, it cannot be determined, from the information submitted that there was a reduction in services.

Services Ordered by Physician: (Items 3, 7, 14, 18 & 22 of Petitioner's Appeal) Physician's Orders are given great weight when determining the level of services authorized for a client. However,

physicians are natural advocates for their patients and, understandably, in an effort to make sure their patients receive adequate services, sometimes err on the side of excess. Furthermore, sometimes physicians are not completely familiar with the non-medical approaches to care that agencies employ. It is nevertheless true that is some circuits, with respect to some services, the orders of the attending physician are dispositive of the issue of whether the services are medically necessary. In other jurisdictions the courts have recognized that while physician orders must be given great weight, they are not dispositive as to the level and type of care appropriate.

We believe that in the 4th circuit, the physician's orders are not dispositive on the issue of medical necessity. In MacKenzie Medical Supply, Inc. v. Leavitt, 506 F.3d 341 (4th Cir., 2007) The court upheld the Medicare Program's rule that said "Even if a supplier has a physician order on file, failure of the patient's medical records to substantiate the condition for which Medicare approves reimbursement subjects the supplier to liability for repayment of that reimbursement to the Medicare program, and possibly to civil and criminal penalties." The result was that a supplier of motorized wheelchairs had to pay money back for not having adequate documentation of medical necessity in addition to the physician's order.

Indeed, the regulations allow the Medicaid agency to set reasonable limits of services. The regulation provides:

> Sec. 440.230 Sufficiency of amount, duration, and scope.
>
> (a) The plan must specify the amount, duration, and scope of each service that it provides for--
> (1) The categorically needy; and
> (2) Each covered group of medically needy.
> (b) Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.
> (c) The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §§440.210 and 440.220 to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition.
> (d) The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.

Provider Recruitment: (Item 12) The State Medicaid Agency is responsible for enlisting sufficient

provider coverage so that its programs, as a whole, reasonably achieve their purposes. Even if that meant (which it does not) that in every case, services coordinators would have an unending supply of service providers that could be effortlessly enlisted, it would not be an issue in this case. The services authorized to Mr. Stogsdill have been provided. It is the quantity of services that is at issue.

Workshops and *Olmstead*: (Items 13, 15, 16, 19, & 20) The *Olmstead* decision stands for the principle that individuals should be provided sufficient supports to allow them to live in the community if their treating professions agree that they can and the provision of such supports does not fundamentally alter the State's method of providing services. *Olmstead v L.C.* 119 S. Ct. 2176 (1999). Mr. Stogsdill lives in the community and is provided community based Personal Care Aide Services. We believe that the evidence will show that his needs are being met with the level of services provided, and that the existence of workshops, which are part of another credible approach of the DDSN, are not somehow reducing the services that Mr. Stogsdill would get if there were no workshops.

Promulgation of Regulations: (Item 17) The DHHS' regulations are at S.C. Code Ann. R. 126.125 et seq. The regulations generally describe the Program as administered in South Carolina. The regulations do not include every detail of the Program. The detailed description of the Program is contained in the various manuals and other documents published by the DHHS and available at it website. Services are provided in accordance with federal and State laws. The impossibility of promulgating regulations that prescribe with specificity the level of service provided in every client's situation is obvious. Mr. Stogsdill's needs are analyzed by his service coordinator, giving great weight to the orders of his attending physician. It is the Department's position that his needs are being met.

Since Mr. Stogsdill's needs are being adequately met by the Respondent through its agent the DDSN, the level of authorization in this matter, must be sustained. Therefore, the Respondent respectfully requests that the Hearing Officer:

1) Inquire into the matter and issue an Order sustaining the DDSN's reconsideration determination of March 3, 2009 issued by then Acting Director Robert W. Barfield;

2) Grant such other resolution of this matter as justice may demand.

Respectfully Submitted,

Richard G. Hepfer
Deputy General Counsel
Department of Health and
Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206
(803) 898-2791 (voice)
(803) 255-8210 (fax)
Attorney for the Respondent

Columbia, South Carolina
June 25, 2009

TRANSCRIPT OF HEARING

BRYSON: All right, we'll go ahead and get on the record. This is an administrative appeal brought by Richard Stogsdill represented by Patricia Harrison. Today's date is May 11, 2010. My name is Jeff Bryson. I will conduct this hearing according to the South Carolina Administrative Procedures Act and the Department of Health and Human Services Regulation 126-150 through 126-158 which is our regulation on appeals and hearings. I will not make a decision today. When I have made a decision I will notify both parties of that decision in writing. During the hearing each party has the following rights: The right to ask questions, the right to call witnesses and present documents, the right to cross-examine witnesses and examine the documents of the other party, and the right to refute testimony of the other party. The Petitioner is Richard Stogsdill represented by Patricia Harrison. The Respondent is the Department of Health and Human Services represented by Rick Hepfer. Other people in attendance we have today is Nancy Stogsdill who is the Petitioner's mother. We have Dawn Shealy of District I, DDSN, Jacob Chorey, DDSN Central Office, Kara Lewis, CLTC, Health and Human Services and Mr. Vastine Crouch, Division of Appeals who's observing today. The issue is whether the Respondents, the South Carolina Department of Health and Human Services Agent, South Carolina Department of Disabilities and Special Needs, was correct in its' decision to reduce the Petitioner's companion and PC II service hours to conform with the limits imposed under the renewed MR/RD Waiver effective January 1, 2010 and to grant an exception of 104 additional units to the 68 hour cap of respite units per month for a total of 172.

HARRISON: Would you go back over that a little bit slower, Jeff?

BRYSON: Yes. All right, the issue is whether the Respondents, that's South Carolina Department of Health and Human Services Agent, South Carolina Department of Disabilities and Special Needs was correct in its' decision to reduce the Petitioner's companion and PC II services hours to conform with limits imposed under the renewed MR/RD waiver effective January 1,

2010 and to grant an exception of 104 additional units to the 68 hour cap of respite units per month for a total of 172.

HARRISON: I have question, Mr. Hearing Officer. Those additional hours were not granted until February after this appeal was filed.

BRYSON: And is that a problem?

HARRISON: Right, well, that would be another appeal. We're appeared to discuss the reduction of the PC II and the companion but we, we certainly the notice that we received didn't inform us that there was, there would be a hearing to reduce the respite hours because when we received that notice those hour—I mean to increase those hours or whether it was correct to increase those because that happened after we filed so, so, that's an issue that we're not prepared today to argue because we haven't received notice that that issue's on the table.

BRYSON: All right so you want to limit the issue to the companion and PC II?

HARRISON: I don't—I mean that's what we received notice of.

BRYSON: All right, does Respondent have any comment about that?

HEPFER: I don't know anything about the timing of the notices. Certainly that will probably come out in testimony but the hearing notice says the hearing will be about the reduction in PC II and companion hours and the allocation of respite services provided to Richard Stogsdill under the MR/RD waiver. It seems like that could include the...

HARRISON: Well, the notice didn't include—the notice did not include a reduction in respite hours so I don't think by a letter ...

HEPFER: I certainly would be willing to go forward...

HARRISON: ...that issue.

HEPFER: ...as you stated if that's—and then see later if indeed the, the adjustment in respite hours are, are, were noticed and when they were noticed.

HARRISON: Well, let's—why don't we go ahead and—I mean we certainly will present our case a different way and have different objections if something—I mean there's no way the notice could have included the question of whether the respite hours are right because they were added

after the notice went out. So I really don't think this court has, has the authority and certainly we're not prepared to address an issue that was not contained in the notice. The Federal Reg's clearly state that...

HEPFER: If, if, if the notice, I would agree, if the notice that was appealed didn't have the—didn't have the adjustment in respite hours then—but I don't know what the timing of the notice was.

HARRISON: The respite hours were approved in February I believe. I mean we didn't even meet with, uh...

HEPFER: The other, other thing is that it certainly would be—and I understand if there's no preparation but it certainly would be economically—economical judicially if we went ahead and took that under consideration but...

BRYSON: Yes, and I guess...

HEPFER: ...and I also don't want to prejudice the Petitioner.

BRYSON: Sure, sure. All right, I do—I notice in my Notice of Hearing of March 19, 2010 it does say that we—that the hearing will be about the reduction of PC II and companion hours and the allocation of respite services provided to Richard under the MR/RD Waiver and whether you can establish the Agency's authority to determine and allocate services under waivers in violation of Federal State Laws Rules and Regulations. Respondent, I'm hearing you don't—you want to proceed with just the PC II and the companion hours? Or do you want to...

HEPFER: Well, I would like to be able to offer in evidence that the respite hours had been adjusted in order to make up in a sense for some of the reduction in PC II hours so in that sense I would like, I would like you to take cognizance of it but...

BRYSON: Well, and in interest of, of, giving fair consideration of all the issues before me today, I, I mean there was no—I got no response from Petitioner's representative to—questioning the—what the hearing would be about based on my notice.

HARRISON: Okay, but the—all of this stems from—there's a process and the process is the notice under the Federal Reg's has to state the law and what is being changed, the notice that is sent out that initiates this process and then you go to DDSN and Dr. Beshemin has to issue a decision and she could not have issued a decision because those services weren't being provided then so we have an opportunity to attempt before any respite hours are reduced, attempt to resolve that issue there then we do the notice of hearing but I don't believe they had been approved when we filed our, our notice of appeal so you just can't—I don't believe that a Hearing Officer can stick a new issue that we haven't had an opportunity to come up through the process with. Certainly I don't have any problem, Rick it's evidence. I won't use that—the tactic that this Agency has used before saying we're not going to let you use this evidence, anything that's happened after you file your appeal because now we know that was wrong. But ALJ sent it back and said you can't do that on evidence. It's evidence. But I think what is being attempted here is to put those hours up for grabs to be able to terminate those or to reduce those and we've received no notice from DDSN about that because I would have, I would have appealed that from there. I think that...

HEPFER: Well, that's okay with me. If you're to exclude cognizance of the 72 hours of respite care. But, but of the appropriateness of that but I do want the right to offer that into evidence of a melioration of the effects of the reduction in PCA.

BRYSON: Well, I, I mean my problem is I mean we are talking about a combination of services consisting of PC II, respite, and companion hours. I don't—and, and, you know, in the interest of economy and expediency I mean I don't, I don't understand—I'm—well, you know, let me think about this. All right so the Petitioner wants to address the companion and PC II hours separate and distinct from the full range of services Petitioner receives?

HARRISON: Well, we filed an appeal back in December or January and the issue was reduction of those services that were being received at that time. Then

later some additional respite was provided and if what's happening now is we're coming today unprepared to argue about whether those services should be reduced. There couldn't be an appeal on whether you reduced the respite services from the—how many an hour, I mean a week is Richard getting now and do we have that authorization?

N. STOGSDILL: I do not have the authorization.

HARRISON: Okay, I have it here somewhere. But we had that authorized in February. I just don't believe that it's appropriate to, to without us—to, to have on the table any reduction in those hours when they were increased after this was filed. I mean that's just—we're giving them to you and we're taking them away.

BRYSON: All right, I will—I'm prepared to proceed but I mean with that restriction, that we will talk about PC II hours and companion hours but, but I just, you know, Petitioner needs to be aware that one of the things I will do here is also is to determine what jurisdiction I do have and if—I would like Respondents to take the time if he will to go through these exhibits and let us try to determine those that are specific to this case and those that are not. You know, I'm very comfortable with what my jurisdiction is and what it isn't and I'm willing to do that. I mean we'll—so the issue is was the Respondent's Agent correct in its' decision to reduce Petitioner's Companion and PC II service hours to conform with limits imposed under renewed waiver effective January 1, 2010 period. Is that it?

HEPFER: Right, except that I would like the leeway to offer evidence in that additional hours were granted in a melioration of the effects of the reduction.

BRYSON: All right, I...

HARRISON: But it's evidence. That's not the issue.

BRYSON: Yeah, all right, I'll allow that. All right, but let us then determine whether or not—I mean my jurisdiction is basically limited to determining whether or not the Agency applied its' policy correctly. And quite frankly, that's what we need to determine right now and that is the extent of my

jurisdiction. That will help me reduce what we see here, something I can manage without keeping us here for days so Respondent if you will take a moment, look at these exhibits and let us decide which are appropriate and germane to the issue before me today and which are not. Or in the interest of time, would the Respondent want to just admit all of them and you know for such probative value as they may contain?

HEPFER: Um...

BRYSON: I mean I don't, I don't know how many of them will be pertinent.

HEPFER: They're all documents. There has been no...

BRYSON: I don't see anything specific to this Petitioner.

HEPFER: And well, since, hey, they're all documents and no one has testified about what they are and where they came from. Some of them are just cases that have been filed or decided and certainly you can take judicial notice of those. The waiver is here and certainly it appears to be a correct and proper copy of the waiver as far as I can tell, of a waiver. No, it's an internal audit report that...

BRYSON: Yeah, this is not the waiver.

HEPFER: It's not the waiver. You got some, it looks like letters from Protection and Advocacy and some articles on protection and advocacy, a Legislative Audit Council report.

BRYSON: Yeah.

HEPFER: A detailed claims report for Mr. Stogsdill which you certainly could take cognizance of. They may have a problem with that but it appears to be an Agency document.

BRYSON: Yeah, all right, well...

HEPFER: So I, I, I without looking through all of them, without having any kind of foundation and I don't have any problem with the affidavits submitted for whatever probative value they have.

BRYSON: All right, so in the interest of time we'll allow them for such probative value.

HEPFER: But I would reserve the right to comment as they are admitted.

BRYSON: Certainly, certainly, certainly. All right.

HEPFER: And my first witness would be (unclear)...

BRYSON: Well, let's, let me go ahead and finish with my preliminaries if you don't mind.

HEPFER: Oh, that's fine.

BRYSON: The official notice of the file for the record I have notice of hearing and receipts for the same from the parties involved. I have Petitioner's Exhibit Number 1 which is the Request for a Hearing and then I guess we have a total now of 29 others for a total of 30. Respondent's Exhibits, a memorandum from J. Chorey to V. Crouch February 18, 2010, one page and a pre-hearing brief of May 6, 2010 prepared by Mr. Hepfer. This testimony will be recorded in the event that a transcript is necessary. I'll ask you to verbalize your answers yes or no. My machine won't pick up a head nod or a head shake. If you don't know the answer to a question, answer truthfully that you don't know. I'd like one witness at a time to speak and for that witness to identify themselves as they begin their testimony. Testimony is sworn. Do I have anyone present today who would have a religious or other prohibition against swearing an oath to tell me the truth in these proceedings? All right. Have an opportunity for opening and closing statements. Although they're not required, they're simply an opportunity to give me a brief statement as to what you hope to demonstrate to me today. The order of presentation is the Respondent first and since it's the Respondent's actions who have brought us here today, Mr. Hepfer do you have an opening statement?

HEPFER: Yes, very briefly. Sometime—some years ago the State (unclear) to a waiver program targeted to this developmentally disabled individuals so the people could live in a community instead of an institution. This was a win/win for the State, saves the State money, participants can get to live in their home, but the State can't afford to be totally responsible to support the individuals in the community and others have to help. Due to budget constraints recently, the testimony will show that the services were limited

and we believe that was an exercise—proper exercise of the State's authority and we believe that in the Stogsdill case those restraints or those limitation were properly implemented.

BRYSON: All right, does Petitioner have an opening statement?

HARRISON: Yes, I do. This case is about Olmstead and about the Americans with Disabilities Act and the Rehabilitation Act, Section 504 of the Rehabilitation Act of 1973. In the Olmstead decision which ironically enough was issued ten years ago and these cuts came during the fiscal year when our President declared 2009 to be the year of community living. The Federal Government has reiterated its' intent to enforce Olmstead and under Olmstead what the requirements for, for succeeding in, in...

BRYSON: Ms. Harrison, let me—it's not an opportunity for testimony yet. I need just a brief statement of what you hope to accomplish before me today.

HARRISON: Okay. Well, I hope—I'm sorry so we can't make opening statements?

BRYSON: Well...

HARRISON: I was talking about the law and...

BRYSON: All right, well, let me—let me stop you right there. My jurisdiction in this case is limited to whether or not the Agency applied its' policy correctly to this Petitioner based on the waiver as it was renewed January 1, 2010. That's the extent of my jurisdiction. That is the extent of what this hearing will cover today.

HARRISON: Okay. And our position is that that action taken by the State is illegal because it violates Federal Law including the ABA, Section 504 of the Rehabilitation Act and the Olmstead decision as decided by the Supreme Court and that this Agency cannot ignore those Federal mandates and for—because they do—they violate those by reducing the services for Richard Stogsdill, that forces Richard into an institutional placement which...

BRYSON: All right, let me stop you again. That is your contention. I do not have jurisdiction beyond whether or not this Agency applied its' policy correctly. The determining factor for me is the waiver as it was approved

by CMS and whether or not in my judgment the waiver was—the provisions of the waiver were implemented correctly in this case. Now, the record contains your contention that this hearing has to do with all these other things from Supreme Court cases to Olmstead to, you know, all these other things, Legislative Audit Council and I'll simply say this. I'm willing to state again, that my jurisdiction is limited to the interpretation of Agency policy in this case. Now, if you're not satisfied with this, that is your right and you may appeal or seek, you know, further appeal on those grounds but the extent of my jurisdiction is Agency policy and how it was applied in this case. I'm not prepared to hear anything else today but that. Now if you're not prepared to proceed, we'll close the hearing and, and we'll try it again either in this venue or some other.

HARRISON: All right, is it your position that Olmstead and the ADA the violations of the Rehabilitation Act are irrelevant....

BRYSON: No ma'am

HARRISON: ...in this...

BRYSON: I have—I'm—I have tried to familiarize myself to the extent that I can but these issues are beyond my jurisdiction. It's not up to me to say whether they apply or not. I mean again, let me say, my issue is, you know, I don't—it's not up to me to decide how the policy got here or or anything other than in my judgment were the provisions of the waiver as amended effective January 1st of this year applied appropriately in Mr. Stogsdill's case period.

HARRISON: Well, I believe we have the right and the Federal Regulations give us right to present the case the way that we believe—and we believe that it is an Olmstead case. We believe that the reason that the State is prohibited from reducing these services is because, you know, when you, when you have—the Medicaid program, it's like a pyramid and at the top you have the Medicaid Act, 1396 et sec. and then below that you have the Federal Regulations...

BRYSON: Right.

HARRISON: ...and then below that you have State statutes and then below that you have State regulations and then at the very bottom of this pyramid you have policies and actions that have been taken by HHS without legislative involvement or regulation.

BRYSON: Right, and let me stop you right there. My jurisdiction is the bottom of that pyramid. You know, I'm not prepared to consider anything above that pyramid and I will say this, it, it appears to me that we are not going to be able to agree today on my jurisdiction, on what I am competent to hear which leads me to believe that we are, we are not going to be able to proceed and I will say for the last time, if you are prepared to argue a case before me today that this Agency made an error in the way it applied the policy spelled out in the new waiver in this case, we can proceed. If you want to speak about anything else then this hearing is closed and we are adjourned.

HARRISON: Okay. Our position is that, that to determine whether the action was taken at the bottom level, this Agency violates the law when you ignore what's above that in the pyramid.

BRYSON: All right, that's, that's your—let me interrupt you and just say, that's your contention, it's clear that we're not going to be able to agree on jurisdiction here today and you—this hearing is closed and you may appeal if you want to take these issues up somewhere else. Does the Respondent have any objection?

HEPFER: Well, I, I would—I guess I would encourage the Hearing Officer to hear Ms. Harrison's arguments and just to determine if you can indeed, as briefly as possible, just to see if you can indeed entertain those issues as jurisdiction and at least today hear some testimony and try to ascertain some facts relative to this case from the Respondent and also certainly from the Petitioner.

BRYSON: All right. Can we limit that testimony to how the Agency applied its' policy which is stipulated by the waiver to the services that are being

provided to Mr. Stogsdill under the waiver as effective January 1st of this year?

HARRISON: Well, here, here's my concern. It's kind of like the Agency came out with a policy that said we will no longer serve black people at this Agency.

BRYSON: Ma'am, I disagree with that. The Federal Government approved in advance the changes we propose to make. If the changes we propose to make in any way were discriminatory to that extent they never would have been approved. I mean what I'm looking at is a—I mean what I have before me is a document that I understand and that is the waiver. And to the extent that this Agency administers the waiver, I'm competent to make judgments about whether the waiver as I understand it was administered appropriately in this case. Now we can talk about Olmstead. I'm pretty familiar with Olmstead. We can talk about a lot of these other things but my opinion does not matter in those things because they're not—they're not within my juris—I'm not competent to make judgments that are more appropriately before the Supreme Court.

HARRISON: Well, here's our problem is that when we've gone to the Supreme Court and we've gone to the Federal Court the Agency has said you're in the wrong jurisdiction, you have to exhaust your administrative appeals and you have to—there is, there is a comprehensive remedial scheme and you're in the wrong place when you're at the Supreme Court and when you're in Federal Court and so here we are back at the administrative level and what we're being told is that the only way this hearing will be heard is if there's a presumption that because CMS approved this waiver, you know, in the Crabtree versus Goetz Case CMS had approved the reductions. In the California case I believe CMS had approved the reductions and what the courts had said is that Olmstead which is administered by a different Federal Agency, the Department of Justice, that that is wrong and that the Agency may not ignore the integration mandate of—the integration mandate of Olmstead and make reductions that CMS approving a cut. I mean CMS—there's documents to show that

CMS has never said no to anything that—any application that the State has approved.

BRYSON: All right, we'll proceed. In the interest of...

HEPFER: Fairness.

BRYSON: Fairness, all right. We'll, thank you, we'll proceed and I'm sorry if I interrupted your opening statement. Would you like to conclude your opening statement?

HARRISON: This case is about a violation of Olmstead and the Americans with Disabilities Act and the Rehabilitation Act. Richard Stogsdill—we'll receive testimony that Richard Stogsdill is a person with disabilities. That's not, that's not at issue which is one of the elements of Olmstead, secondly, that the State determined in this case that these services were necessary and in fact the State, the State increased services last year during a fair hearing over the services that were being provided. We—the third prong of Olmstead is whether the individual prefers to receive services in unity and in this case, Richard Stogsdill—there's no doubt that Richard Stogsdill prefers to receive services. The only issue in this case is the fourth prong of Olmstead which says would providing Richard these services be a fundamental alteration in the way that the State provides services and can these services be provided to Richard in a way that uses the State's resources in a fair and equitable manner? What we're presenting—prepared to present today is to show the court that the—first of all, that the process that these changes were made by was very secretive, that was kept from the legislature and that indeed the changes in this waiver that were implemented due to budget reductions, indeed that DDSN received 31 million dollars that were paid to a rainy day fund instead of providing people like Richard these services. We are prepared to show and the documents that we'll present will show that instead of maintaining the services at the home level what the Agency did when they made these changes to the waiver, is that they increased institutional based respite by seventy percent which was taking the money away from the

people like Richard who want to stay at home. They did away with an option for home-based respite at seventy dollars a day and they replaced it with an institutional rate respite that they were paying one fifty-seven and now they're paying two-seventy. So we will show today that, that these changes, it's all a pretext, that the money has been there, that under the Olmstead Act—the Olmstead Case and the Americans with Disabilities Act, the State can provide services to Richard Stogsdill in his home at less expense than institutional services would cost and we're prepared to present evidence to that effect. We're also prepared to show that the Agency violated the Medicaid Act in failing to provide services that are sufficient in the amount and scope that is necessary to maintain someone like Richard in his home.

BRYSON: All right, good. Is the Respondent prepared to proceed with his case?

HEPFER: Yes sir and, uh...

BRYSON: You can proceed.

HEPFER: ...just in the interest of accommodating Ms. Shealy who has to pick up—has a child care obligation, I would like to call her out of order...

BRYSON: All right, sure.

HEPFER: ...and for the sole purpose of testifying about the, the respite services that are now being provided.

BRYSON: All right, Ms. Shealy, if you will raise your right hand, I'd like to swear you in. Do you solemnly swear or affirm that the testimony you may give me today will be the truth, the whole truth and nothing but the truth?

SHEALY: Yes sir.

BRYSON: All right, you may proceed.

HEPFER: Okay. Ms. Shealy, tell us what you do. Where do work?

SHEALY: I work at the District Office, District I and that's DDSN.

HEPFER: And what's the jurisdiction of District I?

SHEALY: I work with the service coordinators in the Midlands and the Piedmont Regions.

HEPFER: Okay, and would that include the service coordinators in Kershaw County?

SHEALY: Yes.

HEPFER: Okay. Speak up just a little bit because...

BRYSON: We're good. This is state of the art stuff here.

HEPFER: Did you receive a request for an exception to the respite policy for Mr. Stogsdill?

SHEALY: Yes.

HEPFER: And do you have the packet that you received in front of you?

SHEALY: Yes.

HEPFER: Okay. And this is what you use at the District Office to determine how his respite hours should be modified, is that correct?

SHEALY: Yes sir.

HEPFER: Okay. Madam Hearing Officer—Mr. Hearing Officer I'd like to admit this as Petitioner's Exhibit whatever it is or Respondent's Exhibit whatever it is.

BRYSON: All right, does Petitioner have any objection to this item being entered as Petitioners—no, Respondent's Number 3?

HARRISON: I have no objection. What are Respondent's Number 1 and 2?

BRYSON: Respondent's Number 1 is a memorandum from Mr. Chorey to Mr. Crouch on February 18, 2010 and Number 2 is a pre-hearing brief of May 6, 2010. All right, hearing no objection, let's mark this Number 3.

HEPFER: When you received this, Ms. Shealy, what did you do with it?

SHEALY: I reviewed the material and prepared it to be staffed.

HEPFER: Okay. And did you staff it with some other people in your office?

SHEALY: Yes, it was staffed with the Director of District I, John King.

HEPFER: Prior to the staffing, how many hours of respite care had Mr. Stogsdill been approved for?

SHEALY: I think it was 37 hours I believe of respite.

HEPFER: And that would have been limited by the waiver, is that right?

SHEALY: Yes.

HEPFER: Back to, what, 68 hours per month?

SHEALY: Yes.

HEPFER: Okay. And what was your decision, you and your supervisor's regarding Mr. Stogsdill?

SHEALY: With the imposed implementations of the caps that was placed on personal care and companion we thought that 172 hours of respite was sufficient with the other support services per week.

HEPFER: Now that would give Richard what kind of daily coverage would you say? Can you tell?

SHEALY: Well, I hadn't broke it down into how many hours per day.

HEPFER: What about weeks or months?

SHEALY: Per month of what services?

HEPFER: Of respite services and PCH services.

SHEALY: We had recommended 172 hours a month which is equivalent to 40 hours a week of respite.

HEPFER: And the he would have also gotten 28 hours per week of PCH services, right?

SHEALY: Correct.

HEPFER: So that would be a total of 68 hours per week of...

SHEALY: Support...

HEPFER: ...respite and—support services, basically.

SHEALY: Correct.

HEPFER: Okay. All right. And as far as you know right now Richard is still getting the same services he was getting prior to the waiver changes?

SHEALY: Yes.

HEPFER: And but should I guess he not be successful in this appeal it would go back to approximately 40 hours a week of support services—I'm sorry 68 hours per week (unclear)?

SHEALY: 68, yes.

HEPFER: I'm sorry. All right. How long have you been doing this ma'am?

SHEALY: I have worked—I worked at a board, a provider for ten years and I have worked briefly at the Central Office and had done some reorganization

there and as a result of that I'm at the District Office so I've been doing this for about 15 years.

HEPFER: Did you have any personal thoughts or professional thoughts regarding the reductions? What did you think of them?

SHEALY: I can really only speak about the respite but I was—I think that the caps was a good idea, putting caps on some of the services I thought was a good idea.

HEPFER: Okay. Thank you. I have no other questions for Ms. Shealy at this time. Please answer any questions that Ms. Harrison has for you.

HARRISON: Ms. Shealy, what's your full name please?

SHEALY: Catherine Dawn Shealy.

HARRISON: Okay. And tell me, Ms. Shealy, what's your educational background?

SHEALY: I have a Bachelor of Arts Degree. I majored in Sociology and minored in Psychology.

HARRISON: Okay and when and where did you graduate from?

SHEALY: Newberry College in '95.

HARRISON: Okay. And what did you do after you graduated?

SHEALY: I worked with Direct Care at Whitten Center.

HARRISON: And so you were a hands-on caregiver?

SHEALY: Uh-huh.

HARRISON: And for how long did you do that?

SHEALY: Maybe four years, three or four years.

HARRISON: And so you were like the front line caregiver?

SHEALY: Yes, I provided direct care.

HARRISON: Okay, and tell me what happened after—what was your next job?

SHEALY: I worked at the Richland/Lexington Disabilities and Special Needs as a Service Coordinator.

HARRISON: And how long did you do that?

SHEALY: I was there probably seven or eight years.

BRYSON: I will move this a little closer. You've got such a soft voice. Let's put it right there.

HARRISON: And then after you were a service coordinator, what did you do after that?

SHEALY: I worked probably a total of seven years at the Richland/Lexington Disabilities and Special Needs Board. I worked as a Service Coordinator and then I worked as an assistant to the Quality Assurance Director.

HARRISON: And what were your duties there?

SHEALY: QA and files.

HARRISON: And tell me what that means.

SHEALY: We reviewed plans, updated stuff into the data base that they had, updated the CDSS, reviewed files for compliance.

HARRISON: When you say reviewed for compliance, what kind of things were you looking for?

SHEALY: Just to make sure that, you know, like the plan was completed in a timely manner. The service coordinators have to make sure that the plan's monitored, level of care's completed in a timely manner.

HARRISON: So did you make determinations of medical necessity in that job?

SHEALY: No.

HARRISON: Okay. What medical training do you have?

SHEALY: I don't have any medical training.

HARRISON: Okay. So then you worked for—you say you worked for four years as a direct caregiver at Whitten and you worked for eight years as a Service Coordinator and then how long were you doing QA?

SHEALY: I done that less than a year and then I moved on as a Service Coordination Supervisor and I done that in the MR Division as well and the Head and Spinal Cord Injury Division.

HARRISON: Okay. And you did—how long did you hold that position?

SHEALY: I'm not sure. My total years at Rich/Lex combined was probably—maybe seven years.

HARRISON: Okay, so we've got—you said you worked for eight years as a Service Coordinator.

SHEALY: No, my total time including the service coordination, including the QA and including the supervisory roles, my total years at Rich/Lex was probably about seven years.

HARRISON: And how long were you a service coordinator?

SHEALY: I'm not sure. I'm not sure how long I was a service coordinator until I had moved up.

HARRISON: Okay. Thank you. And so for about seven or eight years you were at Rich/Lex but you weren't reviewing—you weren't qualified to do medical necessity reviews?

SHEALY: No.

HARRISON: You were doing just compliance. Did they—do they have all the paperwork in, is that...

SHEALY: Whenever I worked in the quality assurance area, yes.

HARRISON: Okay, now then where did you go from there?

SHEALY: At Rich/Lex or where did I...

HARRISON: Well, you said last we talked you were a service coordinator supervisor. What were your duties there?

SHEALY: I was a supervisor in the MR Division and the Head and Spinal Cord Injury Division and I supervised I think it was about seven or eight service coordinators.

HARRISON: And what did you do there? What were your—when you say you supervise them, what did you do?

SHEALY: I assisted them if they had any questions. You know, I would provide them assistance with anything regarding service coordination. If I needed to go out with them on home visits, court hearings, anything like that.

HARRISON: But you didn't do any reviews of medical necessity of services.

SHEALY: No.

HARRISON: Okay. Now what did you do after you left Rich/Lex?

SHEALY: I worked at Central Office briefly and...

HARRISON: And what did you do there?

SHEALY: I was—well, my job was still the same but they had done some reorganizing at Central Office and then they had developed the District Offices. They developed two districts, District I and District II so my job had moved from Central Office to the District Office.

HARRISON: Okay, I'm sorry. I think we missed something here. You were a service coordinator supervisor at Rich/Lex and then you went to the Central Office and what was your first job at the Central Office?

SHEALY: Well essentially the same thing as program coordinator position.

HARRISON: And what does a program coordinator do?

SHEALY: Basically what I do now which it provides technical assistance to the service coordinators in the Midlands and Piedmont Regions of the State.

HARRISON: And how do you provide that technical assistance?

SHEALY: It's basically as needed. If they're—depending on results from quality assurance reviews, I may have to go out and provide assistance to the service coordinators. I also review plans that the service coordinators do. That's done randomly. I do FTU reports on a quarterly basis.

HARRISON: FTU Reports are?

SHEALY: They're just full time employment of—where we track the service—how many service coordinators we have.

HARRISON: Okay. Now in this job at the Central Office, do you do reviews of medical necessity for services?

SHEALY: No.

HARRISON: Okay. And so then you went to the Dis—how long were you at the Central Office?

SHEALY: I'm not sure how long I was there. It was less than a year and then they had—like I said they done some reorganizing in the Central Office and they had developed the two district offices so essentially my position was moved from Central Office to the District Office.

HARRISON: Okay, and where's your office now?

SHEALY: I'm still with the District Office.

HARRISON: Which is where?

SHEALY: It's located in Clinton. It's on campus at Whitten Center.

HARRISON: Okay. And you provide technical assistance to the service coordinators across the State.

SHEALY: Well, for the Piedmont and Midlands.

HARRISON: Okay. Now—and that's what you do now?

SHEALY: Yes ma'am.

HARRISON: Okay. Tell me something about Richard Stogsdill? What do you know about Richard Stogsdill?

SHEALY: Basically what the service coordinator had submitted to me in the packet for the respite exception. I've never met him. I understand that he has CP and we had determined that he met the medical justification for the respite exception.

HARRISON: Okay. And what, what, tell me what his day is like. What happens when Richard wakes up? Can he get out of bed?

SHEALY: I don't know. I don't know.

HARRISON: Okay. Can he toilet himself?

SHEALY: I don't know. I don't think so. I know that in the justification the service coordinator had said that the mother does have to get up with him periodically for toileting. But I...

HARRISON: Can Richard feed himself?

SHEALY: I don't know.

HARRISON: Can Richard take a shower by himself?

SHEALY: I don't know.

HARRISON: Can he get out of—could he get out of the house if the house was on fire?

SHEALY: I don't know.

HARRISON: Okay. What medical reports did you review to determine that 172 hours was sufficient?

SHEALY: We didn't—I didn't review any medical records.

HARRISON: Okay. Have you, have you communicated with his physician?

SHEALY: No.

HARRISON: Okay. Well explain to me—now what are the number of hours that, that, I understand the normal, if you don't have an exception you can only get 68 hours, is that right, a month?

SHEALY: Yes ma'am.

HARRISON: Okay, and what's---if you get an exception, what is the maximum number of hours you can receive?

SHEALY: 240.

HARRISON: 240 hours a month?

SHEALY: Yes.

HARRISON: Okay. Now explain to me please how you determined that Richard should receive 172 instead of 240.

SHEALY: Like I said, we determined that he did meet the medical justification for the exception. Based on the schedule that the service coordinator had provided we thought that 40 hours a week in addition to the other support services that were being provided was enough.

HARRISON: Okay. So explain to me if Richard has 40 hours a week of these services.

SHEALY: Of respite?

HARRISON: Right. And if his PCA and adult companion were reduced, explain to me how he would live. How many hours does he need to have someone get him out of bed in the morning?

HEPFER: Mr. Hearing Officer, Ms. Shealy's already testified that she didn't—she was not aware of Mr. Stogsdill (unclear).

BRYSON: Yes, and we seem to be focusing on respite and with all due respect, Ms. Harrison, didn't you want to exclude that today and talk only about PC II and companion?

HARRISON: Well, the issue of what is on the table to be cut is PC II and companion. Mr. Hepfer wanted to present the respite issue as evidence to show that that because they're providing these additional hours which are not on the table to be cut because they weren't part of the original notice but I agreed to allow him to provide that as evidence and my point here is that there—

this is all arbitrary, the number of hours that are allowed. No one has contacted Mr. Stogsdill's doctor. No one has...

BRYSON: All right. You may proceed if that's where you're going. You may proceed. But if she's answered your question, she's answered your question.

HARRISON: Okay.

BRYSON: Go ahead.

HARRISON: If he has 68 hours a week total of services that, that leaves a lot of hours in the day. So can you tell me how, in deciding not to give him the 240 that he didn't need additional hours, how did you determine that his safety will be maintained? I'm sorry, how did you determine he would be safe with that number of hours?

SHEALY: Based on the information that was received and reviewed and the schedule that was submitted by the service coordinator again, we thought that we—it was noted that the father works full time outside the home. The mother works part time and we just felt that 40 hours a week of respite was sufficient.

HARRISON: Okay. What obligation does a parent of an adult child have to provide services for an adult child?

SHEALY: What, I'm sorry.

HARRISON: What legal obligation does a parent have to provide services?

HEPFER: Mr. Hearing Officer...

BRYSON: She's not an attorney. I don't know that that...

HEPFER: I don't think that Ms. Shealy can answer that.

HARRISON: Let me ask you this. Were you aware that Ms. Stogsdill has six part time jobs?

SHEALY: No.

HARRISON: Would that have made a difference if you knew how many hours—so did you know how many hours Ms. Stogsdill works a week?

SHEALY: I was told whenever I spoke with the service coordinator and that was the last time I talked with her was last week that the mother works one part time job. That was informed to me by the service coordinator.

HARRISON: Did you ask how many hours a week the mother works?

SHEALY: No.

HARRISON: Okay. So do you have some formula or tell me how you come up with the number of hours between 1 and 240, how do you come up with that number?

SHEALY: We first determine whether or not you know Richard would have met the category and we, like I said, we determined that he did meet the medical criteria for the exception. We look at the other support services that's provided. We look at the schedule that was submitted. We look at the parents, whether or not it's a single caregiver or if there's two caregivers in the home, what, if they work full time and if so, what their hours are.

HARRISON: But you don't ask how many—if someone's working six part time jobs, you wouldn't be interested in how many hours they work?

SHEALY: Usually whenever the service coordinator says that they work full time then I'm assuming that's 40 hours a week but she said that the mother worked a part time job. I wasn't aware that the mother worked six part time jobs.

HARRISON: And how many hours were requested by the service coordinator?

SHEALY: The service coordinator requested 228 hours of respite.

HARRISON: So how did—explain how you decided that those additional 50 or so hours a week were not needed. Do you have a formula or do you—who do you talk with to make that decision or do you make the decision?

SHEALY: I staff it with a District I Director and we had thought that keeping the schedule of Monday through Friday respite the way it was requested, we thought that that was allowable, that, that, you know, that was something that we should approve for the work—the family's work schedule. Saturday and Sunday respite was requested from 8 a.m. until 9 p.m. And so we had elected to reduce those hours.

HARRISON: Okay. And how does, how does, if Mr. Stogsdill was only getting 28 hours a week of PCA and companion, how would he get his lunch prepared or how would he go to the toilet in the middle of the day if the PCA provider wasn't there?

SHEALY: I don't have anything to do with PCA or companions. I didn't reduce that.

HARRISON: Okay, what I'm saying is if the PCA is reduced to 28 hours a week, right, that would be 28 divided by 7, that would be 4 hours a day, right? And so do you know how long it takes him to get ready in the morning, to get out of bed and ready?

SHEALY: No ma'am.

HARRISON: Okay. Do you know how long it takes him to toilet him during the day?

SHEALY: No.

HARRISON: Do you know how long it takes to get his supper ready and to get him prepared for bed in the evening?

SHEALY: No.

HARRISON: Okay. So if, if it takes a couple of hours in the morning to get him up and a couple of hours at night to just put him in bed, if you don't have those respite hours on Saturday and Sunday how will he—how will his needs be taken care of?

SHEALY: I was under the assumption that the family would be able to provide those services.

HARRISON: Did you ask whether either of the parents have an obligation to work on Saturday or Sunday?

SHEALY: I can't remember if the weekend hours were discussed or if it was I don't know if the service coordinator was able to provide me with that information.

HARRISON: Okay. So did anybody with an understanding of Richard's medical needs review his needs during this process to determine how many hours would be provided to him?

SHEALY: I pulled the plan off the CDSS, the plan, the assessment as well as the support plan that the service coordinator completes yearly as well as

monitoring every quarterly and based on the assessment and the support plan it was determined that, like I said, 40 hours a week plus the other support services was sufficient.

HARRISON: Okay. And tell me, the service coordinator, what—is the service coordinator, does she have medical training?

SHEALY: No, a service coordinator doesn't have medical training.

HARRISON: Okay. You said your supervisor is Mr. King?

SHEALY: Yes, John King.

HARRISON: Okay, does he have any medical training?

SHEALY: I don't know.

HARRISON: What is his educational background, do you know?

SHEALY: I don't.

HARRISON: Okay. Are you familiar with decubitus ulcers?

SHEALY: Yes.

HARRISON: Okay, can you tell me how do those—how do those occur?

SHEALY: From being in one position too long like if one wouldn't get turned or repositioned or something like that then it causes skin breakdown.

HARRISON: Did you consider whether if Richard didn't have respite services on Saturday and Sunday whether that could be a problem for him?

SHEALY: I, I'm not sure if that was actually considered or discussed whenever we had made our decision.

N. STOGSDILL: The only question is why that she thought the caps were a good thing. I didn't quite understand that.

HARRISON: That's a good question. Tell me, you said that you thought the caps was a good idea. Can you explain that statement?

SHEALY: Maybe the caps wasn't—they aren't good for all situations. Respite in the past and this is totally opinionated but respite in the past has been widely abused. I'm not saying that it is abused in this case but I've been working in the system for quite awhile. I worked as a service coordinator, a service coordination supervisor and I saw that respite, you know, has been abused

in the past and that's why I said that in some situations caps on services I think is a good thing.

HARRISON: Tell me how you think respite has been abused. You say it's been abused. Explain what you mean by that.

SHEALY: Just that respite hadn't been provided the way it should have been. You know, it just wasn't—I mean like a lot of families have received a lot of respite hours and I just—in my opinion it was like abusing the system because we didn't have caps or maybe the service coordinator wasn't monitoring the situation the way they should have. You know, I don't know but like I said it's on a case by case basis.

HARRISON: Have you ever taken care of a—how much does Richard weigh?

N. STOGSDILL: 120.

HARRISON: A 120 lb. adult for a 24 hour period?

SHEALY: No, not for a 24 hour period. Like I said I worked direct care at Whitten Center shortly after I got out of college and I changed adult diapers, you know, I lifted them, I used the Hoyer lift, I lifted them, I bathed them, I showered them, you know, I turned them, I made sure that they were toileted and clean, I—you know.

HARRISON: And how many hours a day would you work that job?

SHEALY: I worked 40 hours a week.

HARRISON: Were you tired at the end of the day?

SHEALY: Uh-huh. Yes.

HARRISON: How often—did you ever do two shifts?

SHEALY: Yes I have.

HARRISON: Were you tired? Tell me how you felt at the end of two shifts.

SHEALY: Tired.

HARRISON: Are you aware that the—are you familiar with the band system?

SHEALY: I am somewhat familiar with the band system. Not a lot.

HARRISON: Okay. Do you know after January 1st if the bands have been reduced? The bands amounts that were paid to the DSN Board, have they been reduced since January 1st?

SHEALY: I think so. I know they have been reduced. I'm not sure of the date.

HARRISON: But you don't know for certain whether since January 1st they've been reduced?

SHEALY: I don't know.

HARRISON: Okay. Was there a corresponding decrease in the amount Boards were paid when these cuts were implemented?

SHEALY: I don't know. I don't, um, I don't know. I've worked with the service coordinators and I don't know how much is paid to the Boards or anything like that.

HARRISON: The PTOT personal care assistants adult companion services, are they usually provided by the DSN Board employees or by outside contractors?

SHEALY: Most of my experience they've been provided through an outside agency. You're talking about the PCA service?

HARRISON: Well let's talk about PCA, who provides the PCA services?

SHEALY: I would assume that it's provided through an outside agency, a company.

HARRISON: What about PT?

SHEALY: I would assume it's provided by an outside agency as well.

HARRISON: What about speech?

SHEALY: The same.

HARRISON: Okay. What about respite services?

SHEALY: I think it varies. I mean I know that they have to go through and get qualified. They have to go through, you know, certain classes to become qualified to provide the service.

HARRISON: Okay. What's the hourly rate for a PCA?

SHEALY: I don't know. I don't have that information with me.

HARRISON: Okay. But those generally tend to be non-DSN board employees that provide that service.

SHEALY: Respite?

HARRISON: No, PCA.

SHEALY: Yes.

HARRISON: Okay. Anything else? Okay. That's all I have.

BRYSON: All right. Thank you. You may (unclear) if there's no more questions.

HEPFER: I just have one question.

BRYSON: Sure.

HEPFER: During the time when the waiver cuts were implemented, approximately how many requests for additional respite services did you get?

SHEALY: District I received I think it was maybe around 120 respite requests.

HEPFER: Okay, and you reviewed all of those or some of them?

SHEALY: All of them were reviewed by me and my supervisor.

HEPFER: Okay. Did you specifically remember Mr. Stogsdill's case when you—this case came up?

SHEALY: No. I mean I would have to pull the packet, you know, to, you know...

HEPFER: You reviewed the packet.

SHEALY: Yes, I reviewed all 120 of those.

HEPFER: Okay, and when the case—when you knew the case was coming up today you reviewed his packet specifically?

SHEALY: Yes, to become...

HEPFER: All right, thank you. I don't have any other questions.

BRYSON: All right, then hearing nothing—hearing no objection, you are dismissed.

HARRISON: I have one follow-up question to that.

BRYSON: All right. Sure, go ahead.

HARRISON: Were you aware that Richard S. was a plaintiff in the lawsuit filed in December?

SHEALY: No.

HARRISON: Okay. That's all I have.

HEPFER: I don't plan to recall Ms. Shealy and if possible I'd ask that she be excused.

BRYSON: I have no objection.

HARRISON: No objection.

BRYSON: No objection. You're excused. Thank you for your testimony.

SHEALY: Thank you.

HEPFER: My next witness would be Mr. Jacob Chorey.

BRYSON: Mr. Chorey, if you'd raise your right hand for me. Do you solemnly swear that any testimony you may give in this case will be the truth, the whole truth and nothing but the truth?

CHOREY: Yes.

BRYSON: All right, you may proceed.

HEPFER: Thank you. Mr. Raines can get Ms. Shealy downstairs. Mr. Chorey, we have your name. We know you work for DDSN. What do you do there?

CHOREY: I'm the MR/RD Waiver Program Coordinator.

HEPFER: Okay. And what are your duties in that capacity?

CHOREY: I draft policy revisions. I train service coordination supervisors on changes to policy. I advise them if they have questions on interpreting policy, mainly just deal with policy mostly.

HEPFER: Okay.

CHOREY: Nothing operational.

HEPFER: Okay. And be sure to make sure the Hearing Officer hears your answer and also the...

BRYSON: That thing really has right good coverage but if you'll set it—that's good. Let's put it right there.

HEPFER: How long have you been doing this job?

CHOREY: Eight months.

HEPFER: Okay, and what did you do before that?

CHOREY: Before that I worked at one of the local DSN Boards, the Sumter County Board. I was a day services administrator.

HEPFER: Okay. And how long did you do that?

CHOREY: About three and a half years.

HEPFER: Okay. And then prior to that?

CHOREY: Prior to that I was an Employment Specialist or a Job Coach at that same Sumter Board for approximately two years.

HEPFER: Okay, and what's your educational background?

CHOREY: I have a Bachelor's of Science in Psychology and a Master of Arts in Counseling.

HEPFER: Okay and can you tell me a little bit about this MR/RD Waiver and the limits that came about recently?

CHOREY: Sure, as it's been testified, the waiver's been in existence since the early 1990's. It has to be renewed every five years and this most recent revision on January 1st of this year for the first time to my knowledge included service limits on some of the services within the waiver. It also eliminated some services that were previously in the waiver.

HEPFER: Okay. In implementing the changes did the Department of Disabilities and Special Needs do anything to prepare the community or the service coordinators for that eventuality?

CHOREY: Both. DDSN had I believe six informational meetings throughout the State. Those were run by Dr. Kathy Lacy who is the Associate State Director of Policy and Janet Priest who is the MR Division Director. Also DDSN provided training to the service coordination supervisors at each—in each of the four regions of the State and those supervisors were expected to take back the training provided by DDSN and train their service coordination staff on the upcoming waiver changes.

HEPFER: Okay. I'm going to hand you a document and ask you to identify it please.

CHOREY: This is a memo sent from DDSN to service coordination providers notifying them of the trainings that would be held in November and December of 2009 pertaining to those waiver changes and giving the dates, locations and next locations. Also, there's a...

HEPFER: Okay, and is there a sign-in sheet attached to that?

CHOREY: ... there's a sign-in sheet for those service coordination representatives from the various providers who were in attendance at—this is for the Midlands region meeting held at Central Office on November 30th.

HEPFER: And do you know if someone from the Kershaw County Board was here?

CHOREY: Yes, I see the signature of Ruby Thompson from Kershaw. She is the Service Coordination Supervisor for the Kershaw County Board.

HEPFER: Okay and do you know if—do you know if Mr. Stogsdill's current service coordinator attended that meeting?

CHOREY: My understanding is that his current service coordinator is Suzanne Yankovitz of (Unclear) South Carolina and her signature is also on this sign-in sheet.

HEPFER: I'd like to introduce that please as Respondent's Exhibit.

BRYSON: Four.

HEPFER: Four.

BRYSON: All right, sir. Any objection from Petitioner?

HARRISON: No objection.

BRYSON: All right, thank you. Number 4.

HEPFER: All right, now what was the process for implementing these changes for individuals who were actually going to be impacted by the changes?

CHOREY: Well, the expectation was for service coordinators to have contact with the participants and/or their families, talk to them about the upcoming changes and help to discuss with them what other alternatives there might be, what were the best way to meet their needs. In addition to that expectation, DDSN in an effort to be proactive sent out a letter to all waiver participants who we believed would be impacted by the changes informing them of what changes were going to be made to the waiver, suggesting provision of exception to—specifically to the respite service and directing them to communicate with their service coordinators to determine if they were eligible for an exception or in what other ways they could meet their needs through the waiver.

HEPFER: And that collaboration would be on-going, even after the initial determination.

CHOREY: Certainly.

HEPFER: Okay. All right. You heard Ms. Shealy's testimony regarding the implementation of the waiver where there's limits and the exception request for Mr. Stogsdill. Does that seem out—did that seem out of the ordinary to you or did that seem like a usual...

CHOREY: That sounded like the process. I didn't have involvement in Mr. Stogsdill's determination but what she described sounded like the system

that was set up. The circumstances that she cited as well as some others were considered on a case by case basis so of course you would need to get into specifics of each case to know all the reasons but that sounds like the process as I understood it.

HEPFER: Okay. I don't believe I had any more questions for Mr. Chorey. Mr. Chorey, please answer any questions Ms. Harrison has.

HARRISON: Thank you. Mr. Chorey, where did you go to school?

CHOREY: I attended BYU for my Bachelor's Degree and Webster University for my Master's.

HARRISON: Okay, and when did you finish your Master's Degree?

CHOREY: My Master's I completed in 2006, spring.

HARRISON: Okay. And you say you worked for the Sumter DSN Board.

CHOREY: Yes.

HARRISON: How long were you there? What were the years you were there?

CHOREY: I began in a contract position summer of 2003. I was put on full time staff in summer of 2004 and I remained at the Sumter Board until September of 2009. So a little over six years at the Sumter Board between contract and (unclear).

HARRISON: Okay, so you've only been at DDSN's State Office since September 2009?

CHOREY: Yes.

HARRISON: Okay. So you weren't here when the plans were being made to amend the waiver?

CHOREY: I was not.

HARRISON: Okay. Are you familiar with this letter dated June 9, 2009? It's Exhibit 20. Can you tell me who Andy Laurent is?

CHOREY: Dr. Laurent was interim State Director for DDSN.

HARRISON: Okay. Have you—have you seen that letter?

CHOREY: No, I've never seen this letter.

HARRISON: What is your understanding—you're telling us now, now when these meetings were, were conducted it was already a done deal, wasn't it?

Hadn't the Agency already approved the cuts when these meetings were held across the State?

CHOREY: I don't know when the meetings were held. I wasn't part of the Agency when the renewal application was mailed in.

HARRISON: Okay, I think the letter you just—you just gave us was dated November 6, '09 and these were meetings in November and December.

CHOREY: But those weren't the informational meetings. Those were the trainings DDSN provided for service coordination supervisors separate from the informational meetings.

HARRISON: Okay. That letter from Dr. Laurent, have you taken a minute to read it?

CHOREY: I've briefly glanced over it. May I have a moment to read it more thoroughly?

HARRISON: Uh-huh.

HEPFER: Take all the time.

BRYSON: I have a question. What commission is he referring to here in the first sentence? Can anyone enlighten me on that?

CHOREY: That would be the commission that oversees the Department of Disabilities and Special Needs.

BRYSON: Okay, all right.

CHOREY: Okay.

HARRISON: Were you familiar with the fact that the Commissioners were not aware of these changes to the waiver until they were approved by—until they were approved by HHS?

CHOREY: No, my understanding is that the waiver itself was approved by CMS in November of 2009 and this is dated June of 2009 much prior to that.

HARRISON: Are you aware—are you aware that the changes to the waiver were first presented to the DSN Commission, this is Number 8. Were you aware that that was the first notice that the governing board of the Commission had to the changes that were being proposed?

CHOREY: I was not.

HARRISON: Were you aware that it had already been approved in a—were you aware of the—and, um, I'd like to put this into evidence and I should have mentioned or are they already in?

BRYSON: Yeah, I believe we...

HEPFER: Well, they're marked as...

BRYSON: Yeah, they're marked but we still have to determine whether or not they're relevant but I guess if they're coming up indefinitely.

HEPFER: Yeah, I don't have any objection to Dr. Laurent's memo being introduced. As Mr. Chorey testified, it's the first time he's seen it and he didn't write it or—and was not even at the Central Office when it was issued so I would like the document just to speak for itself.

BRYSON: All right, that's fine.

HEPFER: And also the Board, I haven't looked at...

BRYSON: Minutes.

HEPFER: Which, what...

BRYSON: Number 8.

HEPFER: What date of the Board minutes?

BRYSON: May 21, 2009.

HEPFER: May 21st. I haven't obviously read this in detail but I mean if these are the true minutes of the Board then I—they can take—be taken I think at their face value, whatever, whatever probative value they might have.

BRYSON: Sure, all right.

HARRISON: And do I need to go through each of these things?

BRYSON: Well, how is this relevant?

HARRISON: This is relevant that what we will show is that these changes in the waiver had nothing to do with budget reductions and indeed the Agency had 31 million dollars that it paid to a rainy day account and that—that's one of the legs of Olmstead, can, can the Agency provide the services without fundamentally altering their system and the fact that they changed this waiver without public involvement, without the Board's knowing it, without the families knowing it, without even the Commissioners knowing

about it before NCAC approved it gives credence to our allegation that it had nothing to do with budget and it was—the intent was to force people into institutional services. They increased the rate for ICFMR respite from a hundred fifty-seven dollars a day to two hundred and seventy dollars a day and they were taking personal care aide services and adult companion services away from people that wanted to keep their family members at home which would drive them into those services and they were paying more for that.

HEPFER: Mr. Hearing Officer, I have a suggestion about how this might be resolved.

BRYSON: I wish you would help on this and let me say this first. Ms. Harrison, I understand your concerns and I understand what you're getting at but, but my concern is this. My jurisdiction is very narrow and I have—I, I, I'm not prepared to rule on whether or not the South Carolina Commission on Disabilities and Special Needs took some action that was unlawful in May of 2009. All I have is that I'm aware of in my jurisdiction is whether or not the policy that I have before me was applied correctly and I won't say any more, Counselor, I didn't mean to stop you but I'm worried about jurisdiction here and relevance here.

HEPFER: Right.

BRYSON: You know...

HEPFER: Mr. Hearing Officer, I, with the greatest respect I think you may be able to use your wisdom to resolve more of these issues than you think you can and perhaps if Ms. Harrison agrees I will certainly agree to have all these records proffered as evidence. I don't know whether they should actually be admitted in evidence but if Ms. Harrison agrees, I certainly will be willing to exchange briefs with her on the legal relevance of the initial argument she made about Olmstead and how these documents relate to that and they're all right before you and you can look at them and say why the Agency's actions were improper because of either of these documents or the general law in Olmstead and if I could be given the chance to respond to that brief I'd be...

BRYSON: Please do.

HEPFER: ...I'd be happy to do so if you would like to leave that open and I know that there are a lot of legal arguments that can be made and have been made in other jurisdictions about these limits and I think Ms. Harrison should be able to make those. I'm not sure right here in the open forum is a good place to do it because there are a lot of arguments and obviously a lot of documents so I certainly would be willing to exchange legal briefs with her on these legal issues and then allow us to get some factual evidence in the record also.

BRYSON: All right, that's fine. Then that's what I'd like to do is to see if we can't get some factual evidence specific to this case in the record. It's Respondent's testimony. Continue. Wasn't it Respondent's testimony?

HEPFER: No, Ms. Harrison was cross-examining...

BRYSON: Oh, that's right, Petitioner's test—yes...

HEPFER: ...Mr. Chorey.

BRYSON: ...Respondent's case is finished. All right, I'm sorry. Go ahead.

HARRISON: Okay, I'm sorry, we've kind of gone around a number of things. I need to focus back where we were. So you came in September and you were not aware then that these changes were approved by HHS before the Commissioners or DDSN knew about that?

CHOREY: No.

HARRISON: Okay.

CHOREY: That's not my understanding.

HARRISON: Then we're going to agree—see my concern is that, that the review at LJ is not de novo, it's based on the record we have here.

BRYSON: Sure, absolutely.

HARRISON: So if, if the, if the understanding—if my understanding is correct that we will be able to get all of these, these documents and these facts in through another—through a brief then...

HEPFER: Yeah, that would be...

BRYSON: I'll allow that so that we don't have to spend the time to try to argue their relevance here.

HEPFER: But to be honest and to be fair, Ms. Harrison and Ms. Stogsdill should be able to present those legal arguments referenced to this—although I'm not sure orally here in the hearing venue is appropriate and Mr. Bryson, Mr. Hearing Officer Sir, you may learn from Ms. Harrison's (unclear) that you can impart more wisdom to this than you think you can.

BRYSON: Well, I'm willing to entertain that possibility so please proceed.

HARRISON: So we will be allowed then to file a brief that will contain all of these kinds of things about...

BRYSON: Yes.

HARRISON: ...about how the waiver changes came to be.

BRYSON: Yes, I have no objection to that. I'm just—I don't know how we could possibly get there today.

HARRISON: Okay, but I—I just, if my only shot is...

HEPFER: Sure.

HARRISON: ...with this witness, then I'm going to...

BRYSON: Take your shot, yes ma'am, please do.

HARRISON: Okay, so we're not going to be able to do the briefs and present these additional things?

BRYSON: Well, yes...

HEPFER: (Unclear) and perhaps maybe—maybe I was unclear but I thought perhaps we could, we could brief—you could brief the relevance and the legal importance of these documents and the cases that you referenced in a brief and you could follow-up with Mr. Chorey on nailing down any factual issues that you wanted to...

BRYSON: Specific to the case.

HEPFER: ...right. Is that okay?

HARRISON: Okay, so we're going to do the briefs?

HEPFER: Right.

HARRISON: And then if there's any questions that come from that briefs we can...

HEPFER: No, I would say Mr. Chorey here as a witness can...

HARRISON: Okay, but I will be able to get these things in through the briefs.

BRYSON: Sure.

HEPFER: Well, if they're relevant.

BRYSON: And that's—and I have concerns about that but I'll entertain briefs from both parties is what I'm hearing.

HARRISON: Okay. I just want to make sure they're in the record so that when we go on up.

HEPFER: Absolutely and they should be.

HARRISON: ...because, I mean we have a basic disagreement here that I think the Agency believes that if we—if the Agency approved this and CMS approved it, all this hearing is about is did we comply with what CMS Atlanta required of us. I mean that seems to be—did we follow the steps that CMS requires? Our position, of course, is that anything both agencies do is, is also under the realm of Olmstead...

HEPFER: Sure.

HARRISON: ...and, and that just because CMS Atlanta approved this waiver amendment, as they've approved everything, that doesn't mean that Richard's rights under the Medicaid Act and rights under the ADA and the Rehabilitation Act were not violated. So I mean I think we have a basic disagreement about what this hearing is about.

HEPFER: And of course you understand also that I guess the Hearing Officer feels some trepidation about trying to get into those legal issues but...

BRYSON: In this forum.

HEPFER: ...I hope, I hope with your brief and with my response brief we'll be able to convince him that he possibly can.

BRYSON: Yes, I'm willing to entertain that.

HARRISON: So do you have any know—any personal knowledge of Richard Stogsdill?

CHOREY: No.

HARRISON: Okay. So tell me what the purpose is for your testimony today. What were you told by someone other than your lawyer—well, it's not your lawyer. Okay, tell me what you were told about your testimony today.

HEPFER: No, I represent Mr. Chorey today and his Department also.

CHOREY: Well, one of my roles in my job is to testify in these type of fair hearings to represent our Agency so even if I didn't have a direct role in the determination, I still would have a role in testifying to the processes that have been developed and any related information that I'm aware of.

HARRISON: So you were told that your purpose of being here was to testify and to show that the process the Agency used met the law?

CHOREY: That the process was implemented appropriately per the regulations that we operate under.

HARRISON: So is it—do you have any information other than the fact of how after the decision was made to make these cuts, how people were informed and how the Agency went about carrying out that decision? Do you have any personal information about how the cuts and why the cuts were really made?

CHOREY: I know why the cuts were made for personal care to and companion services.

HARRISON: Okay.

CHOREY: It's due to a new service limit.

HARRISON: And why were they...

CHOREY: I also understand that respite was cut due to a new service limit and that there was opportunity for an exception and I've been brought here today in part to talk about the process for obtaining an exception and the process for determining the number of hours through an exception.

HARRISON: Okay. Let's talk about—why was a PC II cap implemented?

CHOREY: Why the cap was implemented?

HARRISON: Right.

CHOREY: I may have been misunderstood. I understand why those services were reduced for consumers, for waiver participants and that reason is because

there was a cap instituted. I was not part of the reason or part of the meeting involving the reasons for the cap being instituted.

HARRISON: So you don't know why they instituted the cap?

CHOREY: I don't have a full understanding of those decisions.

HARRISON: Okay. Do you know—the PCA services and adult companion services, are those provided mostly by the local boards or by private providers?

CHOREY: Personal care services to my understanding are usually provided by agencies (unclear) DHHS.

HARRISON: So agencies that are not DSN (unclear).

CHOREY: Correct.

HARRISON: What about adult companion services, are they usually provided by DSN Boards or private providers?

CHOREY: Off the top of my head, I don't recall.

HARRISON: What about the nursing services that were capped? Are those usually provided by private providers or DSN Boards?

CHOREY: Those would be provider agencies.

HARRISON: What about speech services, are those usually provided by the DSN Boards or were they provided by private entities?

CHOREY: Private entities.

HARRISON: OT?

CHOREY: Yes.

HARRISON: PT?

CHOREY: Yes.

HARRISON: Okay. So it appears that most of these services that were cut were the services that were provided by private agencies versus the DSN Boards, is that an accurate statement?

CHOREY: I guess that depends on how you look at it. If you consider reductions to respite for which a lot of the providers could have been Board employees, then that casts a different light on it.

HARRISON: Okay, let's take out respite for a minute. All the other services that were cut or capped, were they mainly DSN Boards or mainly, or mainly...

CHOREY: Mainly contracted providers.

HARRISON: Okay. Let's talk about the respite. Are those mainly DSN services or mainly DSN Board provided services or mainly, or mainly private entities?

CHOREY: I don't know what the breakdown is for how many are provided by outside companies and how many are by DSN Boards.

HARRISON: But is it accurate to say that many of the respite services are provided by the DSN Boards?

CHOREY: I honestly don't know how many. I can't give an estimate as to the percentage.

HARRISON: Okay. Do you know why they allowed the exception for respite but no exception for the PCA II services?

CHOREY: I do not know.

HARRISON: Who made that decision?

CHOREY: I don't know. I didn't work for the Agency at the time of the decision.

HARRISON: Okay. And who is your supervisor?

CHOREY: Angela Syfert. She's the Director of Service Coordination and Plan Development.

HARRISON: And her supervisor is?

CHOREY: Janet Priest, Mental Retardation Division Director.

HARRISON: That's all.

BRYSON: No more questions?

HEPFER: I have no other questions for Mr. Chorey.

BRYSON: All right.

HEPFER: I have no other witnesses.

BRYSON: All right, so that' the extent of Respondent's testimony. Do you have some additional testimony for me?

HARRISON: Yes, we have Ms. Stogsdill.

BRYSON: All right, please proceed. Do we need to dismiss Mr. Chorey or may you have some additional questions for him later. Any preference?

HEPFER: You're welcome to stay, Mr. Chorey. I don't plan to recall you.

HARRISON: Could we have a bathroom break?

BRYSON: Yeah, absolutely. We'll go off the record until you return. All right good. All right, we are back on the record. As I recall Petitioner was testifying or preparing to testify, Ms. Stogsdill I believe. Are you ready for me to swear her in, Ms. Harrison?

HARRISON: I am.

BRYSON: Ms. Stogsdill, will you raise your right hand. Do you solemnly swear any testimony you may give me today in this case will be the truth, the whole truth and nothing but the truth?

N. STOGSDILL: I do.

BRYSON: Thank you very much. Ms. Harrison, you may proceed.

HARRISON: Okay, would you please state your name for the record.

STARR: Nancy Stogsdill.

HARRISON: And...

HEPFER: Before you get started Ms. Stogsdill and Mr. Hearing Officer I think my—both of my main witness, Mr. Chory and the observer Ms. Lewis would possibly like to leave in some reasonable time this afternoon.

BRYSON: Give me a nod and you'll be dismissed.

HEPFER: All right. Thank you.

BRYSON: If Petitioner has no objection.

HARRISON: No, I have no objection. Okay. And I believe that you are the mother of Richard Stogsdill.

N. STOGSDILL: I am.

HARRISON: Tell us something about Richard.

N. STOGSDILL: Richard is 22 years old. He was born three months premature and has been diagnosed with cerebral palsy, severe. His mind is just fine. He is a very normal young man in a body that just can't do. He wants all the things that a normal 22 year old would want. He wants to do all the things that a normal 22 wants to do and he cannot do it by himself. He is incapable of I guess the every day, normal, daily routines that we all take for granted. He tries. But he is incapable. He can with help do some

things but he cannot be by himself for any length of time. He is stuck in a wheelchair.

HARRISON: What can he do by himself?

N. STOGSDILL: He can drive his wheelchair. He can work with maybe one or two fingers on his left hand on a computer. He can feed himself if his food is prepared, cooked and prepared and cut up. I mean, you know, small things, very small things.

HARRISON: Now when I went to high school the kids with disabilities went to a regional center or somewhere else and they weren't in our classroom. Can you describe Richard socially and what his high school experience was like. Was he hanging mainly with the disabled kids or was...

N. STOGSDILL: No, not at all. He was hanging with the football team. Those were his buddies. Those were the people that he ate lunch with. Those were the people that supported him in school. He didn't hang with the kids with disabilities because he'd known—I mean he's just been brought up with normal people, normal kids, normal, you know—and therefore I guess he wants that. That's very important to him and he's got very, very good friends that are normal kids, in college, getting out of college. He's very frustrated by the fact that he can't be a part of their life because he's stuck and—but he's got a good attitude. I mean he does what he can when he can and I have—even though I'm his mother and I know I'm prejudiced but he's a good kid. He—you don't feel sorry for him because he's got that kind of a upbeat attitude but I know he's frustrated and I know he gets upset but if ya'll saw him, you would never know it.

HARRISON: Now Richard was in school until what age? How old is he now?

N. STOGSDILL: He will be 23 in August. He was in school until he was 21.

HARRISON: So up until two years ago he was in school?

N. STOGSDILL: Uh-huh.

HARRISON: Okay. And what happened after—so you were receiving personal care services and you were—what was your day like when he was in school? What was his day like when he was in school?

N. STOGSDILL: What was his day like? Two aides would arrive at the house about I think it was six o'clock in the morning. They would get him up. They would get him dressed. They would get him showered. Feed him breakfast. Get him ready for school. Make sure all his books were together and then they would drive him to school. And so that's about—from six to about seven-thirty, I think he was due at school by seven-thirty, quarter of eight, give or take and then in school he would have a personal aide supplied by the school district that would be with him the whole time he was at school.

HARRISON: So he had somebody one on one with him the whole time in school?

N. STOGSDILL: Yes he did.

HARRISON: Okay.

N. STOGSDILL: And then at two-thirty, quarter of three, whenever he got out the aides would go pick him up and take him to whether it was a doctor's appointment or—he walks with a great deal of support so they would take him to various and sorted places so he could walk with his gate trainer or his walker or at that point it was a Rifton gate trainer I think.

HARRISON: Now when you say he walks, can he walk by himself?

N. STOGSDILL: No. No, no, no. I mean he is strapped in. He's got arm supports, leg supports. He's got a seat because he spasms and he buckles and so he—no, he cannot stand by himself. He cannot—he can't really sit by himself.

HARRISON: So he walks in this contraption.

N. STOGSDILL: Yes.

HARRISON: That, that helps him that—can he do that by himself...

N. STOGSDILL: No.

HARRISON: ...or does someone have to be right there?

N. STOGSDILL: No, you need two people to get him in. You need two people to get him out and you need two people with him at all times.

HARRISON: So you had, while he was in school, two personnel. Why does it take two people?

N. STOGSDILL: His spasticity hits him and he doesn't know when it's going to hit so he could be sitting in a chair then all of a sudden he would just sort of fall

over. Same thing when he's walking. His legs buckle on him. His right side is very much more involved than his left so his right side has very little strength. He cannot pull himself up without help.

HARRISON: So can he kind of drape his arm around you to, to get him out of bed or is it dead weight?

N. STOGSDILL: He's dead weight.

HARRISON: Okay.

N. STOGSDILL: I mean he tries. What can I say? He tries but you've got to be careful because he could spasm at any second and then he would lose complete control and you would have no recourse but he'd fall.

HARRISON: Okay. And how tall is Richard?

N. STOGSDILL: He must be about 5'5" I guess, 5'4", 5'5", something like that.

HARRISON: And how much does he weigh?

N. STOGSDILL: Between 115 and 120.

HARRISON: Okay. And then after school, now you worked full time...

N. STOGSDILL: I did.

HARRISON: ...when he was in school, did you not?

N. STOGSDILL: I did.

HARRISON: And what was your job?

N. STOGSDILL: I worked as a bookkeeper for a landscaping company.

HARRISON: Okay. Now when he left school did that leave a hole in his services?

N. STOGSDILL: It did. We waited and waited and waited for VR services, Vocational Rehab. We were told that he would get it as soon as he got out of school. Well, it was I think the following February so he went from May until February with nothing, literally nothing to do.

HARRISON: So were you able to keep your job?

N. STOGSDILL: I kept it for awhile but it was—it was too tough, it was too tough. He was being left alone far too long. It made me nervous. His dad was out of town a lot on his job. I was 45 minutes to an hour away and we relied on friends—and I don't have any immediate family in the area. My husband does but they're—they all work. They're—some of them are very elderly.

I just couldn't do it anymore. I did it for a few months and then I just—I had to quit because I—you know. I just—I'm sorry, he comes first.

HARRISON: Okay. Did, did—can he be left alone?

N. STOGSDILL: No, no. He, he should not be left alone.

HARRISON: And why is that?

N. STOGSDILL: Well, he lives in a house separate from us. It is attached by a breezeway but it is a total separate entity. We have intercoms, we have alarm systems. We've done everything we can but if he drops something, his phone, he can't pick it up. He can't call for an emergency. If he—he gets tired easily. People with CP tend to burn many, many more calories and he wears out quite easily. He wants to go lie down in his bed. If he's in his bed, he can't work his phone, he can't punch the emergency button. He can't do anything. So somebody has to either be in his house with him or at least within intercom distance and we have two sets in case one doesn't work. We have backup.

HARRISON: So does Richard want to work?

N. STOGSDILL: Oh, he would love to work. He volunteers right now. He volunteers at two places in Camden and loves it because it's people oriented and he likes the socialization.

HARRISON: And what does he do there?

N. STOGSDILL: He works at the vol—at the fine arts center. He hands out programs. He takes tickets, he welcomes people, he chats with people. He has a great time. And then he works at the local long term care which is part of the hospital and he goes up there and he reads to the residents and he'll play bingo with the residents and the best part is if he wins, he gives it back to the residents and they just think he is top notch because they don't win very often. But again, he's with people. He cares for people and he likes to help people. That's part of him.

HARRISON: Now to get to these jobs, now were you able to stay retired?

N. STOGSDILL: No, no.

HARRISON: So tell me about your work situation.

N. STOGSDILL: Well, I don't know where the one part time job came from because I actually work six part time jobs in Camden, well, one of them is out of town but five of them are in town and it's six part times equals one full time at least. I mean I couldn't stay retired. I had to make ends meet and Richard's, you know, it's not inexpensive, it's not cheap to have a child with disabilities. And my husband works out of town sometimes. He's on the road a lot and for me to be an hour away, it just didn't work. So now I'm at least, you know, within phone call distance, in fifteen minutes usually.

HARRISON: Okay, so Richard went to VR to try to get a job.

N. STOGSDILL: Right.

HARRISON: And now he can't ready to go by himself, can he?

N. STOGSDILL: No, no, he needs...

HARRISON: So he still has the personal care attendant.

N. STOGSDILL: Yes.

HARRISON: There's two to get him ready in the morning?

N. STOGSDILL: Yes, yes.

HARRISON: Okay, now do you have any health problems, back problems?

N. STOGSDILL: I do have back problems. I've been seeing a chiropractor for quite awhile. I'm—I've been to orthopedic people. I've been to, you know, massage people. I mean I've done—but the back, the lower back is the biggest issue for me.

HARRISON: So are you able to lift him?

N. STOGSDILL: No, I cannot.

HARRISON: Okay. So he has two people to lift him in the mornings and to get him ready.

N. STOGSDILL: Uh-huh.

HARRISON: And if he, if he went to a workshop, would he still need that?

N. STOGSDILL: If he went to a workshop? Yes, he would still need—oh yes, to get him ready to go, absolutely, absolutely.

HARRISON: Okay. And then has some personal care att—so he has how many hours in the morning?

N. STOGSDILL: They come in at seven from seven to eight-thirty and then they come back at, well it depends on the day. Mondays and Wednesdays they come in at one-thirty to six, Tuesdays, Thursdays and Fridays they come in from three-thirty to six. They do take him to his volunteer work. That's the difference in the hours.

HARRISON: And now his, his adult companion takes him to these jobs, does...

N. STOGSDILL: The adult compan we have up to at the moment, we have up to fifteen hours a week. They tend to do more social things. They go to a library so he can use—learn how to use different computers because we think maybe one day we might find him a little part time job so—he loves computers. He would like very much to become much better on it. They go to the grocery store so he can learn how to buy groceries.

HARRISON: Now if he didn't have these hours and you're working, what are the—would it be safe for him to be at home?

N. STOGSDILL: It would not be safe.

HARRISON: Okay.

N. STOGSDILL: Absolutely not.

HARRISON: Okay. Now how would—are you familiar with the Disabilities Board in Kershaw?

N. STOGSDILL: Uh-huh.

HARRISON: I believe at one point you served on the Board.

N. STOGSDILL: I did.

HARRISON: So you're pretty familiar with what they do.

N. STOGSDILL: Uh-huh.

HARRISON: Can you describe please for the Hearing Officer what the workshop is like at the Disabilities Board.

N. STOGSDILL: The workshop is a group of individuals that are, I believe, assigned to different areas, different tables. I don't know how or why they're assigned but anyway they sit there a lot doing what, I think it depends on how many

contracts they have, whatever piece work I think they call it and I have been—I have not been there as much recently as I was when I was on the Board but I have been there enough recently to know that that would be unbearable for Richard. There are—when I have been there I have not seen anybody that could communicate on Richard's level. This is—this is the extra tough part is Richard is normal mentally. Physically he fits right in but mentally he would be devastated to have to go to a workshop setting and he would not get anything out of it. I mean it would be just biding his time.

HARRISON: How—approximately how big is the room with the, with the, um, with the workshop?

N. STOGSDILL: The workshop, oh, it's huge.

HARRISON: And how many people are in there?

N. STOGSDILL: That would be a real guess. I don't know that I could answer. I'm guessing sixty, fifty. I really don't know. I can't answer that.

HARRISON: So you've got a big room with fifty or sixty people with disabilities.

N. STOGSDILL: Uh-huh.

HARRISON: And what do they do at the workshop? Can they walk around and...

N. STOGSDILL: I think they're pretty much assigned to that table. I know there are some folks out there that due to their disability they get up and walk around but I don't think that's—that's not what they want them to do but there's just—there's a lot of things that go on out there that—I mean these people have no control over what they do and so they have behavior issues. They have anger issues. They have—they just have all sorts issues that Richard doesn't have.

HARRISON: Are people ever assaulted at the workshop?

N. STOGSDILL: They have been. I do know that, yes.

HARRISON: Have you seen the affidavit of Lennie Mullis?

N. STOGSDILL: Have I? Yes.

HARRISON: And tell me who Lennie Mullis is.

N. STOGSDILL: Lennie Mullis is, I don't know by degree. She's, she's a social—she's a social worker.

HARRISON: She's—I believe she provides behavior support services.

N. STOGSDILL: She does. Okay, I didn't know what—but anyway she has counseling.

HARRISON: Counseling, okay.

N. STOGSDILL: She has been working with Richard for several months. We were concerned and this actually took place because there was some, some people said they thought Richard was depressed and we wanted to make sure that this was not going to be—become anything serious. Lennie came in and talks to him and lets him vent and lets him express himself and I can't speak for Lennie but I think she would agree that Richard's problem came from being stuck and that is the term he used. I'm tired of being stuck and not getting out and not doing things that I want to do and Lennie's been great because she has allowed him to vent those things, not that he doesn't tell us but sometimes it helps when you tell somebody outside a family member and Lennie has done a great job.

HARRISON: What is her opinion about whether the workshop—have you talked to Lennie about...

N. STOGSDILL: I have...

HARRISON: ...whether the workshop would be appropriate?

N. STOGSDILL: ...and she says it would not be good for him. It would be—he would be stigmatized. She said she feels that because he would not have a relationship, a communicating relationship with many of the people out there she feels that he would regress and it would not be a healthy environment for him physically or mentally.

HARRISON: Now when Richard was in school did he receive PT and I would bring ya'll's attention to the affidavit of Lennie Mullis.

BRYSON: I think you got it right here.

HEPFER: That's right.

HARRISON: Do I need to move these in or they're all in?

BRYSON: I think they're...

HEPFER: She obviously can't—she can testify who Lennie Mullis is but she obviously can't testify as to the truth of this. I mean your witness of—so I think the affidavit...

HARRISON: But do I need to—these are considered to be in evidence for purposes...

BRYSON: Well, for the purposes of preparing briefs I believe. Correct me on this. Didn't we agree we would take them for such probative value as they may contain?

HARRISON: Okay.

HEPFER: (Unclear).

BRYSON: So I guess that they're included.

HARRISON: Okay.

HEPFER: To say they're in evidence is a little bit—I mean there's been no...

BRYSON: There's been no (unclear).

HEPFER: I have no, I have no problem with them being a part of the record, proffered for—to be a part of the record but to say they're in evidence is a little bit more than I want to agree to and I think you understand why.

HARRISON: Well, I want to make sure that if we do need to appeal...

HEPFER: Yes, they are...

HARRISON: ...they'll be in the record.

HEPFER: ...I think they're part of the record for a (unclear), yes ma'am.

BRYSON: Right. I'll concur with that.

HARRISON: Okay. Now when, when Richard was in school, did he receive PT services?

N. STOGSDILL: He did. Through the school and OT and speech.

HARRISON: Okay. And why does Richard need to receive PT services?

N. STOGSDILL: Well, he, with cerebral palsy, if you don't use your muscles, they—you can draw up even more than he is. You could, just like anybody else, you've got to exercise to maintain—for advance, I mean this is a young man that was told he would never walk and yet due to his determination and some fantastic physical therapists, he is walking, with a lot of support

but needless to say he's, you know, in my book there's a lot of stuff he could be doing but he needs help. I mean...

HARRISON: Have you seen any regression without these services?

N. STOGSDILL: Yes, absolutely.

HARRISON: Tell me about the regression.

N. STOGSDILL: His right, right hand and arm have drawn up quite a bit. I mean he used to be able to keep it down like this and now it's pretty much up like that. His right leg draws up much more. We have to strap it down in his wheelchair for safety reasons and it—you can see the resistance because he has marks if we're not really careful with padding, you can see marks on his foot from the strap.

HARRISON: Now have you been able to avoid with the services you have in place Richard getting decubitus ulcers?

N. STOGSDILL: He has had—he has had one and it—because he was sitting in his chair for too long without getting out or at least changing his position and it came up so fast I, I mean I was shocked and unfortunately it comes up fast and then takes forever to go away because it was right on his fanny and it's hard to keep them off if you don't have somebody there to, you know, move them.

HARRISON: Will it be more likely that he will be sitting in his chair if these services are reduced?

N. STOGSDILL: Yes, yes.

HARRISON: What about OT? Tell me about why Richard needs OT.

N. STOGSDILL: Well, from a practical point of view, it would be nice if he could use his right hand to do something. At this point he cannot use his right hand to do anything. He used to be able to. He used to be able to hold a cup. He used to be able to use his thumb on the computer. He used to be able to use it to kind of push things on a spoon if he was feeding himself. He used to be able to hold the book with one hand and turn the pages with the other and that's all gone.

HARRISON: Okay. What about speech services?

N. STOGSDILL: If Richard was sitting here and was talking to you all, you all probably would not understand very much of what he had to say. If you know Richard you can understand him most of the time. His speech has definitely declined.

HARRISON: Since those services were terminated?

N. STOGSDILL: Yes, yes, very much so.

HARRISON: Now up until recently you were using the DSN Board to provide your service coordination, were you not?

N. STOGSDILL: I was.

HARRISON: Was the service coordinator from the DSN Board effective in getting the services he needed?

N. STOGSDILL: No, she was not. I had been asking and asking and asking for months if there wasn't something we could do to help Richard get out of the house. You know, was there any service available that could get him out of the house and she said no. Well, come to find out here's this adult companion. She never brought it up. She never recommended it. I mean even—I mean I didn't know the terminology but I knew what we wanted for Richard and it was never brought up.

HARRISON: But under the caps if you...

N. STOGSDILL: It's gone.

HARRISON: ...if you keep the PCA services that he has to have...

N. STOGSDILL: Yeah.

HARRISON: ...will that be gone?

N. STOGSDILL: Yeah. Yeah, because we'll need every minute of PCA to—which means adult companion will be out the window.

HARRISON: Okay.

N. STOGSDILL: And also I might add that this service coordinator when we switched over to a new coordinator put in this form that cancelled a bunch of Richard's supplies coming in and the reason she said they were—needed to be canceled because he moved out of state.

HARRISON: Okay, and I do want to get that into...

N. STOGSDILL: And that was very scary for us. I didn't even know about it. Our new service coordinator picked up on it and thank goodness was able to re-implement it.

HARRISON: So when you moved from the—using the DSN Board service coordinator, you're telling me she did a notice of termination saying he'd moved out of state?

N. STOGSDILL: Yes, she did. I think I've got it.

HARRISON: Okay, could you show us that?

N. STOGSDILL: Uh-huh.

HARRISON: So what was the—what—if the new service coordinator had not caught that, what would the effect have been? Could those providers have billed Medicaid for the service?

N. STOGSDILL: Well—no, no. Here.

HARRISON: Okay. Can....

N. STOGSDILL: That might be two copies. I'm not sure.

HARRISON: I believe there's another provider also.

N. STOGSDILL: I think that was the only two I have.

HARRISON: Did Richard ever move out of state?

N. STOGSDILL: No. He's been living—we've been living in the same house for over ten years. And I just...

HARRISON: And I believe—here it is. Hawthorne Medical. I believe she also sent a termination notice—what does Hawthorne Medical do?

N. STOGSDILL: They're the peo—they provide Richard's supplies, his diapers and gloves and wipes and—and then you know there might have been the other one which is Medical—what is it, Medical something, anyway about he uses a condom catheter for bathroom and I believe they got a letter too terminating all of his supplies.

HARRISON: Okay, but you were—you did catch that and you were able to get those restored before...

N. STOGSDILL: Yes, yes.

HARRISON: Okay. And this is I believe Number 30 and 31. Is that correct?

BRYSON: 29 is the last I had so yes, this will be 30 and 31.

HEPFER: I want to get a copy of this. Need the original back?

N. STOGSDILL: Yeah, I think those are—I think those are originals.

HARRISON: Okay, do you have both of them? I've got...

BRYSON: I have both.

HEPFER: Yes, I have two, one of each.

BRYSON: I have those but I'll make you a copy of this one. Might want the original back.

HARRISON: Okay. Is this, and this would be 32 I believe.

BRYSON: Uh-huh.

HARRISON: Can you tell me what this is, Number 32?

HEPFER: I have no objection by the way to these being admitted...

BRYSON: Thank you very much.

HEPFER: ...obviously. Obviously yeah, Department of Disabilities and Special Needs Notices of Termination signed by the then service coordinator.

BRYSON: Service coordinator, yeah.

HARRISON: Can you tell me what this is? Who is Rick Huntress?

N. STOGSDILL: He was I believe the head of the service coordination?

HARRISON: No, I think he's on the Commission.

N. STOGSDILL: I'm sorry. Oh yes, I'm sorry, yes, yes, yes.

HARRISON: So can you tell the Hearing Officer who Rick Huntress is?

N. STOGSDILL: He's on the DDN Comm—DDSN Commission.

HARRISON: Okay. Is this communication between you and...

N. STOGSDILL: Yes, he sent it to me.

HARRISON: Okay. And was this when the services were cut?

N. STOGSDILL: Yes.

HARRISON: When the deci—when HHS first voted on the termination of services May 19th, did you know anything about the changes to the waiver program?

N. STOGSDILL: And this was when, Tricia?

HARRISON: May 19th. What did you know about the changes to the waiver program, the proposed changes?

N. STOGSDILL: On this past—this past May?

HARRISON: May of last year.

N. STOGSDILL: Of '09, yeah.

HARRISON: You were pretty linked in, weren't you, at one time you were a Board Chairman?

N. STOGSDILL: Yeah. But that's been a while ago.

HARRISON: But were you informed that there were changes being considered to the Medicaid Waiver?

N. STOGSDILL: I tell you going back to May a year ago, I don't know exactly when I was informed about it or aware of it.

HARRISON: When do you first remember being informed about it?

N. STOGSDILL: I would say last fall.

HARRISON: Okay.

N. STOGSDILL: I mean in, in—I think that's when we were told that there was as of January 1st, that's when the cuts were going to be implemented and it was a scramble. I don't remember having much warning of it.

HARRISON: If you had been informed that they were cutting services before the Legislative session ended, what would you have done?

N. STOGSDILL: I would have called, written, emailed, gone to see as many legislators as I could.

HARRISON: Do you think there's other family members that would have done that?

N. STOGSDILL: Absolutely.

HARRISON: Okay. To your knowledge was there any legislation that approved these reductions in services?

N. STOGSDILL: Not that I know of.

HARRISON: Who is Dr. Thomas Joseph?

N. STOGSDILL: He is Richard's pediatrician since day one

HARRISON: Okay. And his affidavit is numbered. Do we have the number there?

N. STOGSDILL: 28.

HARRISON: 28, okay. So he's treated Richard for how many years?

N. STOGSDILL: 22 years.

HARRISON: Okay. And does he know Richard pretty well?

N. STOGSDILL: He knows him very well. Yeah, we, we spent a lot of time with Dr. Joseph.

HARRISON: Okay, what are some of the procedures he's been—Richard's had a number of surgeries, hasn't he?

N. STOGSDILL: He has. Tommy does not do surgeries but he has followed Richard and his surgeries through a Dr. Mark Locke. They're, they're very—they coordinate very well together and Tommy (unclear) he does follow-up when Richard comes home and, you know, I mean he'll even come to the house to see him if we need him. He's very concerned about Richard because he's—he's seen him progress a lot and then he has seen him kind of regress and he—he's actually one of the ones that said to me, you know, is everything okay with Richard? And this is a while back and I said well, yeah, why? He said, well, he just didn't—he saw him somewhere like at the Fine Arts Center and he said he just didn't seem right to me and this is when this—all this boredom and frustration and stuff and I thought that was pretty amazing that a pediatrician would tune-in to something like that.

HARRISON: What does—has he, I believe in his affidavit he talks about the decubitus ulcers and the danger.

N. STOGSDILL: Oh yes, I mean it can—for somebody like Richard who is non-ambulatory who sits all the time in the same position, it could be very dangerous, very dangerous.

HARRISON: And Dr.—

N. STOGSDILL: And to the point of hospitalization.

HARRISON: And Dr. Thomas I believe talked about his spasticity. Does that affect how much he's able to do for himself?

N. STOGSDILL: Very much so. Like I said his right arm is—it's definitely regressed. His left arm because he uses it, it's the only thing he's got to use. Again, he—it's not as good as it could be if he had some therapy going.

HARRISON: And I believe Dr. Joseph, according to his affidavit, has he discussed with you that the P10 010, the exercise, would help avoid surgeries? Have ya'll talked about that? Tell me what he's told you.

N. STOGSDILL: Well, it's just like all of us, if you sit there and vegetate, things are going to start—you know, your muscles are going to just, you know, they just atrophy. With Richard because of the cerebral palsy it would draw up—it'll draw him up more. Sitting in a chair he's got—when these muscles start drawing it could affect his spine, neck, I mean the whole body is involved.

HARRISON: Now he's been having some pretty severe...

N. STOGSDILL: Leg spasms.

HARRISON: Tell us about those. What happens?

N. STOGSDILL: We don't know why in the last six weeks, maybe a little bit longer, six to eight weeks, he has had horrible spasms on his right—in his right groin and the doctor asked him on a scale of zero to ten how bad were there and Richard's got a pretty good tolerance of pain and he said a nine. And it's to the point where he turns white and he sweats and he moans and he—I mean almost to the point of tears. He has cried a couple of times. We're looking into it. We're going to an orthopedic surgeon that we know that's done surgery on Richard several times to see if we can find out the cause of this. He's been put on medication for it. You know, we're not wild about lots of medication but we'll give this a go until we get down to the reason behind it. He's been put on pain killers and everything else and when he has one he has got to get out of his chair. He has got to be stretched. He has got to be, you know, his leg's got to be moved to one side or drawn up. I mean you just have to play with it. We all know what it's like to have a muscle spasm and they do hurt and he can't do anything about it by himself. He can't stretch his leg, he can't pull up his leg because it's his right side and his right side is more involved and it's just a—it's a vicious cycle for him. And it's desperate when we have to watch him go through it.

HARRISON: Now, what has Dr. Thomas recommended? I believe I'm on Number 17 in his affidavit. He's made some recommendations about personal care services he needs.

N. STOGSDILL: Uh-huh. Yeah. Tommy knows him well enough. He has seen him have a spasm for instance when we are transferring him from his wheelchair to the examining table, Richard will be sitting there and all of a sudden he'll just—he'll fall over. He just has—he can't tell you it's coming. Tommy is about that far away from him because he said he's not going fall, you know, on my duty. But he has seen him do it and he said Nancy, you cannot—this child goes so fast you've got to have somebody on both sides of him because nobody knows which way he's going to go. And the leg spasms are the same way. When he's trying to support himself for anything, he just buckles.

HARRISON: And Dr.—Dr. Joseph, I just want to call him Dr. Thomas, Dr. Joseph made recommendations I believe on Number 18 about the need for adult companion services.

N. STOGSDILL: For his physical and mental health. As I said, you know, Tommy picked up on his not being Richard and, you know, something was going on. Richard was—he was upset because he was stuck in the house. He didn't have any place to go. He, you know, he just sits there. I mean there's just so much you can do at home when you can't do anything for yourself.

HARRISON: Now previously under the old waiver there was a daily respite option, was there not?

N. STOGSDILL: There was.

HARRISON: And tell me how that worked.

N. STOGSDILL: It was a one—we were allowed one day a month I think it was where you could have somebody come in to give you sort of an eight hour day off I guess you could call it but that's no longer. It's gone into hourly.

HARRISON: What did they replace that with?

N. STOGSDILL: With the hourly respite.

HARRISON: Okay, but that's limited. Did they not--did they not replace that with an institutional option?

N. STOGSDILL: Yeah. I mean we could—there's all sorts of things that they say they can do by sticking Richard in an institution.

HARRISON: What are they offering in terms of an institution?

N. STOGSDILL: I guess it's the ICFMR.

HARRISON: What would that involve if you had to resort to using respite services at an ICFMR?

N. STOGSDILL: What would it mean to Richard (unclear)?

HARRISON: I mean you would—I assume you need to pack him up and what would—what would the process be if the services were reduced and that's what you had to resort to?

N. STOGSDILL: Well, I guess we'd try to find placement but from what I gather, there are no slots even available. I mean he qualifies for them but I mean that would be—that would kill Richard. That would kill Richard. I mean he'd be—there'd be no individualism there. There would be—he'd be stuck again. I think they, you know, I mean even at the workshop they group them together and throw them in all in a van and take them all to the same place. I mean there's no—that's not a life for somebody that is a normal mentally human being. I just—I don't know if that answered your question, Trish. I'm not sure I...

HARRISON: Okay. If you'll look at this chart.

HEPFER: Is this 33?

HARRISON: Right. I think. Is it...

HEPFER: Email from Huntress is 32?

HARRISON: Right. As a former Board chairman, you're familiar, are you not, with the waiver and the option of the ICFMR?

N. STOGSDILL: Uh-huh.

HARRISON: Tell, tell the Hearing Officer what an ICFMR is.

BRYSON: That's all right. I'm familiar with an ICFMR.

N. STOGSDILL: Okay. You could probably—you probably know more than I do at this point.

BRYSON: And Ms. Harrison, can we move it along a little bit?

HARRISON: Okay. How does the cost of the ICFMR compare to home-based services?

N. STOGSDILL: It's much more, much more. I mean 2008 it's three-twenty versus one thirty-eight.

BRYSON: Counselor, relevance. ICFMR is an existing resource. The existing resource is there. It's apples and oranges. They—you pay a—an individual to come into your home to provide respite. It can't be equated with a facility that is already there that's available if there's a bed.

N. STOGSDILL: But, but, if you don't mind my asking. I don't believe that there are any slots and if there are I believe the waiting list is unbelievable.

BRYSON: That is possible. That is possible.

HEPFER: And Mr. Hearing Officer I believe you can take notice that in the waiver, in the MR/RD Waiver the, uh, the, uh, neutrality formula is measured against ICFMR Services. And, you know, therefore the State agrees or assures to the Federal Government that the community services will not be more than the daily cost of or the average area cost of institutional care for the same number of people.

HARRISON: And in this case in the waiver change, previously Richard could have home-based respite at home for seventy dollars a day. There always has been—there always has been the option of ICFMR respite for people in the MR/RD Program but with these waiver changes in the last year they increased the reimbursement rate when people like Nancy Stogsdill sent her son to the ICFMR, this time last year they were being reimbursed one fifty-seven for that. They were saying there's budget reductions and if you'll look at—there's two charts that the waiver year 5 and the waiver year 1, if you'd look at those two charts, those are—I hope I've—okay, number 14 and 15. If you'll look at those two charts and I know them by heart so.

BRYSON: I have chart A and B.

HARRISON: Okay. No, Number 14 and Number 15.

BRYSON: Oh, the exhibits, I'm sorry.

HARRISON: Exhibit 14 and Exhibit 15. Oh, here we are. Okay.

N. STOGSDILL: You got it?

HARRISON: If you will look at those charts, Number 14 is the neutrality calculation under the old waiver. I can't find 14. So under the old waiver if Richard Stogsdill had to receive respite service, previously there was no limit to the home-based respite services but under the new caps there's a limit to the number of respite services at home. They have now unlimited the number of days an individual can stay at an ICFMR under the MR/RD Waiver program. I'm not talking about being admitted permanently to ICFMR. I'm talking about now there's an unlimited number of days so Nancy could say I can't take it anymore. I've got to go away for a month and there is no doubt that she would be entitled to the ICFMR respite services because she has no legal obligation to take care of her son but if you will look on the second page of Exhibit 5 and compare that with Exhibit 1, prior to the amendments of the waiver they estimated that 30 people would need ICFMR services. The average number of units that would be needed under the waiver would be 22 and that the cost would be a hundred and fifty-seven dollars and thirty cents a day and that the total cost of everybody under the waiver that needed—that used ICFMR services...

HEPFER: Mr. Hearing Officer, obviously Ms. Harrison is testifying and I wonder if this wouldn't be better to be brought out in the brief.

BRYSON: Yeah, I agree. Yes. Ms. Harrison, we'll cover these exhibits in your brief.

HARRISON: Okay.

BRYSON: I'd like to limit Ms. Stogsdill if we can to testimony specific to her case and her son's case.

HARRISON: How would Richard react to being packed up and taken off to Pee Dee Center for respite services?

N. STOGSDILL: He would object violently. And I mean he would—he wouldn't understand why we were doing it. He—I mean he would think that, what happened, you know, what did I do? Why am I being punished?

HARRISON: Would he feel stigmatized with other disabled people?

N. STOGSDILL: Absolutely.

HARRISON: I think the rest of what I have we can present in the briefs. Mr. Hepfer?

HEPFER: No. Well...

HARRISON: Do you have any questions?

HEPFER: Thank you. Yes. I just wanted to get a couple for clarification. I know—I've met Richard. I've had the pleasure of meeting him. He does seem like a remarkable young man and he's very fortunate to have you all as parents. Does he have a cell phone?

N. STOGSDILL: He does.

HEPFER: And he uses it?

N. STOGSDILL: He does.

HEPFER: Is he on Facebook?

N. STOGSDILL: Yes.

HEPFER: Okay. Does he have any social activities other than the rehabilitative activities that you mentioned?

N. STOGSDILL: Other than the volunteer work you mean?

HEPFER: Right.

N. STOGSDILL: He does go out one night a week.

HEPFER: Okay. You have a lift, a Hoyer lift, is that right?

N. STOGSDILL: We do.

HEPFER: And is...

N. STOGSDILL: But it has never been used because he gets—he got in it once and it was not properly used and it scared him and he will not go back in it.

HEPFER: Have you had it adjusted to be—to accommodate him appropriately?

N. STOGSDILL: The Hoyer lift?

HEPFER: Yes.

N. STOGSDILL: He won't get in it. I mean I'm sorry, but he...

HEPFER: Do you have any other kind of lift?

N. STOGSDILL: We do. We have a—it's called a Surehands.

HEPFER: And—okay, you have a—any other special equipment in the house?

N. STOGSDILL: In the house. We have a special door. He has a special door that is—it's like an electronic door that can be opened (unclear).

HEPFER: How about transportation?

N. STOGSDILL: He has a special van.

HEPFER: Okay. How much are you there now at the house? How many hours would you say?

N. STOGSDILL: During the day or twenty-four hour?

HEPFER: Well, twenty-four hour period. You're there at night obviously, most nights.

N. STOGSDILL: Uh-huh, uh-huh. Everybody leaves at six at night so we're there from six and some days I have to leave for work by seven. It just depends on my schedule for the day but we're there and my husband usually leaves around 7:15 in the morning and gets back depending on the day and how far he's driven.

HEPFER: Okay. And then how long—how many hours during the day are you there after that?

N. STOGSDILL: It really depends on my day. I'm not trying to avoid the answer.

HEPFER: Yeah, I understand.

N. STOGSDILL: I honestly—it depends how many jobs—my jobs are—I don't have a set schedule. It depends on when they need me and how long it takes me to undo what they've done.

HEPFER: You pieced together some part time work...

N. STOGSDILL: Yeah.

HEPFER: ...and can you give us an average maybe of how many hours a day you're there?

N. STOGSDILL: I'm there? Yes. I would say I try to get home most lunch times for him. I would say I'm there probably an hour and a half around lunch time.

HEPFER: Right.

N. STOGSDILL: Depending on—sorry, but depending on the bathroom situation.

HEPFER: Sure.

N. STOGSDILL: It takes quite awhile. Sometimes I'm there two hours if need be.

HEPFER: Right.

N. STOGSDILL: I don't usually get home until 5:30, 6:00.

HEPFER: Okay.

N. STOGSDILL: Sometimes later, sometimes earlier. It just, you know…

HEPFER: All right.

N. STOGSDILL: I, I, one of us is always home before the caregivers leave.

HEPFER: Okay. So it's either the caregiver or you are there.

N. STOGSDILL: Not during—not all the time because they leave at 8:30, 7:00 to 8:30 in the morning they're gone. Monday's and Wednesday's they don't come back until 1:30. Tuesday, Thursday, Friday, they don't come back until 3:30.

HEPFER: Okay, so it'd be…

N. STOGSDILL: So he's by himself.

HEPFER: Late morning he'd be by himself a lot of times.

N. STOGSDILL: Uh-huh, uh-huh.

HEPFER: Okay. All right. Did you understand the—that DDSN would be providing (unclear) sixteen hour a day coverage when you first began accessing the waiver?

N. STOGSDILL: Sixteen hours a day?

HEPFER: Well, excluding hours of sleep.

N. STOGSDILL: Was I aware that DDSN…

HEPFER: Did you think, did you think they would be providing sixteen hour a day coverage?

N. STOGSDILL: To be honest with you I felt like they would provide whatever Richard needed.

HEPFER: Okay.

N. STOGSDILL: And I can't put that in numbers because it changes depending on where he is and what his condition is and, you know, what his day is. I mean we're

trying to get him out of the house as much possible but, you know, it's hard to find a placement for—job placement for somebody like Richard.

HEPFER: What is the purpose—do you know what the purpose of the workshop is?

N. STOGSDILL: I think it's to try to give the people there, try to let them learn some skills that they could perhaps use outside the workshop. I think it's to give them some socialization but I have to say in all honesty that the people that I've seen out there are not on the same level as Richard.

HEPFER: Okay.

N. STOGSDILL: And I think it would be very, very tough on him to be around people that that just—they'll communicate but it's not what we would all consider the level of Richard's communication.

HEPFER: Well, basically it's...

N. STOGSDILL: Like you said, Facebook and a cell phone. I don't know that any of those, I mean that some of those, any of those, most of those people know how to work a computer.

HEPFER: It's job preparation.

N. STOGSDILL: It is job preparation, yes. But more of a physical end than the mental end and Richard cannot do the physical work. He's more on the mental end if that makes sense to you.

HEPFER: It does.

N. STOGSDILL: His capabilities are to be—he needs to be challenged mentally because he can't be challenged physically.

HEPFER: Job skills then, pretty much.

N. STOGSDILL: Yeah.

HEPFER: Okay. Did Dr. Joseph—how did Dr. Joseph learn about adult companion services?

N. STOGSDILL: We talked about it. Yeah. Because I think I probably—I mean I can't say that I did but we—he's always asking me what does Richard do? You know. What's his day like? And so, you know, one thing comes—leads to another and we just—he's, he's very interested in Richard as a whole person, not just as a doctor to a patient.

HEPFER: Yeah, yeah.

N. STOGSDILL: We're very fortunate.

HEPFER: Yeah, he seems very involved with the case.

N. STOGSDILL: He is. He is. And he wished he could have been here to be honest with you but.

HEPFER: You're not suggesting that institutional respite care or are you suggesting that institutional respite care would be used in lieu of hourly respite care, are you?

N. STOGSDILL: In lieu of what he's receiving now?

HEPFER: Yes.

N. STOGSDILL: No, I figured that would be on top of if he was—if that came to that but I wouldn't put him—I can't imagine him being in institutional respite.

HEPFER: All right. It's available, you know.

N. STOGSDILL: For short term.

HEPFER: Yes, for short term.

N. STOGSDILL: Uh-huh, uh-huh.

HEPFER: Okay, all right. Thank you. I have no other questions.

BRYSON: All right, closing statements, Respondent?

HEPFER: Well, several things. I had prepared a closing statement but I think I will leave most of what I had to say really dealt with some of the legal arguments that Ms. Harrison made and I'd probably be better if I left that to the brief.

BRYSON: I'd rather have it in the brief.

HEPFER: I just wanted to say that I appreciate your coming today, Ms. Stogsdill and as I say I've met Richard. He does seem like a very bright, capable, young man mentally and I—but I think we have shown today that if the waiver is legal that we have—the department, both departments have properly complied with the constraints in the waiver and the process was effective and precise with respect to Mr. Stogsdill. Thank you.

BRYSON: Petitioner, closing statements?

HARRISON: I think that's the big if in this case. If the waiver is legal.

BRYSON: I understand.

HARRISON: And certainly it's our position that, that ten years ago the Supreme Court said that separate is not equal and what South Carolina has done—I astute on the Civil Rights Movement and when South Carolina was told you have to have black children in the same school with white children, what South Carolina did was they took money and they built nicer black schools and what our brief will show is that what South Carolina did and what the LAC audit will show is they have taken tens of millions of dollars intended for services that could have been matched with Federal dollars and they have built workshops across the State and they have orchestrated this change in the waiver under the pretext of budget reductions when the truth is the services they are forcing people into, Richard will not be integrated as the integration mandate of Olmstead requires in a workshop. He will not be integrated in an ICFMR institution. I know mom doesn't want to put him into one but the fact of the matter is they're getting older, they're not able to do it and they've got to make a living so if these services are cut, whether that's what anyone wants or not, it's a reality for Richard and it would be just like it would be a violation of the rights of a black child to say you can't sit in the same classroom with a white child. To force Richard to go because he has a disability and to sit in a workshop or to receive respite in an ICFMR institution is discrimination and the Supreme Court has said that the State can't pass that law, a law that—in fact in this case a State didn't even pass a law. What we will show is they snuck it in after the legislative session was over and they implemented it before the legislation started. So all this is is a pretext to keep the money at the DSN Boards, to build up their system. In fact what we'll show is in September DDSN took 2.6 million dollars that would have been enough to restore these services and bought three more workshops. So I think what we'll show in our brief, combined with the testimony of Ms. Stogsdill and I would ask that you also consider the testimony of the DDSN witness...

BRYSON: Sure.

HARRISON: ...that we didn't talk to a doctor, I don't know Richard. I don't know what his day's like but a hundred and seventy-two hours was plucked out of it. All of this is arbitrary. It's about money, it's about keeping the money at the system and it violates Federal law and as such it, it, it should not be allowed.

BRYSON: Thank you. I'm very interested in receiving that brief. I want to thank you for coming, Ms. Stogsdill.

N. STOGSDILL: Thank you.

BRYSON: I want to thank both of you folks. I'm sorry (unclear). And let me just—I want to say one thing before we go. I am highly concerned in this venue with Richard's due process rights to the extent that I have tried to limit my jurisdiction is based on what I believe to be my area of competence. I would not presume to try to make decisions about things beyond my jurisdiction for fear of somehow interfering with his due process rights. That's the only interest I have in trying to limit what is before me today. It was not, you know, and there are appeal rights beyond this venue is what I'm trying to say because I would not want any inability or inexperience or lack of jurisdiction on my part to in any way impede him getting what he needs to get and what may be available to him and that was the motivation for the jurisdictional questions but hopefully we can address all that in the decision. I do thank you for coming again. If there's nothing else from either party...

HEPFER: One...

BRYSON: Yes sir?

HEPFER: ...thing, Mr. Hearing Officer, when would the briefs, did you have an idea of a briefing schedule?

BRYSON: These issues are very complicated. I, I, and if you're willing to take the time to put into these briefs, I'm not inclined to limit that time. I'm much more interested in quality than I am in speed.

HEPFER: Well, from the Respondent's...

BRYSON: What do you think would be appropriate?

HEPFER: ...from the Respondent's point of view I understand that the services are on-going.

BRYSON: I understand that. What would be reasonable do you think for the Respondent?

HEPFER: I would like at least ten days after Ms. Harrison's brief is due.

BRYSON: And when do you think you could get me a brief, Ms. Harrison?

HARRISON: I—let's see this is...

BRYSON: The 11th of May.

HARRISON: I'll need two weeks.

BRYSON: Is there an objection to two weeks?

HEPFER: No, no objection at all.

BRYSON: All right, so we're talking about what, the 25th of May for Ms. Harrison and then so June 5th or 8th or 10th, June 10th, Mr. Hepfer?

HEPFER: That's fine.

BRYSON: All right, May 25 for Petitioner, June 10 for Respondent.

HEPFER: I want to make sure that that's...

HARRISON: What is—what is today?

BRYSON: 11th.

HARRISON: Okay. Could we have until that following Monday until June 1st?

HEPFER: I have no objection.

BRYSON: All right, all right. We'll give Petitioner June 1. Is June 10 still—well, what do you need Mr. Hepfer?

HEPFER: I tell you what, why don't you give me until, let's see 13, I guess the 14th would give me a little, a little, in case I get jammed up and have to do it on the weekend.

BRYSON: I understand. It's not like this is the only case we have, right.

HEPFER: Right.

BRYSON: All right.

HEPFER: Now by those dates or close of business on those dates?

BRYSON: Let's make it...

HEPFER: Close of business just to be specific?

BRYSON: Yes. Again folks, thank you for coming. I appreciate your time and your interest very much. And hearing nothing we are closed and we are off the record.

HARRISON: Thank you.

N. STOGSDILL: Thank you very much.

BRYSON: We are back on the record. This is 10-MISC-042. We're back on the record for the purpose of receiving post-hearing briefs. I have Petitioner's Exhibit C-2, post-hearing brief dated June 1, 2010. I have Respondent's post-hearing brief. This is Respondent's Exhibit Number 5 received on 6/14/10 and we're off the record.

DOCUMENTS IN ADMINISTRATIVE LAW COURT PROCEEDINGS

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Associate State Director
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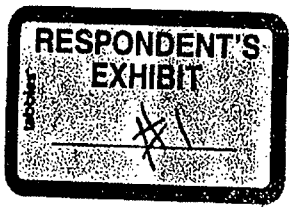

To: Mr. Vastine G. Crouch, Director
SCDHHS Division of Appeals

From: Jacob Chorey, MR/RD Waiver Program Coordinator
SCDDSN Mental Retardation Division

Date: 18 February 2010

Re: Richard Stogsdill

Prior to the renewal of the MR/RD Waiver on 1 January 2010, Richard Stogsdill was authorized to receive the following amounts:

- 15 [hourly] units per week of Companion
- 220 units (54 hours) per week of Personal Care 2
- 1872 units (annually – i.e. 36 per week) of Hourly Respite

When the waiver was renewed, it included service limits of 28 hours per week for both Companion (28 units) and Personal Care 2 (112 units), or for any combination of the two, and 68 [hourly] units of Respite per month. These changes were approved by the Centers for Medicare and Medicaid Services (CMS). Mr. Stogsdill's services were, consequently, to be reduced as follows to comply with the terms of the renewed waiver.

- Companion and Personal Care 2 reduced to a combined total of 28 hours per week. The actual number of units for each was never agreed upon by the family and the Service Coordinator. They were working that out when the request for reconsideration was made. They ceased those efforts because the choice was made to keep services at pre-renewal amounts during the reconsideration/appeal process. The family was informed that they would be responsible for the cost of services over the limit if they lose the appeal.
- 68 [hourly] units of Respite per month – Mr. Stogsdill has since been approved for an exception to the service limit for Respite. The exception grants him 104 additional units per month, for a total of 172.

DISTRICT I
P.O. Box 239
Clinton, SC 29325-5328
Phone: (864) 938-3497

Midlands Center - Phone: 803/935-7500
Whitten Center - Phone: 864/833-2733

DISTRICT II
9995 Miles Jamison Road
Summerville, SC 29485
Phone: 843/832-5576

Coastal Center - Phone: 843/873-5750
Pee Dee Center - Phone: 843/664-2600
Saleeby Center - Phone: 843/332-4104

South Carolina Department of
Health & Human Services

Emma Forkner • Director
Mark Sanford • Governor

May 6, 2010

Mr. W. Jefferson Bryson, Hearing Officer
Division of Appeals and Hearings
South Carolina State Department of
Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206

Re: Stogsdill v. SCDHHS, 10-MISC-042 (MR/RD)

Dear Mr. Bryson:

Enclosed for your consideration is the Departments' Prehearing Brief in this matter. Please take this letter as my notice of appearance in this matter and my certification that a true and correct copy of this Brief has been sent to Ms. Patricia L. Harrison, Attorney at Law, 611 Holly St., Columbia, SC 29205.

Please contact me if there are any questions. My direct is (803) 898-2791.

Sincerely,

Richard G. Hepfer
Deputy General Counsel

Enclosure

cc: Patricia Harrison, Attorney for the Petitioner

OFFICE OF GENERAL COUNSEL
P.O. Box 8206 • Columbia, South Carolina 29202-8206
(803) 898-2795 • Fax (803) 255-8210

THE STATE OF SOUTH CAROLINA
IN THE SUPREME COURT

IN THE ORIGINAL JURISDICTION OF THE SUPREME COURT

Karen W., Edward M., Richard S.,
Susan E., Rob L., Peter B., Ann J.,
Corrie D. and Robyn P.,

Plaintiffs,

v.

Marshall C. Sanford, Individually and in his Official Capacity as the Governor of South Carolina and Member of the South Carolina Budget and Control Board; Converse A. Chellis, III and Richard Eckstrom, Individually and in their Official Capacities as Members of the South Carolina Budget and Control Board; Daniel Cooper and Hugh Leatherman, in their Official Capacities as Members of the South Carolina Budget and Control Board, Emma Forkner, Individually and in Her Official Capacity as the Director of the South Carolina Department of Health and Human Services; Kelly Hansen Floyd, Individually and in her Official Capacity as the Chairman of the South Carolina Department of Disabilities and Special Needs, W. Robert Harrell, Individually and in his Official Capacity as former Chairman and Current Commissioner of the South Carolina Department of Disabilities and Special Needs; Otis Speight, Richard Huntress, Susan Lait, Deborah McPherson and Nancy Banov, in their Official Capacities as Commissioners of the South Carolina Department of Disabilities and Special Needs; and Thomas Waring, Individually and in his Official Capacity as Budget Analyst for the South Carolina Department of Disabilities and Special Needs, and David Goodell, Individually and in his Official Capacity as Associate State Director of the South Carolina Department of Disabilities and Special Needs,

Defendants.

COMPLAINT

Karen W., Edward M., Richard S., Susan E., Rob L., Peter B., Ann J., Corrie D. and Robyn P. ("Plaintiffs") complaining of the Defendants herein, allege the following:

PARTIES

1. Plaintiffs are citizens of the State of South Carolina who have severe disabilities and rely upon Medicaid services provided by the South Carolina Department of Disabilities and Special Needs. Karen W., Edward M., Richard S., Susan E., Peter B., Ann J., Corrie D. and Robyn P. receive services through the MR/RD Medicaid waiver program. Rob L. receives services through the HASCI Medicaid waiver program.

2. Defendants are Marshall C. Sanford, the Governor of South Carolina, who is sued in his individual and official capacity, members of the South Carolina Budget and Control Board; Converse A. Chellis, III and Richard Eckstrom, who are sued individually and in their official capacities as Members of the South Carolina Budget and Control Board; Daniel Cooper and Hugh Leatherman, who are sued in their Official Capacities as Members of the South Carolina Budget and Control Board, Emma Forkner, who is sued individually and in her official Capacity as the Director of the South Carolina Department of Health and Human Services; Kelly Hansen Floyd, in her individual and official capacity as the Chairman of the South Carolina Department of Disabilities and Special Needs (the agency that administers the MR/RD and HASCI Medicaid waiver programs), W. Robert Harrell, who is sued individually and in his official capacity as former Chairman and current Commissioner of the South Carolina Department of Disabilities and Special Needs; Otis Speight, Richard Huntress, Susan Lait, Deborah McPherson and Nancy Banov, who are sued only in their official capacities as Commissioners of the South Carolina Department of Disabilities and Special Needs; and Thomas Waring, who

is sued individually and in his official capacity as Budget Analyst for the South Carolina Department of Disabilities and Special Needs, and David Goodell, who is sued individually and in his official capacity as Associate State Director of the South Carolina Department of Disabilities and Special Needs.

JURISDICTION

3. The issues presented within this case are of such great importance as to require immediate resolution. An emergency exists because services which are needed for Plaintiffs to remain in the least restrictive setting are being or have been terminated by the South Carolina Department of Disabilities and Special Needs ("SCDDSN") in violation of the American Recovery and Reinvestment Act ("ARRA") and the Constitutional right of the Plaintiffs to be integrated into the community as required by the Americans with Disabilities Act ("ADA").[1] This will force the Plaintiffs into more expensive congregate facilities where they will be segregated from persons who have disabilities.

4. Resolution of the issues contained in this Complaint is urgent also because hundreds of millions of federal stimulus dollars are at risk if South Carolina does not meet eligibility requirements set forth in the American Recovery and Reinvestment Act.

5. Immediate action is needed because jobs of caregivers across the State are being terminated based on false claims by the South Carolina Department of Disabilities and Special Needs ("SCDDSN") of "budget reductions."

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[1] For purposes of this lawsuit, "segregated" refers to being separated from non-disabled persons. "Integrated" refers to participating in community life with non-disabled persons.

CHRONOLOGY

Introduction

6. Despite having received more than $54 million in federal stimulus funds between February of 2009 and the third quarter of SFY 2010, SCDDSN has systemically reduced medically necessary Medicaid waiver services and has announced further reductions which will take effect on January 1, 2010 under the guise of "budget reductions." This reduction in services will jeopardize the health and safety of the Plaintiffs and will adversely affect their ability to remain in the least restrictive setting.

7. Since July of 2009, Defendants have transferred federal stimulus dollars received under Section 5001 of the American Recovery and Reinvestment Act ("ARRA"), which were intended to maintain Medicaid services and to preserve jobs, to a rainy day fund in violation of the clear Congressional intent that the State spend these funds promptly.

8. Since the election of Governor Mark Sanford, SCDDSN has used tens of millions of dollars allocated to provide services to persons who have disabilities to purchase real estate instead.

9. This has negatively affected the Plaintiffs and thousands of similarly situated individuals, who rely upon MR/RD (Mental Retardation/Related Disabilities) and HASCI (Head and Spinal Cord Injury) services to provide the supports they need to live in the least restrictive setting.

10. These actions have resulted in the termination of employment for thousands of employees and jeopardize the jobs of thousands more caregivers across South Carolina who will lose their jobs or have their hours reduced on January 1, 2010.

11. These funds allocated by the South Carolina General Assembly to provide services have been used to purchase buildings for congregate workshops owned by local DSN Boards. South Carolina Legislative Audit Council Audit of SCDDSN dated December 3, 2009. Appendix C at pages 146-152. Defendants have also used funds intended for services to pay for "vacant" beds. These practices have violated the Medicaid Act because Defendants have not used reasonable standards to maintain eligibility and services, have not provided Medicaid services with reasonable promptness and have taken actions to limit the choice of providers of waiver participants.

12. Services have been and continue to be terminated without adequate notice to the waiver participants and affected employees. Many affected individuals have only received notice of the reductions of life sustaining services within the two weeks. Others who are affected, such as those persons who are not now receiving services that have been reduced or eliminated, but may require such services in the future (such as speech and language, physical therapy or occupational therapy) have not received written notice of the elimination or loss of right to receive these services. Upon information and believe, affected individuals have not received notice of their right to appeal the decision to deny services.[2]

13. The chronology below describes actions taken by Defendants in violation of the ARRA

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[2] Speech and language assessments are necessary to diagnose swallowing disorders that may lead to choking and to determine the need for a assistive communications device, allowing a person who cannot speak to communicate. Occupational therapy provides assistance with skills needed for activities of daily living, such as feeding, dressing and mobility. Physical therapy provides training to develop gross motor skills to build or rebuild strength and mobility.

and the ADA, which requires the State to provide services in the least restrictive setting.

September 2008

When SCDDSN and SCDHHS (the South Carolina Department of Health and Human Services) submitted their accountability reports to the General Assembly, neither report mentioned its intention to reduce home-based services to force waiver participants into "choosing" services in buildings where they will be segregated from the community in DSN Board workshops.

October 2008

14. Every five years, SCDHHS must submit an application to CMS requesting renewal of the MR/RD and HASCI Medicaid waiver programs. These renewal applications identify and define the services that will be provided under the program, how the services will be delivered and how eligibility for these programs will be determined within federal guidelines. According to the director of SCDHHS, Emma Forkner, SCDHHS and SCDDSN officials began working in October of 2008 "diligently to amend the MR/RD Medicaid waiver program." Letter from Emma Forkner to CMS dated June 11, 2009. Appendix F at 43. However, these meetings were conducted without public input, behind closed doors and no mention of the intent to drastically change the service delivery system was made in public meetings at either agency.

15. Unbeknownst to the affected consumers of SCDDSN services, their families, advocates and Medicaid providers, the agencies were also working on amending the HASCI Medicaid waiver program, which was not scheduled to be renewed until 2013. These plans included increasing the reimbursement rates paid for services provided by SCDDSN and its local DSN Boards while eliminating, reducing or lowering

reimbursement rates for services provided by non-DSN Boards.

16. The public would not be notified of this plan until after SCDDSN and SCDHHS presented the amendments to the MR/RD Medicaid waiver program to the Medicaid Care Advisory Committee ("MCAC") at SCDHHS in May of 2009. Minutes of May 21, 2009 SCDDSN Commission Meeting. Appendix E at page 88.

17. SCDDSN and SCDHHS likewise provided no indication to the South Carolina General Assembly that they were intending to drastically alter these waiver programs by using allocated funds to purchase real estate which would be used to provide congregate services at the expense of waiver participants and private providers of waiver services. No mention was made at public legislative committee hearings about the agencies' intentions to reduce home-based services for waiver participants who choose to live at home, which are provided through the MR/RD and HASCI Medicaid waiver programs, in favor of segregated congregate services provided by local DSN Boards which compete with private and faith-based providers of these services. The plan involved the establishment of infrastructure and reducing home-based services so that participants would have to "choose" to attend large congregate facilities where they would be segregated from non-disabled persons. An important element of this plan involved obtaining legislative changes so that the "revenues" from these workshops from work performed by "mentally retarded trainees" would be paid to SCDDSN. Section 24.4 of the Provisos to the SFY 2010 Appropriations Act.

18. SCDDSN responded to the state budget crisis, in October of 2008, by eliminating 145 MR/RD slots and 37 HASCI slots from its budget, in addition to imposing a 1% reduction in reimbursement rates paid to the providers of these services. Minutes of

SCDDSN Commission dated October 16, 2008. Appendix E at pages 3 and 6. SCDDSN state funding was reduced by $21.5 million, an 11.2% reduction. Letter from Stan Butkus to DSN Board Executive Directors dated December 19, 2008. Appendix F at page 131.

19. Upon information and belief, on October 1, 2008, SCDHHS reduced the reimbursement rate for speech generating devices to 77% of the MCRA, effectively eliminating the ability of waiver participants to obtain these devices. At that time, SCDDSN was holding approximately $8 million in "excess debt service funds" which had been collected from Medicaid participants by SCDDSN. South Carolina Code of Laws § 44-20-1170 specifically allows those funds to be used for non-recurring "assistive technology" with the approval of the South Carolina Budget and Control Board. Purchase of these devices, which allow non-verbal waiver participants to communicate, is a non-recurring expense. No effort was made to access stimulus funds or funds contained in SCDDSN's "excess funds" account so as to provide a voice to the voiceless who have been determined by speech and language professionals and their treating physicians to have a medical necessity for these services. By eliminating speech and language services, waiver participants over age 21 could not obtain the assessments necessary to obtain these devices which would allow them to communicate with others.

20. Speech and language services are necessary for many persons who have severe speech and language deficiencies to be meaningfully involved in their communities. Persons who are unable to speak frequently cannot communicate their basic medical needs and they are often excluded from social interaction with others.

21. Speech and language assessments are also needed to diagnose and treat swallowing disorders that can lead to choking.

22. One of the responses of Governor Mark Sanford to the budget reductions in his office during October of 2008 was to eliminate 100% of the state funds provided to South Carolina Protection and Advocacy for People with Disabilities (P&A). These funds were paid to P&A through the Governor's Office. P&A is a private, non-profit organization which is mandated by state and federal law to protect the rights of people with disabilities in South Carolina by enabling individuals to advocate for themselves, by speaking on their behalf when they have been discriminated against or denied a service to which they are entitled, and by promoting policies and services which respect their choices. Protection and Advocacy agencies (P&As), are located in every state and have been the primary non-federal enforcers of the disability rights statutes. Congress intended that P&A organizations serve as a check and balance to protect the rights of people who have limited ability to advocate for themselves, including civil rights violations. Unsuccessful efforts were made at the October 2008 special legislative session by legislators attempting to override the Governor's decision to terminate P&A's state funding. Appendix H at page49.

23. **November 2008**

According to SCDDSN Commission minutes, in November, SCDDSN eliminated 150 MR/RD Medicaid waiver slots and 37 HASCI slots, in addition to eliminating the 60 "residential bed expansion" slots which had been added to the agency's budget for FY 2010. No mention was made in the budget requests submitted to the General Assembly by SCDDSN that the agency was planning to eliminate many of the home based services in the MR/RD and HASCI Medicaid waiver programs. These reductions were in addition to the 1% cut in provider reimbursement rates (which were discussed at the October,

2008 Commission Meeting). November 6, 2008, Minutes of SCDDSN Commission meeting. Appendix E at pages 9-10.

24. In November of 2008, Governor Sanford began his media campaign opposing federal stimulus efforts. *"Don't Bail Out My State,"* Wall Street Journal, November 15, 2008. Appendix G at pages 67-68.

December 2008

25. Governor Sanford continued his anti-stimulus media campaign with the publication of another article in the Wall Street Journal: "*Governors Against State Bailouts*," December 2, 2008. Appendix G at pages 65-66. In that article, Governor Sanford specifically objected to increases in Medicaid funding.

26. On December 2, 2008, Governor Sanford wrote to President-Elect Obama opposing "increasing government spending." Letter from Mark Sanford to President Obama dated December 2, 2008. Appendix F at pages 129 -130.

27. The next day, on December 3, 2008, the South Carolina Legislative Audit Council ("LAC") released its audit of SCDDSN. This audit was requested by President Pro Tem Glenn McConnell, House Speaker Robert Harrell (who is not believed to be related to SCDDSN Commissioner Robert Harrell), Representative Daniel Cooper, Representative James Harrison and Representative Harry Cato. Appendix C at pages 84-183.

28. Governor Sanford's Office had failed to respond to concerns raised by a SCDDSN Commissioner who served on the agency's Audit Committee and the SCDDSN internal auditor. Appendix G at page 44 to 46.

29. Upon publication of the LAC audit of SCDDSN, Governor Sanford immediately blamed the General Assembly for problems at SCDDSN, despite the fact that he appoints every

member of the governing body of SCDDSN and he had the authority to remove members of the SCDDSN Commission. In response to the LAC audit of SCDDSN, Governor Sanford accused the legislature of "borderline dereliction of duty." *Audit Cries Out for Agency Reforms*," Greenville News, December 5, 2008. Appendix G at pages 63-64.

30. These LAC findings should not have been a surprise to Governor Sanford. SCDDSN Commissioner, Mary Katherine Bagnal, who served on the agency's audit committee, "told Gov. Mark Sanford's office nearly two years ago about many of the agency problems that surfaced.." in the LAC audit. *"Ex-Commissioner says she warned Governor's Office of problems*," article in Greenville News dated February 15, 2009. Appendix G at pages 44-46. According to Commissioner Bagnal, Governor Sanford's office was "unresponsive" to her concerns, leading her to work with House Representative Jim Harrison to request the audit. *Id.* Commissioner Bagnal "was asking questions and expressing concerns not only to the governor but to other commissioners." *Id.* She raised questions about why state appropriations "were not being used for new beds as intended." *Id.*

31. The LAC audit of SCDDSN substantiated many the concerns Commissioner Bagnal had raised with the Governor's Office about paying funds to DSN Boards to purchase real estate and paying DSN Boards for vacant beds. *Id.*

32. After the LAC audit was released, Steve Jeffcoat, the former internal auditor for SCDDSN reported that he had attempted to warn top administrators about problems at SCDDSN "beginning in 2003." "*Ex-auditor: Agency didn't heed warnings.*" Article in Greenville News dated February 26, 2009. Appendix G at pages 32-33.

33. The LAC audit reported that the General Assembly paid more than $30 million in additional state dollars to SCDDSN between FY 2006 and 2008 to provide services for new Medicaid waiver participants. According to that audit, SCDDSN spent most of this money purchasing real estate, without notice to or the approval of the SCDDSN Commission or the South Carolina Budget and Control Board, instead of increasing the number of persons receiving MR/RD and HASCI Medicaid waiver services. *"A Review of the Department of Disabilities and Special Needs"* by the South Carolina Legislative Audit Council dated December 3, 2008. Appendix C at pages 146-152. The funds provided to create new residential slots and to serve children who have autism were not expended as allocated by the General Assembly. Instead, SCDDSN paid tens of millions of dollars of these funds to local DSN Boards to purchase real estate.

34. According to the LAC audit of SCDDSN: "..DDSN spent just $10,454 of the $3 million appropriated for services" for the Pervasive Developmental Disability ("PDD") program (serving children with autism) in SFY 07. LAC Audit at page 58. Appendix C at page 150.

35. Out of $7.5 million appropriated by the General Assembly for these autism services during FY 08, "..DDSN spent just $661,463 in FY 07-08, leaving $6.8 million to be carried forward or used for other purposes." *Id.* Upon information and belief, most of these funds were used to purchase real estate in the names of local DSN Boards or agencies treated as local DSN Boards by SCDDSN.

36. Because these funds, provided between 2006 and 2008 by the General Assembly as the state match for Medicaid funds, were not spent as allocated, South Carolina lost tens of millions of dollars in matching federal Medicaid funds. The loss of these federal funds

deprived consumers of vital services, and collaterally contributed to the State's growing unemployment rate and economic downturn.

37. In December of 2008, SCDDSN announced it would eliminate 17 more MR/RD slots and 8 HASCI additional waiver slots. SCDDSN Commission Meeting minutes from December 18, 2008 meeting. Appendix E at page 35. SCDDSN made other reductions to "ancillary" Medicaid waiver services as well and further reduced reimbursement rates paid to Medicaid providers by an additional 1% *Id.*

38. The state director of SCDDSN sent a letter to directors of DSN Boards announcing an additional 7% reduction in state funding, resulting in a loss of $11.9 million in state funding. SCDDSN State Director Stan Butkus wrote:

> Unfortunately, these reductions are necessary because these additional state funds that have previously been provided are no longer available. It is recognized that some consumers and families will lose their current services and some employees, both at DDSN and in the provider organization, will lose their current jobs.

Appendix F at page 131. December 19, 2008, Memorandum from Stan Butkus to DSN Board directors.

39. The economic crisis was worsening across the country at the end of 2008, but Governor Sanford continued to be one of the most outspoken critics of federal interventions. In December of 2008, Governor Sanford refused to apply for federal unemployment benefits.

40. On December 20, 2008, the Greenville News reported that SCDDSN purchased a "Superfund hazardous cleanup site" from Tyco Corporation which was being used to "train[] disabled adults for jobs. " *Taxpayer-funded training on Superfund site alarms state officials,*" December 20, 2008. According to the article, about 200 disabled persons attended the program each day at the Superfund site. Appendix G at pages 57-59.

January 2009

41. No visible action was taken by Governor Sanford in response to the LAC audit for more than two months after that audit was released. In January, Senator David Thomas held hearings "on allegations of safety gaps, unspent or diverted funds and other problems.." at SCDDSN. "*Lawmakers upset that Disabilities and Special Needs board missed first one.*" Article in Greenville News dated February 3, 2009. At a hearing held on January 14, 2009, both former Commissioner Bagnal and former Internal Auditor, Steve Jeffcoat testified about the difficulty in obtaining financial information from agency officials. Senator Thomas asked SCDDSN officials why the agency paid funds allocated to provide services to children who have autism to a private corporation to purchase a toxic waste site from Tyco Corporation. *Id.* This site was on the Superfund cleanup list. Id. Article from Spartanburg Herald Journal "*Cleanup process gets under way at former Holmberg Electronics plant: But much less of a problem than some, officials say*"dated *September 24, 2007 at*

http://www.goupstate.com/article/20070924/NEWS/709240322

See also "Charles Lea Center training program to expand" dated July 5, 2007 at http://www.goupstate.com/article/20070705/NEWS/707050335

Appendix G at pages 50-51 and Appendix G at pages 57-59.

42. At no time during these hearings did SCDDSN officials inform Senator Thomas' committee of its plan to fundamentally alter the MR/RD or HASCI waiver programs to promote congregate segregated services, alleging these changes were necessary due to budget reductions. Both of the SCDDSN officials who testified on behalf of the agency have retired since January 2009. Upon information and belief, SCDDSN officials never mentioned these plans to cut home-based services during any legislative committee hearing during the 2009 legislative session.

43. The fact that jobs have been lost due to federal stimulus funds being diverted to a rainy day fund is undeniable. In explaining the impact of proposed budget reductions on SCDDSN, on January 22, 2009, Deputy Director of SCDDSN, William Barfield informed the Commissioners that:

> Nearly 500 employees will be impacted, 4,500 or more people lost services and 1,200 would have been served otherwise.

Mr. Barfield informed the Commissioners that these reductions were necessary because of a $29,591,457 reduction in *federal Medicaid revenue*. *See* Attachment D to Minutes of SCDDSN Commission dated January 22, 2009. Appendix E at pages 48-52.

February 2009

44. Because of Governor Mark Sanford's vocal opposition to the ARRA, Congress included provisions allowing state legislatures to accept stimulus funds if the Governor refused to accept those funds. "*Clyburn Wields Clout to Thwart Sanford,*" James Rosen, the Charlotte Observer, January 30, 2009. Appendix G at pages 52-53. A provision was also included in the ARRA prohibiting states from using stimulus funds to reduce debt or

create a rainy day fund, as Governor Sanford repeatedly insisted upon doing.

45. On February 4, 2009, Deputy director of SCDDSN, William Barfield provided the SCDDSN Commission the good news that federal stimulus dollars would be retroactive to October of 2008. He assured the Commissioners of SCDDSN and the members of the public attending the February Commission meeting that *"The state government could not place money in a reserve account."* (Emphasis added.) SCDDSN Commission Meeting Minutes dated February 4, 2009. Appendix E at page 55. That is exactly what the Defendants proceeded to do - place 90% of federal stimulus dollars SCDDSN received into a reserve account.

46. Mr. Barfield informed the Commissioners that SCDDSN would receive stimulus funds in "early February, March or April." February 4, 2009, SCDDSN Commission Minutes. Federal Medicaid stimulus dollars actually became available to States on February 25, 2009. But these funds were never used to restore the services that had been eliminated under the guise of "budget reductions," even though the federal government paid the increased matching rate retroactively to October 2008. It was later disclosed that SCDDSN was holding an "excess funds" account which contained more than $7 million which could have been applied to avoid these cuts.

47. Emma Forkner wrote to CMS on February 25, 2009 assuring the federal Medicaid agency that South Carolina met ARRA eligibility requirements:

> South Carolina intends to fully restore eligibility standards, methodologies, or procedures that were made after July 1, 2008 to be eligible for the increased FMAP provided by the American Recovery and Reinvestment Act of 2009.

Appendix F at page 122. Letter from Emma Forkner to CMS dated February 25, 2009.

However, SCDDSN continued to terminate jobs which should have been preserved with federal stimulus fund, terminate eligibility for waiver services and terminate the eligibility of waiver participants.

48. Employees of SCDDSN and SCDHHS were working in concert on amendments which would change the methodology of determining eligibility for the MR/RD Medicaid waiver program by eliminating physicians as persons who could diagnose mental retardation, epilepsy and cerebral palsy and could determine whether the applicant met level of care criteria. Changing eligibility requirements and methodologies was prohibited by the ARRA.

49. While all of the eyes of the General Assembly were on the Governor's refusal to accept a small portion of the stimulus funds (SFS funds), no one was watching what was happening to the significantly larger pot of money - the Section 5001 FMAP (Medicaid) funds. Appendix H at page1.

50. The funds paid to South Carolina as a result of Section 5001 were three times the amount of the funds paid to the Employment Security Commission and the Department of Education, which were the funds that were the subject of the *Williams v. Sanford* litigation. "*Stimulus Expenditures Sorted by Purpose.*" Appendix H at page 1.

51. On or about February 27, 2009, Stanley Butkus resigned as the State Director of SCDDSN. Appendix G at page 30.

52. Governor Sanford waited over 2 months after the LAC audit was released to remove four SCDDSN Commissioners. Appendix G at pages 37-39. Removing these four SCDDSN Commissioners left only three sitting SCDDSN Commissioners during the remainder of the legislative session to inquire about legislative and budgetary issues, including how the

increased FMAP funds would be expended.

53. Two of the SCDDSN Commissioners who were removed were pastors. One Commissioner who asked to resign, John Powell, claimed that the Governor was "posturing" to "concentrate his power" at the expense of the Legislature. *"Ex-Disabilities board member says Sanford 'posturing.*" Article in Greenville News dated February 24, 2009. Appendix G at pages 34-35.

54. Mr. Powell's response to being removed by the Governor was: "As with his dithering over the acceptance of federal stimulus dollars, the only people who will suffer are the most vulnerable elements of our communities." *Id.*

55. These Commissioners were not replaced until after the state budget, including Proviso 90.13 were passed by the House and Senate. Defendants claim that Proviso 90.13 requires SCDDSN to pay all stimulus funds to a rainy day account.

56. Although SCDDSN services continued to be cut during February of 2009, officials at SCDDSN made no known efforts to obtain legislative authorization to use stimulus funds paid during SFY 2009 to avoid these reductions.

March 2009

57. The Kaiser Foundation reported in March that South Carolina was the last state in the country to qualify for federal stimulus funds for Medicaid services. See http://www.scribd.com/doc/16232791/Kaiser-Report-on-ARRA-Effects-on-Medicaid. Appendix H at pages 134 to 136.

58. On March 3, 2009, Proviso 90.13 was quietly attached to the South Carolina Appropriations Bill in the House Ways and Means Committee, requiring agencies that received federal stimulus funds to pay all "unobligated" funds to a reserve account. The

heading of the proviso gave legislators no indication that SCDDSN funds would be affected:

> (SR: Health and Human Services Funding) The source of funds appropriated in this provision is $390,036,948 of Department of Health and Human Services general fund appropriations, carry forward funds and earmarked and restricted special revenue fund accounts.

59. The following language was included at the end of the proviso:

> There is created within the State Treasurer's Office the Health Care General Fund Restoration Reserve Fund which shall be used solely for health care purposes. Agencies shall utilize all *unobligated* FMAP funds received through the American Recovery and Reinvestment Act of 2009 to replace general funds under the respective agencies and agencies shall transfer those general funds to the State Treasurer to be deposited into the Health Care General Fund Restoration Reserve Fund. (Emphasis added.)

60. South Carolina continued to receive national publicity about the refusal by Mark Sanford to accept federal stimulus funds. Appendix G at pages 19-20, 22. During March, correspondence flew back and forth between Mark Sanford and the Office of the President, with Governor Sanford repeatedly asking to use stimulus funds to pay "state debt" and the Office of the President consistently and clearly instructing Governor Sanford that stimulus funds must be spent for the purposes contained in the ARRA. March 11, letter from Mark Sanford to President Obama. Appendix F at pages 119-121. Letter from Peter Orszag to Mark Sanford dated March 16. Appendix F at page 118. March 17 letter from Mark Sanford to President Obama, Appendix F at pages 116-117. March 20 letter from Peter Orszag to Governor Sanford. Appendix F at pages 114-115.

61. Governor Sanford was also sparring over the stimulus funds with members of the General Assembly during March of 2009. On March 26, Senator Hugh Leatherman wrote to Mark Sanford informing him that his refusal to accept stimulus funds would create "absolute

chaos" and would harm South Carolina families. "*As criticism mounts, Sanford not bending*," Charleston Post and Courier, March 31, 2009. Appendix G at pages 16-18.

62. Governor Sanford responded in a letter to Senator Leatherman on March 30, continuing to insist that stimulus funds be used to pay debt. Appendix F at pages 110-113. In that letter, he told Senator Leatherman:

> ...It's incredibly important to remember the simple fact - these monies are not coming from a big piggy bank in Washington...
>
> ...you stymied those efforts at nearly every turn and even went so far as to call me Chicken Little for my predictions that the spending course we were on was absolutely unsustainable.
>
> As revenues grow, we opposed spending too much too fast because both the Bible and the business cycle teach us that sustainable spending can help protect against drastic busts following boom times.

63. As he had done when the LAC audit was released, Governor Sanford blamed the legislature for problems in state government:

> Both you and I know that it's your committee's very decisions that could have taken our state down a more responsible path in years' past, and this year you could still avoid any and all lost education jobs that you so ominously foretell. It's your pen, not mine, that has in large part brought us to this point today. *Id.*

64. Senator Leatherman responded by calling the Governor's plan "smoke and mirrors" and he predicted a financial "Armageddon" if Governor Sanford did not accept stimulus funds. "*Governor appears to have upper hand*," Charleston Post and Courier, April 1, 2009. Appendix G at pages 13-15.

65. The eyes and ears in the General Assembly remained fixed on the Governor's grandstanding over the SFS funds (federal stimulus funds for education and local government), while hundreds of millions of dollars of federal stimulus funds were on

their way through SCDHHS, the Governor's cabinet agency, into a rainy day account.

66. On March 19, 2009, William Barfield, the Deputy Director of SCDDSN, who was then serving as interim director of the agency, assured the SCDDSN Commissioners at the monthly Commission meeting that stimulus funds would avert cuts to services "if the Governor approves the stimulus package..." SCDDSN Commission Meeting Minutes dated March 19, 2009. Appendix E at pages 69 and 73.

67. Mr. Barfield advised the SCDDSN Commissioners that 91 MR/RD Medicaid waiver slots and 42 HASCI slots would be restored with federal Medicaid stimulus funds. *Id.* He did not inform the SCDDSN Commissioners or the public that a plan was underway to transfer 90% of the stimulus funds SCDDSN received to a rainy day fund pursuant to Proviso 90.13.

68. Dr. Eugene A. Laurent, the former director of SCDHHS, was hired as interim director of SCDDSN on March 24, 2009. Dr. Laurent had recently retired as the director of the South Carolina Housing Trust Fund. The Housing Trust Fund had provided matching funding to local DSN Boards to purchase residential real estate (matched with funds from SCDDSN).

69. On March 31, 2009, South Carolina Attorney General Henry McMaster issued an opinion determining that the Legislature could not bypass the governor to accept $700 million in federal stimulus money. However, the Attorney General determined that the final decision must be made by the courts. Letter from Attorney General Henry McMaster to Senator Glenn McConnell dated March 31, 2009. Appendix F at pages 93-109.

April 2009

70. Despite his publicly confirmed philosophical objections to the federal government paying

ARRA funds to South Carolina, on April 3, 2009, Governor Mark Sanford assured the Office of the White House that the ARRA federal funds other than SFS funds (which the Governor refused to accept) would be used in compliance with Act, as intended by Congress. Letter dated April 3, 2009 from Mark Sanford to Peter Orszag. Appendix F at page 92. On April 3, 2009, Governor Sanford sent a letter to Peter Orszag, Director of the White House Office of Management and Budget which provided the following assurances to the federal government:

> On behalf of the people of South Carolina, please allow this letter to certify that *we will accept funds and use them to create jobs and promote economic growth to the extent that our state and respective agencies and governmental programs are able to do so.* Although we have questioned the effectiveness of this legislation, we have said all along that *we will not prevent the state from certifying and receiving stimulus dollars which are scheduled to come to the state programatically through existing federal formulas.* We, therefore would ask that this letter serve as a Section 1607 certification and that funds be released to the appropriate state agencies *to spend in accordance with guidelines set forth in the ARRA and by federal agencies.* (Emphasis added.)

MR/RD and HASCI Medicaid waiver are funds that come to South Carolina "*programatically through existing federal formulas.*"

71. In that letter Governor Sanford assured the Office of the President that the funds would be "allocated in a responsible manner despite our reservations with regard to their ability to produce the intended effect of a more stable national economy." *Id.* Governor Sanford advised the President of his intent to pursue his concerns about accepting stimulus funds with the "policy makers within the General Assembly of South Carolina." *Williams v. State of South Carolina and Mark Sanford, supra.*

72. Either Governor Sanford and Ms. Forkner convinced legislators that most of the FMAP funds should divided between the a rainy day account and to the general fund for non-

health purposes in violation of federal law, or else legislators did not understand the impact of Proviso 90.13.

73. At the April 16, 2009, SCDDSN Commission meeting, again without explaining the financial consequences of Proviso 90.13, Mr. Barfield informed the Commission about the "potential increase in Federal Financial Participation." He explained that SCDDSN "could collect an additional $28.8M of Medical funding this fiscal year." (SCDDSN actually received more than $34 million in stimulus funds during SFY 2009.) April 16, 2008 SCDDSN Commission Meeting Minutes. Appendix E at page 76. Mr. Barfield did not mention the plan to pay 90% of the stimulus funds SCDDSN received to a rainy day fund

74. Also at that meeting, the Commission received and approved the agency's "Comprehensive Permanent Improvement Plan" (CPIP). Appendix E at pages 79- 81. All approved projects were for capital improvements at the SCDDSN Regional Centers except for three "Statewide - Community Facilities" projects:

(1) $235,000 for "Roofs, Gutters and Soffit Repairs,"
(2) $350,000 for "Conversions/Energy and Renovations" and
(3) $225,000 to three local DSN Boards in the Piedmont Region.

The Piedmont Region funds were specifically to pay for fire sprinkler systems at residences in Cherokee, Laurens and Greenville DSN Boards. No funds were approved for capital improvements or renovations at the Babcock Center or to DSN Boards in Horry or Beaufort counties. (Later, SCDDSN would pay $2.8 million to three agencies which were not mentioned in the CPIP, without asking SCDDSN Commissioners to modify this plan.)

75. SCDDSN continued to reduce services provided to persons on the MR/RD and HASCI Medicaid waiver under the pretext of inadequate funding, while hoarding more than $34 million in federal stimulus funds. An executive director of one local DSN Board testified to the Commission at its April meeting that "...she has to tell families not to move to South Carolina with their family member because there are no services available due to budget reductions.." Appendix E at page 77. Again, no mention was made by Mr. Barfield at the SCDDSN Commission meeting about Proviso 90.13 or its effect on the increased FMAP stimulus funding. Neither Mr. Barfield nor Dr. Laurent mentioned at the April 2009 SCDDSN Commission meeting that the SCDHHS Medical Care Advisory Committee (MCAC) would be meeting on May 19, 2009, to approve drastic reductions Dr. Laurent and SCDDSN Officials determined to be necessary because of serious "budget reductions."

76. On April 21, 2009, Proviso 90.13 was amended by the Senate Finance Committee to change the name of the stimulus fund rainy day account from the *"Health Care General Fund Restoration Reserve Fund"* to the *"Health Care Annualization and Maintenance of Effort Fund."* Appendix F at pages 53-54. The amended Proviso 90.13 stated:

> There is created with the State Treasurer's Office the *Health Care Annualization and Maintenance of Effort Fund* which shall be separate and distinct from the General Fund and shall be used exclusively for health care purposes. All agencies, unless specifically exempt by another provision contained in this act, shall transfer unobligated state match funds resulting from the receipt of the increased Federal Medical Assistance Percentage to the State Treasurer to be deposited into the Health Care Annualization and Maintenance of Effort Fund.[3]

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[3] The versions of Proviso 90.13 are compared below, with language removed in *italics* and new language in **bold**.

77. However, changing the name of the fund could not avoid the undeniable fact that transferring these funds to a rainy day account violated Section 5001 of the ARRA. Proviso 90.13 also transferred $225,945,013 of FMAP stimulus funds during FY 2010 to the South Carolina General Fund, for uses other than health care. Other amounts of FMAP funding were transferred to various non-health related agencies. For example, Proviso 90.13 transferred $600,000.00 of FMAP funds to repair a roof at John de la Howe School.

78. In April of 2009, SCDDSN was sitting on more than $34 million in stimulus funds. SCDDSN officials continued to make no known attempt to obtain legislative approval to spend these funds to prevent budget cuts or to save jobs of SCDDSN employees and other MR/RD and HASCI Medicaid waiver providers which would be eliminated due to reductions in state funding.

May 2009

79. The General Assembly passed the 2009-2010 South Carolina Appropriations Act on May 13, 2009. Proviso 90.15 of the Act required the Governor to apply for State Fiscal

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There is created with the State Treasurer's Office the Health Care *(General Fund Restoration Reserve)* **Annualization and Maintenance of Effort** Fund which shall be **separate and distinct from the General Fund and shall** be used exclusively for health care purposes. **All** agencies, **unless specifically exempt by another provision contained in this act,** shall *(utilize all)* **transfer** unobligated *(FMAP)* **state match** funds *(received through the American Recovery and Reinvestment Act of 2009 to replace general funds under the respective agencies and shall transfer those general funds)* **resulting from the receipt of the increased Federal Medical Assistance Percentage** to the State Treasurer to be deposited into the Health Care *(General Fund Restoration Reserve)* **Annualization and Maintenance of Effort** Fund.

Stabilization Funds ("SFS funds") to provide funds for education and local governments. Proviso 90.15 was debated thoroughly by the House and Senate and a joint resolution was passed by the General Assembly on May 13, 2009, clearly confirming the legislature's intent to require the Governor to apply for federal stimulus funds. The public had ample opportunity for input into this legislation, as did the Governor. The Governor refused to apply for the SFS funds and was later ordered by this Court to do so.

80. However, the public had no such notice of or opportunity for review and input into Proviso 90.13. Indeed, Mr. Barfield repeatedly led affected individuals, their families and providers to believe that federal stimulus funds were available and would be used to prevent cuts in SCDDSN programs. According to the information provided by Mr. Barfield, the only hindrance in obtaining these funds to avoid cuts in services was the Governor making an application for the funds. Consumers and families later learned that the Governor never had the option or the authority to refuse to accept the FMAP stimulus funds. No known efforts were made by SCDDSN officials to obtain legislative approval for spending the $34 million of FY 2009 stimulus funds in order to avoid cuts to services.

81. The subject heading of Proviso 90.13 was "(S.R. Health and Human Services Funding)." The heading of the proviso did not mention of SCDDSN or Medicaid. The section of the Appropriations Bill dealing with SCDDSN, Section 24, did not mention federal stimulus funds for SCDDSN programs being paid to a rainy day fund instead of being used to avert cuts to the waiver programs. That was contrary to the language contained in Section 24.4.of the Appropriations Act, titled "DDSN: Medicaid Funded Contract Settlements."

Section 24.4 states that "the department is authorized to carry forward and retain settlements under Medicaid-funded contracts." This provision and the heading of Proviso 90.13 misled consumers, families, advocates and probably legislators into believing that any unspent FMAP funds would be available to preserve services and to avoid reductions during FY 2010.

82. Section 24.4 of the State Appropriations Act stated that SCDDSN was authorized to carry forward settlements of Medicaid funded contracts. This evidences the intent of the legislature to use Medicaid funds to provide services to persons served by SCDDSN, not to return those funds to the State Treasury or some other fund.

83. Without consultation with or notice to the SCDDSN Commissioners and a week after Proviso 90.13 was passed by the South Carolina House of Representatives and Senate, SCDHHS staff informed the SCDHHS Medical Care Advisory Committee on May 19, 2009 that budget reductions to SCDDSN mandated the termination of the following MR/RD waiver services:

Physical Therapy (PT),
Occupational Therapy (OT),
Adult Companion Services (ACS),
Audiology Services,
Adult Vision Services,
Adult Attendant Care Services,
Personal Care I Services,
Speech and Language Pathology Services.

Appendix E at pages 92-93.

84. Most of these services are provided by non-DSN Board providers. SCDDSN was holding between $7 and $9.1 million in "excess" funds collected from residents of SCDDSN programs for room and board which could have been used to avoid these reductions.

85. At the meeting of the MCAC, SCDHHS staff member SamWaldrup advised the Committee that personal care services, hourly respite services, nursing services, specialized medical equipment, supplies (including liquid nutrition) and assistive technology must be reduced because of state budget reductions.

86. Under the proposed amendments, daily respite could no longer be provided in the home. Inexplicably, instead of paying less than $70.00 per day for in-home respite, the changes proposed by SCDHHS required that participants go to ICF/MR facilities (nursing homes for people who have mental retardation or related disabilities) operated by SCDDSN or local DSN Boards to receive daily respite services, a clear violation of *Olmstead*. The new plan provided $270.00 per day for respite services provided in ICF/MR facilities operated by SCDDSN and its local Boards (an increase from the rate of $157.00 per day paid for these same services during 2009). The plan eliminated the option of participants receiving daily respite in their own homes at a cost of $70 per day. Hourly respite services were limited to 32 hours per month.

87. Personal care services were limited to 28 hours a week and nursing services were limited to 56 hours a week under the proposal approved by MCAC. (Previously there had been no cap on the number of hours.) Mr. Waldrup informed the Committee that budget reductions also required SCDHHS to impose limits on the number of diapers and nutritional supplies provided to MR/RD Medicaid waiver participants. Diapers and nutritional supplies would be provided if waiver participants elected to receive services in Medicaid funded institutions, instead of receiving waiver services in the community.

88. The MCAC was informed that the services which were being eliminated only affected a few individuals. However, in actuality, all of the waiver participants who were receiving

"residential habilitation" services were affected by the elimination of these services. They were not "counted" in the number of persons affected. Once these changes go into effect, a person receiving residential habilitation would no longer have a right to receive speech and language assessments needed to prevent choking or to be assessed for an assistive communications device, physical therapy, occupational therapy, nutritional supplements (in excess of 2 cases a month), etc.

89. None of these changes were based on an individualized assessment of need or a cost analysis of alternative care which would be required when these services were reduced or eliminated. No assessment was made of the availability of nursing home and ICF/MR beds which would be needed when these home-based services were reduced and waiver participants opted to receive more expensive institutional services. Not only were the members of the governing board of SCDDSN not advised of the plan to eliminate and reduce these services, the decision to reduce these Medicaid waiver services was made without a cost analysis. In May of 2009, Dr. Laurent, who holds a doctorate in economics, determined that $4.6 million of MR/RD and HASCI Medicaid waiver services must be cut to balance SCDDSN's budget. Dr. Laurent determined that simply cutting the services identified above would save the agency $4.6 million. The reductions did not consider the costs of day program services for participants who previously did not receive those services but would be forced to attend SCDDSN workshops because they could no longer spend the day in their own homes. The decision did not take into effect, the costs of institutionalization of waiver participants who could no longer remain in their homes and communities or the increased costs in hospitalizations and emergency room services that would result from the reduction and elimination of these services. No

consideration was given to the very real economic costs that would result from parents losing their jobs when attendant, nursing and respite hours were cut.

90. In addition, there is no indication that SCDDSN intended to reduce the capitated band payments paid to local DSN Boards. SCDDSN pays local Boards a capitated "band payment" for all services received by an individual, based on where the individual lives.[4] Cutting services without reducing band payments would not save any money. But the proposed reductions/eliminations would reduce participation by private providers, whose costs are normally paid by the DSN Boards out of "band" payments. (If private providers bill SCDHHS directly, the cost is deducted from the "band payment" paid to the local DSN Board.) Eliminating or reducing adult companion services, nursing services, respite and attendant care services would also force more waiver participants to attend SCDDSN funded congregate workshops, a cost which was not considered in determining how much money would be "saved" by reducing these services.

91. Based on the reports of severe budget reductions (which were nonexistent when federal stimulus funds were considered) presented by Mr. Waldrup, the MCAC voted to totally eliminate daily in-home respite, physical therapy, occupational therapy, adult companion services, speech and language services, audiology, personal care I and vision services from the MR/RD Medicaid waiver program. Recommended caps on other services were approved as requested.

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[4] Under the capitated system used by SCDDSN, the local DSN Board receives the same amount whether it provides a waiver participant one service or a dozen services, thus giving the local DSN Board a financial incentive to reduce or eliminate needed waiver services.

92. The MCAC was not informed that SCDHHS and SCDDSN intended to increase the rate paid for institutional respite from $157 per day to $270 per day once in-home respite ($70 per day) was eliminated. MCAC did not review any of the rates which would be submitted to CMS for approval.

93. Mr. Waldrup never informed MCAC Committee members that SCDDSN was, at that time, holding $34 million, $31 million of which would be deposited into a rainy day fund instead of being used to maintain services and jobs of caregivers.

94. Mr. Waldrup did not explain to MCAC members that the plan would increase rates paid to SCDDSN and local Boards while reducing the reimbursement rates paid for many private providers, thereby further reducing the choices waiver participants have in providers.

95. That same day, Governor Sanford wrote a 33 page letter to the Speaker of the House of Representatives. Appendix F at pages 55-87. In that letter, Governor Sanford blamed the State's financial problems on the South Carolina General Assembly:

> Those "looming lean times" are indeed no longer looming – and legislative leaders must to some degree be held accountable for the missed opportunities over the last five years to prepare for just this rainy day.
>
> ...legislative leaders have failed once again to learn from past mistakes and have missed glaring opportunities to make long-lasting reforms. This lack of foresight and financial planning will continue to harm those working in state government and those served by it now and in future years.
>
> ...spending an unprecedented amount of one-time federal funds on core, recurring needs without making sustainable budgetary and financial reforms, including paying down our high state debt load, allows the General Assembly to avoid the responsibility of making tough decisions.
>
> **I did everything within my power to impede the federal stimulus legislation** as it moved through Congress because I, along with most every Republican

> Member of Congress in Washington, was concerned about the disastrous long-term consequences that would come from spending money we don't have - and in issuing yet more debt to solve a problem that was created in the first place by too much debt.

96. In this letter, Governor Sanford compared the State's receipt of federal stimulus funds to a family winning the lottery. Unlike a family which has won the lottery, however, Plaintiffs and other persons who live hand to mouth and depend upon Medicaid to meet their basic medical needs have no cushion to fall back upon and do not have the option of setting aside funds for a rainy day. For these families the rainy day is now and Congress intended that the federal stimulus funds protect them by maintaining their services.

97. At the May 21, 2009, SCDDSN Commission meeting, Mr. Barfield informed Commissioners that the "General Assembly appropriated $12.7 million in recurring state dollars *as DDSN had requested.*" Appendix E at pages 87-88. (These "recurring" dollars were in addition to the "non-recurring" stimulus funds of approximately $17.2 million.) This amount was $3 million more than the agency requested in the budget submitted in April of 2009. Appendix E at pages 82-85. Budget attached to April 2009 Minutes of SCDDSN Commission Meeting.

98. Mr. Barfield assured the Commissioners and families attending the meeting that the agency "will be able to restore some services since cuts have occurred *but not every service at the level they were July 2008.*" (Emphasis added.) *Id.* Restoring services to the July 1, 2008 level was a requirement Congress placed on the States to receive stimulus money.

99. Commissioners were informed that 91 MR/RD Medicaid waiver slots were funded to be restored in 2010 along with 42 HASCI waiver slots. Attachment C to May 2009 Minutes

of SCDDSN. Appendix E at pages 90-91.

100. The approved budget Mr. Barfield presented included funds for an additional 106 slots for "waivers capacity restoration." In addition to that increased funding, Mr. Barfield reported that the General Assembly had approved 175 additional "residential services" slots.

101. However, SCDDSN Associate State Director, Dr. Kathi Lacy, informed the SCDDSN Commissioners and the public for the first time at that meeting that: "*Due to budget cuts*, some changes were necessary in the waiver." May 21, 2009 SCDDSN Commission Minutes. Appendix E at page 88. According to SCDDSN's website, the reductions to the MR/RD Medicaid waiver resulted from "the devastating state budget reductions DDSN had last fiscal year." *See*

http://www.ddsn.sc.gov/NR/rdonlyres/F7A2F901-B560-4B47-9D5E-F72A6BC0606B/0/MRRDWaiver20090723.pdf.

102. On May 28, 2009, after the amendments to the MR/RD Medicaid waiver had been approved by the MCAC, interim Director of SCDDSN, Eugene A. Laurent, finally sent a letter to "Advocacy Organization Executive Directors, Provider Organization Executive Directors; Interested Parties" asking for input into the plan to reduce MR/RD Medicaid waiver services. Appendix F at page 49. Letter from Dr. Laurent to Directors and Interested Parties. This meeting was held on June 4, 2009, "to receive additional comments specific to this waiver renewal."

June 2009

103. Just a week after learning about SCDDSN's intention to drastically cut home-based services, on June 4, 2009, waiver participants, family members, advocates and providers

packed into a hearing room. All of the families could not fit into the room. Some participated by closed circuit television in a separate room, which was also packed. Others who could not fit into either room flowed out into the hallways to protest the proposed changes to the MR/RD Medicaid Waiver program. Dr. Eugene A. Laurent informed more than 150 consumers and family members that:

> "...the agency has been hit with $41 million in state funding cuts, which amounts to $74 million once matching federal money is included, and that "something has to be cut."

104. The truth was that even with the reductions in state funding, SCDDSN received more funds in SFY 2009 and will receive even more funds in SFY 2010 when the federal stimulus funds are considered.

105. At that time, SCDDSN was holding $34 million in stimulus funds paid during SFY 2009 and the agency was budgeted to receive more than $40 million in additional stimulus funds during SFY 2010.

106. Dr. Laurent informed consumers and families that reductions to the MR/RD Medicaid waiver program were necessary because of a $4.6 million deficit in funding. Even without the excess funds account, the stimulus funds paid to SCDDSN more than covered the shortfall.

107. Families testified to SCDHHS and SCDDSN officials that they would lose their jobs, and some would lose their homes, if the proposed waiver reductions were put into place. Comments received by some of the affected waiver participants and family members are attached. Appendix H at pages 98 to 130. One parent responded that asking which services he wanted SCDSN to reduce was "like asking me in which order do I want my

fingers cut off." Appendix H at 98. Families complained that they had not been notified of or involved in the process of developing the waiver amendments and that these changes were being implemented without a cost analysis.

108. On the same date as this hearing, June 4, 2009, this Court ordered Governor Sanford to apply for and accept SFSF stimulus funds for education and local government purposes. *Williams v. Sanford, supra.*

109. On June 5, 2009, Dr. Laurent, explained to SCDDSN Commissioners that "one-time dollars can fund slots but cannot add and sustain additional dollars." June 5, 2009, Minutes of SCDDSN Commission. Appendix E at page 95. According to Dr. Laurent, "large budget reductions and one-time funds impact the waiver and the operational need to cap services." *Id.* SCDDSN Chairman Kelly Floyd "stated a concern that if the MR/RD waiver is not reduced, budget cuts in other services would have to occur." *Id.* at page 97.

110. The director of SCDHHS, Emma Forkner, spoke at the June SCDDSN Commission meeting. She explained that waiver services must be reduced because of the reduction in state funding. *Id.* at page 96. However, Ms. Forkner admitted in her power point presentation that ARRA prohibits changes in levels of care determinations or medical necessity, reductions in waiver capacity, reductions in waiver slots, and adjustments in cost neutrality calculations resulting in individuals being dropped from the waiver. *Id.*

111. Ms. Forkner advised the SCDDSN Commission and attendees at that June 5, 2009, meeting that SCDDSN was serving 6,054 individuals on the MR/RD Medicaid waiver in FY 2007-2008 and 661 were served under the HASCI Medicaid waiver during that fiscal year. Ms. Forkner urged the Commissioners to approve the reductions, informing them

that all MR/RD would lose their services if the waiver amendments were not submitted to CMS by June 25, 2009. Ms. Forkner did not inform SCDDSN Commission members that the amendments actually contained increases in the rates paid for congregate and institutional services provided by SCDDSN and local DSN Boards, including a 70% increase in the rate paid for respite services provided in SCDDSN institutions. She did not explain why no attempt had been made by her agency to use federal Medicaid stimulus dollars to prevent these reductions or why the SCDDSN excess funds account had not been tapped to avoid these reductions.

112. Ms. Forkner also did not mention at that meeting that her agency changed the procedures and standards for determining eligibility for the MR/RD Medicaid Waiver program in the application her office was preparing to submit to CMS.

113. Upon information and belief, these changes included eliminating licensed physicians as persons who are qualified to diagnose mental retardation, epilepsy, cerebral palsy and related disabilities. Upon information and belief, under the amendments prepared by Ms. Forkner's staff, licensed physicians were no longer qualified to determine whether waiver services were needed to prevent regression or to maintain the applicant's optimal functioning level.

114. The Commissioners of SCDDSN were not consulted about these changes in methodology for determining eligibility nor were they informed that under the new eligibility procedures, only the SCDDSN "CAT" ("Consumer Assessment Team") has the authority to determine whether an applicant has mental retardation or a related disability. Under the new methodology, the CAT has the authority to base eligibility decisions on the "professional judgment" of CAT members, rather than by using established objective

standards.

115. Federal law requires that level of care determinations be made every year. By giving the CAT the sole authorization to determine disability and taking away the authority of the treating physician to determine whether an applicant has mental retardation, epilepsy or cerebral palsy, these amendments enhanced the ability of the agency to respond to criticism with a denial of eligibility.

116. This change also violated the clear directives of Congress in Section 5001 of ARRA prohibiting more restrictive eligibility methodologies.

117. On June 9, 2009, Dr. Laurent sent a memorandum to Executive Directors and Chairpersons of DSN Boards titled "Apology." In that memorandum, he admitted that:

> DDSN initiated proposed reductions and caps in the MR/RD waiver without involving the County Boards in the process, but also without notifying you that the proposal was going to the Commission. An oversight like this should not have happened.

Appendix F at page 46.

118. Surprised that Dr. Laurent obtained MCAC approval for reducing and eliminating MR/RD Medicaid waiver services without consulting the governing board of SCDDSN, at the June SCDDSN Commission meeting, the Commissioners directed Dr. Laurent to request a 90 day extension on submitting the MR/RD Medicaid waiver renewal to the federal Medicaid agency (CMS). As directed by the Commission, on June 10, 2009, Dr. Laurent wrote to SCDHHS asking Ms. Forkner to request an extension on submitting the MR/RD Medicaid waiver renewal request. Appendix F at pages 44-45. Letter from Dr. Laurent to Emma Forkner dated June 10, 2009. In this letter, Dr. Laurent stated that caps had been approved by SCDDSN Commissioners in response to "devastating budget

cuts." Appendix H at page 44.

119. There were no "devastating budget cuts," when federal stimulus dollars were taken into account. That was the purpose of the stimulus dollars - to maintain services despite the loss of state funds. SCDDSN was holding $34 million in federal stimulus funds and more than $7 million in an excess funds account.

120. Ms. Forkner informed the federal Medicaid agency that: "The waiver contains service reductions that have been proposed by SCDDSN *in response to a series of reductions in state appropriations for State FY 2009 and State FY 2010."* Letter from Emma Forkner to CMS dated June 11, 2009. Appendix F at page 43.

121. The first time the public was informed of the plan to transfer federal stimulus dollars to the rainy day account was at the June 18, 2009, SCDDSN Commission meeting. They were informed that: "A special proviso took effect in May that instructs health agencies to deposit stimulus funds in a new special account within the State Treasurer's Office." Minutes of SCDDSN Commission Meeting dated June 18, 2009. Appendix E at pages 120-146.

122. Dr. Laurent explained to the Commission that "the General Assembly spread stimulus funds for the good of the whole state." *Id.* It was true that $225 million of Section 5001 funds were placed in the State's general fund. But $31 million out of the $34 million paid to SCDDSN were transferred directly to the Health Care Annualization and Maintenance of Effort Fund, a rainy day account.

123. At the SCDDSN Commission meeting held on June 18, 2009, Dr. Laurent informed SCDDSN Commissioners that: "we cannot find money but we could use existing money differently..." Minutes of June 18, 2009, SCDDSN Commission Meeting. Appendix E at

123. Dr. Laurent did not inform the audience that DDSN was holding more than $7 million in an excess funds account resulting from accumulated "client fees." He did not inform the Commissioners that his agency was working on a plan to transfer $2.6 million to three chosen DSN Boards to purchase more real estate.

124. At the June SCDDSN Commission meeting: "Mr. Barfield explained the Medicaid stimulus funding coming to SCDDSN. DDSN has been earning stimulus funding but is not allowed to keep all of it."Appendix E at page 123.

125. Dr. Laurent sent a memorandum to Executive Directors of DSN Boards and Executive Directors of Qualified Providers dated June 24, 2009 stating:

> DDSN and DSHHS previously developed a set of some service reductions to the MR/RD waiver. Based upon the input DDSN received from effected (sic) families and advocacy groups, the Commission directed us to develop alternative reduction options. The attached document reflects three revised options and includes specific detail on the number of persons who would be impacted by each service reduction.
> Appendix F at page 34.

126. Upon information and belief, these options were developed by staff, without input from the SCDDSN Commissioners. None of the options involved spending federal stimulus funds to maintain services. SCDDSN still had not performed a cost analysis addressing the relative costs of substituted services or the medical necessity and expected increases of persons requiring institutional services. The proposal did not rely upon individualized assessments of need.

127. June 22, 2009, was the tenth anniversary of the United States Supreme Court case of *Olmstead v. L.C. ex rel. Zimring,* 527 U.S. 581(1999). In that case, the Supreme Court determined that unnecessary institutionalization of individuals with disabilities is a prohibited form of discrimination under Title II of the Americans with Disabilities Act

(ADA). On the anniversary of *Olmstead,* the Secretary of the United States Department of Health and Human Services, Kathleen Sebelious and President Obama declared 2009 the "Year of Community Living." Appendix H at 13 to 25. At the ceremony celebrating this anniversary, Secretary Sebelius reminded the States that "unjustified institutional isolation of persons with disabilities is a form of discrimination" under the Americans with Disabilities Act. *Id.*

128. On June 24, 2009, Dr. Laurent sent another memorandum to Disability Advocacy Organizations and Other Interested Parties explaining why reductions had to be made to the MR/RD and HASCI Medicaid waiver programs. Appendix F at pages 34 to 42. In this memo, Dr. Laurent explained that "DDSN was required to implement last fall due to *our significant reduction in state funding.*" (Emphasis added.)

129. On or about June 25, 2009, Emma Forkner submitted a request to make changes to the MR/RD Medicaid waiver program to CMS. She informed the federal agency that these changes were necessary "Due to the state's budget situation..." The waiver request asked CMS to increase the number of persons served to from 6,000 to 6,300, an increase of 300 participants. Upon information and belief, the only logical explanation for drastically reducing services, while expanding the number of individuals served is that the Defendants intended to force waiver participants into congregate services and to limit the number of services provided.

130. During the month between being notified of the proposed changes in late May and SCDHHS submitting the amendments to CMS, SCDDSN families and consumers bombarded their Congressional and local representatives with requests to continue the community-based services that SCDHHS was proposing to eliminate or reduce in

violation of *Olmstead* and ARRA. On the same day that SCDHHS submitted its MR/RD Medicaid Waiver renewal application to CMS, June 25, 2009, CMS granted a 90 day extension for the submission of the MR/RD Medicaid waiver renewal application. Appendix F at page 33. Letter from CMS to Emma Forkner dated June 25, 2009.

131. On June 29, 2009, the South Carolina Budget and Control Board directed the "Agency Chief Financial Officers" to transfer all "unobligated state match funds" to the "Health Care Annualization and Maintenance of Effort Fund." Appendix F at pages 31-32. According to this directive, "unobligated state match funds" must be transferred each quarter during SFY 2010 within 15 days of the end of the quarter.

132. Late in June, the Deputy Director of SCDDSN, William Barfield, announced his resignation, which was effective July 1, 2009.

133. In June, the mother and guardian of one of the Plaintiffs, Carolyn Brown, was elected as President of Voices for the Voiceless. Voices is an advocacy organization which was established after the June 4, 2009, hearing to advocate for SCDDSN consumers and to oppose reductions in services. Her son's companion services were terminated soon after her election as spokesperson for that advocacy organization. Appendix B at pages 8-10.

July 2009

134. In July, SCDDSN officials informed Senator Thomas that "DDSN has the money to fund all MR/RD Waiver services for the current year." Appendix F at page 30. Letter dated July 9, 2009. However, SCDDSN continued reducing home based services based on it's claims of drastic budget cuts and proceeded with its plans to place arbitrary limits on waiver services.

135. Many of these reductions were made using another pretext for reducing or terminating

services. Appendix B at pages 21-22. Affidavit of Delene Wright.

136. On July 10, 2009, the South Carolina Budget and Control instructed SCDDSN to transfer $31,508,295.67 of "unobligated state match funds" to a rainy day account pursuant to Proviso 90.13. This directive was sent to Tom Waring. Mr. Waring was instructed to deposit these funds into the Health Care Annualization and Maintenance of Effort Fund. Appendix F at page 29. Upon information and belief, these funds were transferred without question by Mr. Waring and other SCDDSN officials.

137. Upon information and belief, at a work session of SCDDSN Commissioners on July 16, 2009, Mr. Waring provided a report to the Commissioners informing them that SCDDSN had an unobligated excess funds account which contained $9.1 million.

138. However, according to an August 25, 2009, report from the Office of the State Treasurer, the balance of the SCDDSN "Excess Debt Service" account was $7,845,444.32 at the end of SFY 2009. Appendix D at page 9. That account contained $8,314,433.00 at the end of SFY 2008 and $1,501,773.00 in "consumer fees" was added to the account during SFY 2009. The difference between the $9.1 million in the account in July and the $7.8 million in August has not been explained.

139. Commissioners were informed by Dr. Laurent that these funds must be used on capital expenditures. However, $67,000 of these funds has been awarded to the former director of SCDHHS under a contract for personal services. (Dr. Laurent requested that the South Carolina Budget and Control Board approve $100,000 for this contract.) There was one competitor who bid on the contract, which was awarded to Kerr and Company. Appendix H at pages 130 to 132.

140. At the Commission meeting on July 17, 2009, an advocacy group, Voices for the

Voiceless, asked the Commission to obtain an independent cost analysis before implementing waiver amendments, since no cost analysis had been done prior to SCDDSN management proposing the changes which were approved by MCAC in May.

141. However, Dr. Laurent responded that a cost analysis was not necessary because "...a cost analysis will not make that decision." July 17, 2009, Minutes of SCDDSN Commission meeting at page 5. Appendix E at pages 147-158. Dr. Laurent advised the Commission that:

> ...the change in state match allows the agency to draw down a large amount of money but the agency does not get to keep the money. DDSN has been billed $31,508,295.60 by the State Budget and Control Board. This money goes to the Office of the State Treasurer in accordance with Proviso 90.13." *Id.*

142. According to Dr. Laurent, the reductions and elimination of services in the MR/RD and HASCI waiver programs were unavoidable because the agency had a $4.6 million deficit in funding. *Id.* However, the Commission was not presented any options which would use "unobligated" stimulus funds to avoid cutting waiver services. Nor was there any effort to use the $9.1 million held in the "excess debt service" account to cover this shortfall. Based on the budget options presented by Dr. Laurent, Mr. Barfield and Mr. Waring, the Commission voted to reduce MR/RD and HASCI Medicaid waiver services as recommended by SCDDSN staff.

143. At the July meeting, the Commission approved the "FY 2009-2010 Spending Plan," which was presented and explained by Thomas Waring. Appendix E at 151. Mr. Waring also presented bids and details for improvements to be made at Whitten Center funded by Whitten Center Trust fund in the amount of $154,799. Dr. Laurent discussed the need to reduce expenditures to meet the $4.6 million cut. However, the spending plan included

$4.6 million for "Capital Development: Program Facilities/Residential" and $3.2 million for Capital Projects for CPIP Regional Centers." No discussion was recorded in the minutes of how the $4.6 million allocated for "Facilities/Residential" would be spent. Presumably, these funds would be spent according to the "Comprehensive Permanent Improvement Plan" (CPIP) which had been approved by the SCDDSN Commissioners in April, prior to the appointment of four new Commissioners.

144. Mr. Waring did not explain to the Commissioners or to the persons attending that meeting why SCDDSN failed to use any stimulus funds paid to the agency for MR/RD or HASCI services during FY 2009 to avoid cuts to services

August 2009

145. On August 4, 2009, the President of Voices for the Voiceless, Carolyn Brown, met with Governor Sanford's Chief of Staff, Scott English, Emma Forkner and Dr. Laurent and other staff members of the Governor's Office, SCDDSN and SCDHHS to explore alternatives to reducing SCDDSN services. Appendix B at page 8 to 10. Mr. English and the state agency directors were asked why SCDDSN would not ask the Budget and Control Board to run a deficit until the legislature reconvened and had an opportunity to amend Proviso 90.13 so that cuts to the MR/RD and HASCI Medicaid waiver could be avoided.

146. At the end of this meeting that lasted nearly three hours, Scott English directed Dr. Laurent to ask the South Carolina Budget and Control Board to allow SCDDSN to run a deficit in order to avoid cutting waiver services. *Id.* Dr. Laurent responded by assuring Mr. English that he would ask the Commissioners for permission to make a request to the South Carolina Budget and Control Board to run a deficit in order to avoid cutting home-based services. *Id.* This now appears to have been an insincere ploy to make it appear that efforts were being made to avoid reductions in services.

147. Dr. Laurent failed to disclose in this meeting that SCDDSN was working on plans to ask the South Carolina Budget and Control Board for permission to spend $5,944,738 of the more than $7 million surplus SCDDSN was holding. These funds could have been used to avert disruption of waiver services instead of being used to purchase or renovate three large buildings for congregate workshops at a cost of $2.6 million.

148. According to the information Mr. Waring provided at the July meeting, the cost of maintaining MR/RD services was less than Dr. Laurent requested to purchase or renovate three large buildings to be used for congregate workshops ($2,593,790 to maintain MR/RD services vs. $2.6 million for the buildings used for congregate workshops).

149. In addition, Dr. Laurent intended to ask the Budget and Control Board to use $3.2 million to upgrade agency computers and to use $100,000 available to be awarded to the former director of SCDHHS. Appendix H at 131 to 133. (However, only $67,000 of the amount approved was actually awarded to the company owned by the former director of SCDHHS). Appendix H at 131.

150. Asking the South Carolina Budget and Control Board to allow the agency to run a deficit would raise questions about why SCDDSN was distributing millions of dollars for the purchase of real estate. Appendix B at page 12. Affidavit of Charles McLafferty.

151. A few days after Scott English directed Dr. Laurent to ask the South Carolina Budget and Control Board to run a deficit, SCDDSN Chairman, Kelly Floyd provided her opinion about the concept. Ms Floyd responded in an email from a parent who was concerned about service reductions:

> I have three young boys who asked for a 4-wheeler for Christmas last year. Finally, I sat them down and told them our Daddy and I couldn't afford to get them a 4-wheeler. My youngest son looked at me like I was crazy and said "It's not going to cost you anything —we are asking Santa for it!" That kind of sums up my feelings about running state govt. on a deficit–eventually someone has to pay for it. Appendix F at page 28.

152. Within a week of that email, Dr. Laurent would ask the Budget and Control Board to approve spending $1 million on a building to be used for a congregate workshop located in Ms. Floyd's home county, Horry. This expenditure in Horry County had never been presented to nor had it been approved by the SCDDSN Commission, despite the assurance Dr. Laurent gave to the Budget and Control Board that these purchases had been "unanimously" approved by his Commissioners.

153. On August 7, 2009, the Finance and Audit Committee unanimously adopted a resolution asking the South Carolina Budget and Control Board to "be keenly aware" of the impact of funding reductions and the fact that SCDDSN kept less than 1/3 of the stimulus funds it received.

154. However, at the August 13, 2009, meeting of the South Carolina Budget and Control Board, Dr. Laurent did not seek permission to run a deficit in order to avoid cuts to

SCDDSN services. Appendix D at pages 14-16.

155. At that meeting, Defendant Eckstrom gave his opinion about the state using taxpayer dollars to purchase real estate. He said that "he does not understand why the State moves ahead with additional capital acquisitions." Minutes of August 13, 2009, Meeting of the South Carolina Budget and Control Board. Appendix D at 15 and 16. Comptroller Eckstrom objected to the expenditure of just $400,000 for the purchase of real estate by Winthrop University, saying that "state taxpayers should not have to be using money to buy property now..." He stated that "state taxpayers should not have to bailout the public-private foundations in this current environment." *Id.* Yet, that is exactly what he did at the next South Carolina Budget and Control meeting in approving $2.6 million for local DSN Boards to purchase real estate.

156. On August 14, Dr. Laurent wrote to the South Carolina Budget and Control Board asking for approval to spend $2.6 million to purchase or renovate buildings to be used for congregate workshops. Appendix D at pages 7-8. He requested approval to spend $1 million to purchase or renovate a building in Ms. Floyd's county. He also asked for approval to spend $1.6 million purchasing or improving real estate in two other locations. Mr. Laurent requested approval pursuant to South Carolina Code of Laws § 44-20-1170, however, his request did not comply with South Carolina Code of Laws § 44-20-1140. That section required SCDDSN to show the number of paying clients, the amount of client fees expected in the next succeeding fiscal year or a maturity schedule (not to exceed twenty years) for repayment of monies for state capital improvement bonds. The documents Dr. Laurent presented to the Budget and Control Board contained no provision for repayment.

157. On August 18, 2009, Mr. Waldrup again presented reductions for the MR/RD Medicaid waiver to the MCAC (a Committee of the cabinet agency, SCDHHS). He also presented requests to reduce HASCI waiver services. The MCAC approved reductions to both the HASCI and MR/RD Medicaid waiver program.

158. Members of the Committee were informed that these reductions were required in the HASCI waiver program "due to state budget reductions." Appendix H at pages 139 to 140. Mr. Waldrup requested authorization to reduce HASCI attendant care services from 56 hours a week to 49 hours a week. He did not inform MCAC that there had previously been no authorized cap on HASCI nursing services. The MCAC also voted to limit the maximum number of combined hours per day of attendant care and nursing services in the HASCI program to 10 hours per day. *Id.* According to Felicity Meyers, Deputy Director of SCDHHS Medical Services, SCDDSN determined that these HASCI reductions would save $667,193 a year. *Id.* However, no cost analysis was conducted by SCDDSN nor SCDHHS. The agencies failed to take into consideration the costs of alternative services and the costs of extended hospitalizations and nursing home placements for persons whose needs could not be met within the new limitations.

159. At that meeting, the MCAC also approved cuts to the MR/RD Medicaid waiver program. Appendix H at 137 to 138. Sam Waldrup informed the MCAC that these reductions were necessary "due to the state's budget situation..." He informed the Committee that reducing MR/RD Medicaid waiver services would save the State $2,123,790 a year. (This was less than the amount the Budget and Control Board had approved to be spent purchasing/improving three congregate day programs without the consent of the SCDDSN Commissioners.) However, no cost analysis had been completed to determine

the offsetting costs of institutional and congregate services which would be required to replace the services that were being reduced or eliminated.

160. Under the plan approved by the MCAC, physical therapy, occupational therapy and speech language pathology were eliminated as waiver services. Nursing services for MR/RD waiver participants were limited to 56 hours per week for LPN services or 42 hours per week of RN services. In-home respite was limited to 68 hours per month and the option of daily respite in the home was totally eliminated. In-home respite cost less than $70.00 per day. While eliminating this cost effective home-based service, the plan allowed for unlimited respite days in institutional settings. SCDHHS increased the reimbursement rate paid for institutional respite from $157.00 per day to $270.00 per day. Staff did not inform the MCAC about the plan to significantly increase reimbursement rate for institutional services or that failure to use federal stimulus funds or the SCDDSN "excess funds" account to avoid these reductions.

161. No consideration appears to have been given by MCAC to the offsetting costs of persons who would be forced to remain in nursing homes, hospitals and ICF/MR facilities because home-based waiver services were not available to meet their needs for support at home. There was no discussion of using stimulus funds to avoid these cuts or of the possibility of requesting permission from the South Carolina Budget and Control Board to operate at a deficit until the legislature reconvened to amend Proviso 90.13.

162. At the August 20, 2009, SCDDSN Commission meeting, William Barfield (who was retained by Dr. Laurent as a "consultant" after he retired as deputy director for SCDDSN in July) strongly advised the SCDDSN Commission not to request permission from the South Carolina Budget and Control Board to operate at a deficit. Appendix E at 159 to

164. Mr. Barfield said that SCDDSN should not request permission to operate at a deficit because the South Carolina Budget and Control Board would inquire about how the agency was handling its finances. Affidavit of Charles McClafferty, CPA. Appendix B at page 12. SCDDSN Commission Chairman, Kelly Floyd vehemently objected at that meeting to running a deficit in order to maintain waiver services. The deficit that would have been required until the Legislature convened to reconsider Proviso 90.13 would not have exceeded the amount distributed to her county DSN Board to purchase real estate. Based on these objections, the SCDDSN Commission voted to deny the request to operate at a deficit.

163. The full Commission unanimously approved sending the resolution to the South Carolina Budget and Control Board asking that the agency be spared further cuts and objecting to 2/3 of the federal stimulus dollars paid to SCDDSN not being used for SCDDSN services. Appendix E at page 171. The Commissioners were not informed of the plan to spend $2.6 million purchasing or renovating buildings for workshops.

164. At that Commission meeting, one Commissioner raised issues about the lack of availability of dental, physical therapy, occupational therapy and speech therapy services under the MR/RD Medicaid waiver. Dr. Lacy "explained the difficulty of the lack of dentists in each county who are willing to serve individuals with disabilities." Yet, despite knowledge that reimbursement rates were not sufficient to enlist dentists willing to serve waiver participants, SCDDSN made no effort to increase the payment rate to dentists. Instead SCDDSN reduced the rate paid to dentists from $112 per visit to $102. Appendix H at 140 to 143. Yet, the rate paid to SCDDSN and its DSN Boards for institutional and congregate services was increased by more than 70%. *Id.*

165. Dr. Lacy assured Commissioners and the public that MR/RD waiver participants could receive physical therapy, occupational therapy and speech and language services through other funding sources, but she did not explain what funding source would cover these services. Medicaid is a payer of last resort, had there been another source, the services would not have been covered by the waiver in the first place. ("Regular" Medicaid does pay for persons under age 21 to receive these services. There is no known source that provides these services for adults covered by the waiver programs.)

166. According to SCDHHS, in August of 2009, the number of individuals receiving MR/RD Medicaid services had dropped from the 6,054 reported by Ms. Forkner in June, to 5,765 in August. 1,380 individuals were on the waiting list, an increase of nearly one-third. *See* SCDHHS Medical Care Advisory Committee report dated August 18, 2009. Appendix H at page 137. This was a reduction of 289 individuals from the number of MR/RD Medicaid waiver participants SCDHHS director Emma Forkner reported to be receiving MR/RD Medicaid waiver services on June 5, 2009. Appendix H at 111.

167. At the August SCDDSN Commission meeting, the Commissioners refused to request that they be allowed to operate at a deficit until the South Carolina General Assembly could reconsider Proviso 90.13. Appendix B at page 12.

168. Despite serving fewer waiver participants and drastically reducing services due to "budget reductions," SCDHHS asked CMS to increase the number of persons served under the MR/RD Medicaid waiver by 300, from 6,000 to 6,300 participants. Appendix H at 111 and 131.

169. On August 31, 2009, SCDHHS submitted waiver amendments for the MR/RD and HASCI Medicaid waiver programs to CMS. The amendments submitted to CMS

drastically reduced services individuals need to remain in their homes and communities so as to avoid institutionalization.

170. SCDHHS informed CMS that these reductions were required because of the lack of funds due to budget reductions. That was not true. When the federal stimulus funds are counted, SCDDSN actually received more money in SFY 2010 than it had received in prior-years.

171. Although the limitation on respite hours allowed in the home under the MR/RD Medicaid waiver were increased from the 32 hour limit SCDDSN proposed in May to 68 per month, and vision and adult companion services were restored (but capped at 28 hours a week), most of the rest of the MR/RD application submitted to CMS was substantially similar to that submitted on June 15, 2009. Reimbursement rates for many private providers were reduced from the rate paid during FY 2008-2009. In addition to the reduction in rates paid to dentists, reimbursement rates for psychological services were reduced from $72.77 per hour to $60.00 per hour compared to the rates paid in 2009. H at 140 to 143. Rates for behavior support services were also reduced in the MR/RD and HASCI waiver renewal applications. *Id.*

172. However, rates paid for those services provided by SCDDSN and its boards were increased in the amendments submitted to CMS. The rate paid for ICF/MR (Institutional) Respite Services was increased by more than 70%. Appendix H at 140 to 141. All ICF/MR Respite Services are provided either by SCDDSN or the local DSN Boards. The reimbursement rate for these services in the final year of the current MR/RD Medicaid Waiver contract (which expires in 2009) was $157.00 a day. Under the amended MR/RD Medicaid Waiver application, DDSN and local Boards would receive $270.00 per day for

ICF/MR Respite Services. *Id.* The amendments submitted by SCDHHS eliminated the daily respite option where respite services have been provided in the participants own home or community for years at a cost of less than $70.00 per day. The rate paid for hourly "residential habilitation" more than doubled from $17.51 per day to $55.00 per hour. More than 90% of these services are provided by local DSN Boards, not private or faith-based providers. The reimbursement rate paid for daily residential habilitation (in a group home, foster home or supervised apartment setting) was increased from $159.18 per day to $167.00 per day. Practically all of these services are provided by DSN Boards, not private or faith-based providers. Appendix C at 125 to 129. Surrounding states have a significantly higher rate of residential services being provided by private providers. Appendix C at 128.

173. Limitations to the HASCI program were imposed, without regard to the medical needs of participants or the cost of institutional services that would be required when waiver participants' needs could not be met due to the limitations imposed by the waiver amendments. No consideration was given to the tremendous costs to State taxpayers for care provided to survivors of head and spinal cord injuries who will be forced to remain in hospitals or nursing homes for months, if not years, because adequate (and less expensive) supports are not available in their homes and communities because of these arbitrary caps on HASCI services. The costs of institutional services for current HASCI participants who will be forced into a more restrictive level of care were not calculated into the cost assessment.

174. The MR/RD Medicaid waiver renewal application also changed the procedure for determining eligibility for the waiver in violation of ARRA. Appendix H at pages 86 to

97 (2004 to 2009) and pages 71 to 85 (2009 to 2010). Upon information and belief, the amendments terminate the ability of physicians to determine whether applicants and participants have mental retardation. Under the procedure used for many years, physicians are qualified to determine whether applicants meet level of care criteria to qualify for the MR/RD Medicaid waiver. Appendix H at page 86.

175. However, upon information and belief, under the revisions proposed by SCDHHS, the SCDDSN CAT Team has the sole authority to arbitrarily determine eligibility, based on the "professional judgment" of the Team's members, without giving weight to the opinion of the treating physician or even determinations of disability made by the Social Security Administration (SSA).

176. This change in methodology and procedures violates not only the ARRA, which prohibits states from enacting procedures or methodologies more restrictive than those in effect on July 1, 2008, but it also violates 42 C.F.R. §§ 540 and 541, requiring the State Medicaid Agency to accept the determination of disability made by SSA. (42 C.F.R. § 540(a) requires States to use the same definition of disability as used under SSI...")

September 2009

177. On September 3, 2009, Dr. Laurent appeared before the South Carolina Budget and Control Board. Instead of presenting his Commission's resolution asking to spare the agency from further cuts or asking to run a deficit to avoid having to cut waiver, Dr. Laurent asked the Board for permission to use "$5,944,738 of excess debt service funds to meet various improvement needs of the agency." Minutes of September 3, 2009, Budget and Control Board. Appendix D at pages 1-6.

178. There had been no discussion in SCDDSN Commission meetings about Dr. Laurent

obtaining permission to purchase or improve buildings to be used for congregate workshops with SCDDSN funding. According to minutes of the South Carolina Budget and Control Board: "The current cash balance in this debt service fund is approximately $7.8 million." Dr. Laurent asked for permission to transfer $1 million to Horry County DSN Board for a "Day Program Building" (SCDDSN Chairman Floyd resides in Horry County), and $800,000 each for day program buildings for the Babcock Center, Inc. (a private corporation) and the Beaufort DSN Board. According to the minutes of this meeting, Dr. Laurent told the Budget and Control Board that "the DDSN Board is supportive of the request and that there was a unanimous vote on this matter."

179. There is no evidence in Commission minutes that the commissioners were even aware of these real estate deals. Certainly, they had not approved these expenditures. Dr. Laurent asked to spend $3.2 million of these excess funds "to meet the agency's obligations for SCEIS implementation" and $100,000.00 to be used to "improve its Medicaid billing capabilities."

180. The Comprehensive Permanent Improvement Plan (CPIP), the agency's two year capital expenditure plan did not mention any of the three agencies that would receive $2.6 million. That plan, which was approved by the SCDDSN Commission at the April 2009 Commission meeting, included a total of $225,000 to pay for sprinkler systems in three local DSN Boards in the Piedmont area of the State. Appendix E at page 42. It included $350,000 for "conversions/energy and renovations" and $235,000 for "roofs, gutters and soffit repairs" in community facilities statewide. All other capital projects involved SCDDSN state-owned regional centers and SCDDSN central offices, not local Boards.

181. No capital expenditures were approved by the governing board of SCDDSN in the CPIP

to purchase or improve buildings to be used for congregate workshops operated by DSN Boards.

182. Comptroller Eckstrom made a motion to approve "facilities at three local Disability Boards," which was approved without objection, despite the objections he raised just a month before about taxpayer dollars being used to purchase real estate.

183. Approving capital funds for local DSN Boards is clearly contrary to the 2008 recommendations of LAC, which strongly criticized SCDDSN for imposing barriers to competition from private providers of waiver services. That audit criticized SCDDSN for providing "little choice of providers," finding that most services are provided by DSN Boards. LAC reported that only 3% of residential and day services were provided by non-DSN Boards. Appendix C at page 125.

184. Federal regulations require the State to provide Medicaid participants a "free choice of providers" who are willing to provide services to them. 42 C.F.R. § 431.51. The 2008 LAC audit of SCDDSN criticized the agency for maintaining barriers to non-DSN Boards. As noted by LAC, if there are no providers to choose from, having consumers sign a form stating they were offered a choice of providers is "a meaningless activity." Appendix C at page 126. This has been a longstanding problem in South Carolina. In 2004, the federal oversight agency recommended that SCDDSN increase choices of providers because most services were provided by DSN Boards. The 2007 audit of SCDDSN by SCDHHS found that "DDSN should continue to find a way to bring more qualified providers into the system..." Buying real estate for local DSN Boards did nothing to encourage these private competitors to offer these services

185. At the September 17, 2009, SCDDSN Commission meeting, Nancy McCormick, Senior

Attorney for P&A, presented a report on the study conducted by P&A titled "No Place to Call Home," a study of Community Residential Care Facilities (CRCF's) in South Carolina.[5] P&A's findings included resident neglect and abuse by untrained and unmotivated staff, some with criminal backgrounds including sexual abuse and assault; unsanitary, unsafe and unacceptable living conditions, including cockroach infestations, bloodstained walls and urine-soaked furnishings; inadequate documentation, administration and storage of medications; failure to ensure basic personal hygiene, including one resident receiving only one shower over the course of five months and failure to meet food quality and sanitation standards.[6] Appendix C at pages 1-83. According to the minutes of that meeting, Ms. McCormick stated that "DDSN responds quickly to concerns and issues" but she also discussed problems P&A experienced in obtaining records of SCDDSN residents living in CRCF facilities. Appendix E at page 177.

186. SCDDSN Associate State director, David Goodell reported that DDSN "does not endorse" placing SCDDSN consumers in private nursing homes, however, SCDDSN has been converting ICF/MR facilities to less regulated CRCF's for years. Mr. Goodell admitted that "budget cuts will likely affect the enhanced service coordinator monitoring

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[5] In October of 2008, Governor Sanford eliminated 100% of P&A's state funding while this study was underway.

[6] This study found similar conditions to those reported by SCDHHS in its 2006 audit of the MR/RD Medicaid waiver: "Some homes were unsanitary ...'to the point of being uninhabitable...'" "Consents for psychotropic medications were falsified..." Appendix C at page 285.

of the boarding homes." SCDDSN does not have the capacity to provide residential services to all of those waiver participants whose needs will not be met at home once the reductions go into effect on January 1, 2010, so it is likely that many waiver participants will be forced into CRCF's.

187. At the September 2009 SCDDSN Commission meeting, Dr. Laurent discussed how the 4.04% budget cut was affecting the agency's service system. There was no discussion of the availability of federal stimulus funds to replace funds lost to budget reductions.

October 2009

188. On October 15, 2009, David Goodell wrote a letter to families stating that:

> Nearly 20% of DDSN's funding has been eliminated. This serious funding loss has required DDSN to stop services to more than 1000 individuals. Plans to serve 1000 currently un-served individuals are on hold indefinitely and hundreds of employees in the DDSN system have lost their jobs. Appendix F at pages 135 to 136.

189. On October 26, 2009, at the request of Senator David Thomas, the South Carolina Legislative Council drafted an amendment to Proviso 90.13 which maintain waiver services would require FMAP funds paid to SCDDSN to be used providing services. Appendix H at 331 to 335. On October 27, the General Assembly met in special session to address an issue related to federal funding to extend unemployment benefits and to provide financial incentives to bring Boeing Corporation to South Carolina. However, legislative leaders limited issues to those two issues and would not allow the introduction of the proviso amendment.

190. On October 28, 2009, Mr. Goodell wrote a letter to waiver providers advising them that

SCDDSN would identify MR/RD and HASCI waiver providers which would be forced to their reduce bed capacity by 28 beds. Appendix F at pages 25-26. According to Mr. Goodell, this relocation of waiver participants was necessary because of a $6.7 million reduction in state funding for SFY 2010. His letter did not explain how funds would be saved by moving residents from their chosen provider to providers chosen by SCDDSN. The "unobligated" FMAP funds that SCDDSN is receiving from Medicaid would more than cover these services, regardless of where they were provided. Out of approximately $40 million SCDDSN will receive in federal stimulus dollars this fiscal year, only $17.2 million will be used by the agency to provide services. The remaining $22.8 million of stimulus funds will be repaid to the South Carolina Budget and Control Board to be deposited into the Health Care Annualization and Maintenance of Effort Fund. In this letter, Mr. Goodell advised providers that:

> We will be freezing existing residential vacancies by November (up to 28 vacancies). Once the reduction criteria have been finalized, DDSN will identify the providers that will need to reduce capacity (tentatively we are looking at 7 providers reducing by one 4 person CTH II each). Since the frozen vacancies likely will not be in residential settings operated by the providers identified for capacity reduction, this will then require movement of consumers for the providers that will reducing capacity to the providers with the frozen residential vacancies.

191. This directive violated 42 U.S.C. § 1396a(a)(23), which grants waiver participants the right to choose between all qualified providers of waiver services who are willing to serve the participant. With this directive, Mr. Goodell attempted to force waiver participants to receive services from providers they did not choose.

November 2009

192. South Carolina's unemployment rate reached a new all-time state high in November of

2009 of 12.3 percent. Unemployment rose for the fourth straight month. South Carolina was tied for third-highest in the nation. The number of unemployed passed an all-time high, rising by 5,896 last month to 266,330, according to preliminary calculations.

193. On November 17, 2009, Mr. Goodell wrote to directors of local DSN Boards and directors of "Qualified Private Residential Providers" informing them that SCDDSN"sustained a $6.7 million (4.4%) reduction to our state funding this year." According to Dr. Goodell:

> One component of the DDSN plan to accommodate the funding cut was to reduce bed capacity of our community residential service system by 28 persons. Appendix F at page 15.

194. In this letter, Dr. Goodell presents the agency's "Residential Capacity Reduction" plan to providers. He identified six providers that SCDDSN had determined must lose residents. He informed the providers that they would each be required to select 4 waiver participants to move to another agency, most likely in another part of the state. In another letter sent that same date to the individual "losing" providers, Dr. Goodell included a list of individuals who had been identified by SCDDSN to be involuntarily relocated. None of these individuals had any prior knowledge that their current placement was in jeopardy. Many of the individuals on the list to be moved from UCP (United Cerebral Palsy) had fought for many years to move out of the Babcock Center. Although the Babcock Center was ordered to "downsize" after a 2004 report by SCDDSN documented that the agency's rate of substantiated cases of abuse and neglect was four times the statewide average, the Babcock Center was one of the "receiving" agencies that did not lose any consumers in the plan. Appendix F at pages 18 to 19.

195. This plan would have allowed SCDDSN to arbitrarily move Medicaid waiver consumers around the state under the guise of "budget reductions" in violation of their civil rights, without regard for the federal requirement requiring SCDDSN to allow waiver participants a free choice of providers. 42 U.S.C. § 1396a(a)(23). Some of these

consumers had fought for years to move away from providers treated by SCDDSN as "local DSN Boards." Now they found themselves at risk of being sent back to those facilities.

196. Two days after informing providers that 28 waiver participants would have to be relocated to other parts of the State because of "budget reductions," SCDDSN agreed to give an additional $200,000 capital grant to the Babcock Center to purchase a large building to be used for congregate workshop services.

197. Dr. Beverly Buscemi was hired by the SCDDSN Commission as permanent director and began her duties in November of 2009. The decisions to reduce waiver services instead of using federal stimulus funds to pay for these services were made prior to her assuming her duties as State Director.

198. Upon information and belief, the SCDDSN Commissioners approved a request by the Babcock Center at the November Commission Meeting giving that agency an additional $200,000, in addition to the $800,000 given to the Babcock Center pursuant to the request Dr. Laurent made to the Budget and Control Board. (As of December 22, 2009, the November Minutes have not been published on the SCDDSN website.)

199. Before leaving, Dr. Laurent issued a statement explaining why federal stimulus funds paid to SCDDSN had not been used to provide services and jobs. Appendix H at page 144. In this statement he said:

> Explanation of Stimulus Funding and Economic Impact of This Year's Services
>
> A lot of people do not understand why DDSN and its provider network are reducing staff and services when the Department is earning federal stimulus dollars.

200. Dr. Laurent explained that "Unfortunately, DDSN does not get to keep all of the additional Medicaid dollars the Department earns as a result of the lower match." *Id.* He explained that the state "took away" all but $3.1 million out of $34 million SCDDSN "earned" in stimulus funds during SFY 2009. He explained that SCDDSN would only be allowed to retain $17.2 million out of the "$40 million in stimulus dollars" the agency earned. According to Dr. Laurent, these funds were being returned "In accordance with the wishes of the state legislature" and being placed "in a special account at the State Treasurer's Office to meet other needs of the state." *Id.* According to Dr. Laurent, additional budget cuts could further reduced services to waiver participants.

December 2009

201. Upon receiving the directive from David Goodell instructing UCP to select 4 waiver participants to be relocated, UCP director Diane Wilush instead notified approximately 70 families that SCDDSN had ordered them to select four waiver participants who would be involuntarily relocated to a facility chosen by SCDDSN. Appendix F at pages 1-6. UCP also contacted Dr. Buscemi objecting to this violation of freedom of choice of providers and met with the Director to oppose the relocation plan. *Id.* at pages 7-10.

202. Upon information and belief, at the SCDDSN Commission meeting held on December 17, 2009, Dr. Buscemi demonstrated leadership skills in announcing that the agency would not proceed with the implementation of Dr. Goodell's bed reduction plan because it violated participants' rights of choice of provider.

203. A document titled "History of State Budget Reductions and Appropriations as of December 16, 2009" (Appendix H at page 147) was presented at this meeting which showed the following reductions and increases in funding:

Reductions - Oct. 2008 to Dec. 2009		$55,934,000
Increases - Oct. 2008 to Dec. 2009		
	Increase in budget items	$12,753,000
	Proviso 90.13	$17,253,491
Net decrease		($25,927,509)

However, when the stimulus funds paid to the rainy day account ($31 million in July of 2008 and approximately $22 million during FY 2010), SCDDSN would have an increase of more than $27 million. When the "excess debt service" funds are added, SCDDSN's surplus during SFY 2010 would have been more than $36 million.

204. Further deficits and reductions are expected to occur in 2010 because more than half of the federal stimulus dollars paid to SCDDSN are being transferred to the Health Care Annualization and Maintenance of Effort Fund.

205. A new reduction plan was presented to the Commissioners at the December SCDDSN Commission meeting requiring a reduction of an additional 68 beds. These reductions would be avoided if SCDDSN applied federal stimulus funds to maintain waiver services.

The Plaintiffs

Rob L.

206. Rob L. is a thirty-eight year who spent months in hospitals after sustaining a severe had injury. Affidavit of Mary Self. Appendix B at pages 18-20.

207. Forty nursing homes in South Carolina denied admission to Rob because of his medical complexity and age. Rob was in a vegetative state when his mother finally, with the help of Governor Hodges, located a nursing home which would accept him.

208. Rob's mother was unable to bring him home because SCDDSN informed her that there

was an absolute cap of eight hours a day for care in the home under the HASCI program.

209. Medicaid paid the cost of his care in the nursing home, where he spent four years, from 2002 to 2006.

210. During the first year Rob was in the nursing home, his mother drove more than an hour a day to visit him. Due to the distance from his home, she visited only five times a week for the next three years.

211. Rob's mother is 59 years old and his step-father is 68 years old. His mother is scheduled to have surgery to remove a mass in her abdomen.

212. Rob weighs 194 pounds and he has trouble with impulse control because of his head injury.

213. Rob's mother is concerned that when his services are cut to less than eight hours per day, she will have trouble finding and keeping caregivers because she cannot offer full time employment.

214. Rob becomes afraid when he is around caregivers who are not familiar with him and he is likely to react with hostility. In the past when he has become frustrated, he has jerked tubes out of his body.

215. Rob still requires tube feeding and assistance with all activities of daily living, including moving out of the bed, dressing, toileting, shaving and bathing. He is so heavy, his mother has to use a mechanical lift to get him out of the bed and to move him from the wheelchair to the bed.

216. Rob requires nebulizer treatments, with suctioning to keep him from choking.

217. Rob's emotional status has been described by his physicians as "liable" and with increased awareness of his condition, he has manifested aggression, frustration and

depression.

218. Rob has limited use of one hand, but he has only gross motor movements.

219. Since Rob returned home in 2006, HASCI has limited his services to eight hours a day of personal care attendant services.

220. Materials published by SCDDSN inform families that HASCI waiver participants could receive up to twelve hours a day of services.

221. When Rob's mother asked about receiving additional hours, she was told that Rob did not have "extenuating circumstances" that would allow him to qualify to receive 12 hours of services a day.

222. Rob's SCDDSN service coordinator has informed his mother that he does not qualify to receive waiver respite services because a respite provider could not administer medications or tube feeding. Since 2006, Rob's mother has had two breaks of a few days in caring for him seven days a week when a family member came from out-of-state to provide care for Rob.

223. Rob's SCDDSN service coordinator has informed his mother that SCDDSN will reduce his services to 7 hours per day effective January 1, 2010 because of "budget reductions" at SCDDSN.

224. The greatest fear in Rob's mother life is Rob having to go into an institution where he might be abused or neglected.

Karen W.

225. Karen is a 56 year old woman who has severe mental retardation and lives in the home of her eighty year old mother, who is her sole caregiver and is in poor health. Appendix B at pages 21-22. Affidavit of Delene Wright.

226. **Karen has been on the waiting list for SCDDSN residential services for 18 years, since 1991.**

227. **Karen has been in the Emergency Room at Palmetto Richland Hospital since December 18, 2009 because SC DDSN has refused to provide her services she needs to remain in the community.**

228. Karen's pastor has attempted to assist her in getting services. Appendix I at 2. Letter from Pastor documents the family's attempts to obtain services from SCDDSN.

229. Even when the General Assembly provided funding for 630 new residential slots, Karen was not offered residential services. LAC Audit of SCDDSN. Appendix C at pages 146-149.

230. Instead, SCDDSN used funds which had been allocated by the South Carolina General Assembly to provide 630 new residential slots to families with aging caregivers to purchase real estate instead, most of these funds being used to buy buildings to build up the capacity of congregate "day program" facilities (commonly referred to as "workshops.") *Id.*

231. Karen attended a Babcock Center workshop funded by SCDDSN until early 2009. She became very afraid to return to the workshop after a traumatic event occurred there.

232. Karen is terrified of an employee from the workshop and when she has encountered him in the community, Karen has become hysterical. *Id.*

233. Her records document "inappropriate contact with a male" at the workshop, but her mother was only informed at the time that she was "kissing" another consumer.

234. After this incident, psychological services were recommended by staff at the workshop, but Karen's SCDDSN service coordinator never informed her mother that psychological

services had been recommended or that psychological and behavioral support services were approved MR/RD Medicaid waiver services which should have been made available at no charge to Karen or her mother.

235. According to the arguments made to this Court by SCDDSN and the Babcock Center, they have no duty of care to protect consumers who have mental retardation from sexual assault. *Madison v. Babcock Center and SCDDSN*, Appendix H at page 36.

236. The SCDDSN workshop Karen attended is located in a windowless metal building where persons who have disabilities are crowded into large rooms with other disabled persons.

237. Karen does not like the noise at the workshop and she is afraid of aggressive persons who attend the program.

238. After the event at the workshop, Karen became depressed and, for the first time in her life, became aggressive toward her mother at home.

239. After this incident Karen required treatment by a psychiatrist, a service that was not needed prior to the incident at the workshop.

240. In April of 2009, Karen's SCDDSN service coordinator informed her mother that she would lose her MR/RD Medicaid waiver eligibility if Karen did not return to the workshop within 30 days, but Karen was afraid to return to the workshop.

241. Instead of informing Karen about feasible alternatives to this service, such as adult companion services, psychological services, behavior support services or respite services, her SCDDSN service coordinator terminated Karen from the MR/RD Medicaid waiver program because she did not use a MR/RD Medicaid waiver service for 30 days.

242. When a state offers waiver services, it must inform individuals likely to require nursing

home or ICF/MR care about "any feasible alternatives available under the waiver" and the participant must be given the "choice of either institutional or home and community-based services. 42 U.S.C. § 1396n(c)(2); 42 C.F.R § 441.302 (d).

243. Although Karen's decision not to return to the workshop for 30 days was used as a pretext for terminating her eligibility, these services were actually terminated as part of the reduction plan which was approved by the SCDDSN Commission based on false claims of "budget reductions."

244. When Karen's services were terminated, SCDDSN was holding more than $34 million in stimulus funds instead of using these funds providing services like psychological services, behavior support services and respite services, which aging parents like Karen's mother need.

245. When Karen's mother learned in October of 2009 that she was entitled to other appropriate and medically necessary services which had not been offered to her, SCDDSN determined that Karen's needs are not "critical" and she was placed on the "regular" waiting list for MR/RD Medicaid waiver services. Appendix I at page 3.

246. SCDDSN informed Karen's mother that there are 1,522 persons ahead of Karen on the "regular" waiting list . *Id.*

247. In November of 2009, Governor Sanford's office was contacted by Karen's aunt, requesting his assistance with her placement.

248. On December 18, 2009 became uncontrollable and she was admitted to the emergency room, where she has remained now for more than three days.

249. Two open beds are available at qualified private providers whose reimbursement rate is equal or less than the rate SCDDSN pays local DSN Boards for residential services.

250. Karen is currently receiving services in a hospital which could have been avoided had her mother been provided with supports at home.

251. Karen is at immediate risk of institutionalization if waiver services are not provided.

Susan E.

252. Susan is a twenty-five year old woman who has profound mental retardation, cerebral palsy, lupus, immune deficiency, seizures, severe osteoporosis and hydrocephalia. She is nonverbal, is unable to walk, incontinent of bowel and bladder and is legally blind. Susan's IQ is 14. Appendix B at pages 13-14.

253. Susan is totally dependent upon others for every activity of daily living.

254. Susan attended school until she was twenty-one. She received physical therapy and occupational therapy at school, but these services have not been provided since she left school.

255. Susan's parents, who are 65 and 62 years old, provide care for her twenty-four hours a day, seven days a week. She cannot be left alone, for even a brief time. Last year, Susan's father suffered a heart attack and spent more than a month in the hospital.

256. Susan's sister-in-law was paid approximately $70 per day to provide respite services through the MR/RD Medicaid waiver, but SCDDSN terminated these services.

257. SCDDSN has informed Susan's parents that one of them must remain in the home at all times when respite services are provided through the MR/RD Medicaid waiver because the respite caregiver cannot administer her medications or her tube feeding. This effectively eliminates Susan's ability to access respite services.

258. Susan's plan of care calls for 2,160 hours a year of LPN services, however, there is a shortage of nurses in Horry County and nursing services have not been available due to

the low reimbursement rate for these services paid by Medicaid. Although the MR/RD Medicaid waiver amendments submitted to CMS in 2009 increase the reimbursement rate for institutional respite services by more than 70%, the rate for nursing services has not been increased. According to SCDDSN, there are no residential providers in Horry County that can meet Susan's needs.

259. When Susan is not able to find appropriated providers of services contained in her plan, the local DSN Board is allowed to retain her unexpended "band" funding.

260. Due to her conditions, Susan must be sedated in order to examine and clean her teeth and has been on a waiting list each year at Palmetto Health because no dentists in her area provide dental services for persons who have mental retardation and require sedation. She is required to travel more than two hours to obtain dental services.

261. Despite SCDDSN's knowledge of the lack of availability of dental services for persons like Susan, the waiver amendments submitted to CMS reduced the reimbursement rate paid to dentists by approximately 10%.

262. The MR/RD Medicaid waiver program provides Susan with diapers, wipes and nutritional supplements, however Defendants have told her that she would be limited to two cases of nutritional supplements January 1, 2010.

263. Susan has been using 2 ½ cases of Ensure a month because she is very limited in what she can eat. Many foods cause her to bleed. Her neurologist ordered Susan to drink 2 cans of ensure a day. When she began this therapy, Susan gained from 40 pounds to a healthy weight of 135 pounds.

264. If Susan is forced to move to an institution funded by Medicaid, all of her nutritional needs and diapers would be funded by Medicaid, at a significantly greater expense to

taxpayers than the cost of providing these medically necessary items at home.

265. Susan is at imminent risk of institutionalization due to the health of her parents and the inability to access home-based services which are needed to keep her safely at home.

Edward M.

266. Edward is a thirty-five year old individual who has severe mental and physical disabilities, including profound mental retardation and cerebral palsy. Appendix I at pages 4 to 186. These conditions have existed from birth and are lifelong. He is toxic to water and has only one kidney. Edward has pica, an eating disorder characterized by an appetite for non-nutritive substances (e.g., soil, paper, insects, soap, mucus, etc.). This is a serious condition which requires constant supervision to avoid life-threatening consequences of eating hazardous substances which can cause choking or bowel obstructions. Edward is nonverbal and expresses pain of discomfort by making crying sounds.

267. Edward lives with this aging mother, who cleans houses for a living. When his mother does not have someone to supervise Edward, she cannot work.

268. Edward currently receives eight hours a day of respite services at a cost of $70 per day.

269. SCDDSN has informed Edward's guardian that effective January 1, 2010, he can only receive 68 hours a month of home-based respite services, but he can receive unlimited daily respite in an ICF/MR at a cost of $270 per day.

270. On January 1, 2010, SCDDSN will increase the reimbursement rate for ICF/MR respite services from $157 per day to $270 per day.

271. Between 1999 and 2005, Edward lived in an ICF/MR, but he was repeatedly injured there.

272. When Edward lived at Clusters ICF/MR, an institution operated by the Babcock Center and supervised and funded by SCDDSN, he experienced frequent "unexplained" injuries and judicial records document that he was actually beaten by an employee.[7] After this assault, Edward's mother attempted to remove Edward from the facility. In response to this effort, SCDDSN successfully secured an order from the Probate Court having Edward involuntarily committed to the custody of SCDDSN.

273. According to the GAL appointed by the Probate Court, she was provided inaccurate and misleading information in order to cause her to recommend that Edward be involuntarily admitted to the custody of SCDDSN. Appendix I at pages 152 to 154.

274. After this assault, Edward's plan of care was changed to provide one-on-one supervision in the institution. However, despite his plan of care requiring one-on-one supervision, Edward was beaten across his face and body with a belt. Appendix I at page 216. The cost of Edward's services in the Babcock Center ICF/MR exceeded more than $100,000.00 a year.

275. Without notice to Edward's mother or his physician, his "one-on–one" supervision was terminated when he was moved by the Babcock Center to a different ICF/MR after his mother had requested placement at UCP.

276. Edward experienced "unexplained" injury at this Babcock Center ICF/MR in May of 2005, just seven months after his roommate choked to death in the facility. Appendix F at page 74. The injury required six stitches to his genital area. Appendix I at page 45. At the

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[7] Even though the assault was witnessed by two other employees, Edward's mother was not informed of the beating. A warrant was not issued until a year after the assault, when the employee pled guilty to simple assault. Appendix I at page 21 to 24.

time of this injury, DHEC had issued a letter to parents of the residents of that facility informing them that the facility was being decertified. Appendix I at 86. However, even though parents had been given notice of the decertification and informed of the right to move their child out of the facility SCDDSN objected to Edward's release from the ICF/MR.

277. General Counsel for SCDDSN, James Hill, appeared at the Probate Court objecting to his mother being appointed as Edward's guardian and he filed objections with the Court on behalf of SCDDSN. Appendix I at 111.

278. Despite SCDDSN's efforts to oppose Edward's mother being appointed as his guardian, she was appointed by the Richland County Probate Court in 2005 and was finally able to secure his release from the facility where he had been injured and his roommate had died.

279. Edward has lived at home with no serious injury or illness since 2005. When Edward moved home from the facility, despite SCDDSN decreasing his funding from more than $65,000 (from approximately $100,000 until his mother asked to move him to UCP in 2003) to Band B, which is currently only $12,360 a year.

280. The waiver amendments that take place on January 1, 2010 terminate Edward's ability to receive daily respite in his home or the home of his respite caregiver (which cost $70 per day), but SCDDSN will provide unlimited institutional respite to Edward at a cost of $270 per day.

281. On January 1, 2010, Edward's home-based respite services will be reduced from eight hours a day to 17 hours a week (68 hours per month).

282. Unless this Court grants an injunction, either Edward be forced into institutional services or his mother will not be able to continue her job as a domestic worker. As a single parent, Edward's mother is not financially able to retire.

283. Edward's mother is fearful of his safety if he returns to an institution, because of the many injuries he received while living in two ICF/MR facilities and the repeated findings by P&A, state agencies and the federal government substantiating abuse and neglect in SCDDSN facilities.

284. Edward is at risk of immediate institutionalization if this Court does not grant an injunction.

Richard S.

285. Richard is 22 years old. He weighs 130 pounds. Richard has severe cerebral palsy but he has normal intelligence. Appendix B at pages 6-7.

286. Richard has the same interests as non-disabled young adults.

287. Richard lives independently in an apartment adjacent to his parents' home and both parents work outside of the home. Richard did not graduate from high school because his physical disability is so severe that his therapies took many hours during the school day as did his recovery from many surgeries. Richard requires total assistance for any/all daily needs/functions. He requires assistance in bathing, toileting, dressing and preparing food.

288. It takes two people to safely lift Richard out of the bed in the morning and to return him to bed in the evening because of his size and spasticity.

289. When Richard was in school, most of his friends were non-disabled peers. Although he enjoys attending special needs athletic events, Richard prefers to spend his time in the

community with persons who do not have disabilities.

290. Richard would like to have a job, but he does not want to work on contracts at the workshop, where he would be required to spend most of the day sitting around a table in a metal building with other disabled persons.

291. When the local DSN Board that receives Richard's capitated waiver funds reduced his hours of care, Richard filed an appeal with SCDHHS. Richard learned for the first time during this appeal that Adult Companion Services were available to him and should have been offered by his SCDDSN services coordinator as an option. Richard's service coordinator never informed him that he was entitled to receive Adult Companion Services under the MR/RD Medicaid waiver. Since his appeal, Richard has been receiving Adult Companion Services, but these services will be terminated on January 1, 2010.

292. However, SCDDSN will pay for him to attend the congregate workshop operated by the DSN Board.

293. At the time of his hearing at SCDHHS, Richard had been attending a program operated by the South Carolina Department of Vocational Rehabilitation, but his parents had to leave their jobs during the middle of the day to assist Richard with toileting. The South Carolina Department of Vocational Rehabilitation determined that they could not meet Richard's needs due to the severity of his disability and he no longer attends that program.

294. Richard's physician has determined that he additional hours of Personal Care services and Adult Companion Services.

295. The hearing officer ordered SCDHHS to reassess the number of Personal Care hours

Richard needs taking into account the recommendations of Richard's treating physician.

296. The costs of the services Richard needs to remain safely in his own home are less than the cost of services which would be required if Richard were moved to an institution. CMS has approved, and Defendants bill Medicaid for "one-on-one services" provided to persons who live in group homes funded by the MR/RD Medicaid waiver. SCDDSN receives more than $150,000.00 per year for some of these individuals who receive one-on-one services in more restrictive settings, but this level of supervision is not provided to those individuals who choose to remain in their homes.

297. The recent changes to the MR/RD Medicaid waiver, which were approved by CMS based on claims of budget reductions, without regard to the stimulus funds sitting in the rainy day account, approved caps which will prevent people like Richard from remaining in their homes.

298. The following chart shows the services contained in Richard's plan of care now, the services his physician has determined that he needs each week and the services he will receive effective January 1, 2010:

	Ordered by Treating Physician	2009 Plan of Care	Effective Jan. 1, 2010
Adult Companion		15	None
Personal Care II	112	53	28
Personal Care I			6
Respite (hourly)	46	46	17
Respite (daily) 1	1		0
Total hours/week	158	114	51
Respite (daily) 1 (at home)	1 (at home)	Unlimited (only in ICF/MR)	

None (at home)

299. Effective January 1, 2010, Richard can only receive daily respite if he is admitted to an ICF/MR. Hourly respite at home is limited to 68 hours a month.

300. SCDDSN determined that Richard does not meet its definition of "severely disabled," which would allow him to receive 240 hours of respite services each month.

301. Providing the services Richard needs at home would not fundamentally alter the State's waiver program.

302. Richard is at imminent risk of institutionalization if he does not receive the services prescribed by his physician.

Peter B.

303. Peter B. is a forty-three year old person who has moderate mental retardation, hydrocephalus and diabetes. Affidavit of Carolyn Brown. Appendix B at pages 8 to 10. When he was a teenager, Peter moved from the home of his mother to an institution (ICF/MR) funded and supervised by SCDDSN. Peter later moved out of the institution and into a supervised apartment setting where he pays for room and board, but his support services are funded by the MR/RD Medicaid Waiver.

304. When Peter moved from the ICF/MR, he experienced a serious loss of weight and developed anxiety and other psychological problems which required treatment and his physical health deteriorated. Peter began receiving 12 hours a week of companion services more than 14 years ago. His mental and physical health improved when these services were being provided and the progression of his diabetes has been delayed because of these services. Appendix B at pages 8-10.

305. SCDHHS bills Medicaid and pays SCDDSN more than double the cost of Peter's

Medicaid services. These payments are made by SCDHHS to SCDDSN under Peter's name and social security number, but more than half of these funds are spent for other purposes than providing services for Peter. SCDHHS pays SCDDSN more than $150.00 a day for Peter's "residential habilitation," but SCDDSN pays the provider less than one half of this amount.

306. Peter's guardian filed a complaint with the U.S. Department of Health and Human Services Office for Civil Rights which resulted in Peter's provider having to repay him more than $7,000. This was for reimbursement for transportation costs Peter had paid out of pocket when the provider was receiving funds from Medicaid to cover those costs. Soon after the last payment on this debt was made to Peter, the agency terminated the 12 hours a week of companion services Peter had received since 1992. Peter filed an appeal and the agencies agreed that these 12 hours a week would be provided during the appeal.

307. However, in June of 2009, the agencies terminated these services during the appeal after Carolyn Brown was elected as President of Voices for the Voiceless, a large state-wide grassroots organization advocating against reductions in SCDDSN services.

308. Peter's physicians have determined these twelve hours a week of adult companion services are medically necessary. Appendix I at 189 to 190.

309. His physicians and psychological services provider have determined that Peter would be at risk of a decline in his independence and psychological health, as well as physical decline, due to his condition of diabetes, if these companion services are not provided. *Id.*

310. SCDDSN and SCDHHS terminated these services, without medical justification, or even input from any physician or psychologist, based on a change made by employees of

SCDDSN to an agency manual. Appendix I at 187 to 188.

311. This SCDDSN Manual amendment, which affects hundreds, if not thousands of individuals would otherwise be eligible for these services, was made without the approval of the Commissioners of SCDDSN. Appendix I at pages 187 and 188. This change in the SCDDSN manual was intended to force waiver participants into congregate workshops operated by the SCDDSN Boards. SCDDSN acknowledges that it would pay for Peter to attend a segregated, congregated workshop, at a significantly higher cost to the State.

312. The SCDDSN manual conflicts with federal regulations and the Olmstead Act, which require SCDHHS and SCDDSN to provide services in the least restrictive setting. It is undisputed that SCDDSN would pay for Peter to attend the workshop operated by the Charles Lea Center, but he does not want to attend that large congregate workshop, where he would be segregated from non-disabled persons.

313. Peter was receiving twelve hours a week of companion services, under appeal, on July 1, 2008 after his guardian became president of a large advocacy organization opposing the reduction of waiver services. Since these services were terminated, Peter has become anxious and is not getting the exercise his doctors have determined that he needs to prevent the progression of his diabetes. Appendix B at pages 8 to 10.

314. Peter is at risk of having to move to a more restrictive placement if the services which were being provided on July 1, 2008 are not restored.

Ann J.

315. Ann formerly resided in a large regional center operated by SCDDSN. She later moved to a supervised apartment setting and attended the same SCDDSN funded workshop that Karen attended. Ann was assaulted at two different Babcock Center workshops, requiring

emergency room treatment on both occasions. Afterwards, like Karen, Ann became afraid to return to the workshop. Ann's psychological services providers have determined that Ann needs adult companion services, which are an approved services under the MR/RD Medicaid waiver program.

316. Although SCDDSN will pay for Ann to attend a segregated congregate workshop, SCDDSN has refused to allow Ann to choose to receive less expensive adult companion services. For a year, Ann received no day services, but she was required to spend most of the day riding in the van transporting other residents of her apartment complex to and from the workshops they attend. Ann subsisted primarily on frozen dinners she could cook herself. For more than two years, Ann attempted to move out of her placement at the Babcock Center, but she encountered barriers when she tried to move.

317. After Ann's health deteriorated at the Babcock Center, Ann's guardian was finally able to move her out and into a group home operated by UCP during 2009. Still, SCDDSN would not allow Ann to choose to receive adult companion services instead of attending a day program, despite determinations by her psychologist and counselor that Ann needs these companion services. SCDDSN would pay for Ann to attend a congregate workshop.

Corrie D.

318. Corrie moved to a home in Columbia operated by the Babcock Center and began working at a job where she would package medical supplies in 2000.

319. Corrie has an excellent work history at her job.

320. The Babcock Center was forced to "downsize" in 2005 after its rate of abuse and neglect exceeded four times the statewide average and the management of Corrie's home was transferred to the Burton Center.

321. The group home burned and Corrie got out with the clothes on her back, but the Burton Center did not pay her for the property she lost.

322. Corrie was very unhappy at the Burton Center and wanted to move.

323. Corrie's guardian agreed to allow her to move to a supervised apartment setting supervised by UCP, but SCDDSN cut Corrie's funding by more than ½ if she moved to an apartment. (In either location, Corrie pays her own room and board.)

324. The group home operated by the Burton Center was very loud and not well maintained.

325. While Corrie was living at the group home operated by the Burton Center, and while her guardian was attempting to move her to UCP, most of Corrie's teeth were pulled without notice to her guardian. Corrie has required extensive reconstructive surgery and she was unable to eat solid food for months because of the lack of proper dental hygiene and the unauthorized removal of her teeth.

326. Finally, Corrie's guardian was successful in moving her to a home in Columbia operated by UCP.

327. Corrie would like to move from the group home operated by UCP to an apartment supervised by UCP, but SCDDSN will cut her funding in half if she moves from the group home to a less restrictive setting, which will not pay for the supervision she needs.

328. Despite having a "money follows the person" policy, SCDDSN will not allow Corrie to move her funds to a different setting.

329. In fact, SCDDSN sent UCP a letter advising them that Corrie should be moved to home operated by the Berkeley County DSN Board.

330. This was done without regard for the fact that Corrie has worked with the same employer in Columbia for many years and she enjoys her job and does not want to move.

331. Corrie is being forced to live in a more restrictive setting due to SCDDSN's refusal to provide the funds needed for the supports Corrie would need if she moved to an apartment, which would cost less than the cost of the group home where she now lives.

Robyn P.

332. Robyn P. receives a monthly disability benefit because the Social Security Administration determined when she was eighteen years old that she has a primary diagnosis of mental retardation. Appendix B at pages 15-17. Robyn has been diagnosed by at least seven treating physicians as having mental retardation, in addition to two licensed psychologists. Robyn is planning to have brain surgery in early 2010, which has been recommended by her treating neurologist and neuropsychologist to attempt to control her seizures.

333. These seizures have been documented by three different in-patient EEG studies, one at Duke and two more recently at the Medical College of Georgia. Appendix I at pages 193 to 204. Robyn's seizure disorder results from brain injury at birth. MRI studies document severe injury to sixty percent of the right hemisphere of her brain.

334. Robyn also has cerebral palsy, which causes her to limp and limits her use of her left hand and leg.

335. When Robyn was in school, the school psychologists never determined whether she has mental retardation, but identified her as having a "learning disability" because they did not have classes in her school for persons diagnosed as having "mental retardation."

336. After Robyn appealed the denial of services by SCDDSN, in 2003, SCDDSN determined that Robyn qualified to receive MR/RD Medicaid waiver services because of her seizure disorder and condition of cerebral palsy. In 2003 Robyn filed a lawsuit naming the

director of SCDDSN, Stanley Butkus, and Associate Director, Kathy Lacy as defendants alleging that SCDHHS and SCDDSN had violated the Medicaid Act by failing to provide Residential Habilitation services with reasonable promptness, as required by 42 U.S.C. 1396a(a)(8). This lawsuit is still pending in the United States District Court.

337. After this lawsuit was filed, SCDDSN offered to allow Robyn to move to a home operated by the Newberry DSN Board, however, they would not allow her to move from Newberry to a vacant bed either in her home community (operated by UCP) or in Charleston.

338. SCDDSN continued to refuse to provide "Residential Habilitation" services to Robyn and would only provide temporary "Respite" services at Newberry.

339. Each time beds operated by UCP came open in the community, SCDDSN would deny Robyn's request to move to a home operated by UCP.

340. SCDDSN convinced the federal judge to dismiss Robyn's case, advising the court that she had been determined to be eligible for services and those services were being provided. The district judge granted summary judgment, which was reversed by the Fourth Circuit.

341. While Robyn's appeal was pending in Richmond, without notice to or the consent of Robyn's guardian, a SCDDSN school psychologist was sent by the Deputy Director of SCDDSN to assess Robyn to determine whether Robyn's seizures were "real."

342. The director of the Newberry DSN Board informed this school psychologist that Robyn had only experienced seven seizures. This was not true. His staff had recorded many more seizures. Appendix at page 214.

343. After this information was provided by the director to cause Robyn to be determined not

to qualify for the MR/RD Medicaid waiver, SCDDSN paid the Newberry DSN Board more than $330,000 for "vacant beds" in one year.

344. Based on an assessment by the school psychologist contracted by SCDDSN, the DSN CAT determined that Robyn's seizures were not epileptic and that she was faking seizures. The CAT determined that Robyn no longer met level of care requirements for the MR/RD Medicaid waiver because she does not have severe epilepsy. This decision, that Robyn's seizure disorder was not severe and that she does not have mental retardation, was made based on the "professional judgment" of the CAT team.

345. Robyn's neurologist, her psychiatrist nor any of her treating physicians were consulted before the CAT determined she was ineligible for SCDDSN services.

346. Robyn appealed the decision to terminate her services in a three day "fair hearing" before a SCDHHS hearing officer.

347. During the appeal, the hearing officer determined that Robyn's health and safety were being jeopardized at Newberry and he ordered SCDDSN to move her.

348. A bed was open at UCP in Robyn's home community, but SCDDSN would not allow her to move to that group home.

349. Instead, SCDDSN gave the Aiken DSN Board funds to purchase a home and Robyn was moved to Aiken.

350. The decision of the SCDDSN hearing officer is now on appeal to the South Carolina Court of Appeals.

351. Robyn spent more than a month in the hospital because her neurologist could not control her seizures.

352. Robyn's treating physicians diagnosed her as having mental retardation during her

teenage years. However, the SCDHHS hearing officer determined that she does not have mental retardation because the school psychologist did not identify Robyn as having mental retardation before age eighteen, and instead identified her as having learning disabilities.

353. According to SCDDSN CAT, Robyn does not qualify under the "Related Disability" criteria because she is "faking" seizures, although the epileptic nature of her seizures have been repeatedly documented in repeated inpatient EEG studies.

354. Robyn's treating neurologist at the Medical College of Georgia has recommended brain surgery to try to control her epileptic seizures based on two separate inpatient EEG assessments, each involving three days of evaluation. Robyn has been receiving "respite" services, which are by definition "short term" services, for more than six years now. The SCDDSN Consumer Assessment Team ("CAT") determined, based on its "professional judgment," that Robyn P. does not have mental retardation or a related disability and her that her seizures are not "real." No member of the CAT was a licensed psychologist nor had any member of the team which determined that she no longer met eligibility requirements ever examined her in person. Robyn P. appealed the decision to terminate her MR/RD Medicaid waiver services to SCDHHS in 2005.

355. Since that time, Robyn spent more than a month in the hospital because of her seizure disorder and she has undergone two additional inpatient hospital stays to confirm the diagnosis of "intractable epilepsy" and the severity of her seizures.

356. SCDDSN continues to litigate Robyn's eligibility for the MR/RD Medicaid waiver, claiming that her seizures are volitional.

357. When SCDHHS submitted the waiver amendments to CMS in September of 2009, they

changed the eligibility requirements and the methodology for determining waiver eligibility so as to eliminate physicians as persons who are qualified to diagnose mental retardation or a seizure disorder.

358. Rendering a determination of medical necessity or a decision affecting the diagnosis and/or treatment of a patient is the practice of medicine in South Carolina. Under the amended eligibility procedures, only the CAT in its "professional judgement," can determine whether a person has mental retardation, epilepsy or cerebral palsy and whether this condition is severe.

359. Members of the SCDDSN CAT, who have not personally examined a patient, are not qualified to determine whether the individual has mental retardation, epilepsy or cerebral palsy or to determine the medical necessity for waiver services.

360. Elimination of the right of physicians to diagnose and treat mental retardation, epilepsy and cerebral palsy is a violation of the South Carolina Medicaid Practice Act and the ARRA, which prohibits states from enacting more restrictive eligibility criteria.

361. SCDDSN and SCDHHS amended the eligibility standards, methodologies and procedures for determining level of care for the MR/RD Medicaid waiver in order to gain an advantage in litigation with Robyn P.[8] *Doe v. Kidd, supra.* Robyn's action for injunctive relief alleging that State actors have violated her right to receive Residential Habilitation services with "reasonable promptness" is pending in the United States Federal District Court in Columbia. Her appeal of the threatened termination of her eligibility for MR/RD Medicaid waiver services is pending in the South Carolina Court

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[8] Robyn is "Sue Doe" in these proceedings.

of Appeals and Robyn's lawsuit to determine whether SCDDSN provided services with "reasonable promptness" is pending before the South Carolina Federal District Court. Robyn is at risk of having her MR/RD Medicaid waiver services terminated if the more restrictive eligibility standards, giving the CAT team authority to make eligibility determinations based on "professional judgment" and eliminating physicians as persons who can diagnose mental retardation, epilepsy and cerebral palsy.

362. Robyn P. requests an injunction requiring SCDDSN and SCDHHS to comply with the requirements of the ARRA, and specifically not to impose more restrictive eligibility requirements than those used in the SSI program and in effect on July 1, 2008.

363. For more than six years Robyn has received"respite" services in a group home (CTH II). The waiver amendments which take effect on January 1, 2010 only allow daily respite to be provided in a more restrictive setting, an ICF/MR. If an injunction is not granted, Robyn will be forced to move to an ICF/MR to receive respite services.

DISCUSSION

364. SCDDSN received more than $34 million in stimulus funds during SFY 2009, but $31 million of those funds were paid to a rainy day account established by Proviso 90.13, the Health Care Annualization and Maintenance of Effort Fund, instead of being used to maintain jobs and services. The chart at Appendix H at page 147 documents the reductions and the increased funding SCDDSN has received since October of 2008. This chart was prepared by SCDDSN and presented at the December 17, 2009 Commission Meeting.

365. During SFY 2010, SCDDSN will receive more than $40 million in federal stimulus funds, but more than $22 million of these funds will be paid to the Health Care

Annualization and Maintenance of Effort Fund. Appendix H at page 145.

366. At the start of SFY 2010, SCDDSN was holding more than $7.8 million in an "excess debt service" fund. Nearly $6 million from this fund was used to purchase and/or renovate buildings, to pay for a computer system and provide a personal contract awarded to the former director of SCDHHS. Appendix D at pages 7 and 8.

367. SCDDSN actually will receive more funding in SFY 2010 than in SFY 2008.

368. Although the numbers provided by SCDDSN have not been consistent, SCDDSN has reduced or eliminated services to thousands of persons and thousands of jobs have been or will be eliminated due to "budget reductions."

369. SCDDSN has continued to spend millions of dollars purchasing and renovating large buildings to be used as congregate workshops instead of using these funds to provide services. Appendix D at pages 5 to 8.

370. The expenditure of $2.6 million approved by the South Carolina Budget and Control Board to purchase three buildings in Horry, Richland and Beaufort Counties was never approved by the SCDDSN Commissioners. In response to Senator Leatherman's inquiry about his Board's support of the expenditures, Dr. Laurent advised him that "there was a unanimous vote on this matter." Appendix D at page 5.

371. By using these funds to purchase real estate for local DSN Boards, SCDDSN has continued to establish barriers to private providers who compete with SCDDSN to provide services instead of encouraging competition and choice. The LAC audit recommended that SCDDSN increase the number of private providers of services and the actions taken by SCDDSN have the opposite effect.

372. Unless federal funds were used to purchase or improve the three buildings approved by

the South Carolina Budget and Control Board at a cost of $2.8 million (which would have been a violation of federal law), SCDDSN lost more than $11 million in matching federal funds because those funds were used to purchase real estate instead of providing Medicaid services. Many jobs were lost due to this decision.

373. The facts are undisputed that SCDDSN has drastically reduced the number of persons receiving MR/RD and HASCI Medicaid waiver services and has reduced the duration, scope and amount of services which were provided on July 1, 2008 in violation of the ARRA.

374. These reductions were based solely on claims of budget reductions at a time when millions of dollars were available, both in the stimulus fund rainy day account and the "excess service debt fund" to maintain these services.

375. Not only have Defendants violated ARRA by not maintaining services, thousands of jobs have been and will be lost because SCDDSN has not maintained MR/RD and HASCI Medicaid waiver services.

376. Services and eligibility have been reduced based on an arbitrary decision to reduce the cost of the MR/RD and HASCI Medicaid waiver programs, without individual assessments of the needs of waiver participants in violation of the Americans with Disabilities Act and *Olmstead.*

377. SCDDSN has failed to consider the treatment decisions of responsible treating physicians in determining eligibility for waiver programs and treatment needs for participants, as required by *Olmstead.*

378. Maintaining services in effect on July 1, 2008, and any services determined by treating physicians to be medically necessary since that time, would not result in a fundamental

alteration in the way the State provides services. Funds are available to provide these services and the State has a duty to protect the health and welfare of all waiver participants.

379. During SFY 2009 and SFY 2010, SCDDSN terminated or reduced waiver services based on pretextual reasons, especially the services of those participants who did not choose to attend congregate workshops.

380. Recently, courts in other states have prohibited States from reducing home-based services based on claims of the State that budget reductions require reductions in services.

381. On December 14, 2009, a federal judge in Eastern North Carolina granted a temporary restraining order in response to a complaint filed on December 11, 2009 by disabled persons asking the court to prohibit the State from reducing services Plaintiffs need to remain in their homes. Just three days after the complaint was filed, that court determined that the State should be enjoined from reducing services due to alleged violations of the Americans with Disabilities Act. *Marlo M. v. Lanier Cansler*, No. 5:09-CV-535-BO, December 14, 2009. Appendix H at 150.

382. In *Crabtree v. Goetz,* a court in Tennessee prohibited the State from reducing Medicaid services where reductions were likely to force waiver participants into nursing homes or to suffer other serious harms. N 3:08-0930 (M:D. Tenn.), 2008 WL 5330306, Dec. 19, 2008.

383. The United States Department of Justice has recently filed amicus briefs in three separate cases in Connecticut, Virginia and New York to enforce the rights of persons who have disabilities to live in the least restrictive setting, as required by the *Olmstead* decision.

Appendix H at page 154. In Connecticut, the Department of Justice opposed a motion to dismiss a lawsuit challenging the State's lack of community resources, which require persons with disabilities to be housed in large, private nursing homes. In New York, the Department of Justice filed a brief in support of plaintiffs objecting to services being provided in "large congregate homes." In Virginia, the Department of Justice filed an amicus opposing the dismissal of a lawsuit objecting to the State spending millions of dollars building new, large segregated facilities for persons who have intellectual disabilities.

384. Waiver participants in SC in this case were not individually notified of the denial, reduction, suspension or terminated of their SCDDSN services until December of 2009 and some were notified that caregivers who have worked with them for many years will lose their jobs.

385. Participants were not provided with written notice of their right to appeal these denials, reductions, suspensions and terminations of services.

386. Exclusions and inflexible caps are causing Plaintiffs to lose vital home-based services. Without these services, Plaintiffs will be forced into more restricted, segregated settings.

387. Pursuant to the ARRA, the Defendants had a duty to maintain Medicaid services which were in effect on July 1, 2008.

388. Using federal stimulus funds to provide the services requested in this Complaint is a ministerial act.

389. Plaintiffs have a right to receive waiver services with reasonable promptness based on needs as determined by responsible treating physicians. *Olmstead, supra* and *Doe v. Kidd, supra.*

390. Plaintiffs have no other remedy than to petition this Court for a writ of mandamus.

391. Plaintiffs request that this Court maintain the status quo, with services not to be reduced from the level provided on July 1, 2008 without a determination by the participant's treating physician that the services are not needed.

392. Plaintiffs request an injunction prohibiting Defendants from paying funds for the purchase of real estate to be used for congregate segregated services.

393. Plaintiffs request an order directing that any funds distributed pursuant to the request of Dr. Laurent to the South Carolina Budget and Control Board for any capital projects not specifically authorized by the SCDDSN Commissioners in the capital plan approved in April of 2009 be immediately returned to SCDDSN.

FIRST CLAIM FOR RELIEF

(American Recovery and Reinvestment Act ("ARRA"))

394. Plaintiffs adopt and restate the allegations set forth in the paragraphs above.

395. The ARRA requires the State to maintain services at the level funded on July 1, 2008

and prohibits the State from placing funds in a rainy day or reserve account.

396. Congress' intent in the ARRA was to maintain jobs and to stimulate the economy by promptly spending federal stimulus funds paid to South Carolina.

397. Plaintiffs are intended beneficiaries of the ARRA.

398. The interests of the Plaintiffs are not too vague or amorphous to be beyond the competence of this Court to enforce.

399. The statute provides a binding obligation upon the state.

400. A justifiable controversy exists between the parties as to (1) whether the Defendants have correctly interpreted Proviso 90.13 to require that federal stimulus funds paid to SCDDSN be transferred to a rainy day account instead of using those funds to maintain MR/RD and HASCI Medicaid waiver services.

401. This justiciable controversy is now ripe and Plaintiffs have standing to raise the issues set forth herein.

402. Plaintiffs seek a writ of mandamus, or alternatively a declaratory judgment, prohibiting the SCDDSN Commission from transferring any funds attributable to federal stimulus funds to the Health Care Annualization and Maintenance of Effort Fund and requiring the agency to use those funds to maintain and restore MR/RD and HASCI waiver services.

403. Plaintiffs request an order requiring that stimulus funds received by SCDDSN be used to provide Medicaid waiver services, as has been determined by the Plaintiff's treating physician to be needed to prevent regression and to maintain and improve the functional level of waiver participants.

404. Plaintiffs request that this Court order SCDDSN to apply reasonable standards, based on needs which are identified by the treating physician, and that these services be provided with reasonable promptness.

405. Pursuant to Rule 57, SCRAP, Plaintiffs further request a speedy determination of the matters contained within this complaint due to the time-sensitive nature of the dispute.

406. Plaintiffs request legal fees and costs which shall be determined to be reasonable by the Court.

SECOND CAUSE OF ACTION

(Supremacy Clause of the United States Constitution)

407. Plaintiffs adopt and restate the allegations set forth in the paragraphs above.

408. The ARRA contains an unambiguous prohibition against transferring any funds attributable to federal stimulus funds, directly or indirectly, to a reserve or rainy day account. ARRA, Section 5001(f)(3).

409. The ARRA prohibits Defendants from applying eligibility standards, methodologies, or procedures which are more restrictive than the eligibility standards, methodologies and procedures in effect on July 1, 2008. The purposes of the ARRA are as follows:

> (1) To provide fiscal relief to States in a period of economic downturn.
>
> (1) To protect and maintain State Medicaid programs during a period of economic downturn including by helping to avert cuts to provider payment rates and benefits or services, and to prevent constrictions of income eligibility requirements for such programs, but not to promote increases in such requirements. (Emphasis added.)

410. Defendants have violated the ARRA and the intent of Congress by transferring funds attributable to federal stimulus funds to a rainy day account and have applied eligibility standards, methodologies and procedures which are more restrictive than those in effect on July 1, 2008, in violation of the Supremacy Clause of the United States Constitution.

411. In so doing, Plaintiffs have lost services or are threatened with the loss of eligibility or services in violation of their constitutional rights. 42 U.S.C.1983.

412. Plaintiffs request an order requiring the return of funds attributable to the ARRA to SCDDSN from the Health Care Annualization and Maintenance of Effort Fund and an order prohibiting SCDDSN from transferring additional funds to that rainy day account.

413. Plaintiffs request an order requiring SCDDSN to spend those funds providing direct services in the least restrictive setting chosen by waiver participants, requiring that these services be provided with reasonable promptness as set forth in the First Cause of Action.

414. Plaintiffs request payment of legal fees and costs, as determined by this Court to be reasonable.

THIRD CAUSE OF ACTION

(Americans with Disabilities Act)

415. Plaintiffs adopt and restate the allegations set forth above in this complaint.

416. Title II of the Americans with Disabilities Act ("ADA") provides that "no qualified individual with a disability shall, by reason of the disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity or be subject to discrimination by such entity." 42 U.S.C. § 12132.

417. A "public entity" is defined as any State or local government or other instrumentality of

a State or local government. See 42 U.S.C. 12131(1)(A)&(C).

418. Regulations implementing Title II of the ADA require that a public entity administer its services, programs and activities in "the most integrated setting appropriate" to the needs of qualified individuals with disabilities. 28 C.F.R § 35.130(d).

419. Regulations implementing Title II provide that:

> "A public entity may not, directly through contractual or other arrangements, utilize criteria or other methods of administration (I) that have the effect of subjecting qualified

420. Plaintiffs request preliminary and permanent injunctions enjoining Defendants and all persons who may be in active concert and participation with them from reducing services which are needed for the Plaintiffs to remain or move to the least restrictive setting below the level provided in July of 2009, except where the participant's treating physician determines that these services are not needed.

421. Plaintiffs request that SCDDSN and SCDHHS be required to make reasonable modifications in the programs operated by SCDDSN so as to provide services in the least restrictive, most integrated setting chosen by the waiver participants.

422. Plaintiffs request payment of legal fees and expenses.

FOURTH CAUSE OF ACTION

(Section 504 of the Rehabilitation Act)

423. Plaintiffs adopt and restate the allegations set forth above.

424. Plaintiffs are "qualified person[s] with disabilities" within the meaning of Section 504, because they have physical and/or mental impairments that substantially limit one or more major life activities, and they meet the essential eligibility requirements for long term care under the MR/RD Waiver and HASCI Medicaid Waiver programs.

425. Defendants' denial of Medicaid funding for the in-mone health services that Plaintiffs require to avoid segregation in an institution and remain in the integrated home settings that are appropriate to their needs constitutes unlawful discrimination in violation of Section 504 of the Rehabilitation Act, 29 U.S.C. §794(a), and its implementing regulation, 28 C.F.R. §41.51(d).

426. Defendants have also utilized criteria and methods of administration that subject Plaintiffs to discrimination on the basis of disability, including risk of unnecessary institutionalization, by (1) failing to assess properly the services and supports that would enable Plaintiffs to remain in the community, (2) failing to ensure that Plaintiffs have access to Medicaid-covered services that will meet their needs in the community, and (3) compelling health care providers to reduce recommended levels of in home nursing and community based services, thereby violating Section504 and its implementing regulations.

FIFTH CAUSE OF ACTION

(Civil Rights Act, 42 U.S.C. §§ 1983, 1985 and 1988)

(Against Individual Defendants Sanford, Forkner, Floyd, Harrell, Waring and Goodell)

427. Plaintiffs adopt and restate the allegations set forth in the paragraphs above.

428. Individual Defendants Sanford, Forkner, Floyd, Harrell, Waring and Goodell have acted in concert to deny Plaintiffs federal benefits to which they are entitled under the Medicaid Act, the Americans with Disabilities Act and the ARRA as set forth in this Complaint.

429. These acts violate 42 U.S.C. §§ 1983 and 1985 and violate the civil rights of the Plaintiffs.

430. Defendants have reduced services and terminated eligibility in violation of the Civil

Rights of the Plaintiffs.

431. Services have been reduced, terminated or withheld in the least restrictive setting, in an effort to increase the attendance at congregate workshops operated by SCDDSN, where waiver participants are segregated from non-disabled persons and are, in some cases, subjected to workplace violence that would not be tolerated outside of these settings.

432. The civil rights of the Plaintiffs have been violated by the Defendants actions restricting the right of choice under 42 U.S.C. 1396a(a)(23) and right to receive services in the least restrictive setting with reasonable promptness (42 U.S.C. 1396a(a)(8)).

433. Defendants have established and applied eligibility standards which are more restrictive than allowed by federal law to reduce services and rolls for the MR/RD and HASCI Medicaid waiver programs in violation of the rights of the Plaintiffs.

434. Plaintiffs pray for attorney fees and costs as shall be determined by this Court to be reasonable.

PRAYER FOR RELIEF

Plaintiffs request a writ of mandamus or a declaratory judgment determining that SCDDSN was "obligated" to use the increased FMAP funds to maintain Medicaid services. In the alternative, Plaintiffs request an order directing these funds to be retained by and returned to the South Carolina Department of Disabilities and Special Needs because payment to the Health Care Annualization and Maintenance of Effort Fund violates the Supremacy Clause of the United States Constitution for the reasons set forth herein. Plaintiffs request that this Court issue an order directing Defendants to restore all eligibility and services that were provided on July 1, 2008 and other services determined by participant's treating physician to be medically necessary.

Plaintiff's request the relief requested in this complaint and such other relief as shall be

determined by this Court to be just and equitable. Plaintiffs request payment of legal fees and costs of this action.

Dated: December 23, 2009

Respectfully submitted,

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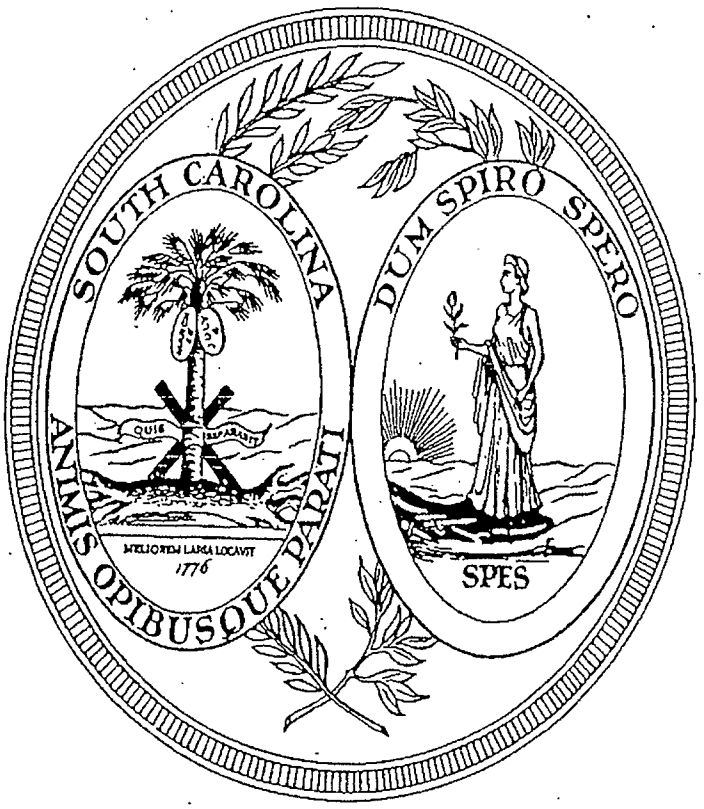

South Carolina Department of Health and Human Services
Director's Internal Audit Report

A REVIEW OF THE MR/RD WAIVER AS OPERATED BY THE DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

Performed by the Division of Audits

February 28, 2006

EXECUTIVE SUMMARY

The Division of Audits in the SC Department of Health and Human Services (DHHS) has conducted a limited scope audit of the Medicaid Mental Retardation/Related Disabilities (MR/RD) Waiver program. Through this waiver program, individuals with mental retardation and related disabilities receive a broad range of services to assist them to live in the community instead of an institution. This program is a joint effort of DHHS and the SC Department of Disabilities and Special Needs (DDSN). DHHS provides administrative oversight and monitoring to ensure compliance with Medicaid requirements and the health, welfare and safety of the waiver beneficiaries. DDSN has the primary responsibility for the daily operation of the program.

DHHS has both a contract and a memorandum of agreement with DDSN for the management of the MR/RD waiver program. Waiver services are provided by a network of Disabilities and Special Needs (DSN) Boards and private providers. In federal fiscal year 2003, total MR/RD waiver expenditures were $157,878,607 before cost settlement, with 69.7% federal Medicaid funds and 30.3% state and other funds provided by DDSN.

We reviewed the management and cost of the MR/RD waiver program in order to determine whether Medicaid funds are spent effectively, efficiently and in compliance with contractual, state, and federal Medicaid requirements, and also to determine whether there is an effective system of oversight to ensure clients are properly served. Concerns about DDSN allocation and expenditures of Medicaid funds, as well as issues that surfaced in FY 2003 during a review of a major DDSN provider, The Babcock Center, Inc., were the impetus for this review. While this audit focused on DDSN and DHHS management of the MR/RD waiver program, we tested certain program and financial aspects in-depth at two major providers: The Disabilities Board of Charleston County (Charleston) and The Babcock Center, Inc. (Babcock).

Overall, we identified several areas where both DDSN and DHHS need to improve the oversight of the MR/RD waiver program. Findings are listed below.

Quality Assurance, Sanctions, and Inspections

Three major programs review home and community-based waivers and other services provided to DDSN clients to ensure that quality of care and program standards are met: (1) First Health Services of South Carolina, Inc., reviews all DDSN home and community based programs, using national benchmarks and quality indicators, in order to determine client outcomes, consumer satisfaction, and adherence to policies and procedures; (2) the DDSN State Licensing Division inspects DSN Board programs and residential facilities; and (3) the University of South Carolina, under contract with DHHS, has conducted on-site quality reviews of DSN Boards for compliance to waiver program standards. We noted several issues and impediments to the effectiveness of these programs.

- According to DDSN management staff, the goal of the First Health reviews has been quality improvement, not necessarily compliance with Medicaid requirements. Because many of the standards used to determine service quality (quality indicators) are unique to DDSN, and were developed without input by DHHS, the First Health quality assurance system does not fully meet the needs of DHHS for waiver oversight.

- Some of the key quality indicators reviewed by First Health are also required Medicaid components. For example, all waiver clients are required to have a current single plan (plan of care) and level of care determination in place before waiver services can be billed to Medicaid. Failure to meet these standards results in an unallowable Medicaid payment, which must be refunded to DHHS.

- We found, however, the amount of sanctions applied to the DSN boards, and the money DDSN has refunded to DHHS for non-compliance with its standards, does not accurately reflect actual Medicaid costs and is not a full repayment.

- For example, for fiscal years 2003 and 2004, we determined that Medicaid payments to DDSN totaled $796,530 for MR/RD waiver services provided to clients during the time their single plans or level of care determinations were either missing or invalid. Of this amount, we could verify only $191,576 in refunds that DDSN made to DHHS as the result of sanctions identified by First Health reviews. DDSN should pay back the federal share for these unallowable Medicaid payments or $422,077.

- Statistics reported by First Health show a steady improvement in DSN boards' adherence to quality indicators from FY 2003 to FY 2005. However, there are 265 quality indicators, and non-compliance with key indicators such as having a valid plan of care can be diluted by 100% compliance with less important indicators

- DDSN has the responsibility for licensure and certification of the residential and day program facilities for waiver consumers. DDSN has closed or de-certified a small number of community residential facilities in response to serious licensing and certification violations found during annual licensing reviews. DDSN recently added more staff to this process in order to conduct a follow-up review when there is a significant deficiency related to health, safety, or management of funds.

- DHHS does not receive DDSN state licensing inspection reports of waiver facilities and programs, even if serious deficiencies reflecting abuse or neglect of waiver consumers are discovered.

- DDSN licensing inspections found a number of deficiencies at Babcock, including homes that were unsanitary and in need of repair and maintenance; a lack of background checks on caregivers; and multiple medication errors. In response to this and other problems, DDSN has required Babcock Center to downsize by 50%.

Waiver Funding System

DDSN uses a band payment system to provide the DSN Boards with funds in advance in order to operate the waiver and other programs. For clients with special needs, DDSN also provides outlier funding. We concluded that the current method for funding the waiver program is similar to average, per diem payments made for other types of Medicaid services, although it is difficult to compare band payments with actual Medicaid reimbursements for services.

- We found that while some types of residential facilities were less expensive for the boards to operate, and thus the boards had revenues in excess of costs for these homes, this did not seem to be influencing where clients were placed.

- Average costs for a small number of individuals in the MR/RD waiver program exceeded the average cost of care for an ICF/MR. However, we found no indications that the waiver program does not meet required financial conditions.

- DDSN has improved its process to ensure that all residential outliers are re-justified in writing, and that the consumers' medical and/or behavioral conditions show the continued need for outlier funding.

- We reviewed a sample of MR/RD clients who were or had been receiving outlier funding. Although we found minor discrepancies in the clinical records, we concluded that the continued need for outlier funding was sufficiently documented.

Cost Reports And Administrative Expenditures

We reviewed regional cost reports, audited financial statements, and other documentation for FY 2003 to determine whether MR/RD waiver costs are properly settled in compliance with Medicaid reimbursement methodologies and whether appropriate fiscal oversight of the waiver is provided. These cost reports also are critical since they are the basis for cost settlements made by DHHS to DDSN, and for setting future rates for Medicaid reimbursement for waiver services. We concluded that there is a lack of fiscal oversight of the MR/RD waiver program by both DHHS and DDSN.

- DDSN's administrative costs are not separated from the direct service costs but rather are included in total waiver costs that become the Medicaid rate paid for waiver services. For the two boards reviewed, waiver allocated costs and central office administration amounted to approximately 14%-17% of direct service costs.

- In 2003 the DSN boards, including Charleston and Babcock, had costs higher than the band payments received from DDSN plus other revenues, but their accumulated fund balances provided a cushion. During the same year, total cost for waiver services was lower than the Medicaid funds reimbursed to DDSN, and therefore DDSN has made an interim settlement to DHHS of $2,150,000. There is a wide variance in actual DSN Board costs for waiver services.

- We identified some unallowable room and board-related expenditures in the waiver cost reports: $182,450 for Babcock CTH II homes and $54,446 for Charleston CTH II homes.

- There have been no reimbursement audits performed on the regional cost reports compiled by DDSN, and DHHS staff in the Division of Ancillary Reimbursements are not reviewing audited financial statements or DDSN reconciliation schedules that support costs reported in the waiver reports. There are no written audit procedures to guide the waiver report desk review process.

Chapter 1: INTRODUCTION

Background

The Division of Audits in the SC Department of Health and Human Services (DHHS) has conducted a limited scope audit of the Medicaid Mental Retardation/Related Disabilities (MR/RD) Waiver program. Through this waiver program, individuals with mental retardation and related disabilities receive a broad range of services to assist them to live in the community instead of an institution. This program is a joint effort of DHHS and the SC Department of Disabilities and Special Needs (DDSN). DHHS provides administrative oversight and monitoring to ensure compliance with Medicaid requirements and the health, welfare and safety of the waiver beneficiaries. DDSN has the primary responsibility for the daily operation of the program.

In federal fiscal year (FFY) 2003, 4,654 Medicaid-eligible clients with mental retardation and related disabilities received home and community-based services in South Carolina. Total MR/RD waiver expenditures before any cost settlement for FFY 2003 were $157,878,607 — 69.7% federal Medicaid funds and 30.3% state matching funds. DDSN provides the matching funds from its state appropriation and other sources.

The MR/RD waiver program offers an array of services to Medicaid-eligible clients as an alternative to institutional care in an intermediate care facility for the mentally retarded (ICF/MR). These services include:

- Personal care services,
- Habilitation services designed to help individuals live in the community and achieve and maintain their maximum functioning level,
- Environmental modifications, such as ramps and widening of doorways,
- Respite care,
- Specialized medical equipment, supplies and technology,
- Adult companion services,
- Adult day health services,
- Nursing services,
- Private vehicle modifications, and
- Behavioral and psychological services.

In addition, waiver recipients receive extended state plan Medicaid services such as two extra prescription drugs each month; physical, speech, and occupational therapy; and adult dental and vision services.

Through a contract with DHHS for the *Purchase and Provision of Home and Community-Based Mental Retardation/Related Disability Waiver Services*, DDSN provides home and community-based services to Medicaid-eligible clients. In addition, a *Memorandum of Agreement between DHHS and DDSN for the Provision of Home and*

Community-Based Waiver Services establishes how the two agencies will coordinate program activities and conditions for reimbursement. Under the SC Code of Laws Section 44-20-240, DDSN was created with the authority over all of the state's services and programs for the treatment and training of persons with mental retardation and related disabilities. DDSN uses a network of 39 county Disabilities and Special Needs (DSN) Boards, plus other service organizations, which provide waiver services directly to clients or which sub-contract with private providers. County DSN Boards are authorized to plan for, administer, or provide services to people with mental retardation and related disabilities. (SC Code of Laws Section 44-20-375 [C]). For example, the Babcock Center, Inc., is considered a local DSN Board and serves a four county area.

The "entry point" for potential waiver recipients is the local DSN Board, which screens applicants and then links them with a service coordinator. The service coordinator determines eligibility for services, assesses the client's care needs, and creates a written plan of care, called the "single plan". Medicaid will pay only for those waiver services that are specified in this plan. The DSN Boards provide most (94% for FY 2003) of the services funded through the waiver as well as service coordination, although the consumer is required to be given a choice of providers whenever possible.

Audit Objectives and Scope

We have reviewed the management and costs of the MR/RD waiver program in order to determine whether Medicaid funds are spent effectively and efficiently and in compliance with applicable contractual, state, and federal Medicaid requirements, and also to determine whether there is an effective system of oversight to ensure funds are spent on client needs. Concerns about DDSN's allocation and expenditures of Medicaid funds, as well as issues that surfaced in FY 2003 during a limited-scope review of a major DDSN provider, The Babcock Center, Inc., were the impetus for this review. Our specific audit objectives are as follows:

- Determine whether quality assurance activities conducted by both DDSN and DHHS effectively ensure clients are properly served, and whether results of quality assurance activities are reported and deficiencies are appropriately addressed.

- Determine whether the capitated or "band" payment system implemented by DDSN ensures that adequate funding is provided to meet clients' needs.

- Determine whether additional or "outlier" funding is provided to clients whose single plans justify the need for extra services, and whether this funding is actually spent on these clients.

- Determine whether waiver program costs are properly settled in compliance with Medicaid reimbursement methodologies, and whether safeguards are in place to ensure that only allowable costs are born by the Medicaid program.

- Determine whether both DDSN and DHHS provide appropriate fiscal oversight of the MR/RD waiver.

We reviewed costs and services only for DDSN clients who are MR/RD waiver recipients, and did not review any intermediate care facilities for the mentally retarded (ICF/MR). Even though the level of care provided and clients' needs may be similar to that in a community-based setting, ICF/MRs are institutions and therefore different licensing and certification requirements apply. We did not review the Head and Spinal Cord Injury Waiver (HASCI) or other Medicaid services provided by DDSN, such as early intervention and service coordination. We also did not review some components of the waiver program, including level of care, plan of care, and freedom of choice, as these are reviewed by DHHS and DDSN through their quality assurance programs. The time period of our review ranged from FY 2002 through FY 2004. Appendix A contains definitions for terms and the legal authority.

In general, we identified several areas where both DDSN and DHHS need to improve oversight of the MR/RD waiver program. The following pages detail multiple findings and recommendations involving quality assurance, payment of sanctions, serious licensing discrepancies at residential facilities, unallowable waiver costs, and a lack of financial audits.

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Chapter 2: REVIEW OF QUALITY ASSURANCE EFFORTS

Background

One of our audit objectives was to verify that quality assurance efforts put forth by the SC Department of Disabilities and Special Needs (DDSN) and the SC Department of Health and Human Services (DHHS) are substantial and effective in ensuring that the requirements of the MR/RD waiver are being met. A second objective was to determine whether findings noted during the QA reviews are properly reported, corrective action plans are developed and implemented, and appropriate follow-up is conducted to ensure problems have been satisfactorily addressed. Both DHHS and DDSN are responsible for monitoring care provided to Medicaid MR/RD waiver clients.

There are three major programs that review home and community-based waivers and other services provided to DDSN clients to ensure they meet applicable quality of care and programmatic standards:

- First Health Services of South Carolina, Inc. (First Health), is under a five-year contract with DDSN to conduct a quality assurance review program in accordance with a request for proposal awarded in December 2001. First Health reviews all Disabilities and Special Needs Boards (DSN Boards) and qualified providers annually, and issues a report of findings to DDSN and the DSN Board reviewed. In addition, First Health is required by its contract to conduct consumer interviews, follow-up reviews, and special circumstance reviews. First Health reviews include DDSN home and community-based services and are not just limited to MR/RD waiver services or Medicaid clients.

- The DHHS Division of Waiver Management is contracting with the University of South Carolina to conduct on-site QA reviews of the 39 DSN Boards on a scheduled basis. Currently the division is restructuring its QA process to incorporate enhanced CMS quality oversight requirements for waiver programs.

- The DDSN State Licensing Division inspects all DSN Boards and qualified providers on an annual basis, as DDSN is responsible for the licensing and/or certification of home and community based facilities. The SC Department of Health and Environmental Control licenses "institutional" facilities such as intermediate care facilities for the mentally retarded (ICF/MR), and community residential care facilities.

Issues Involving First Health's QA Reviews

We have reviewed the quality assurance system administered by DDSN through its external contractor, First Health Services, and have determined that its effectiveness in ensuring compliance with Medicaid requirements could be improved. We reviewed the

First Health QA process in general as well as the outcomes of First Health reviews for multiple DSN Boards, and calculated the amount owed to Medicaid based on First Health findings of serious service deficiencies. We also reviewed specific First Health reports for the Disabilities Board of Charleston County and the Babcock Center, Inc.

According to DDSN management staff, the goal of the First Health reviews has been quality improvement, not necessarily compliance with Medicaid requirements, although compliance and quality improvement are obviously related. However, DDSN views the First Health QA process as its "own" system, and in fact DHHS has operated a separate monitoring process for waiver services through a contract with USC. We also found that the sanctions imposed as a result of DSN Boards' failure to comply with First Health's quality indicators do not result in a complete and accurate repayment to Medicaid for funds spent inappropriately.

Even though DDSN developed the First Health process to meet its own quality assurance goals, the costs for the First Health contract are allocated to the Medicaid services DDSN claims for reimbursement. About 70% of the costs for First Health are reimbursed by federal Medicaid funds. The five-year cost for the First Health contract is $4,481,934. Therefore, both DHHS and DDSN should coordinate quality assurance reviews to make sure this process meets the goals and needs of both agencies.

FOCUS OF FIRST HEALTH REVIEWS

In the waiver submitted to CMS for approval, DHHS certifies that it "...will have in place a formal system by which it ensures the health and welfare of the individuals served on the waiver, through monitoring of the quality control procedures described in this document...Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that plans of care are periodically reviewed to ensure that services furnished are consistent with the identified needs of individuals."

The First Health quality assurance system, as it has been developed and implemented by DDSN, does not fully meet the needs of DHHS for waiver oversight, for the following reasons:

- While core standards (quality indicators) for the waiver program and the First Health QA process are essentially the same, many of the quality indicators reviewed by First Health are unique to DDSN.

- First Health goes well beyond assessing compliance with program requirements because it also is geared toward measuring personal outcomes and consumer satisfaction and providing an assessment of consumer services. First Health reviews a sample of DDSN clients, not all of whom are Medicaid clients, and also reviews other services that are not part of the MR/RD waiver, including service coordination, early intervention, and head and spinal cord injury (HASCI) waiver services.

- Sanctions resulting from First Health reviews are not necessarily linked to Medicaid non-compliance, have been capped by DDSN, and have not been reported timely to DHHS.

First Health Standards

The quality indicators used to assess the MR/RD waiver and other DDSN programs were developed by DDSN in conjunction with First Health. DHHS had no input into the assessment standards, although we found no evidence that such input was either required or requested by DHHS. The First Health QA system utilizes National Core Indicators. These indicators or benchmarks are the result of collaboration among state agencies participating in the National Association of State Directors of Developmental Disabilities Services and the Human Services Research Institute, with the goal of developing a systematic approach to performance and outcome measurement. Through this collaboration, participating states pool their resources and knowledge to create performance monitoring systems, identify common performance indicators, work out data collection strategies, and share results.

First Health is required to attempt to interview approximately five percent of DDSN's consumers annually, as well as conduct provider surveys and satisfaction surveys. (Not all consumers consent to the interview.) The QA process utilizes quality review tools that incorporate the National Core Indicators to compare outcomes with nationally recognized benchmarks. The focus of the First Health QA reviews is not just the waiver program and Medicaid clients, but all DDSN community-based programs and clients. These review tools cover several areas:

- Administrative quality indicators – administrative and fiscal areas, based on DDSN policies.
- General agency quality indicators – the single plan, service operation, and waiver funded services.
- Early intervention quality indicators – referral intake, individualized family service plan, family training, service notes, other documentation, waiver funded services, and BabyNet services.

As of March 2005, there were 265 quality indicators – 44 administrative, 112 general agency, and 109 early intervention. Some of the key quality indicators reviewed by First Health are also required Medicaid components. For example, all waiver clients are required to have a current single plan (plan of care) and level of care determination in place before waiver services can be billed to Medicaid. These indicators are reviewed both by First Health and DHHS's own reviewers for compliance. However, many of the First Health standards go beyond minimum requirements in order to assess service quality and outcomes. At the same time, other components of MR/RD waiver services might not be reviewed and reported by First Health.

The Code of Federal Regulations states, "In order for an agency to qualify as the Medicaid agency—The agency must not delegate, to other than its own officials, authority to—Exercise administrative discretion in the administration or supervision of the plan, or issue policies, rules, and regulations on program matters." [42 CFR 431.10 (e) (1)] Under the Memorandum of Agreement, "SCDHHS is the final authority and shall make all final decisions regarding all matters related to the administration of the MR/RD and HASCI waivers." Therefore, DHHS should have final approval on the quality indicators used by DDSN and First Health to evaluate Medicaid services.

SANCTIONS FOR NON-COMPLIANCE WITH STANDARDS

DDSN sanctions the DSN Boards that fail to meet critical First Health quality indicators. If the DSN Boards and other providers fail to meet certain quality indicators, then they must repay DDSN the funds they received for services that did not meet the standard (sanctions). According to DDSN executive staff, they initiated a process of sanctioning the DSN Boards in order to improve compliance with the quality indicators considered by DDSN to be a priority. First Health QA reports identify these quality indicators. Examples of sanctionable quality indicators include the single plan was not reformulated or completed annually, or the intake process was not completed within required time frames. Because DHHS has paid DDSN for the services provided to Medicaid clients, once DDSN levies a sanction on a DSN board, it should refund the federal Medicaid share to DHHS.

However, we found that DDSN did not base these sanctions on the amount Medicaid should have been refunded for unallowable payments made for MR/RD waiver services. The money DDSN has refunded to DHHS for non-compliance with its standards does not accurately reflect actual Medicaid costs and is not a full repayment, for the following reasons.

First, DDSN bases the amount of the board sanctions on the "band payment" sent to the board prior to service delivery. DDSN uses the following calculation to determine the repayment amount for each sanctionable indicator:

- Full formula: $1/365^{th}$ of the payment (either the band payment or the payment for the individual service) for each day the file was out of compliance.
- Capped formula: Full formula limited to 30 days maximum. Additionally, cites related to training goals are calculated at one-half of $1/365^{th}$.

As discussed in Chapter 3, the band payment is not the same as the amount Medicaid reimbursed DDSN for the MR/RD waiver or other services. Since band payments are funds that DDSN advances to DSN Boards based on average, expected costs, the amount Medicaid reimbursed DDSN for a service could be more or less than the amount the board was given to provide it.

Second, not all the "sanctionable indicators" found in the First Health reviews are Medicaid discrepancies or improper payments. For example, DDSN might apply a sanction to a board for failing to provide new training goals to a client once he or she has

mastered the goals. This is not necessarily a discrepancy that DHHS Medicaid reviewers would sanction for, although it does indicate low quality of services.

Finally, DDSN caps the amount it would sanction a board to 30 days in order to shield the boards from large repayments. For example, if a consumer in the MR/RD waiver program lacked a valid plan of care for 150 days, DDSN would base the sanction on 30 days worth of band payments, rather than the waiver services actually paid during the 150 days.

We determined the amount DDSN should have refunded DHHS for Medicaid payments for instances when a DSN board was in clear violation of MR/RD waiver requirements. This determination was based on information provided by DDSN regarding the First Health sanctions applied to all the DSN Boards reviewed for two fiscal years, 2003 and 2004. We determined the amount of Medicaid reimbursement for those clients, where First Health found that:

- The single plan (plan of care) or family service plan was out of date or there was no plan;
- The services were not adequately documented on the plan; and
- The level of care determination was out-of-date or not made in a timely fashion.

The reason we focused on these three discrepancies is that these conditions *must* be met before DDSN can claim federal Medicaid reimbursement for the services rendered, and both First Health and DHHS review for compliance to these standards. In the waiver agreement, DHHS certifies that "FFP (federal financial participation) will not be claimed for waiver services furnished prior to the development of the plan of care (single plan). FFP will not be claimed for waiver services which are not included in the individual written plan of care." Furthermore, the waiver agreement specifies that:

> The plan of care is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability. The minimum schedule under which these reviews will occur is every 12 months.

In a similar fashion, DDSN is required to ensure that a level of care (LOC) determination is performed and up-dated annually to ensure the individual is still eligible for services. Therefore, having a valid plan of care and meeting LOC eligibility requirements are key components of the waiver program, and failure to meet these requirements results in an unallowable Medicaid payment which should be refunded.

We used information from the First Health reviews for FY 2003 and FY 2004 to identify 71 clients receiving services under the MR/RD waiver program, and the amount that, according to DDSN, they sanctioned the DSN Boards for the discrepancies in the services to waiver clients. We then used Medicaid claims reports to determine what was actually

paid to DDSN for the dates of service when the waiver clients did not have a valid single plan or LOC determination. Table 1 shows the difference between these two amounts.

Table 1: Unallowable Medicaid Payments for MR/RD Waiver Services

First Health Review Year	Total Medicaid Paid for MR/RD Waiver Services (1)	DHHS Sanctions from First Health Reviews (2)	Difference
FY 02-03	$336,186	$44,012	$292,174
FY 03-04	$460,344	$44,308	$416,036
TOTAL	$796,530	$88,320	$708,210

Source: First Health reports for Contractual Compliance Review; DHHS SURS reports.
Notes: (1) Total Medicaid reimbursement for MR/RD waiver services furnished to Medicaid eligible clients during only those dates when the single plan or level of care determination was missing, invalid, or not timely.
(2) Amount DDSN has required the DSN Boards to pay back for these discrepancies and clients.

This does not take into account billing discrepancies or other overpayments which should be refunded to Medicaid, but which cannot be clearly distinguished in the reports furnished by First Health. Therefore, the sanctions assessed as a result of the First Health reviews are not an accurate reflection of the Medicaid funds that have been spent inappropriately by the DSN Boards.

The DHHS contract with DDSN for waiver services states, "SCDDSN...agrees that it shall be solely responsible for any costs that are not in accordance with the Medicaid State Plan, SCDHHS policies, Medicaid regulations and the terms of the waiver". The contract also states, "SCDDSN shall be solely responsible for the performance of any subcontractors". Therefore, DDSN is responsible for repaying DHHS the federal portion of unallowable costs, minus what it has already returned as a result of the First Health findings.

Tracking Sanctions a Problem

We then reviewed the amount of funds DDSN reports it paid back to DHHS for these discrepancies. DDSN reports that it has sanctioned the DSN Boards a total of $606,135 for sanctionable discrepancies identified by First Health reviews during fiscal years 2003-2004, and has subsequently refunded the Medicaid share of $423,987 to DHHS. Again, these sanctions were based on payments made by DDSN to the boards, and not on actual Medicaid payments to DDSN, and also covered all services, not just MR/RD waiver. In addition, we found it impossible to tie refunds to Medicaid with corresponding First Health sanctions because of the way this information is reported by DDSN.

Once sanctions against a DSN Board are determined, DDSN is responsible for informing DHHS of the Medicaid share so these funds can be taken out of the Medicaid payment to DDSN. DDSN writes a memorandum to appropriate DHHS program staff stating,

"DDSN has identified Medicaid reimbursement claims, where billing errors have occurred. Accordingly, we are requesting the Department of Health and Human Services to adjust future remittance advices for DDSN to refund these funds to the Medicaid program." DHHS staff are supposed to reduce the reimbursement to DDSN by posting the sanctioned amounts as a "gross debit adjustment" to the Medicaid Management Information System (MMIS).

The letters from DDSN do not indicate whether debit adjustments are the result of sanctions from First Health QA reviews nor do they specify what discrepancies were found and the DSN Boards involved. For example, in February 2005, DHHS staff received a debit adjustment request from DDSN in the total amount of $278,630.77 for MR/RD and HASCI waiver recipients. DDSN did not provide supporting documentation to show that part of this debit request was the accumulated result of several First Health reviews of multiple DSN Boards that had occurred over the prior two years.

The debit adjustments reported by DDSN also include adjustments based on reasons other than First Health reviews. The funds repaid by DDSN appear to be a mixture of First Health sanctions and corrections for various billing errors, and we could not tie the debit request letters from DDSN back to the First Health sanction reports. Also, because of the process used to calculate and refund the Medicaid share of sanctions imposed from First Health reviews, it is possible that DDSN has repaid to DHHS funds that were not considered overpayments from a Medicaid standpoint.

However, the most we could verify that was actually paid back to DHHS, resulting from sanctions assessed to the DSN Boards because of discrepancies identified by First Health in reviews for FYs 2003 and 2004 and involving only MR/RD waiver clients, was $191,576. This would include all First Health sanctions applied for any reason to the DSN Boards, not just those involving the timeliness of the single plan and level of care determinations. Therefore, allowing DDSN the $191,576 in debit adjustments we could trace, DDSN is responsible for $422,077 – the federal share of remaining unallowable Medicaid payments, as shown in Table 2.

Table 2: Required Pay Back for DDSN, FY 2003 and 2004 Combined

Total Medicaid Paid MR/RD Waiver Services (1)	DDSN Debits Waiver Services (2)	Difference	Combined FFP Rate (3)	Amount DDSN Pay Back
$796,530	$191,576	$604,954	69.77%	$422,077

Notes:

(1) Total Medicaid reimbursement for MR/RD waiver services furnished to Medicaid eligible clients during only those dates when the single plan or level of care determination was missing, invalid, or not timely, based on First Health reviews for FY 2003 and FY 2004.

(2) Debit Adjustments made to DDSN Medicaid reimbursement for MR/RD Waiver Services that could be traced to First Health sanctions applied for any MR/RD waiver services reviewed during FYs 2003 and 2004.

(3) Average of the federal composite match rate of 69.69% applied in FY 02-03, and 69.85% applied in FY 03-04.

REVISIONS NEEDED IN QA PROCESS

Because the First Health reviews were not designed as a Medicaid compliance tool, DHHS has developed its own process of external reviews of clients' records. This process is currently being revised. Therefore, we find that the timing is right to re-design both processes in order to have a more unified and consistent approach to quality assurance that meets the goals of both agencies.

In order to conduct more focused waiver reviews, the Division of Waiver Management within DHHS has contracted since July 1, 2002, with the University of South Carolina, Centers for Disability Resources (USC) for quality assurance record reviews for the HASCI (Head and Spinal Cord Injury) and MR/RD waivers. The USC reviewer, in conjunction with DHHS program staff, has reviewed approximately 24 DSN Boards. DHHS recouped the federal portion of $99,417.89 from these reviews in FY 2004 and identified approximately $353,000 in potential recoupments in FY 2005. (DDSN has appealed part of this recoupment.) Most of the findings discovered during these QA reviews were related to level of care re-evaluations, timely plan of care re-evaluations, and incorrect billing to Medicaid for residential or day habilitation services. The results of these findings have led DHHS program staff to require DDSN to issue policy memorandums and hold special training sessions for DSN Board staff regarding identified findings.

In effect, the waiver program was being reviewed under two different programs that were developed separately and used different review tools and samples, although both reviews contained similar elements. The federal Centers for Medicare and Medicaid Services (CMS) conducted a review of South Carolina's MR/RD waiver. The CMS draft report, dated February 2004, was generally positive about waiver quality assurance. However, CMS offered two recommendations in its report relating to quality assurance. The first recommendation encouraged DHHS and DDSN to coordinate and collaborate on findings noted from their respective QA systems. CMS also recommended that DDSN "...develop a detailed reporting system of their QA activities and statistical sampling to be reported to DHHS and discussed at the quarterly meetings".

As noted, DHHS is currently revising its own QA process in order to better delineate its quality management oversight responsibilities for the two home and community based waivers operated by DDSN, and has retained the services of a CMS national quality contractor to strengthen its oversight of the waiver. This contractor has recommended that DHHS and DDSN identify any gaps in DDSN's quality management system for producing and using evidence for oversight purposes. According to this contractor, "It is only once DHHS has a firm understanding of DDSN's QM system and its ability to produce and use evidence (and to share this evidence with DHHS) that DHHS will be in a position to determine strategies appropriate to its oversight role." The contractor also recommended that DHHS request "DDSN produce evidence based on a representative sample of waiver participants" and that "DDSN increase case management contacts with participants". The contractor will also be reviewing First Health findings for accuracy and appropriateness, and according to DHHS program staff, they plan to incorporate

licensing and certification reports of community-based programs and critical incidents reports for MR/RD waiver clients into this review as well. According to DDSN, they also have obtained a contractor to evaluate the validity and reliability of its statewide quality assurance/quality improvement program.

DDSN and DHHS also had differing systems for assessing financial sanctions on DSN Boards for deficiencies identified under the two review systems, although many of the standards reviewed were similar. If DDSN wishes to continue using sanctions in order to enforce quality standards, the funds returned to DHHS should be in line with what Medicaid paid for the services. This will require staff from both agencies to jointly develop a reporting process that clearly shows the First Health findings, the resulting Medicaid discrepancy, and the amount of the improper payment that should be recouped (based on Medicaid reimbursement and not band payments). DDSN should provide supporting documentation to link the amount that Medicaid should be reimbursed with the applicable First Health sanctions. Also, as part of this process both agencies should explore the feasibility of using the "void and replace" claim-specific adjustment process, instead of using gross-level adjustments as it is currently done. This may help ensure that First Health findings are tracked in a timely manner, and that Medicaid funds are recouped shortly after the discrepancies are identified by First Health. Ultimately, it is DHHS' responsibility to oversee and monitor the quality assurance and sanction process.

Recommendations

1. The Department of Health and Human Services and the Department of Disabilities and Special Needs should revise the quality assurance process as it is currently being conducted by First Health to meet the goals and needs of both agencies. This should include all the Medicaid-funded services reviewed for quality assurance by DDSN. The quality assurance standards and QA review process should incorporate both quality indictors as well as Medicaid requirements. DHHS should have final approval on the quality indicators used to evaluate Medicaid services.

2. The Department of Health and Human Services should amend the Memorandum of Agreement with the Department of Disabilities and Special Needs to include provisions for the two agencies to jointly develop a quality assurance, Medicaid monitoring system.

3. The Department of Health and Human Services and the Department of Disabilities and Special Needs should jointly develop a reporting process that clearly shows the First Health findings, the resulting Medicaid discrepancy, the program and specific service, and the amount of the improper Medicaid payment that should be recouped. Once this process has been developed, DHHS should consider requiring DDSN to make adjustments directly to the specific claims involved.

4. The Department of Disabilities and Special Needs should refund $422,077 to the Department of Health and Human Services as the federal share of funds

inappropriately spent by DSN Boards for fiscal years 2003 and 2004 for services provided when the client did not have a valid plan of care or level of care determination.

5. Department of Health and Human Services in conjunction with DDSN should develop a schedule of potential Medicaid recoupments for fiscal year 2005 (based on the process developed in response to recommendation #3), so that Medicaid recoupments can be linked with the applicable First Health findings. Since this information would involve services in addition to the MR/RD waiver, it should then be provided to the applicable DHHS division — Division of Preventive and Ancillary Health Services, Division of Family Services, and/or the Division of CLTC Waiver Management, in order to make adjustments on MMIS.

REPORTING BY FIRST HEALTH

Statistics reported by First Health show a steady improvement in DSN Boards' adherence to quality indicators. We reviewed the FY 2004 QA reports provided by First Health as well as aggregate data for three years. First Health provides DDSN with quarterly and annual reports for all the DSN Boards and qualified providers reviewed, based on the state fiscal year of July 1 through June 30. DHHS also receives copies of these reports.

First Health is required to review a 5% sample of records at each DSN Board annually, as well as to conduct follow-up reviews within 120 days after the annual review. First Health examines all services for each client selected for review, regardless of whether the client is a MR/RD waiver participant. In FY 2004, for example, First Health sampled records for 1,421 DDSN consumers (1,095 clients receiving MR/RD waiver and other DDSN services; 83 HASCI waiver clients, and 243 clients receiving early intervention services). Table 3 reflects average scores for the administrative, general agency and early intervention indicators for FY 2003 through 2005 for the Babcock Center, Inc., and Charleston DSN Boards, as well as statewide averages for those years.

Table 3: Average Scores by Indicator

Provider	Indicator	FY 2003	FY 2004	FY 2005
Babcock Center	Administrative	87.3%	81.4%	83.3%
	General Agency	77.3%	84.2%	90.5%
Charleston	Administrative	90.9%	93.2%	86.0%
	General Agency	86.5%	94.9%	97.6%
	Early Intervention	90.1%	95.3%	98.7%
Statewide Average	Administrative	92.1%	94.7%	93.9%
	General Agency	86.6%	90.9%	91.2%
	Early Intervention	87.8%	91.3%	94.1%

Source: CCR Tracking Comparison of First Health Reviews, DDSN.
Notes: While this audit focused on MR/RD waiver services, First Health reviews do not segregate this information; so findings relating to other services have been included.

Selected indicators where DSN Boards, on average, had less than 80% compliance for FY 2004 are shown in Table 4; performance on these indicators improved in 2005, as shown. "Sanctionable" indicators, as previously described, are situations where non-compliance results in recoupment of funds from the DSN Board. The following indicators would apply to both waiver and non-waiver services.

Table 4: Selected Indicators with less than 80% Compliance for FY 2004

Indicator	Non-Compliance 2004	Non-Compliance 2005
SANCTIONABLE Board/Provider follows DDSN procedures regarding the reporting and responding to critical incidents as outlined in DDSN policy.	46.2%	29.0%
SANCTIONABLE Service reporting to DDSN is appropriate, adequate, and does not reflect under or over reporting.	35.0%	26.9%
The Consumer/Legal Guardian received a copy of the Single Plan and facilitated Single Plan (when appropriate).	31.4%	12.0%
SANCTIONABLE Progress is made towards meeting identified needs and implementing supports, or revisions are made when satisfactory progress is not indicated.	25.8%	14.9%
SANCTIONABLE Services are monitored as often as needed, but at least quarterly, to assure they are implemented as prescribed.	25.5%	17.0%
SANCTIONABLE The nature, frequency, and intensity of service coordination activity is adequate to identify and address service needs and personal goals.	23.8%	14.9%
SANCTIONABLE The intake process is completed within the required time frames (for new consumers only).	22.5%	15.2%
All Consumers records contain the Behavior Support Plan, if applicable.	21.6%	15.6%

Source: First Health Annual Reports for FY 2004 and FY 2005.

While these statistics do show an improvement in quality of services provided by the DSN Boards based on First Health indicators, this information should be reviewed in conjunction with the DDSN certification and licensing process that is described in the following pages. For example, although Babcock Center showed a better than 80% compliance with administrative and general standards in 2004, DDSN's licensing reports tell a somewhat different story. Furthermore, with so many indicators (265) non-compliance with key indicators such as having a valid plan of care can be diluted by 100% compliance with less important indicators. For example, one quality indicator states that if a consumer is disenrolled from the MR/RD waiver, a Notice of Disenrollment form must be completed within two days. The DSN Boards achieved 100% compliance with this indicator in 2005. DDSN and DHHS staff should review all available information on the performance of DSN Boards in order to determine if the First Health quality assurance process is helping improve waiver service quality and achieve better compliance with program standards. As previously noted, DHHS is already planning to incorporate this in its revision of the QA process.

Issues Involving DDSN State Licensing Surveys

We reviewed the process used by DDSN to license and/or certify residential and day program facilities for MR/RD waiver clients. Under a Memorandum of Agreement with the SC Department of Social Services (DSS), DDSN is granted the authority to license community training homes for children. Since 1982, a proviso initiated by DHEC has granted DDSN the authority to certify community training homes for adults. (DHEC is mandated to license institutional facilities such as ICF/MRs and CRCFs.) DDSN's own state legislation grants it the authority to license day facilities, such as work activity centers or child development centers, for both children and adults.

The DDSN State Licensing division annually reviews community residential facilities for one-third of all adult consumers, all facilities for children, and all day programs. DDSN has developed its own licensing standards, which are approved by DHEC or by DSS if they pertain to children. The standards cover a wide range of requirements, including fire, health and safety, storage and administration of medicine, consumer programs, accountability for consumer funds, reporting of critical incidents, and staff certification. The surveyors physically inspect the facilities selected for review and examine client files as well as personnel records for current staff at the facilities, although personnel records for terminated employees are not reviewed. At the conclusion of the review, DDSN licensing division issues a report to the executive director of the DSN Board, with a plan of correction due one month after the report is issued. The DDSN licensing coordinators review corrective action plans to ensure findings are appropriately addressed.

Reviews conducted by the DDSN licensing division are completely separate from reviews conducted by First Health. Although First Health and DDSN licensing may review records for the same client, First Health's review focuses on reviewing all services that the client receives. DDSN licensing selects the residence or facility that will be inspected and also reviews records for all consumers in that facility.

We reviewed DDSN's policies and procedures for licensure and certification of home and community-based facilities for waiver clients, as well as the license and certification reports for Babcock Center, Inc., and The Charleston DSN board in order to determine how standards for health, safety, and programs for waiver clients are upheld. In general, we concluded that the licensing inspections carried out by the DDSN State Licensing Division were thorough and appropriate. However, DDSN should improve the way it reports and acts upon serious deficiencies identified by the survey teams.

LICENSING REPORTS NOT SHARED WITH DHHS

DHHS has not been receiving DDSN inspection reports of residential facilities and day programs serving waiver recipients, even if serious deficiencies that could harm waiver consumers are discovered. Although annual state licensing reports are normally provided to the executive directors of the DSN Boards, they are not provided to DHHS and

generally not provided to the DSN Boards of Directors. As far as we could determine, DHHS program staff had not ever received DDSN licensing reports for facilities that house MR/RD waiver clients.

While a large majority of the waiver funding is used for residential and day habilitation services and programs, DHHS has no authority over residential facilities themselves, and the room and board charged to consumers who live in the community residential facilities are not allowable Medicaid expenses.

However, the MR/RD waiver agreement requires DHHS to assure "...that necessary standards have been taken to protect the health and welfare of persons receiving services under this waiver", including assurances "...that the standards of any State licensure or certification requirements are met". The Code of Federal Regulations also requires, under 42 CFR 441.302, that the Medicaid agency must provide satisfactory assurance that "...the standards of any State licensure or certification requirements are met for services or for individuals furnishing the services under the waiver; and ...assurance that all facilities covered by section 1616 of the Act, in which home and community-based services will be provided are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities."

According to DHHS waiver program staff, because the waiver funding does not cover room and board, as long as a facility or program maintained its license, the waiver requirements would be satisfied. However, it is difficult for DHHS to provide the required assurances to CMS when agency staff do not receive the licensing reports and have no information regarding how the standards are enforced by DDSN. In contrast with the requirements for ICF/MR, which call for an independent licensing and certification reviews by DHEC, we must rely on DDSN to enforce its own standards for health and safety of consumers in the MR/RD waiver program. Therefore, DDSN needs to communicate serious deficiencies identified by its State Licensing Division to DHHS, and demonstrate what it has done to enforce these standards, so that DHHS can fulfill its responsibility of ensuring the health and safety of waiver clients and that providers are meeting waiver standards.

PENALTIES INFREQUENTLY ASSESSED FOR LICENSING VIOLATIONS

Only a small number of community residential facilities have been closed by DDSN as a result of serious licensing and certification violations found during annual licensing reviews. If a deficiency noted during a DDSN licensing review is so serious that it reflects neglect or abuse of a client, DDSN has the ability to require the provider to take immediate corrective action. According to DDSN, this means the inspectors will not leave a facility or residence until the problem is corrected. For example, a DDSN inspection of a Babcock residence in 2004 found sharp knives unsecured in a kitchen drawer. A lock was replaced on the drawer before the surveyors finished their inspection and exited the building.

We could not identify any provision in its enabling legislation that would allow or require DDSN to penalize DSN Boards for failure to meet minimum licensing standards for *residential* facilities. Section 44-20-770 of the SC Code of Laws requires DDSN to deny, suspend, or revoke a license for a *day* facility on any of the following grounds:

> (1) Failure to establish or maintain proper standards of care and service as prescribed by the department;
> (2) Conduct or practices detrimental to the health or safety of residents or employees of the day program. This item does not apply to healing practices authorized by law;
> (3) Violation of provisions of this article or regulations promulgated under it.

The standard DDSN contract with the DSN Boards also provides that in the event a provider loses its license from DHEC or DDSN to operate any of the facilities funded through the contract, that particular facility's participation in the contract will be terminated as of the date of decertification or loss of licensure.

In addition, DDSN's internal policy states that, if a re-visit to either a residential or day facility cited for discrepancies determines that the plan of correction has not been implemented, depending on the seriousness and duration of the violation, DDSN may administer the following sanctions:

- Issuing a provisional license with a shorter expiration date;
- Reducing the capacity of the program;
- Suspending or reducing financial payments; and
- Denying, suspending, or revoking the facility's license or certificate.

DDSN does not keep a database to show how often it has applied any of the above sanctions to DSN Boards or other providers for serious licensing or certification discrepancies. During the course of this audit, DDSN furnished us with documentation showing that since December 2001, five residential facilities at four different DSN Boards have either been closed or lost licensure/certification as a result of facility inspections, necessitating the re-location of a total of nine MR/RD waiver clients.

Also, until recently, DDSN had only three state licensing coordinators (surveyors) to perform inspections. Due to the small staff size, these surveyors were unable to conduct follow-up reviews and only performed annual reviews, but they did determine whether deficiencies noted in a prior review had been corrected. In August 2005, DDSN hired a fourth staff person to conduct follow-up inspections, re-directed three additional staff to perform license and certification inspections on a part-time basis, and developed a draft protocol. The protocol provides that DDSN may conduct a follow-up review when there is a significant deficiency related to health, safety, or management of funds or when there are a significant number of repeat deficiencies from the prior year(s). However, the protocol does not specify at what point, if a DSN board fails to improve conditions at its residential or day facilities, DDSN would begin applying the penalties according to its policy.

Chapter 3: WAIVER FUNDING SYSTEM

One of our audit objectives was to review the method used to fund services for Medicaid-eligible clients in the Mental Retardation - Related Disabilities (MR/RD) waiver program. We have reviewed the capitated or "band" payment system implemented by DDSN as well as the system for providing extra funds for waiver clients with special needs ("outlier funding"). We did not find that band payments contravened any Federal regulations, and do not have any recommendations for dramatically altering this system.

Overall, we concluded that the current method for funding the waiver program is similar to average per diem payments made for other types of Medicaid services, and as such may be an effective method of channeling funds to direct care providers. However, we noted several areas of concern, including:

- The difficulty in comparing band payments with actual Medicaid reimbursement;
- Band payments for low-cost clients subsidize the care for high-cost clients;
- Minor discrepancies in the documentation for outlier funding.

We also noted that DDSN has improved its process to ensure that all residential outliers are re-justified in writing. We also found that while some types of residential facilities were less expensive for the boards to operate, and thus the boards had revenues in excess of costs for these homes, this did not seem to be influencing where clients were placed.

The Band Payment System

DDSN contracts with a network of DSN Boards to provide or arrange for an array of services to clients, most of who are eligible for Medicaid funding. The band payments from DDSN to the DSN Boards comprise an advance payment system for both ICF/MR services as well as for home and community-based services. At the beginning of each month, DDSN advances funding to each DSN Board based on the number of clients within each "band" at that particular board. There are five different bands and statewide rates. (See Table 6, p.26) The rate depends on the level of residential care and intensity of services that the clients in each band are expected to need.

The DSN Board provides the services required by the clients' individual plan of care ("single plan") and then sends service provision logs to the DDSN central office by the 5th day of the following month. DDSN processes the expenditures and mails the Medicaid-reimbursable portion to DHHS for payment. The Medicaid reimbursement for waiver services is based on average, statewide interim rates that are later settled to actual costs. Multiple services are bundled into a single rate, and there are individual rates for the residential program, adult day program, respite care, and personal care. DDSN is paid the same rate for each waiver client depending on the individual service and number of units provided. In other words, DDSN is *not* reimbursed the same amount it had forwarded to the DSN Boards but rather is reimbursed based on individual service rates.

Table 6: Statewide Band Rates, 2003

Category	Description	Identifier	Start Rate
At Home – Day Supports	Individuals who live at home and only receive day habilitation support	A	$7,715
At Home – Enhanced Support	Individuals who live at home and receive day habilitation and enhanced waiver services	B	$12,544
Residential Low Needs	Individuals in supervised living arrangements who do not need intensive supervision	C	$19,434
Residential Low – To –Moderate Needs	Individuals in community residential care facilities and CTH II homes who need more care	D	$45,076
Residential High Needs	Individuals also in CRCF and CTH II homes, as well as ICF/MRs, who need intensive services	E	$65,567

Source: Request for Proposal, Services to Consumers with Mental Retardation, Related Disabilities or Autism and Services Specialized for Consumers with Traumatic Brain Injury, Spinal Cord Injury, or Similar Disability for SCDDSN. See Appendix A for a more detailed description of these programs.

DDSN is required to furnish the state share out of its own state general fund appropriations and other sources of funds eligible for matching purposes. DHHS reimburses DDSN for the federal share (approximately 70%) of Medicaid costs incurred.

Not all the costs covered by the band payments are Medicaid-reimbursable. DDSN uses the band system regardless of whether the client and/or the service are Medicaid-eligible. Some clients are private-pay, and not all services provided by the DSN Boards can be covered by Medicaid.

The band payment is expected to cover all waiver program costs for clients, even though some waiver services, such as dental care and additional prescription drugs, are not provided by the DSN Board but by private providers who bill Medicaid directly. Each month, DDSN receives a tape from DHHS with information on the amount of services for waiver recipients billed directly to DHHS; DDSN then subtracts this amount from each DSN Board's next band payment.

Since the bands are *average* payments, there can be a variation of client needs within each band. For example, one client in Band C may not need $19,434 worth of services and another client may need more. The board does not have to spend the band amount "generated" by a client on that client. Once the total budget is determined, DDSN allows the boards to spend the band funding within all of the programs, as long as individual client needs are met. Finally, some clients have costs so far above the average that DSN allows extra funding, called "outlier" funding, for these clients. This is discussed further on pages 29-30.

COMPARING BAND PAYMENTS TO MEDICAID REIMBURSEMENT

In our review of the band payments, we concluded that there are no Medicaid compliance issues involved because the band payment is not a Medicaid payment from DHHS to the DSN Boards. Medicaid funds are not an issue until DDSN bills DHHS and is reimbursed for Medicaid waiver services. However, the band payment system does make it almost impossible to connect allocated funds (the band payment) with actual expenditures for an individual client's care and Medicaid reimbursement for that cost. The following table for two waiver recipients compares their band and outlier payments and actual expenditures for their care with the Medicaid reimbursement recorded for them in FY 2003.

Table 7: Comparison of Band Payments with Costs and Reimbursements

	Band & Outlier Payments	Client Fees	Total Board Expenditures	Medicaid Allowable Cost	Medicaid Reimbursement
Client # 1	$102,109	$4,800	$114,733	$109,150	$77,912
Client # 2	$162,975	$4,800	$170,837	$158,921	$88,265

Source: "Band & Outlier Payments," plus the "Client Fees" were the revenues the DSN Board received for those clients in FY 2003; "Total Board Expenditures" includes room and board, which are not allowable Medicaid costs for reimbursement. "Medicaid Allowable Costs" are the costs remaining after room and board are subtracted. Both "Total Costs" and "Medicaid Allowable Costs' are based on the FY 2003 audited financial statement of the DSN Board that serves these individuals as well as DDSN waiver cost schedules. The "Medicaid Reimbursement" is based on the claims for FY 2003 adjudicated by the DHHS Medicaid Management Information System.

This table illustrates the fact that neither the Medicaid reimbursement nor the band payments are a reliable indicator of what is actually spent to care for an individual receiving MR/RD waiver services. According to DDSN, the DSN Boards are not able to track costs for each individual client. While the audited financial statements of the DSN Boards provide specific cost data, for most waiver clients this is only at the individual residential or program level. For example, both the Disabilities Board of Charleston County and Babcock Center, Inc.'s, audited financial statements contained a schedule of revenues and expenses for each CTH II and CRCF managed by the boards. Most of these residential facilities have three or four beds. We could review the individual costs for the two clients shown in Table 6 above because they lived in single-bed CTH IIs.

We conducted a limited test to ensure that, for clients in the residential bands, there were charges to Medicaid for MR/RD waiver services. DDSN also reviews a monthly report that shows the clients' residential placements and makes sure this is in line with the band payment levels as shown on Table 6.

BANDS NOT A DISINCENTIVE TO LEVEL OF PLACEMENTS

We also sought to determine whether the band payment system provided any disincentives to placing clients in the most appropriate residential facility. Again, we tested these issues with only two boards, Charleston and Babcock. The audited financial statements for each board show a statement of revenues and expenditures broken out by each residential facility. Revenues are primarily the band payments received from DDSN plus client fees; expenditures are all costs, not just Medicaid allowable costs. With Charleston, the majority of the CTH II homes (which house the largest share of clients), the four ICF/MR facilities managed by the board, and one of the two community residential care facilities had expenditures greater than the revenues in FY 2003. The supervised living residences (SLP I), which are also for those clients with the lowest level of need, had revenues exceeding expenditures by a total of $293,512. With Babcock, the CTH II homes also experienced net losses as well as its SLP II homes in FY 2003. Babcock had excess revenue with its SLP I homes, CRCF, and CTH I homes.

One could conclude, therefore, that under a capitated funding system the DSN Boards made a "profit" from the clients in the SLP I homes. However, as noted, the DSN Boards are allowed to spend their revenues where needed, and the band payment associated with a particular client does not have to be spent on that client – a client can cost more or less than his or her band. For both Babcock and Charleston, the majority of the consumers were in CTH II homes, not in supervised living arrangements. Therefore, while the boards' expenses were less for the SLP I homes, this did not seem to be driving where clients were placed.

The imbalance between revenues and expenditures may also mean that DDSN should adjust the band payments to better reflect actual costs for the different levels of residential facilities. It also indicates that the band payments received for low cost clients are subsidizing the high cost clients. According to DDSN, it is seeking additional state funding in order to re-base the band payments so that actual cost of care can be covered.

Recommendation

12. The Department of Disabilities and Special Needs should review the adequacy of band payments compared to local Disabilities and Special Needs Boards' expenditures and adjust the band payments to better reflect actual costs for the different levels of residential facilities.

HIGH COST OF SOME WAIVER CLIENTS

The costs to care for a limited number of consumers in MR/RD waiver program are high, but we found no indications that the waiver program does not meet required financial conditions. In the waiver agreement with the federal Centers for Medicare and Medicaid Services, DHHS provides three financial assurances about waiver costs:

- The average per capita expenditures under the waiver will not exceed 100 percent of the average per capital expenditures for institutional care (ICF/MR).
- Actual total expenditures will not exceed the cost of institutional care.
- The state will refuse to offer home and community-based services to any person for whom it can reasonably be expected that the cost of home or community-based services furnished to that individual would exceed the cost of a level of care in an ICF/MR.

DHHS provides an annual report to CMS showing all MR/RD waiver and other Medicaid expenditures versus the ICF/MR costs. For federal fiscal year 2003, DHHS reported that the average cost for a waiver recipient was $42,263 versus $75,042 for an individual in an ICF/MR. This cost includes waiver services as well as the cost of other Medicaid services, such as inpatient hospital.

However, some individuals in the waiver program exceeded the average cost of care in an ICF/MR. For example, the Medicaid reimbursement for the two individuals in Table 7 was $88,265 and $77,912. This understates the actual cost of their individual care because, as noted, the Medicaid reimbursement is based on an average rate for all waiver recipients in residential care plus any individual services directly billed to Medicaid. The allowable Medicaid cost for these individuals was actually $158,921 and $109,150, respectively. In addition, annual costs for waiver individuals do not include subsequent cost settlements to DDSN.

However, we found no evidence that serving these consumers in an institutional setting as opposed to a home and community-based setting would have been more cost-effective. The two consumers reviewed were high-cost because of enhanced staffing needs, and the cost to serve these individuals would be high regardless of where they were placed.

Even as some clients in the MR/RD waiver are very expensive to serve, there is a waiting list for waiver services. As of August 2005, there is a regular waiting list of 750 for the MR/RD waiver program plus a "critical" waiting list of another 20 individuals. According to DHHS program staff, consumers on the critical list are waiting on average one to two months, while consumers on the non-critical list may remain there indefinitely.

Review of Outlier Payments

In cases where a consumer's circumstances and needs are substantially higher than average, a DSN Board may receive additional funding from DDSN equal to the difference in the consumer's approved budget and the consumer's band amount. This additional funding is referred to as "outlier funding". The main triggers for outlier funding are the need for intensive nursing care for medically-fragile individuals, many of whom live at home, or for one-on-one staffing for individuals with severe medical, behavioral, and/or other problems. DDSN has established outlier thresholds where the costs for caring for a client must exceed a certain dollar amount before the DSN Board is

eligible to request outlier funding from DDSN. Effective July 1, 2004, these thresholds are $85,718 for consumers residing in a residential facility and $28,560 for consumers living at home.

As of July 2004, a total of 8,239 DDSN clients were funded through the band payment system; 259 or 3% were "outlier" cases that required the increased funding. The two boards reviewed in detail - Charleston and Babcock - received the following band and outlier payments in FY 2003:

Table 8: Outlier Payments for Two DSN Boards, FY 2003

Board	Clients in Bands	Clients in Outlier	Band Payments	Outlier Payments	Ave. Total Payment
Charleston	526	22	$12,066,409	$822,709	$24,504
Babcock	1,134	76	$36, 695,279	$2,786,726	$34,817

Source: DDSN final totals as of November 2005. These figures include the waiver program and ICF/MR beds, and both Medicaid and non-Medicaid clients.

RE-JUSTIFICATION OF OUTLIER FUNDING

Prior to the *Limited Scope Review of Babcock Center, Inc.*, DDSN verbally obtained confirmation from waiver providers that consumers receiving outlier funding continued to have medical and/or behavioral conditions that would justify on-going need for outlier funding. DDSN assumed that providers would notify the agency whenever a consumer's needs changed and outlier funding would no longer be necessary. Due to the significant dollar amounts of outlier funding, we recommended in the *Limited Scope Review* that providers justify in writing to DDSN each year, waiver consumers continued medical and/or behavioral need for greater services.

In response, DDSN established a new policy requiring DSN Boards to re-justify in writing each consumer's medical and/or behavioral condition to show their continued need for outlier funding. The policy also requires that the DSN Board's executive director submit a signed "Certification Statement". DDSN set April 15, 2004, as the due date for providers to submit initial re-justification documentation to the agency, and also required all residential outliers to be re-justified in writing each year within 30 days following the annual plan date noted on DDSN's Service Tracking System. Failure by the DSN Board to submit re-justification within this time period would result in the discontinuance of outlier funding. Outlier funding for nursing services was not required to be re-justified, as this is adjusted quarterly by DDSN based on the level of services delivered.

The following schedule summarizes the results of the initial re-justification for Charleston and Babcock:

Table 9: Results from Initial Re-Justification

Description	# of Consumers	
	Charleston	Babcock
Continued outlier funding approved	3	25
New outlier funding approved	1	0
Paperwork not submitted to continue outlier funding	0	18
Outlier funding approved through 6/30/04, then funding transferred to another consumer	2	0
Outlier funding approved through 6/30/04, and not transferred to another consumer	0	4
Totals	6	47

Source: DDSN Schedule, Residential Outliers by DSN Board, as of April 9, 2004. Does not include nursing outliers.

USE OF OUTLIER FUNDING BY DSN BOARDS

We reviewed a sample of MR/RD waiver clients at Charleston and Babcock to determine whether the recipient's file adequately documents the need for enhanced services requiring outlier funding, and in general to verify compliance with other waiver requirements. Although the overall purpose of this audit is to review the MR/RD waiver as operated by DDSN, we conducted site visits to review MR/RD waiver client records in order to identify any problems with outlier funding that may necessitate further review.

Using outlier re-justification schedules prepared by DDSN, we selected eight waiver recipients at each DSN Board — including at least one recipient for each of the following criteria: continued outlier funding was not requested by the DSN Board; outlier funding was requested to be discontinued as of July 1, 2004, by the DSN Board; or continued outlier funding was requested by the DSN Board. We also selected several Medicaid recipients who received nursing outliers at these two DSN Boards. Using these criteria, the following sample was developed:

Table 10: Medicaid Recipients Reviewed

Criteria	# of Consumers Reviewed	
	Charleston	Babcock
Nursing outlier	5	2
Continued outlier requested	2	2
Outlier not requested	1	2
Discontinue outlier 7/1/04	*0	2
Total Consumers Reviewed	8	8

*Note: Charleston did not have any consumers that met this criterion.

Although we found some minor discrepancies, we do not believe systematic problems with justification for outlier funding were identified that would necessitate further review. In general, our review found that documentation was sufficient and complete at both boards for the consumers where continuation of the residential outlier funding was

requested. However, for two consumers at each DSN Board, where residential outlier funding was provided for the consumers to have one-on-one and/or enhanced staffing, accountability (monitoring) was not consistently documented, progress notes were not consistently completed for each shift, dates were incorrectly shown, and some required activities were not provided. The boards are supposed to maintain sufficient documentation showing that appropriate monitoring was provided to these clients. Also, the DDSN policy implemented in April 2004 for use of outlier funding requires that "Services provided to residential outliers must be properly documented and accounted for." Specific findings for each board are as follows:

Charleston Review Results

- A reasonable and justifiable explanation was provided for the consumer where outlier funding was not requested.

- Fifteen Single Plans were in effect during the audit scope (FY 2004). Of the 15 single plans reviewed, eight (53%) had various minor errors, including questions not being answered, services not being properly or consistently shown throughout the plan, and changes to the plan not being initialed and dated. One major deficiency noted was that Charleston was unable to produce a signed signature page for one single plan documenting the individuals attending the planning meeting.

- The most significant deficiency found concerned one consumer whose behavior was not being formally reviewed and assessed, due to lack of resources in the Charleston area relating to behavior support and because this client chose not to work with a certified staff member at the Disabilities Board of Charleston County.

Babcock Review Results

- Review of consumers where outlier funding was not requested or where outlier funding was requested to discontinue July 1, 2004, clearly showed that Babcock had in the past failed to notify DDSN when consumers' needs changed or they were moved to other facilities. This occurred prior to the re-justification policy implemented by DDSN.

- The Richland/Lexington DSN Board (Rich/Lex) provides service coordination for MR/RD waiver clients served by Babcock. Eleven single plans were in effect during the audit scope for the six consumers selected for review that were not nursing outliers. Of the 11 single plans, 100% had various errors that showed a lack of communication and coordination between Babcock and Rich/Lex. Specifically, we found that Babcock did not have all pages of one plan; another single plan was not updated for changes in the client's medication; and two consumers' plan were not updated for changes in their accountability levels.

- Two consumers' files did not adequately document whether they received the medical and/or dental treatment identified in their single plans and when, and under what conditions, one-on-one staffing should be provided.

Because Babcock employees are involved in the consumers' day-to-day lives and are familiar with medical, physical, and other changes, it is important that Babcock keep Richland/Lexington DSN Board apprised of changes made as a result of called team meetings, medical appointments, etc.

Recommendations

13. The Department of Disabilities and Special Needs should work with the Richland/Lexington Disabilities and Special Needs Board and the Babcock Center, Inc., on developing better communication and coordination of care for consumers served by both boards.

14. Both the Babcock Center, Inc., and the Disabilities Board of Charleston County should ensure that they are following policy promulgated by the Department of Disabilities and Special Needs regarding proper documentation of one-to-one staffing and uses of residential outlier funding in consumer's single plans.

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Chapter 4: COST REPORTS AND ADMINISTRATIVE EXPENDITURES

Included in our audit objectives was to determine whether MR/RD waiver program costs are properly settled in compliance with Medicaid reimbursement methodologies, whether there are program safeguards to ensure that only allowable costs are born by the Medicaid program, and whether appropriate fiscal oversight of the waiver is provided. In this section we review the process used by DDSN and the DSN Boards to report costs attributable to the Medicaid MR/RD waiver and institutional care. These cost reports are critical in that they are the basis for cost settlements made by DHHS to DDSN, and also are the basis for setting future rates for Medicaid reimbursement for waiver services. Our review of the audited financial statements, cost reports, and reconciliations for FY 2003 identified some questions and concerns about the waiver program, including:

- Some unallowable costs are included in the cost reports which are used to establish rates and cost settlements;
- The wide variance in waiver program costs between DSN Boards; and
- There is a lack of fiscal oversight of the MR/RD waiver program on the part of both DHHS and DDSN.

We also determined the percentage of administrative and program operating costs compared to direct service costs for the MR/RD waiver.

The Cost Reporting Process

DHHS contracts with DDSN as the provider of Medicaid waiver services. The contract requires DDSN to submit cost reports that support the expenditures incurred, which will be used to settle interim reimbursement rates to actual costs. Two types of cost reports are used: regional cost reports and Medicaid MR/RD waiver specific cost reports.

There are four regional cost reports (Midlands, Piedmont, Coastal, and Pee Dee) that correspond with the four Medicaid provider identification numbers for the MR/RD waiver services. The regional cost reports include all DDSN program costs, not just Medicaid costs. In addition to expenditures for the waiver program, the regional cost reports also include other DDSN programs as well as ICF/MR costs for those facilities reimbursed through the DSN Boards. (The ICF/MR facilities, which contract directly with DHHS to provide institutional care, file individual cost reports with DHHS.)

The regional cost reports are also used as a mechanism to allocate DDSN's administrative costs for the central state office in Columbia, plus overhead and other general costs, to the four regions. The reports use a step-down methodology to allocate these costs to the various programs within each region. The various components of the waiver program are rolled into one "cost center" for the regional cost reports.

For the Medicaid MR/RD waiver specific cost reports, the DSN Boards compile waiver expenditures by type of program and facility (SLP I, SLP II, CTH I, etc.) at the end of each state fiscal year. DDSN also requires that each board submit an independent audit of its financial statements, as well as a reconciliation of the waiver cost reports to the audited financial statements. Costs attributable to Medicaid recipients are calculated based on the percent of Medicaid recipient attendance in the various programs.

The total waiver cost for each region is then reported in a combined report to DHHS. Staff in the DHHS Division of Ancillary Reimbursements perform a desk review of this report, which becomes that basis for rates paid for MR/RD waiver services. These rates are then used to calculate a final payment to DDSN. If the federal share of actual expenditures reported in the waiver cost reports exceeds what DDSN has received in monthly Medicaid reimbursements from DHHS, then DDSN receives an additional payment or cost settlement from DHHS. If costs are less, DDSN owes DHHS. The cost settlement completes the funding cycle begun by the band payment that DDSN forwards to the boards (see page 25).

COSTS OF WAIVER ADMINISTRATION

Use of Funds for Direct Care

One concern has been whether DSN Boards spent the majority of the band payments on client care. For waiver services plus ICF-MR facilities DDSN requires local boards to spend 98% of their revenues on client services. Funds remaining after the 98% are spent can be used for a two-month reserve for times when the band payments do not cover all of a board's costs. At the end of each year DDSN requires a reconciliation from the boards to show that 98% of revenues, based on the audited financial statements, were spent. If the boards spend less than 98%, they must refund the difference to DDSN.

The total costs for the boards' programs, with the exception of depreciation on buildings and assets, are included in the 98% calculation. This includes all salary and operating costs associated with direct client care and the DSN Boards' overhead and administration. (Allocated costs for central state office functions are not included in the 98% calculation.) Because of the method used by DDSN to account for program costs, administration and overhead are rolled up in the client cost. Therefore, while the boards are required to spend 98% of their revenues on client services, the boards' administrative costs are considered part of client service for this calculation and thus become part of the Medicaid waiver rate.

The audited financial statements are the main sources of information about how the DSN Boards spend their revenues, which include band payments and other sources of funds. As far as we could determine, there is not a waiver requirement for a Medicaid-specific audit.

Administrative Costs

We tried to determine what percent of waiver costs claimed for reimbursement in FY 2003 were administrative costs, including both administration by DSN Boards and by DDSN central state office. Administrative costs for the waiver program include DSN Board-level costs (such as for program supervisors, financial staff and the executive director) and central state office costs of DDSN itself. As noted above, allowable central state office costs are allocated based on a "step-down" in the four regional cost reports, and the waiver program gets its share based on total waiver expenditures versus the rest of the programs for DDSN clients. DDSN central state office administrative and other costs allocated to the MR/RD waiver program were $10,087,085 in FY 2003, or 6.88% of the $146,580,911 total waiver costs reported for the four regions. According to DDSN financial officials, slightly less than half of this amount, $4,971,589, are program costs directly tied to operating the waiver program. For example, this figure would include the annual cost for the First Health quality assurance contract.

The following table illustrates the administrative costs reported for the MR/RD waiver program for FY 2003 for Babcock and Charleston, with a pro-rated share of DDSN's central office administration and other overhead costs from the regional cost reports.

Table 11: Administrative Costs for Charleston and Babcock's Waiver Programs

Expenditure	Charleston	Babcock
Board Waiver Cost	$7,947,236	$21,255,513
DSN Board Level Administration	$759,403	$1,595,336
Percent of Total Waiver Cost	9.6%	7.5%
Allocated Central State Office and Waiver Operational Costs	$578,607	$1,350,448
Percent of Total Waiver Cost	7.3%	6.4%
Total Administration & Allocated Costs	$1,338,010	$2,945,784
Percent of Total	16.8%	13.9%

Source: 2003 Audited Financial Statements and 2003 Coastal and Midlands Regional Cost Reports.

These waiver administrative expenses do not include the costs for the management functions performed by DHHS. We estimated this could add up to one percent. Therefore, waiver operating and central office overhead costs which look relatively minor from the regional cost reports could actually be close to 15% - 18% of direct service expenditures when administrative and allocated costs are added together.

As noted, DDSN's administrative costs illustrated in Table 11 are not separated from the direct service costs, but rather are included in total waiver costs that become the Medicaid rate paid for waiver services. Therefore, these costs are reimbursed with federal Medicaid funds on a 70-30 ratio that is used for direct Medicaid services. DDSN and the DSN Boards are an "organized health care delivery system" (OHCDS), and therefore all waiver allowable costs are eligible for the 70% federal Medicaid funds.

ADEQUACY OF FUNDING

One concern was whether the DSN Boards received adequate funding from DDSN in order to provide for client needs. The past three cost reporting cycles where a settlement has been finalized (FY 2000 through FY 2002) have resulted in a cost settlement to DDSN. This means that expenditures as shown in the cost reports were higher than what the Medicaid rate covered, so DHHS made another payment of federal Medicaid funds to DDSN for the difference. DDSN retained these funds; they were not passed on to the DSN Boards because DDSN had already advanced them funding through the band and outlier payments.

According to DHHS staff in the Division of Ancillary Reimbursements, the waiver rate was increased after several years of cost settlements to DDSN in order to more accurately reflect costs and thus avoid large cost settlements every year. However, for FY 2003, DDSN received more federal Medicaid revenues than allowable waiver cost. DDSN has already made an interim cost settlement of $2,150,000 to DHHS, although the final amount is still under review.

When either DDSN or a DSN Board spends less than revenues, both must refund the excess – the board to DDSN, and DDSN to DHHS. If DDSN reports allowable waiver costs higher than the Medicaid reimbursement, then DHHS provides additional federal Medicaid funds toward the difference. However, if a DSN Board spends more than its band payment and other revenues, as did Charleston and Babcock in FY 2003, there is no cost settlement to the board. The boards are expected to cover any losses with their reserves. These reserves consist of unexpended band payments (up to 2% per year) plus other revenues.

DDSN does not automatically pass on increased waiver rates in the form of higher band payments to the DSN Boards. It should be noted that at the end of fiscal years 2004 and 2005, the band payments were increased to reflect insurance rates and state employees' pay increases mandated by the General Assembly. However, these band increases were not reflective of any general increases in the DSN Boards' costs.

Both boards that we reviewed had total expenditures greater than total revenues in FY 2003, as indicated in Table 12. (However, these operating losses also include depreciation of capital assets reported as an expense.) Also, both Babcock and Charleston had fund balances remaining, although in FY 2004 Babcock Center again experienced financial deterioration with a decrease in net assets of $4,340,739. The external auditors also found weaknesses in internal controls that were reported in a management letter to the Babcock Board of Directors.

On a statewide basis, according to information provided by DDSN, total deficit experienced by the DSN Boards amounted to $6,041,463 – this included all sources of funding and all program expenditures. Again, accounting for depreciation is part of the reason for the boards' deficits and not necessarily inadequate band payments. The accumulated fund balances for all boards amounted to $16.9 million.

Table 12: Changes in Net Assets for FY 2003: Charleston and Babcock

	Charleston	Babcock
Total Program Revenues	$16,409,525	$41,247,224
Total Expenditures	16,525,599	43,269,434
Other Gain (Loss)	(14,152)	777,037
Changes in Net Assets	$(130,227)	$(1,245,172)
Remaining Fund Balance	$529,127	$3,265,041

Source: DDSN and the DSN Boards Audited Financial Reports, 2003. Includes all programs, not just the MR/RD waiver.

Variance in Waiver Residential Costs

There is a wide variation in the cost to provide Medicaid waiver services between the individual DSN Boards. The waiver cost reports submitted to DHHS provide a basis for determining the "unit" (per diem) cost for the different services. The largest cost is for residential services. This includes Medicaid allowable costs for the community training homes, the community residential care facilities, and the supervised living program II, as well as for enhanced waiver services such as physical, occupational, and speech therapy and psychological services. The variance in residential costs is illustrated below for boards in the Midlands (Babcock) and Coastal (Charleston) regions, with the highest and lowest board within both regions.

Table 13: Variance in Unit Costs for Residential Waiver Services, FY 2003

	Statewide Average	Babcock	Charleston	Lowest Board	Highest Board
Per Diem Cost	$144.49	$140.83	$133.87	$96.20	$185.54
Variance		-2.5%	-7.4%	-33.4%	28.4%

Source: Home and Community Based Waiver Statement of Reimbursable Cost.

In conclusion, in 2003 the DSN Boards in general had costs higher than the band payments received from DDSN plus other revenues, but their accumulated fund balances provided a cushion. During the same year, total cost for waiver services was lower than the Medicaid funds reimbursed to DDSN, and DDSN was required to refund this excess to DHHS. Therefore, based on financial reports for FY 2003, we found no evidence that the band payments were inadequate that year, although some boards may have more difficult financial circumstances than others.

UNALLOWABLE EXPENDITURES

We also sought to identify what controls are in place to ensure that only actual waiver program costs, that are allowable and related to client care, are attributed the Medicaid program. Federal law does not allow the Medicaid program to pay for all costs incurred by DDSN clients in the waiver program. We reviewed audited financial statements for

both Babcock and Charleston in order to test, in a limited fashion, the appropriateness of costs claimed for reimbursement under the waiver program.

Unallowable expenditures for room and board are deducted from the waiver cost reports since Medicaid cannot pay for these kinds of expenditures; they are supposed to be paid by client fees. This would include costs for rent, repairs and maintenance, telephone, utilities, basic groceries, depreciation and insurance. However, we determined that some housing-related costs, including household and maintenance supplies, exterminating, and trash removal, are included in the waiver cost reports submitted for Medicaid reimbursement. The following table shows the FY 2003 expenditures reported by Charleston and Babcock in these categories for the CTH II homes managed by the boards.

Table 14: Housing-Related Costs Included in Waiver Rate

	Babcock CTH II Homes	Charleston CTH II Homes
Exterminating	$28,005	$8,505
Trash removal	11,138	Not specified
Household Supplies	99,393	35,922
Maintenance Supplies	43,914	10,019
TOTAL	$182,450	$54,446

Source: Audited financial statements for The Babcock Center, Inc, and the Disabilities Board of Charleston County, for FY 2003

Federal guidance on what should be included as room and board is not detailed. However, DDSN recently provided guidance to the DSN Boards which identifies specific room and board costs that should be included in client fees, including the cost categories of exterminating, trash removal, and maintenance and household supplies. In addition, DHHS waiver program staff told us that they did not intend for the waiver program to include these kinds of costs within its services. Although these costs would have been included in the 2003 waiver cost report, their inclusion did not have a material effect on the statewide waiver rates.

Recommendations

15. The Department of Health and Human Services Division of CLTC Waiver Management, in conjunction with Division of Ancillary Reimbursements, should review all costs currently charged to the MR/RD waiver program and determine which costs are appropriate and allowable. This review should incorporate DDSN waiver cost reports and schedules.

16. The Department of Disabilities and Special Needs should ensure that all room and board-related costs are deducted from waiver cost reports beginning with cost reports for FY 2005.

Audits And Fiscal Oversight

We concluded that there is a lack of fiscal oversight of the MR/RD waiver program on the part of both DHHS and DDSN, although DDSN staff conduct fiscal reviews of the DSN Boards in the process of compiling the Medicaid waiver cost reports. But DHHS performs only limited reviews of these reports, and DDSN's four regional cost reports are not subjected to any type of external audit.

REGIONAL COST REPORTS NOT AUDITED

As previously described, DDSN compiles four regional cost reports annually in order to report expenditures for the MR/RD waiver as well as other DDSN programs and services. These cost reports include all expenditures for the DDSN network of providers except for those ICF/MR and other programs that bill directly to DHHS. These statements establish the direct service costs, as well as the allocated costs for central administration and overhead, for reimbursement by Medicaid. Information from the regional cost reports is used in the MR/RD waiver specific cost reports, which in turn establish waiver per diem rates and cost settlements.

As far as we could determine, there have been no reimbursement audits performed on the regional cost reports in recent years. This holds true for costs for the ICF/MR facilities in addition to the MR/RD waiver program. While the State Auditor's Office (SAO) conducts agreed-upon procedures of DDSN, as it does for state agencies in general, the SAO does not audit DDSN's cost reports. For FY 2003, the four regional cost reports together accounted for $340,492,717 in costs for DDSN programs.

DHHS has a contract with the State Auditor's Office to regularly audit nursing home cost reports at least once every four years. However, no such provision exists for audits of DDSN expenditures.

As a result, there has been no external oversight of DDSN's spending to provide assurances that:

- All costs attributed to the waiver program are allowable and appropriate;
- Medicaid and other federal financial criteria are followed;
- The State Medicaid Plan and contracts between DHHS and DDSN are followed;
- Rates for reimbursement are reflective of costs;
- The central administrative and other DDSN costs are appropriate, Medicaid-reimbursable, and allocated to direct service lines on a statistically valid basis.

The Code of Federal Regulations requires that: "The Medicaid agency must assure appropriate audit of records if payment is based on costs of services or on a fee plus cost of materials." (42 CFR 447.202) DHHS could fulfill this obligation by requiring DDSN to obtain periodic external audits of the regional cost reports.

WAIVER SPECIFIC COST REPORT NOT AUDITED

The waiver specific costs of the DSN Boards are not routinely subjected to an in-depth audit, although they are subjected to a desk audit review process by staff at DDSN and DHHS. In addition, the waiver cost reports can be tied to the DSN Boards' audited financial statements. The Medicaid allowable costs are derived from the audited financial statements via a reconciliation process, and DDSN then aggregates these costs and reports them to DHHS in order to develop average rates for various waiver services. We tested the reliability of the waiver costs reported for two DSN Boards (Charleston and Babcock) by tracing waiver costs reported to DHHS back to the audited financial statements and DDSN reconciliation. While there were some minor exceptions, in general the audited financial statements supported the waiver costs claimed by the DSN Boards.

However, we found that DHHS staff in the Division of Ancillary Reimbursements are not reviewing the DSN Boards' audited financial statements as part of the waiver report desk review process. DHHS staff perform some limited audit steps on the waiver cost reports. For example, they review the math accuracies of the step-down allocations and also verify the days of service reported by DDSN with the reimbursements recorded in the Medicaid Management Information System. DHHS staff do not have any written desk audit procedures to guide this review. In addition, DHHS does not review DDSN reconciliation schedules that support costs reported in the waiver reports.

The external financial statements could provide some assurances that waiver costs are appropriate. For example, DDSN promulgates a provider audit policy that the DSN Boards are to follow for their audited financial statements. Among other things, this policy requires that the external auditors perform the following audit procedures:

- Reconcile adjusted allowable cost for Medicaid programs in the provider's (DSN Board) cost report to total program cost in the audit report;
- Review the cost allocation plans submitted by the DSN Boards;
- Gain an understanding of the controls over consumers' personal funds managed by DSN Board staff;
- Select a representative sample of the Medicaid billable services and determine that documentation is on file to support billings and ensure that supervisory staff are monitoring provision of services; and
- As part of expenditure test work, include a sample of financial transactions made by or on behalf of the executive director and top administrative staff of the DSN Board.

If the boards' external auditors are following this policy, it would help provide assurances that Medicaid funds for the waiver program are being spent appropriately. However, without reviewing the workpapers of the boards' external auditors, it is difficult to tell if they followed these procedures because reporting is done on an exception basis. Also, in our review of the audited financial statements for Babcock Center for fiscal years 2003

and 2004, we could not find a reconciliation of allowable Medicaid costs to total program costs. (Charleston's financial report did provide the reconciliation.)

The Code of Federal Regulations also requires that "the agency will assure financial accountability for funds expended for home and community-based services [and] provide for an independent audit of its waiver program..." (42 CFR 441.302) Because the waiver cost reports are not reviewed in-depth, DHHS lacks the assurance that the waiver reimbursement rates are based on reliable cost information and that the waiver program is paying only for allowable costs.

We also identified a need for periodic on-site audits of the waiver adult day rehabilitation and other programs at DSN Boards in order to verify client attendance as recorded on the service provision logs. Currently, this is not regularly audited although the DDSN internal auditor or its First Health quality assurance provider may sometimes review service logs. The Medicaid per diem rates reimbursed to DDSN are contingent upon allowable Medicaid costs divided by the number of patient days or units of service provided, so this factor is a critical component of the cost.

Recommendations

17. The Department of Health and Human Services should require the Department of Disabilities and Special Needs to obtain an external audit of the four regional cost reports on a periodic basis.

18. The Department of Health and Human Services staff in the Division of Ancillary Reimbursement should develop written desk audit procedures for the review of the Medicaid MR/RD Waiver cost reports. As part of these audit procedures, the division should ensure that the audited financial statements of a sample of DSN Boards and other supporting documentation are reviewed, including results of the required audit procedures and tests of Medicaid billable costs.

19. The Department of Health and Human Services should require DDSN to provide on-site audits of service provision logs maintained by local boards and programs.

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Appendix A: DEFINITIONS AND LEGAL AUTHORITY

Assessment: A method of determining a consumer's current long term care needs through the use of a comprehensive standard instrument.

Babcock Center, Incorporated (Babcock or Babcock Center): A private, non-profit organization founded in 1970 serving people with mental retardation, autism, head and spinal cord injury, and related lifelong disabilities. In order to receive services from the Babcock Center, individuals must be determined eligible for services from the SC Department of Disabilities and Special Needs. Babcock Center provides Medicaid services either under a subcontract with the SC Department of Disabilities and Special Needs or directly through a contract with SC Department of Health and Human Services.

Centers for Medicare and Medicaid Services (CMS): A federal agency within the U.S. Department of Health and Human Services. CMS administers the Medicare program, Medicaid program, and State Children's Health Insurance Program.

Client Funds (also known as personal needs allowance/consumer funds): Funds received or retained by a resident for personal expenses and sometimes deposited and held in an account administered by a facility for the convenience of the individual.

Community Residential Care Facility (CRCF): A facility which offers room and board and which, unlike a boarding house, provides/coordinates a degree of personal care for a period of time in excess of 24 hours for two or more persons, 18 years old or older, not related to the licensee within the third degree of consanguinity. Included in this definition is any facility (other than a hospital), which offers or represents to the public that it offers a beneficial or protected environment specifically for individuals who have mental illness or disabilities. These facilities may be referred to as "assisted living" provided they meet the above definition of a community residential care facility.

Community Training Home I (CTH I): A residential placement similar to foster care in that a private citizen's home which is licensed and where the caregiver is a contract agency employee. Up to three individuals live in the home and receive personalized care, supervision and training.

Community Training Home II (CTH II): A home owned or rented by the agency where up to four individuals live. A caregiver may also live in the home or staffing may be provided in shifts. This model differs from the Community Training Home I placement because, if the caregiver changes, residents will not have to move.

Cost Report: The report required from providers on an annual basis in order to make a proper determination of amounts payable under the Medicaid program.

Disabilities Board of Charleston County (Charleston): The Board was established as provided in Act 1127 of 1974 of the State of South Carolina, as amended to develop, provide and improve community services for mentally retarded persons and others with

Appendix A: DEFINITIONS AND LEGAL AUTHORITY

disabilities and special needs, including autism, head and spinal cord injuries and any other disability not covered by any other

state agency. The Board is qualified to receive funding through its various contacts with the SC Department of Disabilities and Special Needs. The Board also receives funding for its programs from Charleston County, fees charged to individuals served, and various other sources.

Disabilities and Special Needs Board (DSN Board): A local Board which has been established pursuant to S.C. Code Ann. §44-21-810 et seq., the members of which are appointed by the Governor or through the County Council authority and which provides, under contract with the SC Department of Disabilities and Special Needs and SC Department of Health and Human Services, comprehensive community services to eligible residents of a geographic service area designated by DDSN.

Federal Financial Participation (FFP): Any funds, either title or grant, from the Federal government.

Head and Spinal Cord Injury (HASCI) Waiver: A 1915 (c) Medicaid waiver that addresses the long term needs of persons with Head and/or Spinal Cord Injuries.

Home and Community-Based Waiver: A special Medicaid program operated under Section 1915 (c) which allows the provision of a special package of approved services to a defined target population with long term care needs.

Intermediate Care Facility for the Mentally Retarded (ICF/MR): A health related facility which meets the requirement for state licensure to provide care to persons with mental retardation who do not need care in a hospital or skilled nursing facility.

Memorandum of Agreement (MOA): A legal document that binds two or more parties outlining their scope of responsibilities one to the other.

Mental Retardation and Related Disabilities (MR/RD) Waiver: A 1915 (c) waiver which provides a broad range of special home and community-based services to Medicaid eligible individuals with mental retardation or related disabilities to help them live in the community rather than an institution.

Recoupment: Funds previously paid to a provider of Medicaid services or sub-grantee of the state's Medicaid program in error or determined, by post-payment review, to have been improperly paid and returned to the department or withheld from payments owed to the provider or sub-grantee.

Sanction: A penalty imposed for failure to meet standards or improperly billing Medicaid.

Appendix A: DEFINITIONS AND LEGAL AUTHORITY

Service Coordinator: A professional who assists Medicaid clients in accessing appropriate and available services. Also known as a case manager.

Single Plan: A document which provides a comprehensive review of a consumer's problems and strengths. Goals are set based on the consumer's identified needs, and interventions are specified to meet those needs. Also referred to as a plan of care.

Service Tracking System (STS): The Service Tracking System is DDSN's system for tracking information about the individuals applying for and receiving services. STS collects intake, eligibility, waiting list, service assignment, and service delivery data for billing and reporting purposes. The STS is primarily maintained by the staff assigned to coordinate services for individuals requesting/receiving services from DDSN.

SC Department of Disabilities and Special Needs (DDSN): The State agency that plans, develops, coordinates and funds services for South Carolinians with the severe, lifelong disabilities of mental retardation and related disabilities, autism, traumatic brain injury, spinal cord injury and similar disabilities.

SC Department of Health and Environmental Control (DHEC): The State health agency. Section 1864(a) of the Social Security Act directs the Secretary of Health and Human Services to use the help of State health agencies when determining if health care institutions meet provider certification to receive Medicaid reimbursement. 42 CFR part 488 sets forth that the State health agency performs surveys to support its certifications.

SC Department of Health and Human Services (DHHS): The State Medicaid agency as specified in 42 U.S.C. §1396 et. seq. and S.C. Code Ann. §44-6-10 et. seq. to administer the Medicaid Program in South Carolina.

SC Department of Social Services (DSS): The State agency authorized by the Omnibus Adult Protection Act of the South Carolina Code of Laws, to investigate all reports of abuse, neglect and financial exploitation of children and adults living in the community (non-institutionalized) and provide services. Services are provided to meet the adults' basic needs and to ensure their safety.

Supervised Living Program I (SLP I): The least restrictive residential placement which still provides staff oversight. Individuals live in apartments, duplexes or other housing and receive staff support and intervention based on personal need.

Supervised Living Program II (SLP II): Similar to the Supervised Living Program I, except residents need more supervision. Staff are on-site or available within three minutes (they usually live in another section of a duplex or apartment).

Title XIX: The Title of the Social Security Act dealing with Medicaid. Codified at Title 42 of the United States Code, Chapter 7, subchapter XIX (42 U.S.C. §1396 et seq.)

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Appendix B: Response from Department of Disabilities and Special Needs

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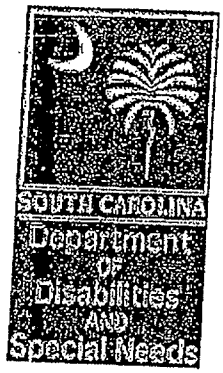

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DDSN's Response to the Recommendations

DDSN is appreciative of the manner in which this audit was conducted and the willingness of DHHS staff to take the time and effort to understand the complexities and difficulties inherit in providing care for individuals with disabilities and their families. DDSN is also pleased that for the most part, we are meeting the State Medicaid agency's expectations. Importantly, the audit identifies a number of areas of improvement where the two agencies can collaborate.

1. DDSN will work with DHHS staff to revise the quality assurance process so as to satisfy the goals and needs of both agencies. DDSN recognizes that DHHS, as the Medicaid agency within the state, has final authority over all Medicaid expenditures and requirements.

2. DDSN will work with DHHS on a joint quality assurance and monitoring system for Medicaid services provided by DDSN.

3. Staff at DDSN will be designated to work with DHHS staff on developing a reporting process related to First Health findings and Medicaid recoupments.

4. A refund of $422,077 will be made for FY 2003 and FY 2004 before the end of the current fiscal year.

5. DDSN staff will coordinate with appropriate DHHS division staff on potential Medicaid recoupments for FY 2005 related to First Health findings.

6. DDSN will coordinate with DHHS staff to implement the recommendations.

7. Starting with next year's review cycle, a timeline will be added for correction of serious deficiencies involving the health and safety of clients.

8. By the start of next fiscal year, DDSN will collect and share data concerning correction of serious licensing and certification violations and any sanctions that were applied with DHHS staff.

9. Starting with next year's review cycle, DDSN will ensure that copies of the annual licensing reports will be shared with the board members.

10. As DDSN continues to track its mandated reduction in program capacity of Babcock Center, Inc., the agency will update the status to DHHS staff.

11. DDSN will refund the Medicaid share of MR/RD waiver services provided when the licensing and certification inspections find that these services were not identified as a need or appropriately delivered as authorized in the consumers' single plans.

12. As noted in this audit, and as DDSN previously recognized, there is a need to adjust the band payments and the agency has requested additional funding as part DDSN's budget request for next fiscal year. DDSN intends to realign the rates next fiscal year if at all possible.

13. DDSN will coordinate with the Richland/Lexington County Disabilities and Special Needs Board and the Babcock Center, Inc., concerning better communication and coordination of care for consumers served by both boards.

14. By March 31, 2006, DDSN will review with both Babcock Center, Inc., and the Disabilities Board of Charleston County the policy concerning proper documentation of one-to-one staffing and uses of residential outlier funding in consumer's plans.

15. DDSN staff will work with DHHS staff on any cost reviews.

16. DDSN has already excluded any room and board-related costs from the waiver cost reports being prepared for FY 2005.

17. DDSN will obtain an external audit of the regional cost reports on a periodic basis as determined by DHHS.

18. DDSN staff will work with DHHS staff on any reviews.

19. Beginning next fiscal year, DDSN will provide for onsite audits of service provision logs maintained by local boards and programs.

PROTECTION AND ADVOCACY FOR PEOPLE WITH DISABILITIES, INC.

The Protection & Advocacy System for South Carolina

October 27, 2005

Dear Elected Officials and Citizens of South Carolina:

South Carolina cannot wait to improve the protection of its most vulnerable citizens: persons with disabilities who reside in facilities across the state. The enclosed report, *Unequal Justice for South Carolinians with Disabilities: Abuse and Neglect Investigations*, clearly shows the need for an independent system within criminal justice to investigate ongoing abuse, neglect, and exploitation.

For many years, investigations of abuse, neglect, and exploitation have been entrusted to state agencies, particularly the Department of Disabilities and Special Needs, and organizations with whom they contract. These entities are failing to protect the individuals with disabilities whom they are charged to serve. As you will learn from the report, we cannot continue to excuse the current system by saying that incidents of abuse, neglect, and exploitation are infrequent or trivial or that incidents are being adequately investigated. This is clearly not the case.

This report includes one homicide, two deaths from choking[1], physical injuries with excruciating pain, and other shocking examples of abuse and neglect. The injured individuals include people who are non-verbal and unable to tell their own stories. This report sets out some of the stories from a sample population. Based on the cases we have reviewed, we believe that procedures for preventing and investigating the abuse and neglect of individuals with disabilities are totally inadequate. The State's "out of sight, out of mind" inadequate response must end now.

A major problem identified by this report is that agencies investigate themselves, with little external oversight. Law enforcement is rarely contacted. Agencies use their own standards rather than following the state's comprehensive Omnibus Adult Protection Act, which was designed to protect vulnerable adults. Investigators in provider agencies and local law enforcement lack expertise in the abuse and neglect of people with disabilities. While the process for investigating abuse and neglect of vulnerable adults is often described as a system, in fact there is no system at all.

Protection and Advocacy for People with Disabilities, Inc. (P&A) calls on the Governor, Lieutenant Governor, and members of the General Assembly to move this issue to the top of the agenda for action this year. P&A also asks the media to assure that this disgrace is in the public

[1] The choking death mentioned in the September 13, 2005 Wall Street Journal is not included in this report.

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eye until addressed. Investigation of abuse and neglect can no longer be left to be handled by the service providers themselves.

Since we completed the review, a member of the press contacted me about an August 2005 death of a middle-aged person residing in a group home. The staff on duty documented that during the shift ending at 11:30 p.m. the resident was making "girgling" (sic) sounds in his chest. Rather than contacting medical personnel, the resident was simply placed on fifteen minute checks. On the following shift, another staff person found the resident unresponsive and contacted administrators before contacting medical personnel. It appears that there was an additional delay of approximately an hour before 911 was called. When paramedics arrived they determined that the resident was dead; a coroner's report is pending.

Some of South Carolina's most vulnerable citizens are needlessly suffering, even dying. They will continue to do so until South Carolina has the will, backed by the funds, to protect persons with disabilities by demanding an effective, independent investigation system to address these often criminal activities. Those least able to speak for themselves deserve no less.

P&A knows that elected officials, family members, the media, and other concerned citizens care about the very vulnerable people who reside in group homes, residential facilities, and long-term care institutions. The data in this report offers the necessary information to begin making desperately needed changes. We are ready to assist in this process and await the opportunity to explore the next steps with all interested parties.

Thank you for your immediate attention to this unequal justice for South Carolinians with disabilities.

Very truly yours,

Gloria M. Prevost

Gloria M. Prevost
Executive Director